A Focus of attention and its effects on the attribution of blame for children's problems

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Faculty of the School of Education
College of William and Mary in Virginia

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

By
Ellen Kean Rudolph
July, 1977
We, the undersigned, do certify that we have read this dissertation and that in our individual opinions it is acceptable in both scope and quality as a dissertation for the degree of Doctor of Education.

Accepted July 1977 by

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ABSTRACT

FOCUS OF ATTENTION AND ITS EFFECTS ON THE ATTRIBUTION OF BLAME FOR CHILDREN'S PROBLEMS

RUDOLPH, ELLEN KEAN, Ed.D.
THE COLLEGE OF WILLIAM AND MARY IN VIRGINIA, 1977

CHAIRMAN: DR. FRED L. ADAIR

This study explored the effects of the child-focus phenomenon on the attribution of blame for problems. It was designed to demonstrate a relationship between parental focus of attention and externalization of problems to the child.

The relationship between deviant child behavior and parental pathology has long been recognized. Systems theory and the family movement have called attention to the existence of a child-focus phenomenon, which describes a mechanism through which the anxiety of marital discord is defused by way of a projection of the problem to a "special" child. Although this process appears to be rigid and highly stabilized within a pathological family system, the Theory of Objective Self-awareness by Duval and Wicklund (1972) suggests it is not.

This theory addresses itself to the nature of the conditions that cause consciousness to focus on the self, and it provides a general model relating focus of attention to attribution of causality. To the extent that a person focuses attention upon one object or area of the environment to the exclusion of other areas, the theory predicts that he will tend to attribute causality for any event to that object or area.

A test of the theory on a highly focused population (N=60) of parents of child psychiatric patients called for a manipulation of the person's focus of attention toward one or another object. Subjects were randomly assigned to two experimental conditions and one control condition and were asked to imagine themselves in ten hypothetical situations involving negative outcomes, where either the subject or another person might be "at fault".

Predicted outcomes and results included:

1. An increase in objective self-awareness will bolster the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences. (Rejected, p<.05)

2. An increase in subjective self-awareness will reduce the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences. (Rejected, p<.05)
3. Subjects judged to be child-focused by a therapist will show less objective self-awareness under all conditions than subjects judged to be more self-aware, and this effect should operate for both neutral and loaded consequences. (Rejected, \( p < .05 \))

Hypotheses 1 and 2 were tested by repeated measures analysis of variance with percentage of blame to the self as the dependent measure, and neutral-loaded scores as repeated measures in a paired comparison mode. A t-test for significance of independent sample means was used to determine if there were differences between subjects judged to be child-focused and those who were judged to be more self-aware. All three hypotheses were tested at the .05 level of significance.

Results indicate that the child-focus phenomenon interferes with the usual process of attribution of causality in some significant ways. The experimental treatments were not effective in this case in altering the process of attribution, but the neutral-loaded variable significantly affected it in the direction of increased self-blame. Previous research did not predict an interaction of this nature in light of the theoretical notion that the person's location of causality is solely determined by the direction and focus of his attention.
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The reality of the other person is not in what he reveals to you, but in what he cannot reveal to you. Therefore, if you would understand him, listen not to what he says but rather to what he does not say.

—Kahlil Gibran
FOCUS OF ATTENTION AND ITS EFFECTS
ON THE ATTRIBUTION OF BLAME
FOR CHILDREN'S PROBLEMS
Chapter 1
Introduction

An emerging trend in child psychiatry is the moving away from intrapsychic ways of viewing and treating children's problems.

A large body of research focuses on the relationship between child deviance and parental adjustment. David Levy’s (1943) classic study of maternal overprotection was one of the first to clearly establish a relationship between pathology in the mother and disturbed behavior in the child. His study showed a correlation between an overprotective attitude in the mother and deprivation of love in the mother’s own childhood.

The concept of the "symbiotic tie" came into currency in the 1950's, ushering in a period of even greater attention to patterns of pathology in relationships. The term referred specifically to a pathogenic relationship between mother and child (Mahler, 1952). Hill (1955) gave attention to the symbiosis between mother and child in schizophrenia, pointing out that the mother of the schizophrenic gives love excessively but conditionally. The patient comes to believe that if he gets well his mother will get sick, so by staying sick he preserves his mother's mental as well as physical sense of well-being. Hill points out that, by meeting the mother's conditions, the child forfeits development of an independent personality.

There have been numerous studies comparing the characteristics of parents of disturbed children with parents of normal children, and many
have found a positive relationship between the presence of child behavior disorders and parental pathology (i.e., Block, 1969; Jenkins, 1966; Wolff & Acton, 1968). MMPI profiles of parents of referred children have often been compared with those of normal control parents (i.e., Hanvik & Bryun, 1959; Lauterback, London, & Bryan, 1961; Liverant, 1959; Wolking, Quant, & Lawton, 1966). Liverant (1959), for example, found that the fathers of disturbed children showed up as more concerned with bodily complaints and illness, gloomier in their outlook on life, and more tense and anxious. The mothers, too, were more impulsive and less mature and more depressed, and they laid blame on other people for their problems. They were also inclined to act out their aggressions and unconventional impulses.

Becker, Peterson, Hellmer, Shoemaker, and Quay (1959) charted the characteristics of the families of two groups of maladjusted children. Parents of the "conduct problem" group were maladjusted, inclined to be arbitrary with their children, and likely to give vent violently and unpredictably to their emotions. The mothers were active and tense and dictatorial, and the fathers were withdrawn from the situation and tended not to enforce regulations within the family. For the group of children with "personality problems," Becker et al. (1959) found the role of the father to be significantly more important than the mother in terms of thwarting the child. Similar findings by Wolking, Quant, and Lawton (1966) support the notion that parents of child psychiatry patients have reliably more signs of personality pathology and poor interpersonal adjustment than adults from the general population.

A series of studies by Jenkins (1966, 1968, 1973) outline the varieties of children's behavioral problems and their relation to family
His 1968 analysis of 1,500 cases of children examined at the Institute for Juvenile Research in Chicago resulted in five computerized clusterings of child disorders: (1) overanxious neurotic, (2) unsocialized aggressive, (3) socialized delinquent, (4) brain damaged, and (5) shy, seclusive, withdrawn, schizoid. He found that mothers of overanxious children were most likely to be characterized as infantilizing and overprotective. Both of the aggressive groups were likely to have mothers whose attitudes were overtly rejecting and punitive. Mothers of unsocialized aggressives were critical, lacking in consistency, and had a deprecative attitude toward the child. Mothers of socialized delinquents were cold, distant, and neglectful, and were not likely to be married to the child's father at the time of conception.

The father's attitudes toward the unsocialized aggressive was characterized by a lack of consistency. Their attitudes towards the socialized delinquent were controlling, rigid, acting out through the child, punitive, cold, and distant. The socialized delinquent's father was also likely to be alcoholic. Both parents of socialized delinquents were not accepting of their involvement in the child's problems, nor were they accepting of therapy for themselves.

Parental correlates also seem to exist in other areas, such as in the etiology of aggression (McCord, McCord, & Howard, 1961); delinquency (Glueck & Glueck, 1950); school phobia (Davids, 1973); schizophrenia (Lidz, 1973); developmental hyperactivity (Bakwin & Bakwin, 1966); and somatic complaints (Looff, 1970). The literature documents an even wider variety of psychiatric syndromes and behavior disorders in children which point to parental psychopathology and marital discord. The implications for clinical work with families in child cases referred
Statement of the Problem

The literature thoroughly defines and describes the deviant child and parental pathologies, but it rarely addresses the factors behind the referral of children to child psychiatric facilities. There is, it seems, a sharp contrast between those individuals who come to a therapist because they want to change their own behavior, and the mother or father who brings a child to a therapist because they want the child's behavior changed.

What are the factors that precipitate such a child referral? Kanner (1960) notes that deviant children will more than likely be referred to clinics in the absence of tolerant and resourceful parental attitudes. A study by Shepherd, Oppenheim, and Mitchell (1966) found that clinic children did not differ from supposedly normal children in their symptomatic behavior. Their survey demonstrated that a normal population included children with behavioral disturbances comparable to those patients at a child guidance clinic, but that certain factors predisposed the clinic parents to seek psychiatric help, such as being anxious, more easily upset, less able to cope with their children, and much more likely to consult with others about their problems. Leighton, Stollak, and Ferguson (1971), too, suggest that the abnormal family seeks help at a clinic because of increasing conflict and decreasing means of resolving these conflicts because of a breakdown in communication.

