1-1-1994

Attribution processes of family members and therapists.

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ATTRIBUTION PROCESSES OF FAMILY MEMBERS AND THERAPISTS

A Dissertation Presented

by

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Submitted to the Graduate School of the
University of Massachusetts Amherst in partial
fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

February 1994

School of Education

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ACKNOWLEDGEMENTS

It is with sincere appreciation that I acknowledge those individuals whose contributions have made the completion of this study and my doctoral program possible. I am especially thankful to the members of my dissertation committee. Thanks to Dr. William Matthews of the School of Education, my advisor and chairperson, for his guidance and support during this project and throughout my doctoral program. Thanks to Dr. Ronnie Janoff-Bulman of the Psychology Department for introducing me to attributions and for her cheerful encouragement. Thanks also to Dr. Stan Scarpati of the School of Education for his willingness to serve on my committee and for his thoughtful suggestions.

I am indebted to the family therapists and family members who participated in this study. Their willingness to take the time and make the effort to participate is greatly appreciated.

Thanks to the many fine and supportive friends, colleagues, supervisors and teachers I have had along the way. They have taught me a great deal about families and family therapy, clarified my thinking in moments of confusion and eased my anxieties.

Thanks to my own and my wife's families for their encouragement, financial support and patient understanding.

Most importantly, thanks to my wife, Jan. The numerous ways in which she has helped me makes this accomplishment as

much hers as it is mine. I could never adequately express my appreciation for her patience, good humor and unwavering support.

ABSTRACT

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FEBRUARY 1994

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The new epistemology of second order cybernetics and constructivism has influenced a shift in the emphasis from behavior to meanings by the systemic family therapies. While this shift to an emphasis on cognition represents a further step in the evolution in the family therapy movement, the manner in which it has been presented provides continued support for a number of criticisms. Included in these are complaints that the systemic family therapies have erroneously rejected individual psychological models, tended to generate theoretical statements that are vague and abstract, and inappropriately discouraged the development of empirical research.

This study employed concepts and research findings from family theory and attribution theory to identify a number of theoretically and clinically relevant issues pertaining to family members and therapists during a course of family therapy. Specific areas of interest included the relationships of family members' and therapists'

attributions at the beginning and after a period of family therapy, the relationships of pre-treatment to post-treatment attributions, and the relationships of attributions to therapeutic outcome.

Eight families and their family therapists participated in this study. All subjects completed an amended version of the 4-ADS, a direct rating instrument that measures an individual's attributions on the causal dimensions of Locus, Stability, Globality and Controllability. A dimension of Intentionality was added, as well. Attributional ratings were made at the start of therapy and following a period of two months for a presenting problem identified by the family. All subjects were also asked to indicate whether or not there had been improvement in the presenting problem following therapy.

For the most part, the attributions made by family members did not differ significantly. Likewise, therapists' attributions did not differ significantly from family members' attributions. Consistent with previous attributional studies of families in therapy, there were only a few instances in which family members' or therapists' attributions changed over the course of therapy. Similarly, there were few instances in which changes in the presenting problem were accompanied by changes in attributions.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

A. Statement of the Problem

The role of social cognition has been the subject of renewed interest in recent theoretical and practical descriptions of systemic family therapy (Bogdan, 1984; Furman & Ahóla, 1988; Hoffman, 1988). The suggested shift in emphasis from behavior to "some kind of meaning" (Hoffman, 1988, p. 114) derives from the 'new epistemology' of constructivism and the cybernetics of observing systems. The adoption of this view affirms the importance of cognitive factors in the precipitation, maintenance and remediation of interpersonal problems. As such, it constitutes a further step in the evolution of the field of family therapy. However, the continued adherence to an epistemological viewpoint predominantly informed by general systems theory, second order cybernetics and constructivism has rendered the practice and theory of family therapy vulnerable to a number of criticisms. Included in these are the notions that concepts and research from individual models of psychology have been erroneously rejected (Held, 1986; Pinsof, 1988), the formulation of theoretical statements has been overly vague and abstract (Reiss, 1988) and the development of "standard research" by family therapists has been

discouraged (Gurman, 1983, p. 227). As a result, empirical information needed to support family therapy is lacking (Gurman, Kniskern & Pinsof, 1986; Wynne, 1988). This, in turn, undermines the field's credibility and limits the understanding of the processes that underlie its effectiveness. Clearly, these deficits have negative implications for practice and training as well as future theorizing and research.

In psychology, the study of cognitive phenomena occurring in social interaction has been of specific interest to social psychologists (Fincham, 1988). Of the theoretical formulations they have used to describe, understand and support research of these phenomena, the models that comprise attribution theory have been dominant (Anderson, 1988; Weiner, 1985). For example, Fincham (1988) observed that Kelley and Michela (1980) found that over 900 papers had been written about attribution theory during the 1970's alone.

Attribution theory aims to explain and describe the formation of causal explanations and their consequences (Totman, 1982). Attribution theory is based upon the assumptions that people seek to understand and predict events in their lives (Shaver, 1975). Responses to questions like, "why did that occur" or "what was the cause of that" represent quintessential attribution phenomena.

In contrast to the criticisms that have been leveled against family theorists, social psychologists interested in

attribution theory have advocated the integration of their ideas and information with other areas of psychology. Specifically, they have suggested that attributional concepts and research findings may be useful in clinical practice with families (e.g., Doherty, 1981b; Munton, 1986). Attribution theorists have been specific in their definition of attributions, developed a taxonomy by which attributions may be classified and formulated models that predict the effects of certain attributions or patterns of attributions (e.g., Abramson, Seligman & Teasdale, 1978; Weiner, 1986). In the study of interpersonal relations, attribution theory has stimulated a large body of empirical research. Fincham (1988), for example, noted that since 1985 there have been at least 25 published studies concerning attributions in marital relations.

B. Significance of the Study

The use of attributional concepts and empirical information in the study of social cognition in family therapy represents an effort to respond to the aforementioned criticisms of the family therapy field. For example, the integration of attributional concepts and research with family theory acknowledges the advantages of incorporating ideas and information from various areas of psychology. In this instance, information will be derived that is important to the generation of specific hypotheses

relating to a number of clinical issues. The identification and classification of attributions contributes to a less vague and abstract definition of cognitive phenomena and provides a way of operationalizing them for use in research. Finally, answers to questions related to instrumentation and research methodology may also be guided by previous studies of attributions in interpersonal relations.

The findings from this study may provide information useful to the practice of family therapy. For example, the identification of differential qualities in attributions or variations in the relationships of family members' to therapists' attributions, as they pertain to clinical change, will improve our understanding of social cognition in the process of family therapy. This information could be used by family therapists to design interventions that are more potent than others.

C. Summary of the Methodology

Family therapists who are known by the author will be recruited for participation in this study. These therapists will be asked to recruit families who are about to enter therapy.

Family members' and therapists' attributions will be elicited two times during a course of family therapy. An amended version of the 4-ADS (Benson, 1989), which is a direct rating scale, will be used for this purpose. In

completing the 4-ADS, respondents will be asked to identify the cause of the presenting problem and respond to a number of items that are used to assess the cause on several attributional dimensions. The four dimensions assessed by the 4-ADS are Internality (Locus), Globality, Stability and Controllability.

Several amendments were made to the scale in order to address the purposes and requirements of this study. Most important of these were the expansion of the bi-polar (internal versus external) locus dimension and the addition of a scale for Intentionality. The former change is consistent with the prevailing thinking about the assessment of attributional locus in on-going interpersonal relations (Fincham, 1985; Newman, 1981). The latter change is supported by social psychological research (e.g., Passer, Kelley & Michela, 1978) and the relevance of intent in clinical work with families (Doherty, 1981a).

Family members will be asked to complete the amended 4-ADS prior to commencement of the first session, while therapists will complete the instrument following the first session. Family members and therapists will complete the amended 4-ADS again following termination or after a period of two months, depending on which occurs first. During the second attributional assessment, subjects (therapists and family members) will also be asked to indicate whether or not there has been improvement in the presenting problem.

Analyses of the data will be conducted to determine a number of relationships. Areas of interest include: similarities and differences in the attributions of family members and therapists before and after therapy; changes in the attributions of family members and therapists from the first time of assessment to the second; and the relationship of family members' and therapists' attributions to the presence or absence of improvement in the presenting problem.

D. Limitations of the Study

In a general sense, the limitations of this study relate to the epistemological and teleological perspectives from which it is viewed. For example, subscribers to the systemic paradigm are likely to consider a study that employs concepts and research from attribution theory, which is interested in issues of linear causality and uses research methods based in reductive analysis, to be flawed from the start and therefore of limited value. However, as has already been noted, the singular adherence to the systemic paradigm has had numerous negative consequences for the field of family therapy. Howard (1991) has noted that the debate between objectivist and constructivist viewpoints has been long-standing and remains unresolved. In the spirit of compromise, Howard recommends the use of a perspective grounded in James' (1908, 1977) notion of epistemological

pluralism. This position, which Howard and Maerlender (1990) have referred to as constructive realism, "sets truth as a never achieved, horizon concept on which our scholarly theories converge" (Howard, 1991, p. 188). Truth or reality is neither the superordinate goal of objectivism nor the relativistic consensus of constructivism. Rather truth or reality emerge from the use of multiple epistemological perspectives and relate to one's beliefs as well as the reasons one assigns to something as true or real. It is in the spirit of constructive realism that this study is being undertaken. And, while the constructivist perspective that underlies current theories of family therapy will be held in mind, the following limitations are based upon considerations pertinent to the reductive or mechanistic/analytic methodological perspective.

Several limitations of this study relate to issues of sampling and the definition and assessment of variables. Sampling decisions such as limiting the study to out-patient therapy, use of a broad definition of family therapy, and the non-random recruitment of therapists and families may introduce bias in the findings and may serve to limit the generalizeability of this study.

The definitions of variables upon which this study centers possess limitations. For example, the presenting problem as it is being used in this study represents only one way in which outcome may be assessed. Future studies may choose other definitions such as asking each family member

to identify the presenting problem or to ask the family and the therapist to identify the presenting problem after they have met for some specified period of time. Decisions to define this and other variables in the manner done in this study have been influenced by theoretical, empirical and practical considerations.

Similarly, decisions relating to the assessment of attributions and improvement in the presenting problem, while influenced by theoretical and empirical information, possess certain limitations. For example, the use of a direct rating questionnaire to assess attributions may increase accuracy while sacrificing ecological validity. The rationale underlying decisions of sampling and variable definition and assessment as well as the limitations they may pose on the interpretation of the data will be addressed in subsequent chapters.

Finally, this study investigates the association of attributional phenomena to relevant issues in the process and outcome of family therapy. As such, it is not a study of the causal relationships of attributions and family therapy. While such a study may be of subsequent importance, Fincham (1988) has pointed out that the absence of an association renders the study of a causal relationship moot.

E. Definition of Terms

Presenting problem: The behavior which family members identify as the reason that the person making the referral call, contacted the family therapist.

Family therapy: For the purposes of this study, the following definition from the report of the 1984 NIMH-Family Process Conference is being employed. "An approach in which a therapist (or a team of therapists), working with varying combinations and configurations of people, devises and introduces interventions designed to alter the interaction (process, workings) of the interpersonal system and context within which one or more psychiatric/behavioral/human problems are embedded, and thereby also alters the functioning of the individuals within that system, with the goal of alleviating or eliminating the problems." (Stanton, 1988, p.9).

Attributions: Causal explanations of behavior (Heider, 1958). These include the identification of a cause and inferences about the cause, such as its locus.

Causal dimensions: A classification scheme of attributional inferences. Included in these are locus, stability, globality and controllability.

Locus: A causal dimension that is sometimes referred to as Internality. This dimension refers to the location of the cause. Usually this relates to internal/external distinctions.

Stability: A causal dimension that refers to the temporal quality of a cause.

Globality: A causal dimension that is sometimes called generality. This dimension refers to the specificity of a cause within or across certain situations.

Controllability: A causal dimension that refers to the extent to which the cause is within one's control.

Intentionality: An attributional dimension that refers to whether the cause represents intent that is either positive or negative.

CHAPTER II

LITERATURE REVIEW

In order to provide a context for a study that investigates the role of attributions in family therapy, this review will present a comparison of the manner in which social cognitions have been addressed by family therapists and attribution theorists and researchers. The first section explains how social cognitions have come to be an issue of importance, particularly in the field of family therapy. The second section discusses the ways that family therapists and attribution theorists have defined and classified cognitive phenomena. In the third section, differences and similarities in the ways social cognitions have been characterized will be discussed. Attention will be focused upon issues of sharing and "conscious" versus "unconscious" processes. The fourth section will involve an examination of the ways that family therapists' and attribution theorists' conceptualizations of cognition have been applied to relevant clinical issues. Areas of interest will include, differences in cognitions in non-clinically involved versus clinically involved families, the relationship of cognitive change to behavioral change during family therapy and the study of therapists' cognitions. The fifth section will present a summary of the review.

A. Interest in Social Cognition

Family therapy's shift to an emphasis on cognition as the "target of therapy" (Hoffman, 1988, p.114) is based upon a concurrent shift in its epistemological bases. Of particular importance to early models of family therapy were epistemological ideas related to General Systems theory (von Bertalanfy, 1968) and first order cybernetics or the cybernetics of observed systems (Watzlawick, Weakland & Fisch, 1974). Taken together, these ideas led to an emphasis upon behavior and systemic organization. In the therapeutic context, this was translated into the belief that the best way to explain family functioning was to accurately describe it in interaction (Watzlawick, Beavin & Jackson, 1967). Golann (1987) summarizes,

> "Instead of asking "why?", they suggested that the observer ask "How and what for?", implying that it was possible to describe a system, such as a family, in interaction, and to do so with varying degrees of completeness and usefulness of the information obtained. Pragmatic description, tracing the patterns of the interpersonal effects of communication (i.e. behavior), was said to be more informative than theoretical explanation and reliance on inference" (1987, p. 331).

This approach represented a significant departure from the dominant therapeutic paradigms of the fifties and

sixties, psychoanalysis and behaviorism (Feixas, in press). The systemic family therapies' emphasis on behavior, defined as both verbal and non-verbal communication, represented a divergence from psychoanalysis' emphasis on the explanation of behavior through theoretical, psychological mechanisms. And, the development of the cybernetically influenced recursive paradigm (Bateson, 1972, 1979) led to changes in the ways behavior in interaction was organizationally understood. In particular, behavioral approaches, utilizing linear ideas from operant conditioning theory and social exchange theory focused attention on describing the factors that maintain positive or negative behaviors (Nichols & Everett, 1986). In contrast, family therapists focused attention on nonlinear sequences or patterns of behavior in an effort to delineate family relationships.

Within the past decade, the first order cybernetic view has been replaced by the 'new epistemology' of second order cybernetics or the cybernetics of observing systems (von Foerster, 1981) and constructivism (von Glasersfeld, 1984). Central to the second order cybernetic view is the idea that it is not possible to separate that which is being observed from those who observe it. As a result, family therapists had to discard the notion that the pragmatic description of a family's interaction constituted an objective analysis. Likewise, the representation of the therapist-as-expert was replaced by recognition of the "therapy system", comprised of family members and therapist (Pinsof, 1988).

Constructivism (von Glasersfeld, 1984) also challenged objectivist epistemological and teleological assumptions. The constructivist position argues that knowledge results from the active organization of one's experience in the world and is not the reflection of an objective reality. Individuals are considered to be consciously operating and goal-directed as they formulate cognitive "constructions" of the world as it is experienced. Constructivism's clinical relevance derives from the idea that an understanding of how we construct what we know "can help us do it differently and, perhaps, better" (von Glasersfeld, 1984, p. 18). Family therapy's acceptance of the constructivist view, with its emphasis on cognition, parallels a similar constructivist influenced shift that has occurred in other areas of psychology as well (Mahoney & Lyddon, 1988).

In contrast to the recency with which the field of family therapy has come to be interested in cognition, social psychologists have a tradition of inquiry into social cognition that dates to the early days of organized psychology. The emphasis on cognition has continued as the contemporary identity of social psychology has evolved from models of cognitive dissonance to attributions to information processing. While the latter has assumed dominance as a guiding framework, attribution theory continues to be of heuristic interest in the study of close interpersonal relations (Fincham, 1988).

B. The Definition and Classification of Social Cognition

1. Definitions

Family therapists have used a number of terms, often interchangeably, to refer to family members' cognitive processes. Included among these are cognitive schemas, constructs and worldviews (Minuchin & Fishman, 1981), shared constructs and paradigm (Reiss, 1981), family construct (Procter, 1981), family belief system (Papp, 1983), maps (Tomm, 1984) and meanings (Hoffman, 1988).

Within the field of family therapy, ideas about family members' cognitions have been primarily influenced by the writings of Gregory Bateson (1972; 1979) and George Kelly (1955). For example, Hoffman (1988) describes meanings as cognitions that occur at the level of constructs and are shared by members in families. She views meanings as similar to Bateson's (1972) notion of premises which are characterized by their broad applicability and unavailability to conscious inspection. Examples include, "in this family, it seems that the parents feel that they have to be perfect; men are always the protectors of women; children feel that their parents are invulnerable" (Hoffman, 1986, p. 33).

Reiss (1981) used Kelly's (1955) notion of constructs that represent templates or patterns through which the world of experience is interpreted and anticipated. Reiss posited

the notion that family members share constructs and that this then serves to unify family members' ideas concerning specific situations. These shared constructs are comprised of "attributions of intent, fantasies and conceptions of the future" (p. 68). Reiss believed that families are not usually consciously aware nor able to articulate these kinds of cognitions.

Procter (1981) also employed ideas from Kelly's (1955) Personal Construct Theory and combined these with systems theory to posit the family construct system (FCS). Procter suggests that the FCS constitutes a common cognitive construction of reality that is negotiated by family members.

In addition to the development of shared constructs, Reiss (1981) also posited the notion of cognitive paradigms operating within families. Reiss defined paradigm as a more general concept than a construct. Paradigms are thought to develop when a particular construct has been useful in helping a family deal with a crisis situation. Reiss believed that the paradigms that emerge serve as "framing assumptions" (p. 174) for the family across a variety of situations.