The most provocative explanation is underscored by Martin and Twentyman's (1976) suggestion of excesses of direct and indirect blame.
on the part of parents as factors precipitating referral. They divide
the domain of troubled parent-child interactions into two broad areas:
(1) one involving how the parent and child talk about a problem and (2)
what they do about it when a problem arises. Martin and Twentyman (1976)
suggest that parents engage in an interactive sequence which they define
as a problem interaction:

Whatever the initiating act, the sequence will tend to follow its
own typical course and outcome for that parent and child. The
parent may press the child with questions, more directly blame
and criticize, or become angry and yell or slap. The child in
turn may withdraw from the interaction, cry, become sullen, or
counterattack verbally or physically. Both participants are
likely to wind up in a state of distress. (p. 145)

This blaming process needs to be more fully explored, particularly
in light of Martin and Twentyman's (1976) conclusion that excesses of
direct or indirect blame is detrimental to successful problem-solving.
Parents who seek psychiatric help for their children seem, indeed, to
have relatively stable attributions regarding the locus of blame for
their children's problems. While some may consider their children's
problems as arising from sources external to parental control (i.e., in-
born temperament, or hereditary factors), and some regard their chil-
dren's problems as being related to their own parental behavior, most
parents come to the mental health setting with their focus upon the
child.

The purpose of this study is to explore the effects of the child-
focus phenomenon on the attribution of blame for problems. The study
will attempt to demonstrate that parent's focus of attention may well
play an important role in both the assignment of blame and in the subse-
quent externalization of the problem to the child.
Theory

A review of theory pertaining to the study is divided into two basic areas. The first is the theory base behind the child-focus phenomenon. The second, which relates to the empirical manipulations of the study itself, discusses the conceptual framework of the objective self-awareness theory of Duval and Wicklund (1972).

Child Focus

Communication theorists such as Haley (1963a) and Satir (1964) define the family as a system with its own rules, roles, and expectations which help to produce and maintain the deviant behavior of its members. They describe human interaction in game-like terms; that is, there are rules, both covert and overt, that govern the interactions among players. How the rules evolve is not as crucial as are the present interactions of the players, and the influence the rules have on future behavior. The system is considered pathological when the rules are set in such a way that the family is locked into a self-defeating pattern that is not open to change. Incapacitating power struggles, destructive coalitions, triangles, and scapegoating (Ferreira, 1967; Haley, 1963b; Jackson, 1968; Satir, 1964) are problems which can cause disturbances in what Hoffman (1976) calls the family homeostatic system.

The family movement has called attention to the fact that symptomatic behaviors "occur in a matrix of other behaviors, that they are linked to and supported by these behaviors, and that the totality constitutes some sort of formal program which has to do with the survival of a larger unit, usually the family" (Hoffman, 1976, p. 503). The child's symptoms, in this context, are interwoven with the behaviors of other members of the family, which supports Ackerman's (1958) earlier
claim that psychiatric illness as a single or isolated instance does not occur in family life.

There is a vast diversity of evidence in the psychiatric literature for the existence of a child-focus phenomenon. In defining it as a mechanism for redirecting tension away from some other area of the family, Hoffman (1976) uses the example of a parental conflict. If the parents begin to struggle with each other more openly, their own relationship may be endangered. Focus on a child allows them to express their disagreement, but in a disguised way around the topic of the child's behavior. As Satir (1964) notes, "the child's symptoms are an SOS about his parents' pain and the resulting family imbalance" (p. 2). The literature repeatedly draws attention to the dysfunctional family system where the anxiety of marital conflict is defused by way of a projection of the problem to a "special" child. The different labels for the process may be unique, but the relationship dynamics are similar.

Fogarty (1976) addresses this issue in his discussion of the dimensions of the self. One of the basic assumptions of systems theory is that all people seek closeness. "As people move closer to one another," Fogarty observes, "the level of emotionality between them rises, and so does the level of expectation. Each person finds it difficult to remain close, and at the same time maintain a space between himself and others" (p. 147). He calls this process fusion, which arises out of the conflict between the two spouses. "To maintain the relationship," Fogarty goes on to say, "the twosome will form a triangle. Rather than face the sensitivities, the increasing distance between them, the emptiness in each of them, they will displace their emotional tensions onto a third party or issue. Thus the twosome avoids a personal
confrontation by discussing difficulties in terms of a third party" (p. 148). Once fusion exists, and once a problem has been acknowledged by a family, they will move to place it either in one person or between people in the family relationship system.

Ackerman (1957) was one of the first to discuss "blame for the disorder" (p. 280) in noting the natural consequences of attribution of responsibility for child-rearing. He thought it conceivable that a parent might accept responsibility for the child and yet reject the accusation of his or her influence. His discussion of the parent's emotional rejection of a child underscores what other theorists (i.e., Bowen, 1965, 1966) were later to describe in more detail as the family projection process:

It is necessary to examine the history of the mother's emotional interaction with her child beginning with her original cravings for a baby, when this was a mere product of her fantasy, reaching up through the events of pregnancy, childbirth, and finally, the sequential quality of her emotional 'give and take' with the child from birth on. There are kinds of emotional rejection of the child that come directly out of the mother's specific emotional response to a particular child; as, for example, a mother who rejects a child because it looks too hairy since she has had a life-long anxiety about having an excess of hair on her legs and breasts; or the mother who, feeling her own buttocks are too large, can't bear to cleanse the child's buttocks after a bowel movement because they are too painful a reminder of her own; or the mother who, having anxiety about childbirth in the first place, sustains an injury in the act of birth and forever after blames this child for it. Then there is the mother, very vain about her body figure, who never forgives the child for the change after birth in the contour of her breasts. (p. 283)

These are specific instances resulting in rejection because the mother associates some threat or injury with a particular child. There are other instances, as Ackerman (1957) goes on to describe, which are only peripherally associated with sources of threat to the mother, but which still result in rejection:
For example, a mother has unresolved guilt towards her own mother. She gives birth to a child shortly after her mother's death. The two events become associated in her mind. Her mother's death induces a crisis of guilt. She reacts to this with a hostile effort to deny it . . . and . . . displaces this hostility to the child. Or, a woman is married to a man who fervently desires a son to carry on his family name. She gives birth instead to a female child . . . feels that she has let her husband down . . . and deals with her guilt by becoming hostile to the innocent female child. (p. 284)

In each instance of Ackerman's (1957) narrative, the mother is reacting to her sense of failure. She can build up the conviction that the child was born bad and there is nothing she can do about it. Or she can take it out on the child by punishing him for her own failure.

Ryan (1971) discusses this issue of "blaming the victim" (p. 5). He sees it as "an ideological process . . . a set of ideas and concepts deriving from systematically motivated, but unintended distortions of reality" (p. 10). It's as though, he contends, we cannot comfortably believe that we can be the cause of our own problems. So we search for deviance in others to explain it, and then we identify that deviance as the cause of the problem. This process leads to what others in the literature refer to as scapegoating.

Bozormeni-Nagy (1965), particularly, discusses the family scapegoating process "... where someone is assigned an object role by the collusive action of several other family members" (p. 60). He contends that at times of stress the system of family interactions almost inevitably includes a certain amount of scapegoating where, quite frequently, "the only expression of tensions in the parental marriage occur in the form of the parents' joint censure of . . . an offspring's misbehavior" (p. 68). He describes scapegoating as an age-old process, designed for the magical expulsion of evil.
It requires the existence of a group, the members of which feel threatened by some implication of evil (plague, sin, etc.) and who agree to use an Other (goat, slave, prisoner, etc.) to impersonate evil, which is ultimately to be gotten rid of through destruction of the scapegoat. Scapegoating, thus, requires at least three participants. Though one person can attempt to project badness upon another, ordinarily he cannot exert a social sanction alone; he needs a third one who will validate his notions of the 'bad' identity of the scapegoat. (Boszormenji-Nagy, 1965, p. 70)

In the family a variety of roles can be assigned to the scapegoat. A young child may be accused of having an innately bad disposition; two children may be assigned the role of being incorrigible and destructive to each other; or the marriage may habitually be referred to as bad. Exaggeration of the focus on the scapegoat reduces the tension elsewhere in the family system.

In some families scapegoating is incessant and the style of blame and attack may shift focus from one family member to another (Lewis, Beavers, Gossett, & Phillips, 1976). Others develop stable internal scapegoats on the order of "Peck's bad boy" (Lewis et al., 1976, p. 4) who will become a "flamboyantly visible behavior problem . . . so that other family members can remain consciously virtuous by projecting their faults and hidden wishes onto their family scapegoat" (p. 64).

Systems theory refers to this as the family projection process (Bowen, 1965, 1966, 1972, 1975, 1976). The most frequent pattern, according to Bowen (1972), is one which operates through the mother—which enables her to become less anxious by focusing on the child. Children "selected" for the family projection process are: children conceived and born during stress in the mother's life; the first child; the oldest son or youngest daughter; an only child of either sex; one who is emotionally "special" to the mother, or one the mother believes to be "special" to the father. Bradt and Moynihan (1971) expand upon
Bowen's list of events in family life which seem to over-determine a child as the emotional center of the projection process. These include: special circumstances surrounding birth (i.e., unwanted pregnancy, premature birth, adoption); introduction of the child into the family system at a time when the family is experiencing some threat to its equilibrium; the child is born after one or more miscarriages; after a long failure to conceive a desired child; after the death of another child, or after the birth of a "damaged" child; a child born into a marriage sharply reacted to negatively by grandparents; a child named after a loved one, or a despised one; or born after other events such as family migration, job stress, retirement, divorce, apparent menopause, or long illness.