In general, each of the terms used by family therapists refers to a general set of ideas, explanations and organizing cognitive frameworks that are unconscious and are shared by family members. Cognitive phenomena are thought to be in a recursive relationship with behavior, each

influencing the other. Information about either cognition or behavior is considered to be revealing of each other and the ways that families are organized (Minuchin & Fishman, 1981).

Heider's (1958) examination of the "naive" or common sense psychology of the ordinary man introduced the definition of attributions as the causal explanations people make for events in their lives. Typified by responses to the question 'why', as in "why did that happen" or "why did he do that", attributions are thought to be consciously formed by individuals and directed towards a particular event or behavior. Causal explanations are also thought to influence observer's affect, expectations about the actor's future actions and, ultimately, the observer's behavior (Weiner, 1986). Totman (1982) offered this summary of the collection of models known as attribution theory,

> "So attribution theory is really a set of distinctions regarding the types of explanation which are typically offered to explain past actions, and a corresponding set of hypotheses about what governs which explanation is selected in which situation and what the effect of selecting one particular type of explanation will be on the person's mood, behaviour and attitudes" (p. 46).

2. Classification

In The Family's Construction of Reality, Reiss (1981) describes several sets of experiments related to the

formulation and investigation of a model of family cognitive organization. Reiss' initial research was stimulated by questions of whether their was a relationship between parents psychological functioning and the development, in their child, of a schizophrenic disorder. Reiss began by conducting a study that compared the problem solving abilities of 15 families that represented three groups: normal families, families with a child (age 15-30 years old) with a diagnosis of character disorder and families with a diagnosed schizophrenic child. Problem solving skills were measured using three standard laboratory tasks. With the exception that schizophrenic families were better than expected at exchanging information, the results supported the predicted differences. Specifically, normal families were better than character disordered families who were better than schizophrenic families on the three problem solving tasks. Analyses of variables used to study interpersonal processing also demonstrated differences between the three groups. In particular, normal families were better than schizophrenic families who were better than character disordered families on measures of family process.

Factor analysis of their findings identified two factors, within-family responsiveness and environmental responsiveness, thought to represent the way that families dealt with being in the experiment. Normal families were high on both factors, character disordered families were low on both and schizophrenic were high on just the first

factor. Using ideas from early psychological experiments on perception, Freud's notion of transference and Kelly's concept of construct, Reiss postulated that a family's response to the laboratory situation was governed by a commonly held cognitive structure or shared construct. Based upon the information from the factor analysis, Reiss posited a typology of shared constructs. This typology included families that are environment-sensitive (normal families), interpersonal distance-sensitive (character disordered families) and consensus-sensitive (schizophrenic families). Reiss also posited several dimensions of problem solving skills upon which these types of families could be classified.

In order to investigate the validity of his typology, Reiss conducted a study using a card sorting procedure similar to one used in the first study. The sample was comprised of three groups, each with 8 families. One group was made up of families in which no member had a history of psychiatric diagnosis or treatment, the second group of families had a delinquent child and the third group had a child diagnosed as schizophrenic. While the results showed some inconsistency, differences between groups were in evidence on a number of problem solving indicators. Reiss concluded that the results were predominantly supportive of the notion that family problem solving was influenced by an underlying family construction of the laboratory situation.

Therefore, Reiss reasoned, problem solving skill could be used as a measure of a family's shared cognitive construct.

Reiss also studied 30 families who had a psychiatrically hospitalized adolescent to see if differences in family construct were associated with differences in perceptions of the psychiatric ward and of families of other patients. A card sorting procedure was used to classify families according to their problem solving abilities. Four groups were developed, three that represented the hypothesized typology (i.e. normal, conduct disordered and schizophrenic) and a fourth called achievement-sensitive. In the first study, families completed a second card sort 6 weeks after admission that was aimed at revealing their perceptions of the ward. In the second study, families completed a card sort 12 weeks after admission that was aimed at revealing their perceptions of other families, With a few exceptions, the results supported the core hypothesis that differences in families perceptions of the ward and other families were associated with a family's shared construct, as measured by their abilities on problem solving tasks.

Early attributional models (Heider, 1958; Jones and Davis, 1965) discussed two tasks related to causal explanation, identifying a cause and forming inferences about the cause. The latter were limited to inferences about personal dispositions or situational factors. However, Weiner (1979) recognized that as humans seek to explain

behavior, their search may result in an infinite number of possible causal explanations. In order to classify these in a meaningful way it was necessary to identify several categories within which a taxonomy of attributions could be developed. Weiner posited three dimensions upon which causal inferences could be made. According to Weiner, the relative placement of a cause on any dimension is both subjective as well as susceptible to change over time or between people.

Weiner (1979) drew upon previous formulations by Rotter (1966) and Heider (1958) in developing his conception of the locus dimension. While Rotter (1966) identified a "locus of control" dimension, Weiner argued that for purposes of causal taxonomy, locus and control should be separated into two dimensions. Weiner's locus dimension followed descriptions of a bi-polar, internal-external categorization that had been previously discussed by Heider (1958). Weiner proposed that internal causes reflect attributes about the person behaving. Examples included ability, effort and mood among others. External causes might include factors such as climate, task and the presence of other people.

The second dimension proposed by Weiner, stability, refers to the relative temporal quality of a cause. For example, Heider (1958) suggested dispositional factors such as ability are considered less likely to change over time (and are therefore more stable) when compared to factors like effort or luck.

The third causal dimension outlined by Weiner is control or controllability. In previous articles, Weiner (1974, 1976) had used the term intentionality, which he had borrowed from Rosenbaum (1972) to refer to this dimension. Weiner (1979) changed this dimension in an effort to reflect the voluntary-involuntary quality of a cause. Weiner used effort and mood as examples of voluntary or controllable and involuntary or uncontrollable causes.

A fourth causal dimension that has been used widely in attributional studies, globality, was added by Abramson, Seligman and Teasdale (1978). This dimension refers to the likelihood of a cause to occur across different situations.

Weiner (1986) reviewed studies that have attempted to empirically derive the dimensional structure underlying causes. Weiner reports that studies using factor analytic and multidimensional scaling methods have demonstrated support for the three dimensions he described. The findings represent studies concerning attributions made for the self and others, using hypothetical and actual behaviors and in achievement and interpersonal situations. For example, two studies that used the factor analytic method (Meyer, 1980; Meyer & Koelbl, 1982) to identify causal dimensions in an achievement context, found that the dimensions that emerged were locus, stability and control. In the former study, attributions were made for the hypothetical behavior of another person while in the latter, subjects were asked to make attributions for their own, actual behavior.

In the studies using multidimensional scaling, half of the subjects were given a list of all the possible pairings of the likely causes for a particular behavior and were asked to rate the similarity of these pairs. The other half of the subjects were asked to rate each cause on a number of bi-polar ratings. In the first study of this kind, Passer (1977) investigated the causes for success and failure in an academic setting. For failure, the dimensions identified were locus (i.e. internal versus external) and intent. Weiner (1986) suggests, without further explanation, that the latter dimension is more appropriately labeled control. For success, only the locus dimension emerged. It is unclear why no other dimension became evident. In another study using this method (Michela, Peplau & Weeks, 1982), the focus was on the causes of another person's loneliness. The dimensions that emerged were locus and stability.

The relatively large number of studies comparing attributions and marital satisfaction provides a substantial body of research related to the concurrent validity of each of the causal dimensions. In studies of this kind, couples have been labeled as either distressed or nondistressed. Typically, distressed couples have been identified as ones seeking marital therapy and have exhibited low scores on either the Dyadic Adjustment Scale (DAS; Spanier, 1976) or the Marital Adjustment Scale (Locke & Wallace, 1959). Non-distressed couples have been recruited from the community

and have earned high scores on one of the two previously identified adjustment scales.

Differences in findings related to the internal/external (i.e. locus) dimension have been reported in a number of studies investigating distressed versus nondistressed couples (Fichten, 1984; Fincham, 1985; Fincham, Beach & Baucom, 1987; Holtzworth-Munroe & Jacobson, 1985; Jacobson, McDonald, Follette & Berley, 1985; Kyle & Falbo, 1985). However, Fincham & O'Leary (1983) and Fincham, Beach & Nelson (1987) report that they did not find differences between distressed and nondistressed couples on this dimension. Fincham (1985) has suggested that this may be due to the inadequacy of a bi-polar dimension for rating the locus of a cause in close interpersonal relations. Newman (1981) has suggested the addition of "interpersonal attributions" in studies of close interpersonal relations. Similarly, Fincham, Beach and Nelson (1987) have recommended the inclusion of attributions to the relationship.

On the stability dimension, a similar picture has emerged where some studies report differences in causal stability while others do not between couples who are in distress versus those who are not. An explanation for this variation has been offered based upon the finding that when a community sample of distressed couples, rather than a clinical sample, was compared with a sample of non-distressed couples differences in causal stability for a partner's negative behavior were found. Fincham (1985) has

concluded that distressed couples who enter therapy are unlikely to view the causes of their problems as being particularly stable. Otherwise, there would be little reason to enter into a therapeutic relationship where one aim may be to resolve problems by altering the causes.

While no studies have empirically derived the globality dimension (Weiner, 1986), studies examining the attributional differences between distressed and nondistressed couples report differences on this dimension to be a consistent finding (Fincham & O'Leary, 1983; Fincham, Beach & Baucom, 1987; Holtzworth-Munroe & Jacobson, 1985). In fact, Fincham (1988) reported that in 10 studies of marital satisfaction this dimension was associated with differences in distress every time.

The controllability dimension has been the least used of the dimensions described by Weiner in studies of marital relations. Fincham (1988) has suggested that the relevance of the reformulated model of learned helplessness (Abramson, Seligman & Teasdale, 1978) to couples presenting for therapy has led researchers to employ the causal dimensions which are outlined in that model. The absence of a dimension of controllability in the learned helplessness model may indicate why controllability has received less attention. However, Holtzworth-Munroe and Jacobson (1985) found evidence to support the hypothesis that group differences occur in the ways that attributions for controllability are made. Specifically, distressed spouses view negative partner

behavior as being caused by controllable factors while non-distressed spouses make the opposite causal inference.

In addition to research directed at the validity of the schemes used to classify cognitions, information relevant to certain elements in their conceptualization may affect confidence in their utilization as a means of describing and understanding families. Elements common to family therapy and attributional definitions of cognition include the question of whether or not cognitions are shared and differences in their emphasis on "conscious" or "unconscious" processes.

C. Characteristics of Social Cognition

1. Sharing

The emphasis on the shared nature of cognitions rather than individual differences is evident in every model of family therapy. Hoffman (1988) refers to a "shared unconscious" (p. 124) that represents collections of ideas by which families make meaning of their world. Procter (1981) elaborates further on the nature of cognitive sharing. In his conception of the family construct system, members are thought to be able to vary slightly, not necessarily sharing in every aspect of the system. However, the opportunities for variation are limited to the extent that family members continue to ascribe to the family

construct system. Conflicts and the assignment of pathology often arise when a family has been unable to negotiate a shared construct. Reiss (1981) adds other elements, suggesting that sharing is a mutual preoccupation, not involving agreement or consensus, that is out of the awareness of family members and signifies the dissolution of individual boundaries. Reiss' view of sharing is that it occurs episodically and, when in operation, serves to direct a family's thinking and behavior.

Reiss (1981) justifies the emphasis on sharing through the use of examples from culture and laboratory experiments with small groups in which the occurrence of shared beliefs is evident. Reiss argues that the sharing of cognitive constructs is a common occurrence that serves to strengthen the construct and diminish challenges to its validity, thereby insuring its stability and decreasing uncertainty. In addition, Reiss' studies of the effects of family process on problem solving seem to support an emphasis on shared cognitions.

For example, while seeking to improve their explanation of the data from their studies of families of hospitalized adolescents, Reiss and his colleagues considered a number of alternative hypotheses. These were grouped according to macrosocial forces (e.g., social class, ethnicity), other internal family processes (e.g., values, power relations), and the skills of individual members. After reviewing their data and the literature related to each group of hypotheses,

Reiss and his colleagues chose to focus on the latter. They conducted an additional set of studies, using three different methods, to examine the question of whether family problem solving skills reflected individual skills or family process. Statistical comparisons of family problem solving with various individual skill variables (e.g., tolerance of ambiguity, field articulation) produced few significant relationships. In another study, family problem solving skills were maintained even when one member's abilities were diminished through the administration of a drug. Finally, limiting access to other family members actually improved problem solving in consensus-sensitive (i.e. schizophrenic) families. Reiss argues that, taken together, these results support the predominance of family process on family problem solving abilities and, in turn, support the importance of shared family constructs in directing behavior.

In contrast to an emphasis on shared cognitions, attribution theory has primarily focused on individual differences in social cognition. The recognition of various forms of parental bias in the formation of attributions underscores the emphasis on difference rather than on sharing of cognition in close interpersonal relations. Parents attributions may be influenced by biases such as the fundamental attribution error (underestimating the effects of the context), self-serving bias, feature positive bias (the tendency to view acts of commission and omission differently), hedonic relevance, personalism and parent

affect (Dix and Grusec, 1985). Each of these forms of bias may lead to differences in the attributions parents and children make for the child's behavior. Although unaddressed, it seems likely that these forms of bias also affect children's' perceptions of their parents behavior. Several studies of attributions in family relationships seem to provide support for the view that attributions in families are not shared.

Munton and Antaki (1988) compared families who changed and families who did not change as a result of therapy. Only one instance was found in which a family level attributional style was evident. Families identified as not having changed during therapy attributed the cause of problem-centered negative outcomes to be more temporally stable than families identified as having changed. This finding was evident during both the first and last session. Evidence of a family level attributional style on other dimensions or with families that changed was nonexistent. Munton and Stratton (1990) compared attributions made by clinical and non-clinical families. Due to the degree of variation in attributions within any individual family, the authors concluded it was impossible to identify a family level attributional style. Finally, Compas et al. (1981) reported on two studies that compared attributions made by parents and children for the child's learning and behavior problems. Parents were found to differ from children in that they

tended to make internal attributions while children made attributions that were external.

Attributional biases seem also to play a role in differences found between marital partners. Several studies have shown that members of distressed couples are more likely to make attributions that reflect a self-serving bias than members of nondistressed couples (Fichten, 1984; Holtzworth-Munroe & Jacobson, in press). For example, Fincham, Beach and Baucom (1987), reported that spouses in distressed relationships demonstrated a negative bias, tending to make attributions that are less benign for their partner's negative behavior than for their own. Spouses in non-distressed relationships demonstrated a positive bias, making more benign attributions for their partner's behavior than their own.

One explanation for the apparent differences between family therapists and attribution researchers over whether or not cognitions can be said to be shared in close interpersonal relationships is suggested by a consideration of differences in the level of cognitive elaboration that is emphasized. As previously mentioned, family theorists have used several terms to denote family member's cognitions. Each of these terms, as they are commonly used, appears to signify a fairly general level of cognition. As with the sharing of cognitions, this feature of the way cognition has been defined by family therapists seems to be tied to its stability. Reiss (1981) and Minuchin and Fishman (1981)

differentiate individual cognitions such as causal explanations from constructs based on their level of elaboration. They suggest that whereas explanations usually refer to ways of understanding human behavior in a particular instance, constructs represent an organized system of explanations and other cognitive activities which may be applied to animate and inanimate phenomena across a number of situations.

The effect that differences in the level of elaboration can have on whether or not a kind of cognition is viewed as shared is displayed in the aforementioned study by Fincham, Beach and Baucom (1987) in which differences in attributions were reported. If the groups of distressed and non-distressed couples in that study are considered separately and if actor/observer differences are taken into account, a shared attributional bias is revealed. Specifically, when spouses in distressed couples make attributions to their spouses behavior, they share the tendency to make less benign attributions. When they make attributions to their own behavior they tend to be more benign. For spouses in non-distressed couples, sharing of attributions in the opposite direction appears to occur.

As one moves to greater levels of cognitive elaboration it may be easier to find evidence of sharing. However, Reiss (1981) cautions that the idea that a family shares in certain cognitions raises questions about the nature of that sharing and whether or not sharing of cognitions occurs as

suggested by family theorists. Reiss wonders, for example, if a construct that is believed in by one or two dominant family members and acquiesced to by others could be thought of as shared.

2. "Conscious" versus "Unconscious" Processing

The manner in which cognition has been defined by family therapists reveals a tendency to emphasize unconscious over conscious cognitive processes. This bias is reflected in the ways cognitions are addressed in various models of family practice and in research. For example, in the structural, strategic and interactional models, clients conscious explanations for their problems are not actively sought and in some instances are actively avoided (Fisch, Weakland & Segal, 1982; Haley, 1976; Madanes, 1984; Minuchin, 1974). However, all three models demonstrate an interest in the family's underlying cognitive organization. For example, Minuchin (1974) describes strategies like focusing on family members other than the identified patient or on problems other than the one the family presents in an effort to alter the cognitive schemas the family uses to support its organizational structure.

Similarly, Haley/Madanes (Madanes, 1984) use strategic interventions such as pretend techniques toward the same goal. For example, Madanes reports asking a 15 year old girl who has had seizures to pretend having them. Madanes also

asked the family to pretend to respond to the make believe seizures. In doing this, Madanes was hoping to influence various underlying beliefs such as the voluntariness of the seizures and their function as a protective strategy.

Adherents of the MRI model have gone as far as to claim they can conduct therapy without any knowledge of the family's causal explanations for the problem (Watzlawick, Weakland & Fisch, 1974). However, these therapists pay close attention to the notion of "patient position" in the design and delivery of therapeutic interventions. Patient position represents the beliefs, values, priorities and, usually, the attributions the client or family holds in regards to their problem.