The amount of special emotional investment in such children is great, and they gradually become more impaired and more demanding in the face of infantilizing, overprotective parental patterns.

Bowen (1965) describes the terms "blamer" and "self-blamer" as one aspect of the projection process: "People divide themselves into blamers and self-blamers. . . . In a tense situation both look for causes to explain the situation. The blamer looks outside himself; he looks for the cause in the environment, and he is incapable of looking inside the self. The self-blamer accurately perceives the cause in self but he is as impaired at looking outside himself as the blamer is at looking inside the self" (p. 224).

It is probably safe to say that the real cause of any situation is a combination of internal and external factors and, theoretically at least, a mature person can objectively evaluate both factors and be responsible for the part he plays. This notion is supported by Bowen
when he contends that the more immature the person, the more intense the blaming and self-blaming. Under certain circumstances "the blamer can become self-blamer and the self-blamer a vehement blamer . . . when the self-blamer reaches an overload of self-blaming, he can erupt into blaming. The self-blamer is as irresponsible as the blamer in assuming responsibility for self" (Bowen, 1965, p. 225).

In clinical work, family theorists have come to use the term "the triangulated child" (Bowen, 1976, p. 84) to refer to the main focus of the projection process. Bowen (1976) describes the process in some detail:

The parental problem is most often projected to the child by the mother, with the father supporting her viewpoint. She . . . is an immature person with deep feelings of inadequacy who looks outside herself for the cause of her anxiety. . . . The projection goes into fears and worries about the health and adequacy of the child. It searches out small inadequacies, defects, and functional failures of the child, focuses on them, enlarges and exaggerates them into major deficiencies. The projection system can create its own defects (i.e., the mother feels and thinks about the child as a baby, calls him a baby, treats him like a baby -- and when the child accepts the projection, he becomes more infantile). . . , which is a small price to pay for a calmer mother.

(p. 225)

The important function of the process, of course, is to locate and confirm that the "cause" is outside the mother. It is a common assumption among family theorists that the usual psychiatric consultation fits right in with the family projection process. The patient is examined, some pathology is confirmed, and treatment recommendations are given. The entire process condones the externalization of the parental problem to the "patient."

R. D. Laing (1972) speaks of projections in terms of "attributions" (p. 78) which he sees as many times more powerful than overt forms of coercion. "One may tell someone," for example, "to feel something and not to remember he has been told. Simply tell him he feels it. Better
yet, tell a third party, in front of him, that he feels it" (p. 79).

The relationship of one to another, Laing (1972) notes, may be so power-
ful that one person becomes what the other person takes him to be.

He contends that many children begin life in a state like this.

They more or less take up their position in the state we define. As an
example, Laing notes that "... a naughty child is a role in a particu-
lar family drama. Such a drama is a continuous production. His parents
tell him he is naughty, because he does not do what they tell him. What
they tell him he is, is induction, far more potent than what they tell
him to do. Thus through the attribution: 'You are naughty,' they are
effectively telling him not to do what they are telling him to do" (p.
80). This is not a deliberate strategy, but just a part of what the
family gives its members in the way of "distinctions, options, identi-
ties, definitions, rules, repertoires of operations, instructions, attrib-
utions, loci, scenarios, roles, parts to play" (Laing, 1972, p. 121).

Bateson, Jackson, Haley and Weakland (1956) draw attention to an
interesting process in families which they call the "double bind" (p.
251). They found that the child who becomes schizophrenic "is habitually
subjected to conflicting messages and demands that he cannot fulfill
because they are mutually exclusive, and at the same time cannot escape
from the impossible situation because of his dependency upon, and need
for, the parent or parents imposing the demands" (Lidz, 1973, p. 66).
In other words, the child is "damned if he does and damned if he doesn't."

Bateson and his coworkers (1956) identify the following as the
necessary ingredients for a double bind situation: (1) two or more per-
sons, one of which is designated as the "victim"; (2) repeated exposure
to the double-binding theme in the experience of the victim; (3) a
primary negative injunction, such as "Do not do so and so, or I will punish you."
(4) a secondary injunction conflicting with the first, but at a more abstract level, commonly communicated to the child by non-verbal means through posture, gesture, tone of voice, or the implications concealed in verbal comment; and (5) a tertiary negative injunction prohibiting the victim from escaping the field, i.e., through capricious promises of love.

Watzlawick (1963) provides a thorough review of the double bind theory for the interested reader, and Lidz (1973) offers some clinical examples of it from the communication patterns of both skewed and schizmatic families (p. 33-42 and p. 44-55). In the cases he presents, the mother interferes with the child's development of initiative and autonomy by being overprotective and controlling while failing to establish proper boundaries between herself and the child. The double bind grows out of the parent's profound egocentricity, or narcissistic needs.

The child-focus phenomenon is described in the literature in detail from one final perspective, that of the child-centered family (Barragan, 1976; Minuchin, 1974).

Barragan's (1976) statement of the child-centered family is one of the more comprehensive in that she attempts to define what child-centered families are, how they function, what their origins are, and how they can be recognized and identified.

She notes that in such families parents frequently focus on their children in an attempt to provide for them the things that they themselves lacked. The more a couple centers on their children, the easier it is for them to avoid marital confrontation. Barragan observes that because the children's success is extremely important to the continued
functioning of the family, "... its indicators are watched anxiously. Every measurement, every word said by the pediatrician is carefully registered, not to speak about the amount and balance of food, hours of sleep, dental care, and of course, very high on the list, progress in school" (Barragan, 1976, p. 240).

**Objective Self-Awareness**

The theory of objective self-awareness proposed by Duval and Wicklund (1972) addresses itself to the nature of the conditions that cause consciousness to focus on the self. It takes as central the notion that the person will evaluate himself when he focuses on himself, and it provides a new conceptual framework from which the child-focus phenomenon may be analyzed.

Heider (1958) suggested that man attempts to bring order to his world by determining the causal antecedents of events. This process of determining causality has come to be called attribution theory (Shaver, 1975) and several theorists have contributed important clarifications to the basic idea (i.e., Jones & Davis, 1965; Jones & Nisbett, 1971; Kelley, 1967). The present status of attribution theory can be summarized as follows:

Given that man desires to control his environment by understanding the causes of events (changes in his environment), any event that does not already have an adequate explanation will engage the attribution process. This process is essentially a search for the cause of the event, and the search is terminated only when the person infers or perceives dispositional properties of entities in the environment or person that serve as sufficient explanations. Given that the person is searching for the cause of an event, what rules or mechanisms determine where in the total environment he will locate the cause? (Duval & Wicklund, 1973, p. 18)

The major attribution theorists each assume a set of rules for determining causality. Duval and Wicklund (1972) emphasize the area of the environment to which the individual is paying attention. Briefly,
given that an event affects a change in the environment, the theory of objective self-awareness predicts that the direction of the attribution will be determined by the focus of attention. It assumes that at any given moment attention is directed either wholly toward the self, or wholly toward external events, and that attention can oscillate between the two. Stimuli that remind the person of himself will increase objective self-awareness while all other stimuli will tend to draw attention to the environment. In other words, if he is focused upon himself, he should tend to attribute causality to himself. If he is focused on the environment, then he should attribute causality in that direction, and away from himself.

The theory asserts that conscious attention is both bidirectional, meaning that consciousness can either be directed toward the self or away from the self, and dichotomous (Duval & Wicklund, 1972, p. 2), which finds support in Piaget's (1966) concept of egocentrism and in Mead's (1934) construct of the self as both the object and subject of consciousness. Egocentrism, as Piaget (1966) defines it, implies an inability to perceive self-contradictory actions.

Duval and Wicklund (1972) make a definite distinction between objective self-awareness and subjective self-awareness. Subjective self-awareness is a state where conscious attention is focused on events external to the self; he is concerned with other people, other objects and events, and he is not aware of himself as an object. In contrast, in the state of objective self-awareness, consciousness is focused exclusively upon the self and the person attends to himself. The distinction between the two states implies that "attention cannot be focused simultaneously on an aspect of the self and on a feature of the environment"
The theory assumes, further, that the objectively self-aware person will come to evaluate himself as soon as the objective state occurs. Self-focused attention sets into motion an automatic comparison of the self with internal standards of correctness. Theoretically, negative self-evaluation should always accompany objective self-awareness, since there will always be a discrepancy between one's real and ideal self. It follows that the person's immediate reaction to the objective state would be an avoidance of the self-focusing stimuli (Wicklund, 1975).