The Milan model of family therapy, as practiced by the Milan associates, Boscolo and Cecchin, has been probably the most conspicuous of the systemic family therapy models in its attention to family member's cognitions. Boscolo and Cecchin (1987) have used the phrase "meaning driven" to describe the Milan model's philosophy. In theory and practice, Milan therapists have displayed an interest in family members cognitions at both the conscious and unconscious levels, seeking them in direct and indirect ways. For example, Furman and Ahola (1988) note that the question "What is your explanation for that?" is often used in the process of circular questioning. However, while they often ask direct questions about family members cognitions, their belief in the notion that mind is social has

influenced an emphasis on indirectly revealing a family's maps (i.e. unconscious cognitions) through a careful description of behavior and context (Tomm, 1984). In addition, while conscious change is accepted, changes that occur at the level of the family's epistemology (i.e. unconscious) are considered to be superior (Tomm, 1984).

The preponderance of indirect methods used by Reiss (1981) to identify family members cognitions is consistent with an emphasis on unconscious processes. However, without the inclusion of direct questions concerning family members conscious thoughts, it is not possible to conclude that the information Reiss found only represents unconscious processes nor is it possible to conclude that these provide the best explanation for the ways families behaved as they did. For example, of the alternative hypotheses that were used to explain the data from Reiss' studies of hospitalized adolescents, one that was not reportedly considered by Reiss and his colleagues centers on differences in the kind of cognition that is elicited. Throughout Reiss' research, indirect methods (e.g., family sorts of cards with various combinations of letters) were used to investigate family member's underlying (i.e. unconscious) cognitive processes. In the study which examined family member's perceptions of the in-patient psychiatric ward, two of the measures asked for families to directly provide information about their conscious cognitions. The first asked families to sort cards for the accuracy of information about the ward (e.g., "The

psychiatric service is less than five years old"), while the second measure asked them to sort for moral judgments of staff and other patients in general (e.g., "Staff members work to help patients in order to avoid trouble from supervisors"). In this particular study, 20 predictions had been made concerning the data. Three of the five failures to predict occurred on these two measures. It seems conceivable that the reason for this may have been due to differences in the method used, type of cognition that was elicited or both. However, neither of these possibilities were apparently considered.

The study of attributional phenomena has almost always entailed directly asking subjects to identify the cause of an event and the inferences made about the cause. This method led some researchers to question whether or not attributions actually occur or were they an artifact of researcher's questions. Weiner (1985) reviewed 17 published articles that were concerned with the documentation of spontaneous attributional phenomena. These studies used three different methodologies to identify attributions. These included the coding of written material such as newspaper articles (Lau & Russell, 1980), the coding of verbalizations (including a study by Nisbett, Harvey and Wilson, 1979 in which participants' conversations were unknowingly bugged) and the use of indirect attributional indexes (e.g., Pyszcznski & Greenberg, 1981). The latter involved coding attributions gleaned from the content of

responses to materials from studies investigating cognitive processes other than the generation of attributions. Weiner found that in each study the investigators reported that a great deal of attributional activity had occurred. In a study involving interpersonal relations, evidence of spontaneous attributional activity as well as consistency between direct and indirectly elicited attributions was also found. Holtzworth-Munroe and Jacobson (1985) reported that open-ended responses to marital partner's behavior contained attributional phenomena similar to subject's direct ratings on causal dimensions.

D. The Application of Cognitive Typologies

Studies of cognition in interpersonal relations have contributed information useful in comparing the validity of conceptualizations of cognition offered by family therapists and social psychologists. However, the ability to respond to a number of relevant clinical topics constitutes an important test of their relative usefulness. For example, which concepts are most useful in distinguishing between healthy and unhealthy relationships, in developing an understanding of the relationship of cognitive to behavioral change and in describing the role of therapists cognitions in family therapy?

1. Non-clinically Involved versus Clinically Involved Families

The findings from Reiss' studies suggest that it is possible to distinguish between healthy and unhealthy families based upon their problem solving skills. Three dimensions were identified upon which family problem solving skills could be compared. The first dimension, configuration relates to the contribution made by the family as a group, beyond the contributions made by individual family members. The second dimension, coordination, refers to the family's ability to develop similar solutions to problems. The third dimension, closure, refers to the family's ability to apply or withhold the application of appropriate conceptual structures to respond to problem situations. Healthy families were shown to be high on all three dimensions, conduct disordered families were low on all three dimensions and schizophrenic families were high on coordination but low on the other dimensions.

In their initial studies Reiss and his colleagues specified certain variables, such as differences in responses on various trials of a card sort, as the criteria by which these dimensions were measured. However, in the studies that employed their typology to predict differences in the families' perceptions of a psychiatric ward and families of other patients two changes were introduced. First, the closure dimension was not used. Second, new

variables were identified, in each instance, by which the two remaining dimensions, coordination and configuration were to be measured. While the latter changes were intended to improve the validity of the measurements within a particular situation, they cast doubt on the reliability of using the typological dimensions in differing circumstances.

Summarizing studies of attributions in marriage, Holtzworth-Munroe and Jacobson (1987) reported general differences in the kinds of attributions made by distressed versus non-distressed spouses. First, distressed couples (i.e. the kind that are likely to be seen in therapy) make an even greater number of attributions than non-distressed couples.

Second, distressed couples were found to make "distress-maintaining" attributions such as viewing the causes of a spouse's negative behavior as stable, global, dispositional (i.e. internal) and within their control. In these couples, spouses were given little credit for positive behavior, reflecting a pervasive pattern of negative attributions. In contrast, non-distressed couples were more likely to make "relationship-enhancing" attributions. These couples usually considered their spouse's negative behavior to be caused by situational, unstable and uncontrollable factors. Positive behaviors were viewed as being due to dispositional, stable, global and controllable factors.

Gretarsson and Gelfand (1988) found that mothers' attributions, for children perceived as easy to manage, were

similar to those found for non-distressed couples. Specifically, positive behavior was attributed to dispositional causes while negative behaviors were considered to be due to unstable and situational causes. In contrast, mothers of children who were considered difficult to manage identified the causes of negative behaviors as dispositional and stable. Attributions for these children's positive behaviors reflected inferences of instability. This pattern is similar to that for distressed couples. Significant effects for age and sex were not found.

Munton and Stratton (1990) used the Leeds Attributional Coding System (LACS, Stratton et al., 1986) to classify attributions made by 10 families in therapy and 10 control families. The LACS is used to code verbalized attributions on dimensions of locus, stability, globality, controllability and universality. An audio tape of the first session was used for identifying the attributions of clinical families. The attributions of control families were gleaned from transcripts of a structured family interview (Darlington Family Interview Schedule; Wilkinson, Barnett, Calder, Deff & Pirie, 1985). The results demonstrated that clinical families differed from control families in their attributions on several dimensions. Specifically, families in therapy made attributions that were more internal, stable, global and personal.

Mas, Alexander and Turner (1991) studied 49 delinquent families who were randomly assigned to either a satisfying

or dissatisfying set condition. Family members identified four examples of one or the other kind of behavior and then rated these using an attributional questionnaire that included dimensions of locus, stability and globality. Families were also identified as either high or low conflict using their responses to the Family Environment Scale (FES, Moos & Moos, 1981). The results showed that members of low conflict delinquent families are more likely to attribute positive behaviors to dispositional causes and negative behaviors to less dispositional causes. Members of high conflict delinquent families do not seem to differentiate dispositional attributions between positive and negative behaviors.

2. The Relationship of Cognitive Change to Behavioral Change

While there have been numerous suggestions that research on the process and outcome of family therapy might focus on cognitive phenomena (e.g., Wynne, 1988; Carr, 1991), little work has been done in this area. For example, outcome studies have used a variety of criteria including symptomatic improvement such as improved psychosocial functioning and weight gain (Minuchin, Rosman & Baker, 1978), abstinence from substances (Stanton, Todd & Associates, 1982) and measures of family interaction such as expressed emotion (Vaughn & Leff, 1976) and the Family Environment Scale (Moos & Moos, 1981). On the process side,

Gurman, Kniskern and Pinsof (1986) cited Pinsof's (1981) review of family therapy process research which noted the relative absence of studies. They conclude that "the bulk of family therapy theory remains empirically unsubstantiated " p. 597). The findings from studies of Reiss' typology of shared constructs suggests a direction in which improvement in cognition might be expected to occur. However, as far as is known, Reiss' typology has not been used to measure cognitive change in families.

Studies of individual psychotherapy that reported the accompaniment of attributional change with behavioral change (Peterson, Luborsky & Seligman, 1983; Firth-Cozens & Brewin, 1988) have invited a similar comparison using family therapy. For example, Munton and Antaki (1988) compared attributions made by five families who were judged as changed versus five families judged as unchanged following a course of family therapy (the therapeutic approach or model was unspecified). The assessment of family member's attributions was conducted using the Leeds Attributional Coding System, (LACS, Stratton et al., 1986). Attributional statements made by family member's during the first and last sessions were coded on five dimensions, locus, stability, globality, controllability and universality.

The findings indicated that there were no differences in the attributions made by family members in the change group and those in the unchanged group following completion of therapy. This was explained as either reflecting the

absence of a relationship between change in attributions and clinical change or a limitation in the methods used in the study. In regards to the latter, Munton (1986) has suggested that an idiographic approach may reveal differences in attributions that are not revealed when group differences are studied. Attributional differences between members of individual families or between families in a certain group (e.g., a changed group) may be masked when comparisons are made between groups. In addition, some aspects of the measurement of attributions may have contributed to the no difference finding. For example, rather than focusing on attributions for a particular presenting problem, the researchers included attributions to what were determined to be all the significant negative events or outcomes identified by family members during the two sessions. They defend this practice by pointing to the tendency of some people to generalize the use of particular kinds of attributions to a range of negative events (Abramson et al., 1978). However, whether or not this was done by the participants in this study is an unanswered empirical question. And, it is unknown if the goal of therapy matched this assumption. Specifically, therapy may not have been aimed at changing general causal beliefs, but beliefs for a particular problem. Changes in attributions to events or behaviors that were the target of therapy (e.g., the presenting problem) may have been masked by an absence in

changes in attributions to events that were not the focus of treatment.

The use of a coding system to rate attributions occurring naturally in conversation eliminates questions about the potential for experimenter influence that have been raised following the use of reactive measures such as questionnaires (e.g., Bem, 1972). However, the coding methodology has its own limitations. It is unknown if the attributions that were verbalized and coded were the ones that family members would consider the most important. And, it is unknown if family members would rate them in the same way as they were rated by the judges.

Barton, Alexander and Turner (1988) used variations in the ways 16 delinquent and 16 nondelinquent families played scrabble (i.e. competitively or cooperatively) to study how changes in context affect measures of family members communication. Varying the context from competitive to cooperative was thought to represent the kind of attributional manipulation apparent in commonly used family therapy techniques of relabeling and reframing. These researchers found that the rate of negative communication in delinquent families was significantly lower in the cooperative situation than in the competitive one. While this finding supports the use of relabeling or reframing techniques to elicit behavioral change, changes in attribution were not measured. In addition, these researchers also found that, while negative communication

decreased, delinquent families continued to demonstrate lower rates of adaptive communication than nondelinquent families. This finding suggests that while changes in attributions have some effect on families communication, some kind of communication skills training is necessary for there to be improvement in the ways family members relate to one another.

Alexander, Waldron, Barton and Mas (1989) asked members of 61 families with a delinquent adolescent to identify a problem behavior and attempt to resolve it on their own during a five minute discussion. Families were then randomly assigned to one of four intervention conditions: relabeling, positive nonrelabeling, neutral or no intervention. Following the intervention, each family member completed an attributional questionnaire pertaining to the identified problem behavior that included dimensions of locus, stability and globality. Factor analysis yielded a composite attributional score, termed dispositionality, that included scores from the above dimensions. The results revealed no differences between groups for attributions made by mothers and fathers. The authors attribute the absence of attributional change in the relabeling group as possibly due to the experimental setting and the delivery of the intervention by a researcher rather than a therapist. A third explanation may be that the generic relabeling intervention may have lacked relevance for some families thereby decreasing its potency.

Morris, Alexander and Turner (1991) recruited 120 undergraduates for a study of the effects of reframing on an experimenter induced blaming set. The study used two different written vignettes to induce attributions of blame. After reading one of these, each subject was assigned to an intervention condition where they either received a reframing explanation, a placebo or no information. Subjects' responses to a subsequently completed attributional questionnaire revealed differences between attributions made by participants in the relabeling group and participants in the two other groups.

Surprisingly, despite the many studies focusing on attributions in marital relations, not one study was found that has examined attributional change during marital therapy.

3. The role of therapists' cognitions

The second order cybernetic view includes the therapist as part of the therapeutic system in a much more significant way than previously considered. By eliminating the distinction between those who are observed (e.g., families) and those doing the observing (e.g., therapists), the second order view suggests that any discussion of the role of cognition in family therapy must include the therapist's cognitions, especially as they relate to the description of families presenting for therapy and their role in the

therapeutic process. However, research on family therapy has yet to study therapists' cognitions or the role they play in therapy.

The use of attributional concepts to study therapists' cognitions has focused on their effects on treatment assignments (Murdock & Fremont, 1989) and on differences in attributions made by therapists with differing theoretical orientations (Plous & Zimbardo, 1986). In the former study, following an intake interview, therapists were asked to rate the presenting problem according to the causal dimensions. Stability was found to be the best attributional predictor of treatment assignments. Specifically, as stability increased so did the likelihood that long term treatment would be recommended.

In the latter study, the investigators surveyed 30 psychoanalysts, 32 behavior therapists and 78 nontherapist undergraduates. All were asked to give causal explanations for 3 hypothetical problems experienced by either themselves their friends or their clients. Ratings of these causes revealed that psychoanalysts were more likely to give dispositional rather than situational explanations. The opposite was the case for behavior therapists and nontherapists.

E. Summary

1. Family therapy

A review of the family therapy literature reveals that the terms used to describe family members' cognitions are often used interchangeably, reflecting the absence of strong conceptual development. Definitions of these terms are vague and so general they are difficult to operationalize for use in research. With the exception of Reiss' work, there has been little research on family members' cognitions.

Reiss' typology is significant due to its utility as a way of distinguishing differences in cognition in healthy and unhealthy families as well as differences in how they perceive aspects of their environment. However, the typology possesses a number of limitations. For example, it is limited to three kinds of families, normals, schizophrenic and conduct disordered. The number of dimensions and the variables used to measure them has varied from one study to another, raising questions about the reliability of the dimensions. And, family members' behaviors have been the only basis for conclusions about their cognitive beliefs. While it may be reasonable to conclude that there is a reflexive relationship between behavior and cognition, in the absence of an isomorphic relationship the possibility exists that behavior and cognition may be quite different (Tomm, 1984). Within the Milan model the discrepancy between

behavior and maps (i.e. cognitions) is thought to often signal the onset of symptoms. In light of the fact that Reiss' studies usually involved families with a schizophrenic or character disordered member, conclusions about cognitions that are solely based upon behavior must be viewed with skepticism.

Furthermore, Reiss' research focuses on the family's view of the outside world, to the exclusion of an examination of their views of themselves. Reiss defends this practice, citing the notion of transference in which the patient's projections about the analyst form the initial and predominating basis for changing behavior. However, the failure to also study the effects of cognitive constructs on the family's view of itself overlooks a substantial portion of psychological theory and research (e.g., Bem, 1972).

Another limitation relates to Reiss' emphasis on shared cognitions. While he demonstrates some empirical evidence in support of the shared nature of cognitions, Reiss acknowledges that this assumption needs further articulation and study. The kinds of changes in cognitive functioning that might be associated with therapeutic improvements are suggested by the distinctions between healthy and pathological family that are drawn by Reiss' typology. However, this review did not reveal any studies of this kind in which the typology of shared constructs has been used.

Finally, despite the obvious relevance of the therapist's context in the second order cybernetic view of

therapy and its frequent mention in the family literature, no studies have been published in which therapists cognitions have been the focus of study.

2. Attribution theory

This review of the attributional literature pertaining to relationships like those in families has focused upon the development and use of the causal dimensions. The validity of these dimensions has been demonstrated in a large number of studies, in a variety of circumstances and relationships, using differing methodologies. In addition, studies using the causal dimensions have identified a number of factors that are likely to affect their measurement and generalizeability.

The findings from studies of attributions have revealed information pertinent to elements in their definition. For example, various forms of bias are likely to diminish the possibility that cognitions at the level of attributions are shared amongst family members. As these biases are accounted for, cognitive activity becomes more elaborated and the prospect for finding evidence of sharing may improve. Unlike definitions of cognition in family theory, attribution theorists have emphasized conscious processing. This feature has made it possible to use direct methods of measurement in the study of cognitive phenomena and to

enable comparisons with unconscious processes through the use of indirect methods.

The application of the causal dimensions to relevant clinical topics has demonstrated their utility. Causal inferences have been shown to distinguish between healthy and unhealthy relationships, the latter representing a wide range of psychiatric diagnoses. The relationship of cognitive change, as measured by attributional inferences, to behavioral changes during a course of psychotherapy has been demonstrated for individuals but not for families. However, a number of measurement and methodological considerations that were discussed may have precluded the observation of a significant relationship. Finally, the study of therapists' attributions reveals patterns consistent with the therapists' theoretical orientations and the effect of attributions on therapists' decision-making.

CHAPTER III

METHODOLOGY

For the purposes of examining a number of issues related to the role of attributions in family therapy, this study requested that family members and therapists disclose their attributions and assess the outcome of the therapy. The areas of interest in this study were guided by theoretical and empirical information related to attributions in close interpersonal relationships and family therapy. Decisions regarding questions of methodology and research design were influenced by the demands of the study's hypotheses, precedents from previous research and a realistic appraisal of the author's resources.

A. Hypotheses

1. The Relationships of Family Members' and Therapists' Attributions

1. Prior to family therapy, mothers, fathers, children and therapists will not differ significantly from one another in their attributional ratings on each of the dimensions measured by the amended 4-ADS.

2. Following family therapy, mothers, fathers, children and therapists will not differ significantly from one

another in their attributional ratings on each of the dimensions measured by the amended 4-ADS.

3. Mothers, fathers, children and therapists will not differ significantly from one another in the difference between their attributional ratings before and following therapy on each of the dimensions measured by the amended 4-ADS.

2. The Relationships of Pre-therapy Attributions to Post-therapy Attributions

4. Mothers', fathers', children's and therapists' attributional ratings prior to therapy will not differ significantly from their respective attributional ratings following therapy on the dimensions measured by the amended 4-ADS.