Whether the person is in one state or the other at any given moment is determined primarily by factors in his present situation. The assumption is made that subjective self-awareness is the primary state and that "the environment is normally a strong enough stimulus to draw attention to it" (Duval & Wicklund, 1972, p. 7). The theory predicts that a person will actively seek the subjective state and will seek out methods of moving out of the objective state whenever he finds himself there. The theory thus provides some insight into possible motivational consequences underlying the direction of consciousness. In discussing the factors controlling the focus of attention, Duval and Wicklund (1972) stress the following:

The attention of the organism is not considered to be under the control of the will . . . but is assumed to be causally determined by certain forces in the environment interacting with the properties of consciousness. Thus at any given moment, the direction of a person's attention to one object instead of another, to himself as opposed to the external world, or even to certain dimensions of himself, is assumed to be predictable on the basis of knowledge of the existing configuration of forces and stimuli that effect the directionality of consciousness. (p. 67)

They compare the states of objective and subjective self-awareness to a Gestalt figure (Duval & Wicklund, 1972, p. 69) in which two
separately organized areas of the environment alternately become the figure or the ground. They assert that "the laws that determine whether or not an area within a Gestalt configuration is focused upon are the laws that determine whether consciousness will be directed to the causal agent self or to the not self" (p. 69). The not self refers to the state of subjective self-awareness.

According to the Gestalt school (i.e., Koffka, 1935), attention will focus upon the "stronger" region of the field. In the subjective self-awareness condition, the environment is the object of focus of attention and thus is the stronger region of the field at that moment. In the objective state this situation is reversed. The self is the focus of attention and it becomes the "figure," with the not self or the environment receding into the background or "ground." This description underscores what Duval and Wicklund (1972) mean when they say that causal attention will follow the focus of attention.

Finally, the theory proposes that the ratio between objective self-awareness and subjective self-awareness can be altered experimentally by means of any stimulus that reminds the person of himself. A mirror or a television camera focused on the person have been used in experimental manipulations (i.e., Wicklund & Duval, 1971) to test the efficacy of objective self-awareness as an independent variable.

**Summary**

Objective self-awareness theory is a motivational theory which addresses itself to the nature of the conditions that cause consciousness to focus on the self. The central notion that the person will evaluate himself when he focuses on himself provides the empirical
bridge to the as yet largely theoretical notion of the child-focus phenomenon.

The conceptual framework of objective self-awareness theory allows for a new way to analyze the factors which influence child-focus. If externalization of the problem to the child reduces the parent's own level of objective awareness, then it can be said that the focusing upon the child saves him from having to focus upon himself. Self-focus, in this case, may cause him to experience too great an intensity of anxiety and self-blame for the problems that befall his child. The direction of his attribution of blame in the form of the child-focus could reflect a defensive maneuver to guard against the immobilizing effects of such anxiety.

**Definition of Terms**

Terms important to the understanding of the research and discussion are operationally defined to facilitate consistency in interpretation.

**Attribution of Causality**

The decision a person makes in terms of where in the total environment he will locate the cause of an event.

**Child-focus**

A phenomenon in a dysfunctional family whereby stress in the marriage causes the parents to focus on a child. This focus allows for anxiety and tension to be redirected away from themselves at the expense of the child.

**Child Psychiatry Patients**

Children referred to a mental health setting for reasons of aggression, hyperactivity, slow learning, somatic complaints, delinquency,
phobias, or other behavioral disorders requiring intervention.

**Loaded Consequences**

Attribution of responsibility outcomes which are both relevant to the observer and situationally similar to some of his own personal experiences, such that they may be perceived as threatening (Shaver, 1973).

**Neutral Consequences**

Attribution of responsibility outcomes which are situationally ambiguous and therefore are perceived by the observer as plausible but not threatening.

**Objective Self-awareness**

A state in which consciousness is focused exclusively upon the self, causing the person to become the object of his own consciousness.

**Subjective Self-awareness**

A feeling of control over the environment. A state of consciousness in which attention is focused on events external to the self.

**Hypotheses**

The objective self-awareness approach postulates that attribution of causality for an event follows the focus of attention. A test of the theory with a population of parents of child psychiatry patients would predict that attribution of causality will be in the direction of focus of attention in spite of the bias of the child-focus. The hypotheses are:

**Hypothesis 1.** An increase in objective self-awareness will bolster the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.
**Hypothesis 2.** An increase in subjective self-awareness will reduce the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.

**Hypothesis 3.** Subjects judged to be child-focused by a therapist will show less objective self-awareness under all conditions than subjects judged to be more self-aware, and this effect should operate for both neutral and loaded consequences.

**Plan of Presentation**

The presentation of the information relevant to this investigation has been structured into five parts designated as chapters. The present chapter serves to introduce the reader to the subject, present the problem, state the theoretical background, define important terms, and present the hypotheses. The four following chapters include a review of related literature; research methodology; analysis and results of data; and the summary, conclusions and recommendations drawn from the study.
Chapter 2

Review of the Literature

This chapter reviews the empirical evidence underlying the development and extension of the theory of objective self-awareness.

The theory rests on the distinction between "objective" and "subjective" self-awareness. The studies to be discussed, therefore, attempt to create the experimental conditions necessary in order to reflect this dichotomous state. Each experimental paradigm assumes (1) that the objective self-awareness state may be brought about by external stimuli which cause the person to perceive himself as an object; (2) that the subjective self-awareness state may be brought about by engaging the person in an activity which demands him to focus externally on his environment; (3) that the primary state is the subjective state, and that the person will seek to avoid the conditions leading to the objective state; and (4) that conscious attention cannot be focused simultaneously on the self and on a feature of the environment.

The studies to be discussed will focus on the broad areas of attribution of causality, and avoidance of the objective state; on the relationship of objective self-awareness to self-esteem, and efforts to reduce self-criticism; on dissonance reduction; and on the effects of objective self-awareness on perceptions of control and on physical aggression.

The review of the objective self-awareness literature will contribute to an overall understanding of the motivational consequences of
the underlying theory. It will be comprehensive, in that the theory is of recent origin (Duval & Wicklund, 1972), and the empirical base is not as yet extensive.

Attribution of Causality

Duval and Wicklund's (1973) test of the effects of objective self-awareness on attribution of causality provides the model for the field experiment to be performed in this study, with some minor variations. They conducted two experiments to test the proposition that attribution of causality will be determined by the focus of attention. In experiment I, the subjects were 12 female and 21 male undergraduates at the University of Texas. They were asked to respond to ten hypothetical situations, each one presenting the imagined possibility that either the subject or someone else might be the cause of a negative consequence. The following is an example of the type of negative consequence they were asked to respond to:

You're driving down the expressway when suddenly the woman in front of you slams on her brakes and you run right into the back of her. (Duval & Wicklund, 1973, p. 21)

After each such situation, the subject was asked to estimate in percentages the extent to which he was responsible for the negative consequence, and to use any combination of percentages as long as they added up to 100%. In the control condition the subject was shown the turntable of a pursuit rotor and was told that later in the session he would be asked to rotate it slowly. In the experimental condition the subject was required to rotate the turntable while he simultaneously responded to the ten attributional situations by assessing "percentage at fault."

Their hypothesis was that the percentage of self-blame would be
less in the turntable condition, where subjects were active, and the results were in the predicted direction. The combined means of percentage of self-blame for the turntable condition was 49.65, and the mean for the control condition was 57.63 ($F (1,28) = 5.06, p < .05$). No significant effects were found for sex differences ($p > .20$ in every case). The experiment demonstrated that motor activity decreases a person's focusing of attention upon himself.

The second experiment involved both negative and positive hypothetical situations to test the assumption that the favorability of the consequences should not affect the attribution process. The experimental manipulation this time was the reverse of experiment I, where the attempt was to reduce objective self-awareness. In experiment II, objective self-awareness was increased in order to test the hypothesis that it would increase the subjects' tendency to attribute causality to themselves. In the experimental condition, the subject was exposed to a mirror image of himself throughout the procedure.

The results demonstrated that there was more self-attribution with the mirror than without the mirror ($F (1,39) = 14.43, p < .001$), and that there was no effect for the positive-negative variable ($p < .20$) nor an interaction ($p < .20$). The two experiments taken together support the assumption that the focus of attention determines the locus of causality, irrespective of the favorability of the consequences. The theoretical idea assumes "that the adult will attribute causality for an event only to those objects which he believes possess the potential to have caused the event. Thus, the present formulation is limited in its application to situations containing at least two objects that could cause the event in question" (Duval & Wicklund, 1973, p. 28).
An experiment by Duval (reported in Duval & Wicklund, 1972, p. 103) also demonstrates that the objectively self-aware person is more likely to attribute causality to himself. Approximately half of his subjects were seated in front of a mirror, while the rest were seated in front of the non-reflecting back side of the mirror. They were asked to imagine themselves in a set of five hypothetical situations, either positive or negative in outcome, and to estimate the degree to which their behavior caused the event in question. The results indicate rather strongly that persons who were forced to focus upon themselves in the mirror showed a greater tendency to attribute causality to themselves \( p < .001 \). Again, the mean "percentage at fault" was essentially the same regardless of the favorability of the outcome.

Somewhat similar experimental effects were reported by Wicklund and Duval (reported in Duval & Wicklund, 1972, p. 194), except that this time they were trying to bring about the subjective state. In all three of their experiments, Wicklund and Duval used attribution to the self or other as the dependent measure. As before, the hypothesis was that the attribution of responsibility for an event is determined by the focus of attention.