3. Therapists' Attributions on the Locus Dimension

5. Therapists' attributional ratings prior to therapy on the Locus dimension for mothers, fathers and children will not differ significantly from one another.

6. Therapists' attributional ratings following therapy on the Locus dimension for mothers, fathers and children will not differ significantly from one another.

7. The difference in therapists' attributional ratings from prior to therapy to following therapy on the Locus

dimension for mothers, fathers and children will not differ significantly from one another.

4. Attributions and Therapeutic Outcome

8. The attributional ratings prior to therapy of family members and therapists who identified the presenting problem as improved will not differ significantly from the attributional ratings prior to therapy of family members and therapists who identified the presenting problem as unimproved.

9. The attributional ratings following therapy of family members and therapists who identified the presenting problem as improved will not differ significantly from the attributional ratings following therapy of family members and therapists who identified the presenting problem as unimproved.

10. The difference in attributional ratings from before therapy to following therapy of family members and therapists who identified the presenting problem as improved will not differ significantly from the difference in attributional ratings from before therapy to following therapy of family members and therapists who identified the presenting problem as unimproved.

B. Sample

The subjects who participated in this study included the members of families about to begin a course of out-patient family therapy and each family's therapist. The rationale underlying several decisions regarding the characteristics of this sample are offered:

1. The Use of Actual Families

Fincham (1988) reported that prior to the 1980's there was an unspoken assumption that findings from basic attributional research could be directly applied to interpersonal relationships like married couples. However, the findings from several studies support the argument that the type or quality of the relationship under study is a significant factor to consider in the generalization of attributional research. For example, attributional studies have demonstrated the importance of relational factors such as whether the actor (i.e.the person exhibiting the behavior) and the observer (i.e. the person who makes an attribution) are acquainted (Taylor & Koivumaki, 1976), whether the observer expects to or thinks he or she is currently interacting with the actor (Knight & Vallacher, 1981) and the type of attitude and affect that the observer has for the actor (Regan, Straus & Fazio, 1974). Taken together, these studies underscore the importance, in the

study of attributions, of utilizing samples from populations to which one wishes to generalize. Therefore, this study utilized families who were actually engaged in therapy.

2. The Use of Actual versus Hypothetical Problems

Evidence from attribution research has shown that the use of hypothetical rather than real life scenarios has no differential effect on the study of attributional phenomena (Fincham, Beach & Baucom, 1987; Madden & Janoff-Bulman, 1981) However, in an effort to respond to calls for studies of families in clinical settings (Munton, 1986; Wynne, 1988), this study focused on the actual problem that brought the family to therapy.

3. The Size of the Sample

The target size of the sample was set at 20 families. This number was thought by the author to be a realistically attainable figure. Pressures related to therapists heavy workloads, lack of available time, logistics and anxiety about the start of therapy combine to limit the size of willing particpants, both families and therapists. The sample size was also influenced by the size of samples in previous studies of clinically involved families. For example, in the Munton and Antaki (1988) and Munton and Stratton (1990) studies, both of which examined the

attributions of families in therapy, the number of families in therapy was 10. Although the sample sizes in some of Reiss' studies and several of the studies conducted by Alexander and his colleagues were larger, this likely reflects the relative ease of recruiting hospitalized and court involved clients.

4. The Use of a Sample that is Heterogenous in Terms of Presenting Problem

The inclusion of families presenting with a variety of problems is consistent with samples used in the Munton and Antaki (1988) and Munton and Stratton (1990) studies. The authors of the latter study argue that the attributional variability within and similarity between families identified by diagnostic categories justifies the use of a heterogenous sample.

5. The Time between Assessments

The use of a two month interval between assessments allows for an average of 8 weekly sessions. This number is consistent with the average number of sessions for families in the Munton and Antaki (1988) study. In addition, Gurman, Kniskern and Pinsof (1986) reported that positive outcomes in family therapy have been shown to occur within brief periods of time such as in 1 to 20 sessions.

6. The Age of the Youngest Participating Child

This study included children as young as nine years old. This figure was based on data from Benson's study regarding the validity and reliability of the 4-ADS and on piloting of the amended version used in this study with several children about this age. In addition, Dix and Grusec's (1985) studies suggest that around age 10 differential effects related to the child's age are no longer apparent in attributions made by parents.

7. The Therapists who Participated in the Study

The therapists participating in this study were identified as practicing family therapy. Most were former colleagues of the author. Several were referred to the author by former colleagues. While demographic data were not collected on the therapists, most are very experienced. The author estimates that most of the therapists participating in the study have 10 years of experience treating families. All of the therapists are employed in out-patient settings. These sites included private practice, private psychiatric hospital outpatient department and community outpatient services.

C. Recruitment Procedures

Therapists who participated in this study were recruited by the author. Initial recruitment was done by telephone with an explanation about why the study was being conducted, a brief explanation of the nature of the study, a description of the responsibilities entailed in participation, a description of the mechanisms to insure confidentiality and a brief discussion of the definition of systemic family therapy.

Therapists who indicated an interest in participating were sent a packet of information that included a number of items. Included was a letter to the therapist describing in some detail the issues just mentioned, a letter to family members explaining a number of the same issues, instruments regarding confidentiality and the attributional questionnaires needed to participate in the first stage of the study (see Appendices A-D).

Therapists were contacted shortly after receipt of the packet. Procedures to be used in recruiting families and collecting data were discussed. Therapists were invited to ask questions of the author regarding the methodology of the study and were encouraged to contact the author regarding questions that family members might have.

Families were recruited by therapists at the time of the referral call. The following information was given to

therapists to help them determine if a family was appropriate for the study:

--family is defined as including at least two members, one of whom is the parent and the other is their child or adolescent.

--children must be at least 9 years old to participate.

--single parent families may participate.

--parents or parental figures and children/adolescents who are not biologically related (e.g., children from previous relationships or adopted children, step-parents or significant others) may participate.

--the focus of therapy may be directed at at child/adolescent or parental problem.

--a minimum of two family therapy sessions is required for a family to be included in the study. Family members who participate are expected to have attended at least two therapy sessions.

Families meeting the inclusion criteria were asked if they would be willing to participate in a study of family members explanations during a period of family therapy. If a family consented, they were either invited to come in early to the first session to complete the questionnaire or, in instances where this was not possible for the family or the site, the questionnaires were mailed to the family with instructions to bring them to the first session.

D. Confidentiality

In order to insure the rights of all participants, they were asked to read and sign a consent form (Appendix B) that briefly outlined the nature of the study, their rights and the mechanisms used to insure the family's confidentiality. In addition, several steps were taken to keep private the identity of families. For example, identification numbers were used to identify each therapy system (family and therapist). Family members were instructed not to put their names on any parts of the questionnaires. Therapists recorded and kept in their files an index card noting which family belonged to which identification number. Also, each therapist checked the consent form, signed it and kept it with the family's records to insure privacy. The therapist signed a consent confirmation form (Appendix B), indicating that the consent form had been signed by family members and would be held in the therapists file for one year.

E. Procedure

When families arrived for their first session they were given an envelope in which was enclosed a letter explaining the study, a consent form and the necessary copies of the amended 4-ADS. Families completed these materials and gave them to their therapist. Following the first session therapists completed their version of the amended 4-ADS.

Completed questionnaires were either mailed to or picked up by the author.

In the second stage of the study, family members and therapists completed the post-therapy version of the amended 4-ADS and answered several questions concerning the number of sessions attended, their judgement of whether or not there was improvement to that point of the presenting problem and the identification of any new problems. Again, completed questionnaires were collected by the therapist and either mailed to or picked up by the author.

F. Instruments

1. Assessment of Attributions

As mentioned in chapter 2, in the Munton and Antaki (1988) study the failure to find evidence of attributional change associated with clinical improvement may have been due to problems with measurement. This study sought to avoid some of those problems in a number of ways. First, was the decision to use a direct rating questionnaire. The use of questionnaires insures accuracy in assessing attributions both in terms of the causal judgement and the inferential ratings. Second, this study focused on the presenting problem as identified by the family. Wynne (1988) argued that the family's view of the presenting problem should be a basic part of any research of family therapy. Third, this

study included families in which the identified patient could be either the parent or child. Gurman and Kniskern (1986) reported that developmental level of the IP (e.g., child/adolescent/adult) does not significantly affect treatment outcomes.

Fourth, this study asked subjects to identify a single cause for the presenting problem. Howe (1987) has argued that people may develop multiple causal acounts of social interactions. However, in the study conducted in which this was demonstrated, Howe assessed the attributions of undergraduate observers for hypothetical marital interactions and not of married couples engaged in actual interactions. In addition, the attributions were not focused on a single behavior as in the present study. Contrary to Howe, a study by McGill (1991), as well as other studies cited by her, provides evidence in support of people's tendency to choose a single cause to explain an event.

The 4-ADS was chosen for use in this study as a measure of family members and therapists attributions. This choice was based on a number of considerations such as evidence of adequate validity and reliability, appropriateness for use with children and inclusion of the dimensions of locus, stability, globality and controllability. While a number of other attributional measures have been developed for use in research, none more closely met these criteria.

The 4-ADS is a direct-rating questionnaire that asks the respondent to identify the reasons for a circumstance or

event and to then complete 16 multiple choice items that provide attributional ratings on the dimensions of locus, stability, globality and controllability. Each of the 16 items is scored on a 1 to 5 basis according to which of the five ordered alternatives is chosen. The score for each dimension is based on the sum of ratings for the four items of which it is comprised. Half of the items on each dimension are reverse scored.

In a test-retest assessment of reliability conducted over a period of 12 days, Benson (1989) reported the following correlations for each of the four dimensions of the 4-ADS:

Internality (Locus)	.59
Controllability	.68
Globality	.79
Stability	.77

The validity of the 4-ADS was demonstrated by the orthogonality of the four dimensions and by its high degree of consistency with a number of hypothesized relationships predicted by attribution theory (Benson, 1989).

The 4-ADS as it was used in this study is presented in Appendix D. A number of modifications were made for use in this study. To begin, since it was important that all family members and their therapist make attributions to the same presenting problem, a separate section called Part A was developed in which families were asked to identify a single presenting problem and the person or persons exhibiting it.

Part B, which represents the 4-ADS, was changed in a number of ways. First, an orienting paragraph was added as suggested by Benson (1989), in which an example of an attributional statement is given. Next, rather than asking for a complete listing of causes, the 4-ADS as used in this study asks the subject to identify the primary or most important cause. Also, in the original version of the 4-ADS, Benson used the terms cause and reasons interchangeably. However, in an effort to avoid the controversy over the accurate use of these two terms (see Locke & Pennington, 1982) only the term 'cause' is used.

Items related to the locus dimensions were replaced with a single multi-level item. In the family's version, respondents were asked to rate to what extent the cause had to do with either themselves, other family members, the relationships of family members and the circumstances. In the therapist's version the same question asked to what extent the cause had to do with each family member, the relationships of family members and the circumstances. Ratings ranged from not at all (1) to mostly (5). This format is consistent with suggestions mentioned in chapter 2 (Fincham, 1985; Newman. 1981).

Items number 8 and 16 of the original 4-ADS were changed from responsibility to control. In the following discussion regarding the inclusion of a dimension of intent it will be made clear that questions about responsibility are inappropriate in a dimension of controllability.

Finally, a dimension of intent was added to the 4-ADS. Since this constituted a significant change, the rationale underlying it is addressed at some length.

The distinction drawn by Weiner (1979) between control and intentionality or intent reflected an effort to emphasize the voluntariness of a cause. While this separation appears logical, it is not entirely clear why a dimension of intent was not included in his theoretical formulation. It may be, as he mentioned, that he believed the two dimensions would correlate highly and were, therefore, redundant. However, this is puzzling in light of the example he provides regarding the concept of legal negligence in which the possibility of control without intent is accepted.

The inclusion of a dimension that reflects intent has been the subject of considerable attention (Doherty, 1981a; Fincham, 1985; Shaver, 1985) and apparent confusion within attribution research. For example, Fincham and his colleagues (Fincham, Beach & Baucom, 1987; Fincham, Beach & Nelson, 1987; Fincham & Bradury, 1987) have repeatedly argued for the inclusion of responsibility attributions, of which intent is considered to be a central element, in the study of marital relations. They support their argument by citing studies in which responsibility attributions produced group differences between distressed and non-distressed couples with greater reliability than the casual dimensions. However, a number of conceptual and assessment problems

raise questions about this conclusion. For example, Fincham, Beach and Nelson (1987) report that the three elements of responsibility attributions (inferred negative intent, selfish motivation and blame) were highly correlated. While they conclude that this suggests the existence of an overall evaluative process, it more directly suggests the redundancy of the three elements. Conversly, Shaver (1985) and Shaver and Drown (1986) have argued that responsibility and blame are distinctly separate concepts, a conclusion acknowledged by Fincham, Beach and Baucom (1987), and one that seems to run counter to the use of judgements about blame as a measure of responsiblity.

Intent, it may be recalled was considered by Weiner (1979) to be distinct from control. Whereas control connotes voluntariness, "intent connotes a desire, or want" (p. 6). Fincham and Bradbury (1987) reported evidence supporting the distinction between voluntariness and intentionality. Their data demonstrated differences in predictions between perceived intent and perceived voluntariness as each pertained to conflict-related behavior. Specifically, "intent was positively related to partner blame when the partner was the causal locus and positively related to efficacy when the self was identified as the locus" (p.1114). Both relationships had been predicted for the voluntariness dimension but only the latter was found.

In contrast, Shaver (1985) combines intent and voluntariness, arguing that intent is the element of

"choice" or "deliberation" in voluntary behavior (p. 85). Shaver concludes that the opposite of intentional is not unintentional, but involuntary. Finally, Passer, Michela and Kelley (1978) make no distinction at all between intent and voluntariness, referring to them as the same.

Two issues related to the assessment of intent further add to the confusion. First, it is unclear if the assessments provided by subjects are directed at the same target. In both the Fincham, Beach and Nelson (1987) study and the Fincham and Bradbury (1987) study causal attributions were based upon subjects' ratings of the cause of behavior on the locus, stability and globality dimensions. In contrast, on the responsibility dimensions (i.e. intent, selfishness and blame), subjects were asked to direct their attributions to the behavior itself and not the cause. The validity of the findings from these studies regarding differences between causal and responsibility dimensions is questionable since it is unclear if the differences in causal and responsibility ratings are due to actual differences or to their rating of different phenomena. Stratton et al. (1986) have noted the importance of distinguishing between attributional judgements that relate to the cause, the outcome (behavior) or the relationship between them. They point out that considerable confusion and unreliable findings are the likely result of a failure to be explicit about which element judgements are made.

Second, the manner in which the elements have been defined for assessment is another factor adding to confusion. In Heider's original formulation intent was characterized as being either present or absent. According to Heider, the presence of intent is a central element in determining personal causality. In the development of a theory of blame, Shaver (1985) deals extensively with the concept of intent, always referring to it as being either present or absent.

Fincham and Bradbury (1987) followed Heider's use of intent as either present or absent when they asked subjects to assess intent based upon the following description, "The things my child says or does that contribute to conflict between us are done intentionally rather than unintentionally" (p.1110). However, Fincham, Beach and Nelson (1987) asked subjects for a different assessment of intent. Subjects were asked "to indicate the extent to which their spouse's behavior was intended to be positive versus negative or destructive" (p.76). Curiously this description was used in the Fincham and Bradbury (1987) study, not to assess intent, but rather as a measure of motivation. In that study subjects were asked to assess motivation based on the following, "The things our child says or does that contribute to conflict between us [are intended]to be [negative or unhelpful] [italics]". The findings from these two studies are confounded first by the use of the same description to describe two different elements and then due

to the change in assessments of intent from a present/absent dichotomy to one that is positive/negative. While it is unknown why one method of rating was used to denote intent in one study and motivation in another, the shift in rating intent from absence versus presence to positive versus negative has some basis in attributional research.

In an effort to empirically determine the dimensions underlying attributions, Passer, Kelley and Michela (1978) used a multidimensional scaling analysis of subject's ratings to the similarity of 13 causes given by either the actor or observer of a negative behavior. The results of this study yielded two dimensions in both the actor and observer conditions. The first dimension was interpreted as positive versus negative attitude toward spouse. Attributions related to this dimension were exhibited by both actors and observers of negative behavior in close interpersonal relationships. The second dimension differed depending on whether the actor or observer were making attributions. When actor's attributions were analyzed, the dimension that emerged was one interpreted as intentional versus unintentional. In the observer condition, the second dimension that emerged was actor's traits versus circumstances or states.

An examination of the second dimensions reveals that, in the actor condition, Passer et al. (1978) interpreted the attributions using the same dichotomy as that postulated by Heider (1958) in which intent is characterized on a

continuum of presence or absence. In the observer condition, the second dimension to emerge is the same as the internal-external dimension that had been employed by a number of attributional theoreticians.

However, it is the first dimension that is of particular interest here. To begin, this dimension was identified in both the actor and the observer conditions. The dimension, which Passer et al. (1978) have interpreted as positive versus negative attitude toward spouse consists of attributions like, "actor thought in partner's best interest" (positive attitude) versus "actor doesn't care for partner" (negative attitude) (p. 955). The identification of this dimension appears to provide support for Fincham, Beach and Nelson's (1987) conclusion that attributions possessing an evaluative quality are important for the understanding interpersonal relations. However, as Fincham (1985) noted, this dimension has been overlooked in the formulation of attributional models. Passer et al. (1978) offer an explanation for this. First, as already noted, the identification of attributional dimensions has not been done empirically, but has used a method of logical analysis (e.g., Weiner, 1979) and predictive utility. Second, Passer et al. suggest that certain properties of attitudes have contributed to their absence from models of attributions. For instance, Passet et al. argue that attitudes are internal, fairly stable and general causes of behavior. And, unlike causal dimensions which vary in magnitude, attitudes

are defined by their evaluative qualities like positive versus negative or good versus bad (Eiser & van der Pligt, 1988). Passer et al. blame researchers of attributions in achievement settings for being too narrowly focused on proximal causes of behavior, such as effort or ability, as one reason that attitudes have received such little attention. In the interpersonal realm, distal causes, such as attitudes, have been recognized but not in the positive/negative configuration exhibited in the Passer et al. study. As a result of their findings, Passer et al. argue that a dimension that identifies positive versus negative attitudes should be included in formulations of attributional distinctions.