In experiment I subjects were given a list of six household items and were asked to write a brief description of each of them. Supposedly the descriptions were later to be used in a study of foreign students' ability to understand English. In the control condition subjects were then informed that the experiment would involve a manual dexterity task after they were asked to ascribe responsibility to themselves or to the foreign students for their possible difficulty in comprehending the descriptions. As in earlier experiments, responsibility
was indicated on the basis of "percentage at fault." In the experimental condition subjects were given a hand grip which resembled a nut-cracker, and they were asked to exert a constant pressure on it while they responded to the attribution of responsibility question.

The question required the subjects to imagine the possibility that their descriptions would not be understood, and to attribute a percentage of responsibility for such lack of understanding to herself and to the foreign students. The hypothesis stated that the subjects would not engage self-blame to the extent that they were subjectively self-aware, and the results confirmed this. The mean attribution of responsibility to the self in the control condition was 45.71, and it was 62.50 in the grip condition ($p > .02$). The distribution of responsibility either to oneself or to another as described in the situation above meets the conditions of balance. The subjects are not forced into one state or another by virtue of the nature of the question, but rather are free to move in one direction or another in response to the conditions posed.

In experiment II subjects were read seventeen attitudinal statements and were told to respond to each statement with a number between one and twenty-two. Low numbers expressed strong disagreement with the statement while high numbers expressed strong agreement. After each response the subjects were also asked "How confident are you that your opinion is correct?"—to which they were to respond as they did before with some number between one and twenty-two.

In the control condition the attitude and confidence items were read, followed by this attribution of responsibility question: "Frequently it happens that many of the students in 301 (Introductory Psychology) classes fail to complete the requirements for experiments.
Should this happen to you, what percentage your fault and what percentage the fault of the department would it be?" (Duval & Wicklund, 1972, p. 200). Subjects in the experimental condition were involved in spinning a rotary turntable with their finger during the entire time that the questioning continued. The dependent measures were the confidence items and the attribution of responsibility item, and the hypothesis predicted that the subjects in the turntable condition would be more confident and would attribute more blame to the psychology department.

Their results this time were not so conclusive. Each of the subjects had taken a premeasure of the attribution items a week before in their psychology class, and a mean change was computed for each condition. The mean confidence tends to increase in the turntable condition, but the difference was beyond the conventional level of significance \( (p < .05) \). In the attribution of responsibility item, one subject in the control condition had a score 80 percentage points below the mean for that condition, and so an F-test did not reveal reliable differences. Instead, the subjects were divided at the median and the Fisher Exact test showed a difference of borderline significance \( (p = .054) \) between the two conditions. It is possible that the confidence item, as Duval and Wicklund (1972) argue, served to bring the subject out of the subjective state.

In their final experiment ten attribution of responsibility items were used and subjects were put into experimental and control conditions on a random basis identical to those in experiment II. This time the means of the two conditions were reliably different \( (p < .05) \), and results lend support to the original hypothesis that the focus of attention determines the direction of attributions of responsibility.
Avoidance of the Objective State

Duval, Wioklund, and Fine (reported in Duval & Wioklund, 1972, pp. 16-20) set out to test the efficacy of a mirror in causing an avoidance of self-focusing stimuli in the face of a sizable discrepancy. Subjects first received either favorable or unfavorable evaluations on tests of creativity and intelligence. Then objective self-awareness was varied by putting subjects into an experimental setting in which there was both a mirror and a television camera. Subjects in the control condition were seated facing the non-reflecting back of the mirror with the camera aimed away from them. Following either the positive or negative feedback manipulation, subjects were told that they could leave the experimental cubical after 5 minutes if no one came to get them before then. The dependent measure was simply the number of minutes that elapsed before they left the cubical.

The hypothesis predicted that those who experienced a discrepancy from their standards of correctness (i.e., those who were given negative feedback on the tests of creativity and intelligence) would avoid stimuli that produce objective self-awareness. The results indicate a main effect for the presence of the mirror ($p < .05$). Likewise, a comparison between the means of the mirror-high discrepancy condition (6.39) and the no mirror-high discrepancy condition (8.12) showed reliable results ($p < .02$). The number of minutes spent in the room by subjects in the mirror-high discrepancy condition was less than the mean number of minutes spent there by subjects in the mirror-low discrepancy condition ($p < .05$). These results definitely seem to suggest avoidance behavior in response to high discrepancy-objective self-awareness circumstances.

An experiment by Gibbons and Wioklund (reported in Wioklund, 1975,
focused on avoidance of one's own tape-recorded voice as a function of discrepancy. Male subjects received either a strong rejecting or a strong accepting first impression from a female confederate, following which they listened to a 12-minute tape of either their own or another male voice. Those who had been accepted by the female spent considerably longer listening to their own voices than did those who were rejected ($p < .02$).

The theory holds that self-focused attention will move to the dimension of the self that is most salient to the situation. As such, any stimulus that reminds the person of himself (i.e., a mirror, television camera, or a tape-recording of one's own voice) should bring the person's attention to focus on the salient dimension, even if that stimulus bears no relation to the salient dimension. The above experiments seem to support that assumption.

**Self-esteem and Self-evaluation**

Wicklund (1975) claims that the theory is foremost a theory of self-evaluation and that "all effects stemming from self-focused attention, whether efforts to avoid or seek out the state, or to reduce discrepancies, are presumed to be motivated by the person's affective reaction to his degree of completeness, goodness, or inner consistency" (p. 238). The studies to be discussed next deal with various aspects of self-esteem as it relates to self-evaluation and focus of attention.

Ickes, Wicklund, and Ferris (1973) conducted three experiments to test the notion that self-focused attention can alter self-esteem levels. In experiments I and II subjects were exposed either to the sound of their own voices or to the sound of another's voice while they filled out a self-esteem measure. On each of several dimensions subjects were
asked to indicate her real self as well as her ideal self. The discrepancy was taken to be a measure of self-criticism, which was equated with low self-esteem. This was also the dependent measure. If all seventeen items of the self-esteem questionnaire are averaged together, there is a slight but not a significant tendency \((p > 0.10)\) toward lower self-esteem in the condition where subjects listened to their own tape-recorded voice. But if just the first five items are analyzed, the mean discrepancies for the high and low objective self-awareness conditions are significantly different \((F(1,14) = 4.98, p < 0.05)\).

Ickes et al. (1973) argue for the presence of a sequential effect, suggesting that the own-voice stimulus may dissipate over time. Their second experiment attempted to clarify this. They used a much larger sample \((N = 109)\), and the dependent measure was a modified version of the same real-ideal self questionnaire. The twenty bipolar adjective pairs were counterbalanced this time to eliminate the sequential effect. Again, subjects were exposed to their own voice or to another's voice while they filled out the questionnaire.

No interaction was found between order and level of objective self-awareness \((p > .20)\). The hypothesis predicted a differential linear trend over the twenty items, "such that the mean discrepancy scores are initially greater in the high objective self-awareness condition than in the low, with this difference between conditions decreasing toward the end of the items" (Ickes et al., 1973, p. 208). As predicted, the interaction was significant \((F(1,64) = 4.76, p < 0.05)\). It should be noted in both experiments that the majority of the discrepancy score data are attributable to the real self scores only.

The sequential effect, not accounted for by Ickes et al. (1973) in
their first experiment, can be explained either as (a) "habituation," in which the stimulus has less impact with repeated exposure, or as (b) a situation where the objectively self-aware person attempts to take himself out of the state by distracting himself from the sound of his own voice. An earlier study by Ickes and Wicklund (1971) reported similar evidence for this distraction hypothesis.

The third experiment by Ickes et al. (1973) tests the possibility that feelings of self-worth can be enhanced under conditions of objective self-awareness. The original theoretical statement by Duval and Wicklund (1972) holds that the objective self-awareness state is a state of self-criticism. In this experiment (III) Ickes et al. (1973) attempted to induce a strong negative discrepancy in 32 male subjects prior to their self-ratings by giving them a bogus "surgency" test. Subjects were told nothing about the trait except that it was a highly desirable trait to have. Some were given negative feedback on their scores, and half were confronted with their mirror images during this interval and half were not.

The dependent measure was simply the "goodness" of the self-rating. For surgency taken alone there was a main effect for feedback, with positive feedback subjects showing higher self-ratings ($F (1,28) = 10.73, p < 0.01$). The positive feedback effects had not been observed before, and it posed a theoretical challenge to Duval and Wicklund's (1972) original assumption that the objective self-awareness state was strictly a negative state. In spite of this rather unexpected finding, the three studies taken together provide support for the proposition that self-esteem is a function of self-focused attention.

Carver (reported in Wicklund, 1975, p. 247) used a self-esteem
scale similar to that used by Ickes et al. (1973), with one important variation: an (X) was marked in the center of each self-esteem dimension and was described as the place where the average person would be located. When subjects were not in the presence of a mirror, they invariably rated their real selves as higher than the average. The mirror served to exaggerate that effect ($p < .05$), suggesting that a positive discrepancy can bring about an increased appreciation for oneself. Carver's study, along with the one by Ickes et al. (1973), led to a theoretical revision of the theory to include "a positivity effect for self-focused attention" (Wicklund, 1975, p. 246).