With that recommendation in mind, Doherty (1981a) postulated a dimension of intent (positive versus negative) as a central element in an attributional model of family conflict. Doherty cites the Passer et al. (1978) study and the findings from an earlier study by Orvis, Kelley and Butler (1976) in order to support the inclusion of this dimension. In the latter study, the investigators found that "individuals in close relationships tend to attribute more benign intent to themselves and more negative intent to their partners when describing behaviors that had negative effects on the relationship" (Doherty, 1981a, p. 9).

As a result of this discussion, a dimension of intent was added to the 4-ADS. The wording of the four items that comprise this dimension reasonably mimicked that of the

other dimensions. Key words relating to positive and negative intent were those used in the Passer et al. (1978) study. For example:

Is the cause:

___mostly about being unhelpful

___partly about being unhelpful

___neither about being unhelpful nor helpful

___partly about being helpful

___mostly about being helpful

2. Assessment of Outcome

Family members and therapists were asked to indicate whether or not there had been improvement in the presenting problem.

3. Additional Questions

Each subject was asked how many family therapy sessions they had attended and if any new problems had been identified.

G. Record keeping

When family members arrived for the first session they read and signed the consent form and then completed Part A of the amended 4-ADS (one copy per family) which asks them

to identify the presenting problem and the person exhibiting it. Family members were instructed to use the problem identified by the member who made the appointment, if they could not agree to a single presenting problem. Each family member was instructed to individually complete Part B of the amended 4-ADS (pre-therapy/family version) in which they were asked to identify what they believed was the primary cause of the presenting problem and to respond to a number of questions that would reveal their ratings of the cause on several dimensions. Family members enclosed their copies of Part B of the 4-ADS in an envelope that they sealed and gave to their therapist. Part A was also given to the therapist for reference when completing the therapists copy of Part B of the amended 4-ADS (pre-therapy/therapist). Therapists were instructed to complete their copy of the questionnaire following the first session.

Upon receipt of the pre-therapy questionnaires, the author forwarded a packet of post-therapy questionnaires for completion after two months or at termination if that occurred earlier. The post-therapy packet included an envelope for the family in which Part A was returned to them for reference in completing Part B (post-therapy/family version) and a copy of Part B of the questionnaire for each member who completed the 4-ADS prior to therapy. The cause that each member identified on the pre-therapy version was transcribed onto their post-therapy version and they were asked whether or not they still considered that to be the

cause of the presenting problem. If not, they were asked to identify what they currently believed to be the primary cause of the presenting problem. Then they responded to a number of multiple choice questions aimed at eliciting their causal dimensional ratings. Family members were also asked how many sessions they had attended and whether or not there was improvement in the presenting problem. Finally, they were asked if a new problem had been identifed.

Family members were instructed to place their copies of Part B in an envelope, seal it and give it to their therapist. Part A was to be given separately to the therapist.

The therapist was instructed to complete their copy of Part B (therapist/post-therapy version) using Part A as a reference. Their version also had their pre-therapy cause transcribed on it. Therapists were also asked the same additional questions asked of family members regarding outcome, number of sessions, etc.

CHAPTER IV

RESULTS

In this chapter descriptions of the sample, the data and the methods of analysis will be presented. The hypotheses that appeared in Chapter 3 will be re-stated and the findings of the study will be reported. Discussion of the findings will occur in the following chapter.

A. Description of the Sample

Eight families and the family therapist for each family responded to the questionaires used in this study. The total numbers of mothers, fathers, children and therapists who participated in the study are given in Table 1.

Table 1. Total Numbers of Mothers, Fathers, Children and Therapists

Mothers	Fathers	Children	Therapists
7	4	10*	8**

* In two of the families there were two children who responded to the questionnaires.

** The total number of therapists was actually 5. Three of

the therapists provided two families each for the study. The other two therapists provided one family each.

One additional family responded to the initial questionnaire. However, that family left treatment abruptly and declined to complete the follow-up questionnaire.

The therapists participating in the study were generally quite experienced, each having conducted family therapy for approximately 10 years. All of the families in the study were seen in out-patient settings where payment was made through private insurers.[1]

B. Description of the Data

Raw data from the amended 4-ADS from each of the assessments were hand scored by the author. The data were compiled on each of the dimensions measured by the amended 4-ADS. Means and standard deviations were computed for the responses of mothers, fathers, children and therapists to each of the attributional dimensions before and after a period of family therapy. Means and standard deviations were also computed for the difference between subjects' pre and post treatment ratings.

Ratings on the locus dimension were handled in two ways that differed from those for the other four dimensions. First, mean ratings were computed for each of the four levels that comprised the locus dimension. Second, since

family members and therapists responded to different questions on the first two levels of the locus dimension, comparisons on this dimension were conducted separately for family members and therapists. Specifically, comparisons were conducted between mothers', fathers' and children's pre and post ratings on these levels. For therapists, comparisons were conducted on their pre and post ratings for mothers, fathers and children. Therapists' mean ratings for each of the levels they responded to were kept separate and appear in Table 6.

On the remaining levels of the Locus dimension (i.e. relationship, circumstances) and on the other dimensions comparisons were conducted between groups comprised of mothers, fathers, children and therapists. However, the addition of the variable for outcome rendered what were already small group sizes to, in some instances, groups with only a single subject. Therefore, for the analyses of attributional relationships and therapeutic outcome the subjects were divided into two groups, according to whether or not they judged the outcome as improved or unimproved.

Scores on each of the dimensions and on the levels within the locus dimension ranged from 1 to 5. The meaning that corresponds to each of these scores on each of the dimensions is given in Table 2.

Table 2. Meanings Corresponding to Each of the Scores on the Attributional Dimensions

Dimension	Score 1	2	3	4	5
Locus					
Self	not at all				mostly
Others	not at all				mostly
Relationships	not at all				mostly
Circumstances	not at all				mostly
Globality	low				high
Stability	low				high
Controllability	low				high
Intent	negative				positive

In addition to the data derived from family members' and therapists' dimensional ratings, completed questionnaires were examined for the kinds of presenting problems identified by families as well as the content of the causes given by family members and therapists. In three instances conflict between various family members was identified as the problem for which the families were coming for therapy. Two families identified the presenting problem as a concern about an individual member (i.e. chronic headaches, withdrawn behavior). And, on three occasions the

part of the questionnaire upon which the presenting problem was recorded was not returned following the post-assessment.

There were no easily discernible patterns regarding the content of the causes identified by family members and therapists. In some families there was general agreement over a cause such as stress or a possible neurological problem. In other instances, family members and therapists differed substantially over the cause of the presenting problem. For example, in a family in which family conflict was the identified presenting problem, the following causes were given:

Mother: "Problems in relationship between son and step-father."

Step-father: "Son has a poor attitude."

Son: "Don't know."

Therapist: "Family members' difficulty dealing with changes associated with marriage of mother to step-father"

C. Data Analysis

Significant differences between mothers', fathers', children's and therapists' attributional ratings (pre, post and the difference between pre and post) were determined using the Kruskal-Wallis one-way ANOVA. The Kruskal-Wallis test was also used to determine significant differences between the attributional ratings of subjects (family members and therapists) who identified the presenting

problem as either improved or unimproved. The Kruskal-Wallis test is used to test the differences in the locations of the rank-sums of two or more independent samples.

Significant differences between the pre and post attributional ratings made by mothers, fathers, children and therapists were determined using the Wilcoxon matched-pairs signed-ranks test. The Wilcoxon test is used to test the differences in the locations of the rank-sums of matched or dependent samples.[2]

Significant differences between therapists' attributional ratings (pre, post and the differences between pre and post) on the Locus dimension were determined using the one-way ANOVA test. Type I errors were controlled using the Scheffe procedure. The level of significance was set at $p < .05$ for all comparisons in this study.

D. The Hypotheses

1. The Relationships of Family Members' and Therapists' Attributions Prior to and Following Therapy

1. Prior to family therapy, mothers, fathers, children, and therapists will not differ significantly from one another in their attributional ratings on each of the dimensions measured by the amended 4-ADS.

The means and standard deviations of the ratings made by mothers, fathers, children and therapists prior to

therapy for each attributional dimension are given in Table 3.

Table 3. Means and Standard Deviations of Mothers', Fathers', Children's and Therapists' Ratings Prior to Therapy on Each of the Attributional Dimensions

	PRE							
	Mothers[1]		Fathers[2]		Children[3]		Therapists[4]	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Locus-								
self	1.71	0.95	3.00	1.41	3.20	1.75	----	----
other	2.42	1.61	3.20	1.65	2.90	1.39	----	----
relationship	3.14	1.86	3.75	1.89	2.20	1.75	3.75	1.03
circumstances	4.50#*	0.83	2.75	2.06	2.50	1.65	3.25	0.89
Globality	3.28	0.92	3.12	1.51	3.75	0.82	3.12	0.74
Stability	2.57	0.40	2.12	0.77	2.67	1.30	2.84	0.35
Control-								
lability	3.14	0.72	3.68	1.03	2.67	1.19	3.28	0.52
Intent	2.68	0.34	2.25	0.73	2.20	0.88	2.40	0.32

1: N=7 2: N=4 3: N=10 4: N=8

#: N=6

*: $p<.05$

There was just one instance in which there was a significant difference in mean ratings prior to therapy.

Specifically, mothers' mean attributional rating on the Locus dimension to circumstances was 4.50 (standard deviation of .83) while the mean rating for fathers was 2.75 (SD=2.06), children 2.50 (SD=1.65) and therapists 3.25 (SD=.89). Thus, prior to therapy, mothers considered the cause of the presenting problem to have more to do with situational influences than did other participants.

2. Following family therapy, mothers, fathers, children and therapists will not differ significantly from one another in their attributional ratings on each of the dimensions measured by the amended 4-ADS.

The means and standard deviations of the ratings made by mothers, fathers, children and therapists following therapy for each attributional dimension are given in Table 4.

Table 4. Means and Standard Deviations of Mothers', Fathers', Children's and Therapists' Ratings Following Therapy on Each of the Attributional Dimensions

	POST							
	Mothers[1]		Fathers[2]		Children[3]		Therapists[4]	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Locus-								
self	3.00	1.15	3.50	1.00	2.70	1.70	----	----
other	3.71	1.49	3.00	1.63	3.30	1.76	----	----
relationship	3.85	1.57	3.50	1.91	3.10	1.28	4.14#	0.89
circumstances	3.86	1.07	4.00	1.15	3.40	1.43	3.00#	0.58
Globality	3.25	0.82	2.44	1.05	3.32	0.99	3.41	0.85
Stability	2.60	0.62	2.37	1.16	3.00	1.12	2.78	0.65
Control-								
lability	3.07	1.10	4.25	0.64	3.05	1.19	3.53	0.41
Intent	2.32	0.72	2.12	0.75	2.07	0.75	2.84	0.38

1: N=7 2: N=4 3: N=10 4: N=8

#: N=7

In no instance was there a significant difference found between the mean attributional ratings of mothers, fathers, children and therapists following therapy. Thus, each group of participants was likely to identify the cause of the presenting problem as similarly stable, global, controllable, etc. following therapy.

On the Locus-circumstances dimension, upon which mothers' pre-treatment rating differed significantly from the ratings of the other groups of participants, the absence of a post-treatment difference was due several changes in attributional ratings. Mothers' and therapists' ratings on this dimension decreased from pre to post-treatment assessment, while the ratings of fathers and children increased. As a result, no single group differed significantly from another in their post-treatment rating on this dimension.

2. The Relationships of Family Members' and Therapists' Pre-therapy Attributions to Their Post-therapy Attributions

3. Mothers', fathers', children's and therapists' attributional ratings prior to therapy will not differ significantly from their respective attributional ratings following therapy on the dimensions measured by the amended 4-ADS.

The means and standard deviations of the difference between attributional ratings made before and following therapy by mothers, fathers, children and therapists are given in Table 5.

Table 5. Means and Standard Deviations of the Difference in Mothers', Fathers', Children's and Therapists' Ratings from Prior to Therapy to Following Therapy on Each of the Attributional Dimensions

	DIF							
	Mothers[1]		Fathers[2]		Children[3]		Therapists[4]	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Locus-								
self	-1.28*	0.95	0.50	0.57	0.50	1.35	----	----
other	-1.28	1.70	0.20	1.52	-0.40	1.88	----	----
relationship	-0.71	1.88	0.25	1.25	-0.90	2.13	-0.14#	0.89
circumstances	0.83	0.98	-1.25	2.50	-0.90	2.51	0.14	1.07
Globality	0.04	1.05	0.62	0.92	0.42	0.77	-0.28	1.17
Stability	-0.03	0.64	-0.25	0.84	-0.32	1.40	0.06	0.35
Control-								
lability	0.07	0.90	-0.56	0.72	-0.37	1.00	-0.25	0.46
Intent	0.33	0.96	0.12	0.32	0.12	0.67	-0.44*	0.35

1: N=7 2: N=4 3: N=10 4: N=8

#: N=7

*: p<.05

On the Locus dimension, mothers' mean attributional rating to self prior to therapy was 1.71 (SD=.95), while their mean attributional rating to self following therapy was 3.00 (SD=1.15). Thus, mothers' attributional rating to

self on the Locus dimension following therapy was significantly different from their rating to self prior to therapy. More specifically, the extent to which mothers identified themselves as having something to do with the cause of the presenting problem increased over the course of therapy.

On the Intent dimension, therapists' mean attributional rating prior to therapy was 2.40 (SD=.32), while their mean attributional rating following therapy was 2.84 (SD=.38). Thus, therapists' mean attributional rating on the Intent dimension following therapy was significantly different from their rating prior to therapy. Specifically, over the course of therapy, therapists came to consider the cause of the presenting problem as representing a more positive intent. For example, a father's inability to express his feelings to other family members may have been viewed as an effort to be protective rather than a sign of insensitivity.

3. The Relationships of the Pre to Post Therapy Differences in Attributions of Family Members and Therapists

4. Mothers, fathers, children, and therapists will not differ significantly from one another in the difference between their attributional ratings before and following therapy on each of the dimensions measured by the amended 4-ADS.

The means and standard deviations of the difference between attributional ratings made before and following therapy by mothers, fathers, children and therapists are given in Table 5.

On the Locus-self dimension, the difference in mothers' ratings from prior to therapy to following therapy was significantly different from the same differences in ratings made by fathers and children. The mean difference for mothers was 1.28 (SD=.95), for fathers .5 (SD=.57) and for children -.5 (SD=1.35). Therefore, the increase in mothers' ratings on this dimension constituted a change that was significantly different than the changes made on this dimension by fathers and children. Specifically, over the course of therapy mothers came to view the cause of the presenting problem as having more to do with themselves than they had at the start of therapy and this change was significantly greater than changes indicated by fathers and children.

On the Intent dimension, the difference in therapists' ratings from prior to therapy to following therapy was significantly different from the same differences in ratings made by mothers, fathers and children. The mean difference for therapists was -0.44 (SD=0.35), for mothers 0.33 (SD=0.96), for fathers 0.12 (SD=0.32) and for children 0.12 (SD=0.67). In other words, therapists became more positive in their assessment of the intent associated with the cause

of the presenting problem. In contrast, family members' ratings on this dimension changed only slightly.

4. Therapists' Attributions on the Locus Dimension

5. Therapists' attributional ratings on the Locus dimension prior to family therapy for mothers, fathers and children will not differ significantly from each other.

6. Therapists' attributional ratings on the Locus dimension following family therapy for mothers, fathers and children will not differ significantly from each other.

7. The difference in therapists' attributional ratings on the Locus dimension from prior to therapy to following therapy for mothers, fathers and children will not differ significantly from each other.

The means and standard deviations of the attributional ratings made by therapists prior to and following therapy as well as for the difference between these ratings for mothers, fathers and children are given in Table 6.

Table 6. Means and Standard Deviations of Therapists' Attributional Ratings for Mothers, Fathers and Children on the Locus Dimension Prior to Therapy (Pre), Following Therapy (Post) and the Difference Between Pre and Post (Dif).

	Locus					
	Pre		Post		Dif	
	Mean	SD	Mean	SD	Mean	SD
Mothers[1]	3.25	1.03	3.62	0.74	-0.37	1.06
Fathers[2]	3.75	0.88	4.00	0.75	-0.25	0.71
Children[3]	3.85#	1.46	2.87	1.25	1.00#	2.08

1: N=8 2: N=8 3: N=8

#: N=7

There were no significant differences in therapists' ratings on the Locus dimension for mothers, fathers and children prior to or following therapy. There were also no significant differences in the difference in therapists' ratings from prior to therapy to following therapy on the Locus dimension for mothers, fathers and children.

5. Attributions and Therapeutic Outcome

8. The attributional ratings prior to family therapy of family members and therapists who identified the presenting problems as improved will not differ significantly from the attributional ratings prior to family therapy of family members and therapists who identified the presenting problem as unimproved.

The means and standard deviations of family members and therapists who identified the presenting problem as either improved or unimproved are given for each of the attributional dimensions in Table 7.

Table 7. Means and Standard Deviations of Improved and Unimproved Family Members and Therapists Prior to Therapy

	PRE			
	Improved[1]		Unimproved[2]	
	Mean	SD	Mean	SD
Locus-				
self	2.93#	1.54	2.14##	1.57
other	2.89#	1.40	2.64##	1.70
relationship	3.09	1.58	2.75	1.91
circumstances	3.05	1.50	3.57	1.62
Globality	3.26	0.98	3.68	0.70
Stability	2.69	0.88	2.43	0.76
Controllability	3.25	0.95	2.68	0.81
Intent	2.33	0.52	2.50	0.89

1: N=21 2: N=8

#: N=14 ##: N=7

There were no significant differences in the attributional ratings prior to therapy of family members and therapists who identified the presenting problem as improved and family members and therapists who identified the presenting problem as unimproved.

9. The attributional ratings following therapy of family members and therapists who identified the presenting

problems as improved will not differ significantly from the attributional ratings following therapy of family members and therapists who identified the presenting problem as unimproved.

The means and standard deviations of family members and therapists who identified the presenting problem as either improved or unimproved are given for each of the attributional dimensions in Table 8.

Table 8. Means and Standard Deviations of Improved an Unimproved Family Members and Therapists Following Therapy

	POST			
	Improved[1]		Unimproved[2]	
	Mean	SD	Mean	SD
Locus-				
self	3.28#	1.27	2.28##	1.50
other	3.33#	1.55	3.43##	1.81
relationship	3.75	1.21	3.00	1.60
circumstances	3.75	0.85	2.87	1.55
Globality	3.14	1.04	3.40	0.50
Stability	2.50	0.76	3.44*	0.88
Controllability	3.53	0.94	2.87	1.03
Intent	2.36	0.67	2.34	0.82

1: N=21 2: N=8

#: N=14 ##: N=7

*: $p<.05$

On the Stability dimension family members and therapists who identified the presenting problems as improved had a mean rating of 2.50 (SD=0.76) while family members and therapists who identified the presenting problem as unimproved had a mean rating of 3.44 (SD=0.88). Thus, family members and therapists who identified the presenting problem as improved had a mean attributional rating on the

Stability dimension following therapy that was significantly different from the mean attributional rating of family members and therapists who identified the presenting problem as unimproved. This difference in attributional ratings indicates that family members and therapists who identified the presenting problem as unimproved considered the cause to be more temporally stable (i.e. less changeable) than participants who identified the problem as improved.

10. The difference in attributional ratings from before family therapy to following family therapy of family members and therapists who identified the presenting problems as improved will not differ significantly from the difference in attributional ratings from before family therapy to following family therapy of family members and therapists who identified the presenting problem as unimproved.

The means and standard deviations of family members and therapists who identified the presenting problem as either improved or unimproved are given for each of the attributional dimensions in Table 9.

Table 9. Means and Standard Deviations of the Difference in Attributional Ratings from Prior to Therapy to Following Therapy of Improved and Unimproved Family Members and Therapists

	DIF			
	Improved[1]		Unimproved[2]	
	Mean	SD	Mean	SD
Locus-				
self	-0.36#	1.55	-0.14##	0.89
other	-0.46#	1.70	-0.78##	1.99
relationship	-0.60	1.25	-0.25	2.66
circumstances	-0.75*	1.65	1.00#	2.45
Globality	0.12	1.02	0.28	0.96
Stability	0.21	0.70	-1.00**	0.96
Controllability	-0.28	0.75	-0.19	1.01
Intent	-0.02	0.62	-0.09	0.82

1: N=21 2: N=8

#: N=14 ##: N=7

*: p<.05

**: p<.01

On the Locus-circumstances dimension, family members and therapists who identified the presenting problem as improved had a mean rating of -0.75 (SD=1.65) while family members and therapists who identified the presenting problem

as unimproved had a mean rating of 1.00 (SD=2.45). Thus, family members and therapists who identified the presenting problem as improved had a change in their mean attributional rating on the Locus-circumstances dimension that was significantly different from the change in the mean attributional rating of family members and therapists who identified the presenting problem as unimproved. Specifically, participants who rated the presenting problem as improved increased their rating, following a course of family therapy, of the extent to which the cause of the problem had to do with situational factors while the other participants did just the opposite.

On the Stability dimension family members and therapists who identified the presenting problem as improved had a mean rating of 0.21 (SD=0.70) while family members and therapists who identified the presenting problem as unimproved has a mean rating of -1.00 (SD=0.96). Thus, family members and therapists who identified the presenting problem as improved had a mean attributional rating on the Stability dimension that was significantly different from the mean attributional rating of family members and therapists who identified the presenting problem as unimproved. Specifically, participants who identified the presenting problem as having improved considered the cause of the problem to be less stable following a course of family therapy. In contrast, participants in the "unimproved" group viewed the cause as more stable.

CHAPTER V

DISCUSSION

This study was motivated by an interest in providing specific information about family members' and therapists' cognitions during a period of family therapy. In this final chapter the results and the implications of this study will be discussed as they pertain to practice, theory and research. This chapter will conclude with some comments about the limitations of the study and recommendations for future research in this area.

A. The Relationships of Family Members' and Therapists' Attributions

The first set of relationships under study were the attributions of family members and therapists at the beginning and following a period of family therapy. In Chapter II the author reviewed literature that demonstrated the emphasis placed on the shared nature of cognitions in family relationships by family theorists and researchers. In contrast, it was pointed out, attribution theorists and researchers have often focused upon identifying differences in the attributions made by individuals in close relationships. In neither the family nor the attribution

literature has much been said about the relationship of therapists' to family members' cognitions.

The findings from this study indicated that, with only one exception, there were no significant differences in the attributions made by family members and therapists at the start of and following a period of family therapy. These data are consistent with the family systems emphasis on the shared nature of family members' cognitions and contrast with the findings from previously mentioned studies in which a family level attributional style was not evident (Compas et al., 1981; Munton & Antaki, 1988; Munton & Stratton, 1990). However, before one concludes that these data indicate that family members and therapists share in their attributions about the presenting problem, several other possible explanations should be considered. First, most of the ratings fell near the midpoint of the 5 point scale. Thus, the similarity in ratings may only represent a tendency by participants to avoid making extreme choices in their attributional ratings.

Second, family members and therapists often differed in their identification of the cause of the presenting problem. Therefore, the similarity in their dimensional ratings likely reflects a consistency in a broader cognitive perspective (e.g., a construct or worldview) rather than agreement about a specific cause of a particular presenting problem.

Third, the findings reported here represent comparisons between groups of mothers, fathers, children and therapists. Differences in attributional ratings between members of specific families were not examined.

The relationship of therapists' and family members' attributions was an area of particular interest in this study. The absence of differences between these groups at the start of therapy may be explained as an effort by therapists to accomodate to the family's view of the problem. The development of a therapeutic alliance is a common element in most models of psychotherapy. Within the various schools of family therapy this has been emphasized through descriptions of various joining maneuvers (Minuchin & Fishman, 1981). The finding that therapists' attributions continued to remain similar to the attributions of family members may reflect a respect for a) the views of the family, b) the difficulty with which change in one's views is accomplished and/or, c) an effort to hold a view only slightly unlike that of the family. In regards to the latter, family theorists have addressed the idea that therapists must develop hypotheses (i.e. cognitions) that differ, but are not too different, from those held by the family (Tomm, 1984). Minuchin and Fishman (1981) offered the following reminder to therapists of the delicate balance between ideas that provoke change and one's that may prevent it,

> "Alternatives should not be framed as another world; people are afraid of new things. Besides, few would abandon, like an old shoe, a reality that has served well, and which has many legitimations supporting it. Instead, the therapist offers, en passant, an expansion--a hint of an alternative--something that modifies the boundaries of the unknown" (p. 212).

A cursory examination of the data in Tables 3 and 4 suggests that, in most instances, the therapists' ratings differed (were higher), though not significantly so, than the ratings of family members.

The one instance in which a difference was found in family members' or therapists' pre or post treatment attributional ratings, involved mothers' pre-treatment assessment on the Locus-circumstances dimension. Mothers' mean rating (4.50) differed significantly from the mean ratings of fathers (2.75), children (2.50) and therapists (3.25). It is not clear why this occurred. However, this finding indicates that relative to fathers, children and therapists, mothers believed that situational factors were more influential to the cause of the problem. While speculative, this may have reflected mothers' desires to avoid blaming individuals or the relationships of family members for causing the presenting problem.

B. The Relationships of Pre-therapy Attributions to Post-therapy Attributions

An analysis of the difference in attributional ratings from pre to post treatment found only two changes that were significant. For the most part, the attributions of family members and therapists did not change significantly over the course of therapy. This finding is consistent with other studies that have attempted to identify changes in attributional phenomena in families following family therapy related interventions (Alexander, Waldron, Barton & Mas, 1989; Munton & Antaki, 1988).

In this study, two instances were identified in which there were significant differences in terms of pre to post attributional change as well as when changes in the attributions made by each group of subjects were compared with each other. Specifically, the change in mothers' attributional ratings on the Locus-self dimension from 1.71 to 3.00 was significant. In addition, the amount of change (-1.28) differed significantly from the changes in the ratings of fathers (-0.50) and children (0.50). Following therapy, mothers considered the cause of the presenting problem to have substantially more to do with them than they did prior to therapy. Fathers' and children's ratings on this dimension changed only slightly. The actual meaning of the increase in mothers' attributions to self is unclear. One explanation may be that the change in mothers'

attributions on the Locus-self dimension constitutes a shift towards uniformity in family members' attributions on this dimension. Even though mothers' pre-treatment rating on this dimension was not significantly different from the ratings of fathers and children, by the time of the second attributional assessment mothers' ratings were even more similar to those of other family members.

Another possible explanation regarding the significant change in mothers' Locus-self rating relates to the issue of amenability to change. This finding may represent a greater willingness by mothers to change, particularly in regards to their role vis-a-vis the cause of the problem.

The change in therapists' attributional ratings on the Intent dimension from 2.40 to 2.84 was also significant. This change also differed significantly from the amount of change recorded by mothers (0.33), fathers (0.12) and children (0.12) on this dimension. Therapists' attributions on the Intent dimension became significantly less negative (i.e. more positive) over the course of therapy. This was true even though therapists usually continued to view the cause of the problem as the same following therapy as they did before therapy. For example, one therapist viewed the cause of a child's behavior problems as due to inconsistent parenting and marital problems. While the therapist continued to see these as the primary causes following therapy, her rating on the Intent dimension became less negative.

Family theorists have argued that the principles of systemic therapy are non-pathologizing (Haley, 1980). In addition, the descriptions of interventions such as positive connotation, in which symptomatic behaviors are reframed as having beneficial effects on family relationships (Tomm, 1984), have no doubt influenced family therapists to consider the causes of problem behaviors in a relatively positive light.

C. Therapists' Attributions on the Locus Dimension

Therapists' attributional ratings of mothers, fathers and children did not differ before or following therapy nor were there any significant changes in these ratings over the course of therapy. Family theory has emphasized the relational aspects of problem behaviors. Therefore, it would have been somewhat surprising to have found family therapists identifying the cause of the problem as having more to do with one family member than another. In addition, the attention directed toward the systemic family therapies' concept of neutrality (Selvini-Palazzoli, Cecchin, Prata & Boscolo, 1980) may also account for therapists comparable perceptions of individual family members. Systemic therapists attempt to maintain a neutral stance in regards to aligning with a particular family member or idea. As a result of this, it would be consistent for a systems

therapist to consider all family members as contributing in equivalent ways to the family's problem.

D. Attributions and Therapeutic Outcome

These analyses compared the attributions of individuals who identified the presenting problem as improved versus those who identified it as unimproved. Prior to therapy there were no significant differences. However, following therapy the two groups differed on the Stability dimension. Specifically, the improved group rated the cause of the presenting problem as less stable (2.50) than the unimproved group (3.44). The notion that subjects reporting improvement in the presenting problem are more likely to view the cause as less stable (i.e. more changeable) not only makes intuitive sense but is consistent with the post-treatment findings of the Munton and Antaki (1988) study. These two studies differ, however, in that the difference between the pre and post treatment ratings of the unimproved group in this study (-1.00) was significant. In the Munton and Antaki study, the 'unchanged' families displayed no differences in their attributions from pre to post treatment. In this study, members of the unimproved group viewed the cause of the presenting problem as more stable following than before therapy.

There was also a difference in the change in ratings on the Locus-circumstances dimension. Specifically, improved

individuals indicated an increase in their attributions to this dimension (-0.75) while unimproved individuals indicated a decrease (1.00). One possible explanation for this concerns the special emphasis made by systemic family therapists regarding the contexts in which problem behaviors occur. It may be that improved individuals were able to use the therapists questions to gain a greater appreciation of the contextual (i.e. circumstantial) influences impinging upon the cause of the presenting problem. In contrast, unimproved individuals may have had a converse reaction to the therapists focus on gathering contextual information.

In general, attributional differences were not good indicators of therapeutic outcome. For example, in this study changes in the presenting problem were usually not accompanied by changes in attributions. Participants would likely to have been heard saying, "the problem has improved but our thoughts about why the problem occurred have not changed." The general absence of a relationship between cognitive and behavioral change during family therapy again presents a challenge to the notion that they are linked. It may be, as has been previously suggested, that the failure to find changes in attributions associated with clinical changes is due to various methodological factors. This study attempted to address some of these through the use of a direct rating questionnaire, by focusing only on attributions for the presenting problem, by employing a clinical sample and by comparing individuals rather than

families. Given the continued general absence of cognitive changes associated with behavioral changes following a course of family therapy one must remain open to the prospect that a direct relationship, for whatever reasons, does not exist.

E. Implications of this Study

1.Therapeutic Implications

The findings of this study failed to challenge the notion that therapists should continue to think of families in terms of shared cognitions. However, as has already been discussed, the absence of attributional differences may have been due to a number of methodological issues. The absence of changes in cognition associated with family therapy suggests that the emphasis on meanings may be misplaced. One area in which the findings support an emphasis on meanings is suggested by the differences in attributions between improved and unimproved individuals on the Stability dimension. Consistent with the conclusions of researchers who have argued for the usefulness of changing particular attributions (e.g., Munton & Stratton, 1990), interventions aimed at helping family members view the cause of the presenting problem as less stable may improve the possibility of change. The notion that therapy might usefully be directed at changing ideas about the temporal

stability of the presenting problem and its underlying causes is not new. However, this finding lends empirical support to systemic family therapy interventions that specifically focus on cognitive change in this area (e.g., Chasin, Roth & Bograd, 1989; Penn, 1985).

This study focused on the direct assessment of family members' and therapists' conscious cognitions. As such, it was consistent with clinical authors (Furman & Ahola, 1988; Kirmayer, 1990) who have advocated such an approach. Circular questioning and paradoxical interventions associated with systemic and strategic family therapies may be useful in identifying unconscious patterns of family cognition and circumventing family members' resistance. However, the possibility that these approaches may engender confusion and promote distrust cannot be ignored. The direct questioning of family members' conscious ideas and beliefs may be just as useful and is consistent with the constructivist philosophy upon which the systemic family therapies adhere,

> "Radical constructivism maintains...that the operations by which we assemble our experiential world can be explored, and that an awareness of this operating...can help us do it differently and, perhaps, better" (von Glasersfeld, 1984).

2. Theoretical and Research Implications

This study employed concepts and research from attribution theory in an effort to clarify and study theoretical ideas from the systemic family therapies regarding family members' cognitions. The author argued that, while descriptions of cognitive phenomena by family theorists have been vague and lacked empirical study, attributional concepts are specific and have a large research base. Consistent with the views of several social psychologists, the author argued that incorporating information from attribution theory would serve to enrich the systemic family therapies' in their theoretical discussions of cognitive processes within the family therapy system. While inconclusive, the results of this study are consistent with the systemic family therapies' emphasis on shared cognitions. In almost every instance, efforts failed to identify differences in family members' attributions.

On the other hand, the findings from this study raise questions regarding the therapeutic efficacy of the emphasis on cognition that is advocated by adherents of the 'new epistemology'. Changes in cognition have been shown to accompany clinical improvement in other areas of psychology, and so it is tempting to extrapolate the importance of cognition in the process of family therapy. However, until studies can demonstrate the clinical efficacy of an emphasis

on cognition, families and family therapists may be better served by the 'old epistemology's' emphasis on behavior.

Information from attribution theory was also applied to the study of therapists' cognitions. Therapists' cognitions were found to be quite similar to those of family members. While the explanations offered for this seem reasonable, it remains possible that there were substantial differences between therapists' and family members' attributions and that they simply went undetected. Further study of therapists' cognitions is certainly needed and, as pointed out earlier, is consistent with the second-order cybernetic view upon which the 'new epistemology' rests. One additional area of interest might be the study of what occurs when therapists' attributions do differ markedly from those of family members. Is resistance engendered, as family theory might predict, or are improved outcomes the result?

This study also introduced a dimension of Intent to the examination of attributions. It is of interest that one of the few dimensions upon which pre to post therapy differences were found was on this dimension. Additional study is needed to address the validity of Intent as an attributional dimension and the potential role it may play in the cognitive processes of families and therapists. For example, what is the relationship between changes in therapists' attributions to Intent and outcome?

F. Limitations of the Study

In Chapter I the author indicated that this study was being undertaken in the spirit of constructive realism. This philosophical position attempts to locate a middle ground between the metaphysical reality of objectivism and the relativistic consensus of constructivism. Up to now the report of this study has reflected the objectivist/empiricist tradition. In discussing some of the limitations of this study (clearly, one can never identify all of them, nor would one want to) the author not only wishes to alert the reader to existing and potential impingements on the reliability and validity of the study's findings. It is hoped, as well, that acknowledegement of the limitations recognizes a respect for the constructivist perspective in which we are reminded that the truth we have discovered is largely, if not entirely, a function of the investigators beliefs and methods.

While the author hopes that the reader will find the results of this study to be useful, a number of limitations may have had undue effects. For example, the size of the sample was quite small. This was due to a number of factors that precluded the involvement of most of the family therapists with whom the author spoke. Many therapists were simply too busy and too overworked to participate. However, a substantial number did not participate based upon concerns

that involvement in the study might somehow interfere with the therapeutic process, or that participation in the study might be too anxiety provoking for their families, or that concepts of linear causality are so anti-thetical to their work as systemic family therapists they would not be able to complete the questionnaire. While each of these reasons is open to challenge, it seems sufficient to acknowledge the extreme difficulty encountered when the author attempted to recruit an adequately sized clinical sample of families. Obviously, a larger sample would have produced a more powerful statistical analysis in which one could have greater confidence in the validity and reliability of the findings.