Along these lines, Scheier and Wicklund (reported in Wicklund, 1975, p. 242) told female subjects that they did poorly on a test of psychological mindedness. They fixed the real self mark near the low end of the scale and asked the subject to fill in her ideal, which she did under mirror or no-mirror conditions. It was found that subjects in the mirror condition indicated a significantly higher ideal self than did those in the no-mirror condition ($p < .01$), suggesting that ideals can shift upward when the real self is prevented from changing. The initial reaction to self-focused attention, then, is self-evaluation, but the studies just discussed provide some evidence that this self-evaluation can be either favorable or unfavorable. Apparently it depends on the nature of the salient discrepancy.

**Dissonance Reduction**

Objective self-awareness theory argues that "... if behaviors, attitudes, or traits can readily be altered, focused attention toward a salient discrepancy should result in discrepancy reduction provided that avoidance is impossible" (Wicklund, 1975, p. 257). Self-focused
attention, in other words, should lead to efforts to eliminate any within-self contradictions. The research to be discussed next provides empirical support for this assumption.

In their second experiment, Wicklund and Duval (1971) engaged subjects in counterattitudinal essay-writing, with some exposed to an operational television camera while they wrote. They were given a 20-item questionnaire with five items especially crucial to the experiment, and were asked to indicate whether they "strongly agree" or "strongly disagree" with the attitudinal positions. Then they were given paragraph-long mimeographed speeches relating to the five crucial items which they were instructed to copy on separate pieces of paper. After 20 minutes the prose was collected and the experimenter readministered the attitude questionnaire.

The means for the camera and no-camera conditions after the first administration of the questionnaire were not reliably different ($F < 1$). It was found after administration of the second questionnaire, however, that opinion change in the direction of the counterattitudinal essays was greater among subjects who were exposed to the camera condition ($F (1,18) = 7.27$, $p < .02$). The results suggest the existence of objective self-awareness as one possible mediator of dissonance reduction. Similar evidence from Inako, Worshel, Songer, and Arnold (1973) supports this assertion. This evidence, as well as evidence from an earlier study by Brehm and Wicklund (1970), is consistent with Festinger's (1957) original formulation of dissonance theory, which holds that a person will tend to avoid any increase in the magnitude of dissonance once he experiences it.

The following experiment by Wicklund and Duval (1971, experiment
III) demonstrates that the effects called "social facilitation" (p. 337) can be produced in situations where general drive is not manipulated.

The theory predicts changes in an individual's performance in situations where he is forced to evaluate himself. Subjects were asked to copy as much German prose as they could during two separate 5-minute intervals, approximately half of them performing the task while facing a mirror.

It was predicted that task performance would be enhanced to the extent that objective self-awareness was increased. The dependent measure in this case was the quantity of prose copied, but the important comparison was the difference between the number of total letters copied from one 5-minute interval to the next. There was no significant difference between the conditions in mean quantity copied in the first interval ($t = 1.05$), but there was a greater increase in the amount copied in the mirror condition versus the no-mirror condition ($t(30) = 2.27, p < .05$).

In all of the social facilitation literature, "social" has normally meant the presence of other people, or at least the knowledge that others are attending to one's performance. Wicklund and Duval's (1971) results suggest that a person's image in a mirror carries the same significance as the presence of another person. A similar effect with Swedish words was obtained by Liebling and Shaver (1973), who added a high-low evaluation component to the Wicklund-Duval task. Half of the subjects were informed that performance on the task might reflect their intelligence, while the others were led to perceive the task as non-evaluative.

Liebling and Shaver's (1973) results reflect changes in task performance under the two evaluation conditions. The results were analyzed in a $2 \times 2$ (completely randomized) factorial design with Evaluation
(high vs low) and Mirror (presence or absence) as factors. They found that subjects in the low evaluation condition performed better in the presence of a mirror in contrast to those in the high evaluation condition who did worse. Liebling and Shaver (1973) conclude that extreme self-awareness must be debilitating, "... because to the extent that a person is objectively self-aware he is necessarily not paying attention to the task" (p. 303).

Some assessment of what happened in the above experiment is in order. The original Wicklund and Duval (1971) study was conducted with "relaxed" instructions where there was no hint that the person was being evaluated. The Liebling and Shaver (1973) study, however, introduced a high evaluation component into their replication, which probably served to increase self-focused attention. Under such conditions it is theoretically possible that attention might be diverted from the task to the point of interference with performance. Wicklund (1975) addresses this issue in detail elsewhere.

Conformity behavior as a function of perceived level of personal uniqueness was the subject of a study by Duval (reported in Duval & Wicklund, 1972, p. 98). Eighty-two undergraduate female subjects were given differential feedback concerning the proportion of a sample of 10,000 students who agreed with their ten most important attitudes. Theoretically, the proportion of others who agree with an individual on one dimension should affect that individual's tendency to conform on separate or unrelated dimensions. More specifically, the theory holds that subjects' conformity should be inversely related to the proportion of 10,000 students who believed agreed with their attitudes.

The first manipulation involved giving subjects eleven cards with
circles drawn on them, with part of each circle darkened and part left white. The subjects were led to believe that the darkened area of the circles represented the "agreement" proportion of the sample 10,000 students. In fact, they were simply given cards which randomly indicated that either 5%, 50%, or 90% of the sample agreed with them. Following an unrelated visual perception study, the subjects were confronted with estimates of "bogus" others who disagreed with their estimate of the number of objects presented on the screen. The bogus estimates were considerably higher than the subjects'. One half of the subjects were exposed to their image on a T.V. set during this portion of the experiment.

The dependent measures, as would be expected, were the frequency and intensity of the subjects' change in estimate toward the bogus others. Duval found that the smaller the proportion of others who agreed on the attitude dimension, the greater the conformity on the perceptual task (p < .001). He also found that there was greater conformity when the subject was confronted with her own image on the television screen (p < .05). An analysis of variance indicated a T.V.-no T.V. X Level of Agreement X Blocks interaction, which meant that there was a decline in conformity behavior over the ten trials. This can be interpreted in light of the sequential effect found by Ickes and Wicklund (reported in Duval & Wicklund, 1972, p. 24) discussed earlier.

A second experiment by Duval (reported in Duval & Wicklund, 1972, p. 101) set out to test the notion that a person will alter his opinion in the direction of the other in a situation where there are differences of opinion. Opinion change was in the direction of the mode when subjects were under conditions of increased objective self-awareness (p < .05).
Duval and Ritz (reported in Duval & Wicklund, 1972, p. 35) designed a study to demonstrate that the self is perceived differently in the two states of awareness. Their results suggest that the objectively self-aware person experiences a sense of having less control over the outcome of an interaction between the self and the environment. Theoretically, Duval and Wicklund (1972) claim that this perception of loss of control "... is produced by the person's preoccupation with self as object when he is in the objective state of awareness. With consciousness turned toward the self, to the exclusion of the external world, the line of communication between the causal agent self and external reality is temporarily eliminated" (p. 36). They suggest that this situation makes it impossible for the person to monitor the environment and control his behavior accordingly. Rotter (1966) draws a distinction similar to this objective-subjective dichotomy, but he limits the distinction to the generalized expectancies of control that the individual possesses. Objective self-awareness theory provides for an analysis of the variations in a person's felt control in terms of the mechanisms behind it. It suggests "externality" or "internality" as being related to one's focus of attention.

Thus, while locus of control presumably represents a relatively stable personal disposition according to social learning theory (Rotter, 1966), Duval and Wicklund (1972) suggest otherwise. Geen (1976) discusses a growing tendency of investigators to define personality within the context of both individual differences and situational variables. This approach views personality "traits" not as a fixed characteristic of the person but rather "a predisposing tendency to respond to certain situational variables in certain ways" (p. 246). From this perspective,
objective self-awareness theory offers yet another theoretical framework for viewing behavior as a function of the interaction of personal and environmental variables.

**Effect on Physical Aggression**

One final aspect of the theory to be discussed concerns itself with the relationship between the conditions of objective self-awareness and physical aggression.

Scheler, Fenigstein, and Buss (1974) studied the inhibitory effects of self-awareness on physical aggression. They hypothesized that the person who is self-aware should direct his attention toward his own potentially aggressive impulses, and that when there are standards prohibiting aggression, increased self-awareness should diminish aggression.

The method used to induce self-awareness was a mirror. Forty male subjects participated in a bogus learning task utilizing an "aggression machine" (p. 266). Subjects were assigned the role of "teacher" and a female experimental accomplice was given the role of "victim." The teacher was instructed to flash a "correct" light to the victim after correct responses, and to punish her by administering an electric shock after incorrect responses. There were ten shock buttons, each associated with a different shock intensity, and there were a total of 53 trials to which the teacher had to respond either by delivering a shock or not.