The selection of the sample in this study was not random. Therapists were recruited by the author and families were recruited by the therapists. All of the therapists who participated are friends of the author. Also, the author is aware that therapists were sometimes selective in their recruitment, asking families who appeared more reliable than others. In addition, the sample was limited to families in rural and suburban areas. All of the families were seen in out-patient therapy and all paid for therapy with private insurance. Also, since demographic data were not collected it is not known to what extent these may have affected the results of the study. Generalization of the findings of this study to other populations should be done with cautious consideration of the limits of this sample.

Since this was a clinical study that involved family therapists at several sites, it was difficult to insure uniformity in the practice of family therapy. While all of the therapists identified themselves as sytemically oriented family therapists it is not known to what extent they practice in ways that are consistent with the 'new epistemology'. It may be that the absence in cognitive changes was due to the therapists emphasis on matters other than family member's meanings.

The assessment of outcome used in this study possessed several limitations. Three times as many subjects identified the presenting problem as improved versus unimproved. Even more impressive was that in 7 out of the 8 families in the study the therapist judged the presenting problem as improved. The possibility cannot be discounted that requesting family members and therapists to judge the status of their own therapy may have resulted in overly optimistic assessments. Future studies would be prudent to employ other, less subjective methods of outcome assessment.

A major shortcoming of this study relates to the difficulties encountered modifying an instrument that could adequately manage the complexities of assessing attributions in the relationships of family members and therapists. Changes in the locus dimension that were described in Chapter III represented one effort to address this issue. Attributions made for one's own behavior as opposed to another's were difficult to deal with and may have

confounded the results. Findings that family members share attributions may have been the product of the target of their causal explanation. Typically, attributions are requested for specific behaviors. However, this study required that attributions be made regarding the presenting problem. Ordinarily, the presenting problem is a general statement about problem behavior, such as "he is depressed" or "we don't communicate", rather than the identification of a single, specific event. The similarity in family members attributions may have resulted from the general nature of the behavior for which the attributions were directed. In addition, the self-report nature of the amended 4-ADS renders it susceptible to intentional distortions. It may be that family members' similar attributional ratings reflect an effort to respond in a moderate way. Of the 82 attributional ratings appearing in tables 3 through 10 only 6 were outside the range of 2 to 4. It may that subjects were reluctant to make more extreme ratings. In the two previous clinical studies of attributions in family therapy, members causal explanations were extracted from transcripts or tapes of actual sessions, thereby reducing the possibility of intentional distortion.

Despite efforts to use an instrument understandable even to children as young as 9 years old, there were occasional comments that the questionnaire items produced some confusion. This was, in part, due to the need to change the wording of some items to reflect the possibility that

the attributions were being made about someone other than the respondent. Also, while the addition of the dimension of intent to the 4-ADS was based upon logical reasoning, it lacks the empirical validation provided the other dimensions. Finally, concerns that subjects might make attributional inferences to the presenting problem rather than its cause were apparently borne out. In a few instances, participants responded to the dimensional ratings without having written down a cause. It is unknown if this was simply a failure to record the identified cause or if, in fact, the dimensional ratings related to the presenting problem. Stratton et al. (1986) attempted to address the issues involved when attributions are made for a behavior, its cause or their relationship. However, this remains an unstudied area of attributional assessment; one which goes well beyond the interests and conceptual sophistication of people outside the field of psychology. Suffice it to say, future studies interested in using a direct rating instrument to assess the attributions of family members and therapists will need to pay further attention to these issues.

G. Recommendations for Future Study

The process of conceptualizing, designing, conducting and reporting on a research project such as the one described here has provided numerous opportunites for

learning. While the content of the study rightfully deserves the attention afforded it, the information revealed by engaging in the process of research is also of great value.

The following is a sampling of the conclusions at which the author, having completed this process, has arrived:

1. It is important to integrate ideas and information from various areas of psychology. The systemic family therapies seem quite willing to incorporate information from areas like physics and biology, why not a greater effort to welcome ideas from the various branches of psychology?

2. It is important to do research with families and therapists who are actually engaged in therapy. Analogue studies that utilize college undergraduates or that ask subjects to engage in activities such as playing scrabble or imagining a problem seem to offer little in the way of information that is generalizeable to the typical clinical situation.

3. As a corrolary to #2, it is crucial to future clinical research that clinicians demonstrate a greater willingness to participate. The indoctrination of this viewpoint must begin during the graduate training of therapists and should address the myriad of reasons which might impede students' future involvement in research.

4. It is important to directly question family members and therapists about their conscious cognitions. It may also be useful to assess, through indirect methods, their unconscious cognitions.

5. It is important to do follow-up assessments. Munton & Antaki (1988) questioned if differences in cognition related to therapeutic outcome might emerge sometime after changes in behavior. This author had originally planned to do a follow-up assessment. However, time constraints made this impractical. Nonetheless, future studies should consider making the effort.

6. The quality of the data is directly reflected by the instruments and methods used to gather it. Despite efforts to amend the 4-ADS in ways that would a) keep it simple and understandable, and b) provide the necessary information, problems or questions emerged all too frequently in one area or the other. In order to directly assess family members attributions improvements must be made in the instruments used. Also, whenever possible, it is better if the questionnaires can be administered directly by the researcher. At the start of this study this seemed impractical due to constraints of time, distance and money. However, after months of attempting to recruit therapists and following hours spent trying to insure that the questionnaires were administered properly, the author has concluded that personally administering the instruments would have been worth the sacrifices involved.

FOOTNOTES

1. Due to therapists' concerns about the time required to collect data and due to the investigators's need to rely upon the therapists as the collectors of the data, demographic information was not gathered.

2. The Kruskal-Wallis and Wilcoxon tests are both nonparametric and distribution free statistical methods. They were chosen for use in this study because of the small number of cases and because it could not be assumed that the distribution of scores (i.e. ratings) would be normal. The latter assumption was based upon expectations that various forms of bias would tend to skew the attributional ratings made by members of each of the groups. The major disadvantages of using nonparametric methods are the loss of statistical power and the likelihood of making Type II errors.

APPENDIX A

RECRUITMENT LETTERS

March 1992

Dear colleague,

I am writing to request your participation in a study that I am conducting in order to fulfill the dissertation requirement for my doctorate in Counseling Psychology. Currently, I am a candidate for a Ph.D. at the University of Massachusetts/Amherst.

This study will examine the causal explanations or attributions made by family members and therapists during a period of family therapy. The proposal for this study has been approved by a committee of three faculty members and by the Human Subjects Review Committee of the School of Education, University of Massachusetts/Amherst.

Why study family members and therapists attributions?

Family therapy has been widely accepted as a way in which therapists may help others. However, research aimed at explaining how and why family therapy works is still needed. One important way in which family therapy works is centered on the explanations that are made by family members and therapists for the cause or causes of the problem. Recent theoretical statements in the family therapy literature have called attention to the importance of clients' as well as therapists' cognitions. Until now, family therapists have studied other factors relevant to family therapy, while the study of causal explanations has primarily been of interest to researchers in social psychology. Few studies have combined the two areas in the ways proposed by this study.

Who may participate?

Members of families who are about to begin family therapy and their therapist are needed for this study. The following criteria should be helpful in determining if a family is appropriate for inclusion in the study.

___family is defined as including at least two members, one of whom is the parent and the other is their child or adolescent.

___children who participate must be at least nine years old.

___single parent families may participate.

___parents or parental figures and children/adolescents who are not biologically related (e.g., children from previous relationships or adopted children, step-parents or significant others) may participate.

___the focus of therapy may be on the child's or adolescent's behavior or on a problem that one or both of the parents is having.

___ it is expected that family members who participate in the study will have attended at least two sessions. A minimum of two family therapy sessions is required for a

family to be included in the study.

Therapists who are invited to participate in this study are those that employ therapeutic techniques that are consistent with the term "systemic family therapies".

Approaches that are included under this term are structural, strategic, interactional (e.g., MRI) and Milan models of family therapy. Other models of family therapy that have been influenced by systems theory, constructivism and second-order cybernetics are also appropriate for inclusion in this study.

What must family members and therapists do to participate in the study?

Therapists who are interested in participating should ask families who are about to begin therapy if they would like to participate in the study. Participation in the study involves responding to a questionnaire on two occasions.

Each family will receive one copy of Part A of the questionnaire. Part A asks the family to indicate the problem for which they are coming to therapy and who is exhibiting the problem. Each family member will receive a copy of Part B of the questionnaire. Part B should be answered independently by family members. Family members will be asked what they think is the primary cause of the problem. Then, they will be asked to rate the cause in response to a number of multiple choice questions. Therapists will respond to their own copy of Part B of the questionnnaire, using the family's answers from Part A regarding the nature of the problem and who is exhibiting it.

It is suggested that families arrive approximately 20 minutes before their first scheduled appointment in order to complete the questionnaire. If a family is unable to do this or if this is unsuitable for your site, questionnaires may be mailed to the family for them to complete and bring to the first session.

Family members will be asked to complete the questionnaire prior to the first family therapy session and two months later. Families who terminate before two months may complete the second questionnaire anytime after termination. Therapists will be asked to complete a questionnaire following the first family therapy session and two months later or at termination (depending on which of the latter two occurs first). Instructions for how to complete the questionnaires will be included.

All of the questionnaires will be coded with an identification number to insure that questionnaires from one family and their therapist are not mixed with questionnaires from another family and their therapist. An index card that will be enclosed will be kept by the therapist with the appropriate identifying information recorded on it.

Confidentiality

As just described, each family will be assigned an identification number. A family's therapist will be the only person who will know which identification number corresponds to their family. Participants will complete the questionnaires independently, which means that no one except me will see their responses. The only document that participants will put their names on will be the Consent Form. The Consent Form will be kept by the family therapist and a form that confirms that the Consent Form has been signed will be sent to me.

Parents must give written permission for their child/adolescent to participate in the study. Any participant may withdraw from the study at any time, even after they have completed their questionnaires. Questionnaires from participants who withdraw will be destroyed.

If a family member or therapist has questions about anything pertaining to the study or has other questions that the study raises for them, I will be happy to answer those questions as they arise. For participants interested in the results of the study, I will make available an abstract of the study (which summarizes the results) after the study's completion.

What do participants get from this study?

Participation in this study provides family members and therapists with an opportunity to contribute to the body of knowledge relating to how family therapy works. Without direct participation from families in therapy and therapists, we must rely on generalizations from non-clinical families or worse, college undergraduates.

Responding to the questionnaire itself will likely have some psychological effect. The questionnaire is aimed at clarifying participant's thoughts. Such a process may serve to reinforce already held beliefs or stimulate the formation of new ones. This seems likely to be true for both family members and therapists.

Finally, families and therapists who complete both the pre and post therapy questionnaires will become eligible for one of two drawings (one each for families and therapists). Each winner will receive a $50 gift certificate to the restaurant of their choice.

How does one volunteer to participate in the study?

Anyone who is interested in participating in the study or would like additional information about any aspect of the study may contact me at home (802-257-5228).

Thank you,

Dan Lafleur

March 1992

Dear family,

Thank you for agreeing to participate in my research study. I am conducting the study in order to fulfill the dissertation requirement for my doctorate in Counseling Psychology. Currently, I am a candidate for a Ph.D. at the University of Massachusetts/Amherst.

This study will examine the causal explanations or attributions made by family members and therapists during a period of family therapy. The proposal for this study has been approved by a committee of three faculty members and by the Human Subjects Review Committee of the School of Education, University of Massachusetts/Amherst.

Participation in the study involves responding to a questionnaire on two occasions. The questionnaire takes approximately 15 minutes to complete.

Part A of the questionnaire asks the family to indicate the problem for which they are coming to therapy and who is exhibiting the problem. Part B of the questionnaire asks each family member what they think is the primary cause of the problem. Then, each family member will be asked to rate the cause in response to a number of multiple choice questions.

Family members will be asked to complete the questionnaire prior to the first family therapy session and two months later. Families who are done with therapy before two months may complete the second questionnaire anytime after termination.

All of the questionnaires will be coded with an identification number to insure confidentiality and so that questionnaires from one family and their therapist are not mixed with questionnaires from another family and their therapist. A family's therapist will be the only person who will know which identification number corresponds to their family. Family members' names will not be written on the questionnaires. The only document that participants will put their names on will be the Consent Form, which will be kept by the family's therapist. Since participants will complete their questionnaires independently, no one except me will see their responses.

Parents must give written permission for their child/adolescent to participate in the study. Any participant may withdraw from the study at any time, even after they have completed their questionnaires. Questionnaires from participants who withdraw will be destroyed.

If a family member has questions about anything pertaining to the study or has other questions that the study raises for them, I will be happy to answer those questions as they arise. Questions may be relayed to me through your therapist. For participants interested in the results of the study, I will make available an abstract of the study (which summarizes the results) after the study's completion.

Your participation in this study is greatly appreciated, as it will contribute to the body of knowledge relating to how family therapy works. Without direct participation from family's in therapy we must rely on information from studies of families who are not in therapy or studies done using college students.

Families who complete both the pre and post therapy questionnaires will become eligible for a drawing in which the winner will receive a $50 gift certificate to the restaurant of their choice.

Thank you,

Dan Lafleur

APPENDIX B

CONSENT FORMS

Family Consent Form

We, the undersigned, agree to participate in Daniel Lafleur's doctoral research. We understand that Mr. Lafleur is studying the kinds of explanations made by family members and therapists during a period of family therapy. We also understand that this study has been approved by the Counseling Psychology program and the Human Subjects Review Committeee in the School of Education at the University of Massachusetts, Amherst. We agree to allow our children, _____, _____, _____, to participate in this study, and assume all risks and responsibilities on their behalves.

We understand that we will be asked to respond to questions about our explanations and about whether or not there has been improvement in the problem(s) for which we came to therapy. We understand that the questionnaire used in this study has been tested in previous research.

We understand that our identities will not be known to anyone other than our therapist. We understand that our participation is voluntary and that we may withdraw from the study and ask that our questionnaires be destroyed and not used in the study at anytime and without prejudice. We understand that Mr. Lafleur will attempt to answer any questions we may have about this study at any time and that we may request that Mr. Lafleur provide us with an abstract of the study that discusses its results.

We agree that we will not hold Mr. Lafleur nor the University of Massachusetts responsible for any injury (physical, psychological or otherwise) or damage that occurs in relation to this research.

We are aware of all risks, described or implied, with this research, and agree to participate as an act of our own free will.

_____ _____

Parent's signature/date Parent's signature/date

_____ _____

Child's signature/date Child's signature/date

_____ _____

Child's signature/date Therapist's signature/date

Consent Form Confirmation

Family #_____ Date:_____

In order to insure the confidentiality of family members participating in Daniel Lafleur's research study of attributions in family therapy, it is necessary that their family therapist maintain possession of their signed Consent Form.

I have checked the Consent Form to confirm that it has been signed by the family members participating in Mr. Lafleur's study and I agree to retain the consent form in my records for one year.

Therapist's signature_____

APPENDIX C

PRE-TREATMENT ASSESSMENT and POST-TREATMENT ASSESSMENT

INSTRUCTIONS

1. Ask family to participate in the study.

2. Explain that participation involves completing a questionnaire prior to the first session and again at termination or after a period of two months.

3. Invite family to come in early to complete the questionnaire or mail the packet to the family.

4. Get completed Part B of questionnaires from family. These should be in the envelope they came in which should be sealed.

5. Complete therapist's version of Part B using family members' responses to Part A.

6. Check consent form for signatures and sign Consent Form Confirmation. Write family's name and the date on the index card. Keep consent form and index card in your records.

7. Enclose the family's envelope, Part A of the questionnaire, your completed Part B and the Consent From Confirmation in the larger envelope.

8. Mail the questionnaires back to me. I will then send you the questionnaires you will be using later in the study.

Thank you,

Dan Lafleur

Dear Colleague,

June 1992

Enclosed are the materials needed to participate in the second part of my research project. Included are:
--the original copy of Part A of the questionnaire (for use as a reference when completing Part B)
--one copy of the therapist's version of Part B of the questionnaire
--one copy of the family version of Part B of the questionnaire for each member of the family who participated in the first assessment.

These materials are to be used at a point approximately two months after the inital assessment. I will contact you at about that time to remind you to complete your form and to ask the family members to complete theirs. I am sending these materials to you at this time so that you will have them available to complete should treatment terminate prior to two months. If this occurs, please complete your questionnaire and ask family members to complete theirs at the time of termination or soon thereafter.

If you have recruited more than one family for participation in the study, please check the identification number with the one on the index card that you previously completed to insure that the number corresponds with the appropriate family. Also, if possible, ask family members to make sure they are completing their own copy of the questionnaire. Each questionnaire has been marked to indicate to whom it corresponds (i.e. mother, father, child/adolescent) and contains the cause that person identified at the commencement of therapy.

Drawings will be held upon completion of the study for $50 gift certificates for a therapist and a family who have participated in the study. The winning family will be notified by their therapist.

Therapists who are local to the Brattleboro area may call me to arrange pick up of the completed questionnaires. Therapists from other areas may use the enclosed postage and return label. If you have any questions, please feel free to call me collect at home (802-257-5228).

Thank you again for your help.

Sincerely,

Dan Lafleur

APPENDIX D

ATTRIBUTIONAL DIMENSION SCALES

Family #_____ Date:_____

Attributional Dimension Scale--Part A

Family members may work together to answer the questions on this form. If family members are unable to agree to a single answer to each question, the problem as it was identified by the person who called to make the family therapy appointment should be used.

1. What is the problem for which you and your family are coming to therapy? If there is more than one, please choose the primary or most important.

2. Who has been exhibiting (showing) the problem?

Please do not enclose this form in the envelope. Your therapist will use your answers to these questions to respond to their copy of Part B of the questionnaire.

Attributional Dimension Scale--Part B

Before therapy
Family version

Family #_____

Check one:
__Mother
__Father
*__Child/Adolescent

This form helps us to understand more about the causes of the problems for which people go to therapy. This is not a test, and there are no right or wrong answers.

Remember, family members should work separately to answer this questionnaire.

Often when a problem occurs, people seek an explanation for it. Usually this is done by asking why the problem has or is happening. For example, "why did I do poorly in school?" The answer to a question like this is called a causal explanation or attribution. For example, "because I did not study". Problems may have more than one cause. However, for the purpose of our study, we want you to pick just one.