The dependent variable was the intensity of the total number of shocks delivered to the victim. The main effect for the mirror condition was highly significant ($F (1,36) = 9.00, p < .006$) and the conclusion was that self-awareness tended to inhibit aggression.
An assumption underlying this study was that men would have strong personal sanctions against aggression when the victim was a woman. Despite their results, it is possible that the effect would not hold in another gender combination, since the research on aggression (i.e., Taylor & Epstein, 1967) typically reports gender differences. Scheier et al. (1974) would have done well to manipulate gender combinations before making the generalizations they did.

Carver (1974) did just that. He designed an experiment similar to the one done by Scheier et al. (1974) but with two important differences: subjects were told that a high level of shock would facilitate the victim's learning, and the victims this time were males. As in the previous experiment, a mirror was used to induce objective self-awareness.

Carver (1974) hypothesized that increased attention to the self would facilitate aggression if the salient standard of behavior was one which valued a high level of aggression. The mean level shock for the mirror group (4.0) was higher than the mean for the no-mirror group (2.9), with the difference being statistically significant ($F(1,30) = 5.22$, $p < .03$). Thus the prediction that the mirror group would administer higher levels of shock was confirmed. As such, the results support the assertion that the subject's standards do affect the self-awareness response in varying gender combinations.

**Summary**

The empirical evidence reviewed provides support for the theoretical formulations of Duval and Wicklund (1972). It appears that the initial reaction to self-focused attention is self-evaluation, which can be either favorable or unfavorable. It seems to be difficult, if not
impossible, for a person to focus continually on just one dimension for an extended period of time. Additionally, the onset of self-focused attention seems to generate attempts to avoid stimuli associated with the objective state, which is followed by discrepancy reduction if there is no escaping from the self-focusing stimuli.

The theory espouses the usefulness of looking at situational variables versus individual differences in attempting to discover the determinants of behavior. It promotes the use of "standards of correctness," which approximate the person's mental picture of correct behavior, in lieu of more conventional paper-and-pencil tests of values, the rationale being that direct observation of a person's standards provides more useful information. Theoretically a standard must exist before any evaluation can occur, since without the standard there is no criterion against which measurements can be taken. Experimental manipulations reported intuitively assume that these standards supersede the individual's unique biases and defenses and reflect his ideal image of how things ought to be.

Objective self-awareness research reported in the literature to date deals with normal populations of college students as subjects. An application of the theory to a non-normal population raises some interesting questions regarding the generalizability of some findings. For example, the current assumptions seem to hold true: (1) subjects will engage in self-blame to the extent that they are objectively self-aware; (2) those who experience a discrepancy from their standards will avoid stimuli that produce objective self-awareness; (3) the objectively self-aware attempt to take themselves out of the state by distracting themselves; (4) objective self-awareness leads to efforts to eliminate any
within-self contradictions, causing subjects to avoid any increase in the magnitude of dissonance once it is experienced; and (5) a high evaluation component serves to increase self-focused attention, to the degree that theoretically it can interfere with task performance.

A test of the generalizability of the theory lies in its application to a highly focused, anxious population of parents of child psychiatry patients. As the psychiatric literature demonstrates, this population seems to have relatively stable attributions regarding the locus of blame for their children's problems, and their focus is clearly external to themselves when they come with their child to the mental health setting. The literature defines the very rigid parameters of this focus and the salient systems dynamics behind it. It suggests that focus upon the child serves as a system-preserving, anxiety-reducing, protective maneuver, and that exaggeration of the focus reduces the tension elsewhere in the family system. It also suggests that this is a phenomenon which is highly fixed and resistant to change.

The empirical manipulations of the present study served to test the theory against the dimensions of such a clinical population.
Chapter 3

Methodology

The purpose of this investigation was to examine the effects of the child-focus phenomenon on the attribution of blame for problems. This chapter will present the research methods that were used in the investigation. The chapter is organized to include the following: (a) population, (b) research design, (c) treatment procedures, (d) measurement instruments, and (e) data analysis.

Population

Subjects for the study were 60 male and female parents of child psychiatric patients referred for evaluation to the Tidewater Mental Health Clinic in Williamsburg, Virginia, during the period from September, 1976, through February, 1977.

The geographic location for the population is within the boundaries of the Chapter X Mental Health Mental Retardation Services Board catchment area, which includes Williamsburg, Poquoson, and the counties of James City and York. The Tidewater Mental Health Clinic is a state-supported and operated out-patient facility which serves the Chapter X catchment area exclusively.

The population was obtained for the study by asking clinic parents to participate on a voluntary basis with the full understanding that it was not a part of the diagnostic or treatment process. They were told that they would be assisting the clinic in the development of a new
questionnaire concerning parent-child problems, and that their identity and individual responses would be kept confidential. Parents selected to participate were (1) those whose concern about the child's problem was the primary reason for referral, and (2) those whose children had been identified as having at least one of the more usual child psychiatric symptoms (i.e., aggressive behavior, overanxious behavior, overactivity or hyperactivity, learning problems, somatic complaints, phobias).

The demographic characteristics of the population were recorded on subject data sheets at the time of participation in the study. Of those participating, 60% were residents of York County, 27% resided in James City County, with 12% and 1% from Williamsburg and Poquoson, respectively. Fifty-three percent were under the age of thirty-five, 70% were female, 99% were caucasian, and 72% reported a family income of $10,000 or more, with only 3% reporting an income of less than $5,000.

A breakdown of marital status included 87% currently married, 5% separated, and 8% divorced. An occupational breakdown included the following: housewife (28%), skilled laborer (17%), manager (17%), unskilled laborer (12%), clerical worker (12%), professional (8%), military (3%), and retired (1%). A total of 42% reported some college education and 37% claimed to have finished at least their junior year in high school. The average number of children was rather evenly distributed: one child (18%), two children (22%), three children (22%), four children (20%), and five children (17%).

Research Design

This study used a Posttest-Only Control Group Design (Campbell & Stanley, 1963):
The design adequately answers internal validity questions. In terms of external validity, however, randomized selection of subjects was not possible, so the results are not generalizable beyond a similar population of clinic parents. However, since the study replicated the Duval and Wicklund (1973) experiment with only minor modifications, the results taken together with theirs greatly increase generalizability.

Subjects were randomly assigned to the two experimental conditions and one control condition. The control group gave the comparability required, while the random assignment provided assurance that the groups were statistically equal and that systematic sources of variance had been eliminated.

The procedure for randomized assignment of subjects to experimental and control groups followed Kerlinger's (1973, p. 351) model: (1) a computerized random list of numbers 1-60 was generated; (2) the numbers 1-60 were placed alternately into three groups as they turned up in random order, and (3) the three groups were assigned randomly to the treatments. In the case of the random assignment of the groups to treatments, the following format was used: first, the groups were labeled Group #1, Group #2, and Group #3. These numbers were then drawn from a table of random numbers and their assignment to experimental condition A (OSA), experimental condition B (SSA), and to the control condition followed their position in the random order.

Each subject was assigned a number just prior to his or her participation in the experiment, which was the number that came up next in
the random order list of numbers 1-60. For example, let's say that the numbers 39, 37, 47, 13, 59, and 15 represented the first six numbers in the random list of numbers 1-60. The first subject, under the above procedure, was assigned #39, the second was assigned #37, the third was assigned #47, and so on. This was done to insure adherence to the randomized assignment procedure.

**Treatment Procedures**

Subjects were randomly assigned to one of three experimental conditions and were asked to imagine themselves in ten hypothetical situations involving negative outcomes, where either the subject or another person might be "at fault". In the objective self-awareness (OSA) condition, subjects were exposed to a mirror image of themselves while the ten hypothetical situations were presented to them. Subjects in the subjective self-awareness (SSA) condition were told to rotate a turntable throughout the procedure. And in the control group, subjects were asked to respond to the ten hypothetical situations without OSA or SSA stimuli. All three groups were asked to respond in exactly the same way to an identical set of attribution of responsibility questions which were presented to them by a single trained experimenter.

The experimental room was an 8 x 8 cubical equipped only with a table and three chairs, in addition to the OSA and SSA props. The room was a spare therapy room in the clinic office complex, and had only one window which was draped. There was a sign which said "TESTING" on the door. The cubical was arranged in such a way that the subject could observe only the immediate area around his assigned seat. Prior to the subject's entry into the cubical, the experimenter drew his random number
assignment and readied the appropriate area in the room for him. She then ushered the subject into the room and asked him to be seated immediately without allowing him to make his own decision about where to sit.

In the control condition, the subject was seated behind a painted wooden screen which enclosed him on three sides to prevent him from visual interaction with the experimenter. The effect was to reduce the self-awareness that might result from the gaze of the experimenter. The subject was then asked to imagine himself in each of ten hypothetical situations, and to respond to each of them by indicating the extent to which he or the other person in the situation would be "at fault". The subject received the following standardized instructions:

"For example, when I ask you to estimate the extent to which your behavior caused the event to occur, you might say 20% for yourself and 80% for the other, or 80% for yourself and 20% for the other, or it might be 60% to 40% or 40% to 60%. You can use any combination of percentages as long as they add up to 100%. Do you have any questions about what we are going to be doing?"