1. What do you think is the primary or most important cause of the problem that you wrote down on Part A of this questionnaire? Or, why is the problem happening?

Next, we would like to know what you think about the cause that you just wrote down. While some of the following questions may seem repetitve it is important that you answer every one.

1. To what extent does the cause of the problem have to do with: (circle a number for each choice)

you	not at all	1	2	3	4	5	mostly
other family members (specify) _____	not at all	1	2	3	4	5	mostly
_____	not at all	1	2	3	4	5	mostly
the relationships of family members to one another	not at all	1	2	3	4	5	mostly
circumstances	not at all	1	2	3	4	5	mostly

*If more than one child/adolescent in a family participates, please identify their questionnaire with their first and middle initials _____

For the following questions, place an x next to your choice.

2. Is the cause you wrote down, something that:
___Will stay the same over time
___Can change only a little over time
___Can change a fair amount over time
___Can change a lot over time
___Will change a lot over time

3. Is the cause something that the person(s) showing the problem:
___Can completely control
___Has a lot of control over
___Has some control over
___Has only a little control over
___Cannot control at all

4. Is the cause you gave something that:
___Would happen only in this special situation
___Would happen in a few similar situations
___Would happen in some similar situations
___Would happen in most similar situations
___Would happen in this situation and in other situations

5. Is the cause:
___Mostly about being unhelpful
___Partly about being unhelpful
___Neither about being unhelpful nor helpful
___Partly about being helpful
___Mostly about being helpful

6. Do you think the cause you gave would:
___Never again be present
___Rarely be present again
___Sometimes be present again
___Usually be present again
___Always be present

7. Is the cause you gave, something that happens to the person(s) showing the problem:
___Very often in different situations
___Often in different situations
___Sometimes in different situations
___Rarely in different situations
___Very rarely in different situations

8. Is the cause you gave, something for which the person(s) showing the problem:
___Is not at all in control of
___Is only a very little bit in control of
___Is a little bit in control of
___Is mostly in control of
___Is completely in control of

9. Do you think the cause you gave:
___Reflects a positive attitude
___Only somewhat reflects a positive attitude
___Reflects neither a positive nor negative attitude
___Only somewhat relfects a negative attitude
___Reflects a negative attitude

10. Do you think the cause you gave:
___Could change only a little bit from one year to the next
___Could change a little bit from one year to the next
___Could change somewhat from one year to the next
___Could change a lot from one year to the next
___Could change very, very much from one year to the next

11. Is the cause you gave something that:
___Someone can completely control
___Someone can control very much
___Someone can control a fair amount
___Someone can control only a little
___Someone cannot control at all

12. Would this cause be true for the person(s) showing the problem:
___Only in this special event
___In this event and in some similar events
___In most similar events
___In most areas of the person's life
___In all areas of the person's life

13. Does the cause indicate:
___Selfishness
___Only a little selfishness
___Not selfishness nor unselfishness
___Only a little unselfishness
___Unselfishness

14. Is the cause something that:
___Will probably change a whole lot during a year
___Might change a lot during a year
___Might change quite a bit during a year
___Rarely change even a little during a year
___Never change within a year

15. Is the cause you gave, true for the person(s) showing the problem:
___In most similar circumstances
___In many similar circumstances
___In some similar circumstances
___Only in this type of circumstance
___Only on this particular circumstance

16. Is the cause you gave, something for which:
___No one has control
___Someone has only a very little bit of control of
___Someone has a little bit of control of
___Someone is partly in control of
___Someone is very much in control of

17. Does the cause demonstrate:
___A very caring attitude
___A somewhat caring attitude
___Neither a caring attitude nor an uncaring attitude
___A somewhat uncaring attitude
___A very uncaring attitude

Please place this part (Part B) of every family member's questionnaire in the envelope provided, seal the envelope and give it to your therapist. Also, please give to your therapist Part A of the questionnaire and your signed Consent Form.

Thank you.

Attributional Dimension Scale--Part B

Before therapy Therapist Name_____

Family #_____ Date:_____

This form helps us to understand more about the causes of the problems for which people go to therapy. This is not a test, and there are no right or wrong answers.

While family members and therapists may have different ideas about why the family is coming to therapy, for the purposes of this study we would like you to respond to the presenting problem as it has been identified by the family on Part A of this questionnaire.

Often when a problem occurs, people seek an explanation for it. Usually this is done by asking why the problem has or is happening. For example, "why did I do poorly in school?" The answer to a question like this is called a causal explanation or attribution. For example, "because I did not study". Problems may have more than one cause. However, for the purpose of our study, we want you to pick just one.

1. What do you think is the primary or most important cause of the presenting problem that the family wrote down on Part A? Or, why is the problem happening?

Next, we would like to know what you think about the cause that you just wrote down. While some of the following questions may seem repetitve it is important that you answer every one.

1. To what extent does the cause of the problem have to do with: (circle a number for each choice)

mother	not at all	1	2	3	4	5	mostly
father	not at all	1	2	3	4	5	mostly
child/adolescent (specify) _____	not at all	1	2	3	4	5	mostly
_____	not at all	1	2	3	4	5	mostly
_____	not at all	1	2	3	4	5	mostly
the relationships of family members to one another	not at all	1	2	3	4	5	mostly
circumstances	not at all	1	2	3	4	5	mostly

For the following questions, place an x next to your choice.

2. Is the cause you wrote down, something that:
___Will stay the same over time
___Can change only a little over time
___Can change a fair amount over time
___Can change a lot over time
___Will change a lot over time

3. Is the cause something that the person(s) showing the problem:
___Can completely control
___Has a lot of control over
___Has some control over
___Has only a little control over
___Cannot control at all

4. Is the cause you gave something that:
___Would happen only in this special situation
___Would happen in a few similar situations
___Would happen in some similar situations
___Would happen in most similar situations
___Would happen in this situation and in other situations

5. Is the cause:
___Mostly about being unhelpful
___Partly about being unhelpful
___Neither about being unhelpful nor helpful
___Partly about being helpful
___Mostly about being helpful

6. Do you think the cause you gave would:
___Never again be present
___Rarely be present again
___Sometimes be present again
___Usually be present again
___Always be present

7. Is the cause you gave something that happens to the person(s) showing the problem:
___Very often in different situations
___Often in different situations
___Sometimes in different situations
___Rarely in different situations
___Very rarely in different situations

8. Is the cause you gave, something for which the person(s) showing the problem:
___Is not at all in control of
___Is only a very little bit in control of
___Is a little bit in control of
___Is mostly in control of
___Is completely in control of

9. Do you think the cause you gave:
___Reflects a positive attitude
___Only somewhat reflects a positive attitude
___Reflects neither a positive nor negative attitude
___Only somewhat relfects a negative attitude
___Reflects a negative attitude

10. Do you think the cause you gave:
___Could change only a little bit from one year to the next
___Could change a little bit from one year to the next
___Could change somewhat from one year to the next
___Could change a lot from one year to the next
___Could change very, very much from one year to the next

11. Is the cause you gave something that:
___Someone can completely control
___Someone can control very much
___Someone can control a fair amount
___Someone can control only a little
___Someone cannot control at all

12. Would this cause be true for the person(s) showing the problem:
___Only in this special event
___In this event and in some similar events
___In most similar events
___In most areas of the person's life
___In all areas of the person's life

13. Does the cause indicate:
___Selfishness
___Only a little selfishness
___Not selfishness nor unselfishness
___Only a little unselfishness
___Unselfishness

14. Is the cause something that:
___Will probably change a whole lot during a year
___Might change a lot during a year
___Might change quite a bit during a year
___Rarely change even a little during a year
___Never change within a year

15. Is the cause you gave, true for the person(s) showing the problem:
___In most similar circumstances
___In many similar circumstances
___In some similar circumstances
___Only in this type of circumstance
___Only on this particular circumstance

16. Is the cause you gave, something for which:
___No one has control
___Someone has only a very little bit of control of
___Someone has a little bit of control of
___Someone is partly in control of
___Someone is very much in control of

17. Does the cause demonstrate:
___A very caring attitude
___A somewhat caring attitude
___Neither a caring attitude nor an uncaring attitude
___A somewhat uncaring attitude
___A very uncaring attitude

Attributional Dimension Scale--Part B

After therapy
Family #_____
Date:_____

__Mother
__Father
__Child/Adolescent
_____Initials

Please make sure you have the correct copy of this form. For example, mother's copy has a check above, next to mother. If more than one child/adolescent in a family is participating, check to make sure each child/adolescent has the correct copy, as indicated by their initials.

As you may recall, this form helps us to understand more about the causes of the problems for which people go to therapy. This is not a test, and there are no right or wrong answers.

We are interested in what you now think about the cause of the problem for which your family originally came to therapy. Part A of this questionnaire, with the answers provided by you and your family before the start of therapy, is enclosed in your envelope. Please refer to the answers that you gave at that time when responding to this questionnaire. Family members should respond separately to this questionnaire.

Often when a problem occurs, people seek an explanation for it. Usually this is done by asking why the problem has or is happening. For example, "why did I do poorly in school?" The answer to a question like this is called a causal explanation or attribution. For example, "because I did not study". Problems may have more than one cause. However, for the purpose of our study, we want you to pick just one.

Before therapy, you wrote down that you thought the following was the primary or most important cause of the presenting problem that your family identified on Part A:

Do you now think the cause you wrote down at the beginning of therapy is the primary cause of the problem? Yes___ No___ If no, please write down what you now think is the primary cause of the problem.

Next, we would like to know what you to think about the cause that you currently think is most important. While some of the following questions may seem repetitve it is important that you answer every one.

1. To what extent does the cause of the problem have to do with: (circle a number for each choice)

you	not at all 1 2 3 4 5	mostly
other family members (specify) _____	not at all 1 2 3 4 5	mostly
_____	not at all 1 2 3 4 5	mostly
the relationships of family members to one another	not at all 1 2 3 4 5	mostly
circumstances	not at all 1 2 3 4 5	mostly

For the following questions, place an x next to your choice.

2. Is the cause you wrote down, something that:
___Will stay the same over time
___Can change only a little over time
___Can change a fair amount over time
___Can change a lot over time
___Will change a lot over time

3. Is the cause something that the person(s) showing the problem:
___Can completely control
___Has a lot of control over
___Has some control over
___Has only a little control over
___Cannot control at all

4. Is the cause you gave something that:
___Would happen only in this special situation
___Would happen in a few similar situations
___Would happen in some similar situations
___Would happen in most similar situations
___Would happen in this situation and in other situations

5. Is the cause:
___Mostly about being unhelpful
___Partly about being unhelpful
___Neither about being unhelpful nor helpful
___Partly about being helpful
___Mostly about being helpful

6. Do you think the cause you gave would:
___Never again be present
___Rarely be present again
___Sometimes be present again
___Usually be present again
___Always be present

7. Is the cause you gave, something that happens to the person(s) showing the problem:
___Very often in different situations
___Often in different situations
___Sometimes in different situations
___Rarely in different situations
___Very rarely in different situations

8. Is the cause you gave, something for which the person(s) showing the problem:
___Is not at all in control of
___Is only a very little bit in control of
___Is a little bit in control of
___Is mostly in control of
___Is completely in control of

9. Do you think the cause you gave:
___Reflects a positive attitude
___Only somewhat reflects a positive attitude
___Reflects neither a positive nor negative attitude
___Only somewhat relfects a negative attitude
___Reflects a negative attitude

10. Do you think the cause you gave:
___Could change only a little bit from one year to the next
___Could change a little bit from one year to the next
___Could change somewhat from one year to the next
___Could change a lot from one year to the next
___Could change very, very much from one year to the next

11. Is the cause you gave something that:
___Someone can completely control
___Someone can control very much
___Someone can control a fair amount
___Someone can control only a little
___Someone cannot control at all

12. Would this cause be true for the person(s) showing the problem:
___Only in this special event
___In this event and in some similar events
___In most similar events
___In most areas of the person's life
___In all areas of the person's life

13. Does the cause indicate:
___Selfishness
___Only a little selfishness
___Not selfishness nor unselfishness
___Only a little unselfishness
___Unselfishness

14. Is the cause something that:
___Will probably change a whole lot during a year
___Might change a lot during a year
___Might change quite a bit during a year
___Rarely change even a little during a year
___Never change within a year

15. Is the cause you gave, true for the person(s) showing the problem:
___In most similar circumstances
___In many similar circumstances
___In some similar circumstances
___Only in this type of circumstance
___Only on this particular circumstance

16. Is the cause you gave, something for which:
___No one has control
___Someone has only a very little bit of control of
___Someone has a little bit of control of
___Someone is partly in control of
___Someone is very much in control of

17. Does the cause demonstrate:
___A very caring attitude
___A somewhat caring attitude
___Neither a caring attitude nor an uncaring attitude
___A somewhat uncaring attitude
___A very uncaring attitude

Please rate the problem for which you came to therapy as either:
___improved

___not improved

How many of the family therapy sessions did you attend?

Has a new or different problem been identified? If so, how would you describe that problem.

Please indicate whether or not you would like a summary of the results of this study when the study is completed.

___yes

___no

Please place this part (Part B) of every family member's questionnaire in the envelope provided, seal the envelope and give it to your therapist. Also, please give Part A of the questionnaire to your therapist.

Completion of this form entitles your family to be eligible for a drawing for a $50 gift certificate to the restaurant of your choice. The drawing will occur upon completion of the study. The winning family will be notified by their therapist.

Thank you again for your participation in this research study.

Dan Lafleur

Attributional Dimension Scale--Part B

After therapy Therapist Name_____

Family #_____ Date:_____

As you may recall, this form helps us to understand more about the causes of the problems for which people go to therapy. This is not a test, and there are no right or wrong answers.

We are interested in what you now think about the cause of the problem for which this family originally came to therapy. Part A of the questionnaire, with the answers provided by the family prior to therapy, is enclosed. Please refer to the answers to Part A when responding to this questionnaire.

Often when a problem occurs, people seek an explanation for it. Usually this is done by asking why the problem has or is happening. For example, "why did I do poorly in school?" The answer to a question like this is called a causal explanation or attribution. For example, "because I did not study". Problems may have more than one cause. However, for the purpose of our study, we want you to pick just one.

After the first session, you indicated that you thought the following was the primary or most important cause of the presenting problem that the family identified on Part A:

Do you currently think this cause is the primary cause of the presenting problem? Yes___ No___ If no, please write down what you now think is the primary or most important cause of the problem.

Next, we would like to know what you think about the cause that you currently think is the most important. While some of the following questions may seem repetitve it is important that you answer every one.

1. To what extent does the cause of the problem have to do with: (circle a number for each choice)

mother	not at all	1	2	3	4	5	mostly
father	not at all	1	2	3	4	5	mostly
child/adolescent (specify) _____	not at all	1	2	3	4	5	mostly
_____	not at all	1	2	3	4	5	mostly
_____	not at all	1	2	3	4	5	mostly
the relationships of family members to one another	not at all	1	2	3	4	5	mostly
circumstances	not at all	1	2	3	4	5	mostly

For the following questions, place an x next to your choice.

2. Is the cause you wrote down, something that:
___Will stay the same over time
___Can change only a little over time
___Can change a fair amount over time
___Can change a lot over time
___Will change a lot over time

3. Is the cause something that the person(s) showing the problem:
___Can completely control
___Has a lot of control over
___Has some control over
___Has only a little control over
___Cannot control at all

4. Is the cause you gave something that:
___Would happen only in this special situation
___Would happen in a few similar situations
___Would happen in some similar situations
___Would happen in most similar situations
___Would happen in this situation and in other situations

5. Is the cause:
___Mostly about being unhelpful
___Partly about being unhelpful
___Neither about being unhelpful nor helpful
___Partly about being helpful
___Mostly about being helpful

6. Do you think the cause you gave would:
___Never again be present
___Rarely be present again
___Sometimes be present again
___Usually be present again
___Always be present

7. Is the cause you gave something that happens to the person(s) showing the problem:
___Very often in different situations
___Often in different situations
___Sometimes in different situations
___Rarely in different situations
___Very rarely in different situations

8. Is the cause you gave, something for which the person(s) showing the problem:
___Is not at all in control of
___Is only a very little bit in control of
___Is a little bit in control of
___Is mostly in control of
___Is completely in control of

9. Do you think the cause you gave:
___Reflects a positive attitude
___Only somewhat reflects a positive attitude
___Reflects neither a positive nor negative attitude
___Only somewhat relfects a negative attitude
___Reflects a negative attitude

10. Do you think the cause you gave:
___Could change only a little bit from one year to the next
___Could change a little bit from one year to the next
___Could change somewhat from one year to the next
___Could change a lot from one year to the next
___Could change very, very much from one year to the next

11. Is the cause you gave something that:
___Someone can completely control
___Someone can control very much
___Someone can control a fair amount
___Someone can control only a little
___Someone cannot control at all

12. Would this cause be true for the person(s) showing the problem:
___Only in this special event
___In this event and in some similar events
___In most similar events
___In most areas of the person's life
___In all areas of the person's life
13. Does the cause indicate:
___Selfishness
___Only a little selfishness

___Not selfishness nor unselfishness
___Only a little unselfishness
___Unselfishness

14. Is the cause something that:
___Will probably change a whole lot during a year
___Might change a lot during a year
___Might change quite a bit during a year
___Rarely change even a little during a year
___Never change within a year

15. Is the cause you gave, true for the person(s) showing the problem:
___In most similar circumstances
___In many similar circumstances
___In some similar circumstances
___Only in this type of circumstance
___Only on this particular circumstance

16. Is the cause you gave, something for which:
___No one has control
___Someone has only a very little bit of control of
___Someone has a little bit of control of
___Someone is partly in control of
___Someone is very much in control of

17. Does the cause demonstrate:
___A very caring attitude
___A somewhat caring attitude
___Neither a caring attitude nor an uncaring attitude
___A somewhat uncaring attitude
___A very uncaring attitude

Please rate the presenting problem as either:
___improved

___not improved

How many family therapy sessions were conducted?

Has a new or different problem been identified? If so, how would you describe that problem.

Please indicate whether or not you would like a summary of the results of this study when the study is completed.
___yes

___no

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