In the subjective self-awareness (SSA) condition, the experimental procedures were identical to those above, except that the subject was seated in a chair opposite a turntable and was asked to slowly rotate the turntable as he responded to the ten attribution of responsibility items. He was asked to practice the rotation for a few minutes prior to the start of the questioning, as it was very important that he be able to keep up a constant pace. Following along with this, he was told that after the parent questionnaire he was to take part in a manual dexterity task, which the practice on the turntable prepared him for. During the questioning the subject continued to rotate the turntable
while the experimenter situated herself behind a wooden screen in order to eliminate her presence as a possible OSA stimuli for the subject. All instructions were standardized as before. At the completion of the attribution of responsibility items, the subject was then given a tension grip to squeeze, which had been sitting on the table near the turntable. He was then debriefed if he had any questions before he left the room.

In the objective self-awareness (OSA) condition, the experimental procedures were again identical to those in the other two conditions, except that this time the subject was seated behind a wooden screen which had mirrors attached to its three sides to reflect the image of the subject. He was told that the mirrors were used in certain testing situations in the clinic and for some kinds of therapy, and that they couldn't be moved. Since this was the only spare room available today, he was asked to tolerate them. All instructions for the attribution items were standardized as before.

The experimenter was the same person in all three conditions and was naive to the goals of the study. She was a parent who volunteered to assist with the experiment and was trained and practiced in the procedures during a three-week period prior to the onset of the study. The ten attribution of responsibility questions were randomly ordered in their presentation to the subjects, which was done to avoid the contaminating effect of a neutral versus loaded response set.

**Measurement Instruments**

There exist no standardized instruments to measure attribution of causality. This study used five of the attribution of responsibility questions from the original Duval and Wicklund (1973) experiment as well
as five additional questions designed to focus on the parent-child relationship (See Appendix C for complete list of questions).

The questions from the original experiment are situationally ambiguous and therefore were considered for the purposes of this study as having "neutral" consequences for the subject. The parent-child questions, however, were designed to evoke greater personal and situational similarity to the subject's own experience, and therefore were considered as having "loaded" consequences for him. Shaver (1973) suggests that distortions may accompany attribution situations where the individual is involved or has a stake in the outcome, which he calls defensive attribution. This is the basis for the "neutral-loaded" dichotomy, and it roughly parallels the high evaluation-low evaluation component in some of the studies cited earlier.

The subjects were simply asked to assign the "percentage at fault" to himself and to the other in each of the ten hypothetical situations, which became the dependent measure. This process of assigning the percentage of blame versus a forced-choice paradigm allowed the subjects to maintain a sense of control over the direction that the attribution of causality took.

**Data Analysis**

**Data Collection**

Subjects' responses in the form of "percentage at fault" were recorded by the experimenter on individual data sheets.

In addition, each subject was rated individually by the therapist working with him or her as either child-focused or not at the time of their participation in the study. These were blind ratings in that the therapists were naive to the goals of the study, and they reflected a
real-world clinical assessment of the child-focus phenomenon. Subjects judged to be "child-focused" by the therapist showed evidence of strong denial of any role in the development of symptoms in the child. These ratings were recorded along with the attribution of responsibility percentages and demographic data on the individual subject data sheets.

ID, treatment code, sex, age, neutral-loaded breakdown, child-focus rating, and the ten attribution of responsibility responses for each subject were punched on computer cards and processed by an IBM 370/145 computer at the Southeast Regional Computer Center located at the College of William and Mary.

Statistical Analysis

Statistical treatment of each hypothesis will follow:

Hypothesis 1. An increase in objective self-awareness will bolster the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.

Hypothesis 2. An increase in subjective self-awareness will reduce the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.

Hypotheses 1 and 2 are repeated measures designs. Random assignment of subjects to experimental conditions served to equalize cell frequencies, and yielded an orthogonal 3 x 2 factorial where factors A and B were studied simultaneously to determine the effects of treatment:

<table>
<thead>
<tr>
<th>Treatments</th>
<th>OSA</th>
<th>SSA</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neutral Consequences</td>
<td></td>
<td></td>
<td>Dependent Variable</td>
</tr>
<tr>
<td>Loaded</td>
<td></td>
<td></td>
<td>Criterion Measures</td>
</tr>
</tbody>
</table>
Each of the A, B, and AB mean squares were divided by the error mean square to test the three statistical hypotheses that (1) factor A had no effect on the means of (y), (2) factor B had no effect on the means of (y), and (3) there was no interaction between factors A and B. The alternate hypothesis was that at least two of the means were not equal.

Repeated measures analysis of variance was performed by subprogram MANBIGN of the multivariate analysis of variance program, MANOVA. MANBIGN expands the number of cells permitted in the analysis from 100 to 1000, thus allowing for up to 200 subjects as opposed to MANOVA's 50 subjects. The N of 60 in this investigation called for 120 cells, allowing for each subject score to be placed in an individual cell.

The repeated measures design provides a control for differences between experimental subjects. In this case, it provides a test for statistical difference between neutral and loaded scores. It is more powerful than the t or F test for variance because it extracts a portion of variance within trials (i.e., each subject is matched against himself, which produces a correlation between the sets of neutral-loaded scores) (Kluger, 1970). In short, repeated measures analysis allows for a closer look at the significance of change created by the treatment on the criterion measure.

The one-tailed F-test assumes that the row and column effects are additive, that the (kn) populations are normal and have the same variance, and that the samples were drawn at random. Both hypotheses 1 and 2 were tested at the .05 level of significance.

Subprogram ONEWAY of the Statistical Package for the Social Sciences (SPSS: Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975) was
used to test all possible pairs of group means at the .05 (default) level of significance. The Scheffe a posteriori contrast test, which uses a single range value for all comparisons, was used in conjunction with subprogram ONEWAY whenever the analysis of variance led to a rejection of the null hypothesis. The Scheffe test is the most conservative of the a posteriori contrasts (Nie et al., 1975), in that type II errors will be greater. It is appropriate for examining all possible linear combinations of group means.

**Hypothesis 3.** Subjects judged to be child-focused by a therapist will show less objective self-awareness under all conditions than subjects judged to be more self-aware, and this effect should operate for both neutral and loaded consequences.

Subprogram T-TEST of SPSS was used to test the hypothesis that the means of the child-focused and the self-aware groups were equal, or \( H_0 : \mu_1 = \mu_2 \). The alternative hypothesis \( H_1 \) was that \( \mu_1 < \mu_2 \). Both hypotheses were tested at the .05 level of significance. In tests of this type, where \( H_1 \) specifies that the mean of one group is smaller than the mean of another, the two-tailed probability is divided by two, converting it to the appropriate one-tailed value. As Nie et al. (1975) note, this is necessary since the two-tailed probability is used for obtaining either a value larger than \( t \) or one smaller than \( -t \), and the hypotheses have assumed that the former is not expected.

The mean attribution to self was computed for the three experimental treatments, for both neutral and loaded consequences, along with a combined mean percentage for each. Similar mean and combined mean percentages were computed for child-focus versus no child-focus groups.
Frequency and descriptive data were obtained from subprogram FREQUENCIES of SPSS; and contingency table analyses of child-focus, sex, age, therapist, and treatment variables were performed with sub-program CROSSTABS.
Chapter 4

Results

The results of the investigation are presented in this chapter by hypothesis. Statistical findings will be reviewed and interpreted conjointly for Hypotheses 1 and 2, thus avoiding redundant procedural explanation. Findings for Hypothesis 3 will then follow.

Hypothesis 1

An increase in objective self-awareness will bolster the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.

Hypothesis 2

An increase in subjective self-awareness will reduce the tendency for subjects to attribute causality to themselves, and this effect should operate for both neutral and loaded consequences.

Repeated measures analysis of variance resulted in a significant $F$ value ($F_{1, 27} = 24.31, p < .001$), indicating a change in the direction of attribution of causality towards greater self-blame for loaded consequences (Table 1). Neutral-loaded scores were treated as repeated measures in a paired comparisons mode with an increase in scores indicating movement in the direction of greater self-blame. It will be recalled that loaded consequences are defined as outcomes which are both relevant to the observer and situationally similar to some of his own personal experiences, such that they may be perceived as threatening.
Table 1

Repeated Measures Analysis of Variance
for Neutral-Loaded Scores Across Treatment Groups

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>D.F.</th>
<th>Mean Squares</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Error</td>
<td>12153.500</td>
<td>57</td>
<td>213.219</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within</td>
<td>1128.188</td>
<td>2</td>
<td>564.094</td>
<td>2.646*</td>
<td>.080</td>
</tr>
<tr>
<td>Error</td>
<td>3816.195</td>
<td>57</td>
<td>66.951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between</td>
<td>1627.941</td>
<td>1</td>
<td>1627.941</td>
<td>24.315</td>
<td>.001</td>
</tr>
<tr>
<td>Interaction</td>
<td>475.091</td>
<td>2</td>
<td>238.045</td>
<td>3.556</td>
<td>.035</td>
</tr>
</tbody>
</table>

*p = .05

*Main effects of treatment.

bMain effects for paired comparisons.
The significance of the $F$ value was beyond the .001 level; consequently, the hypothesis for neutral-loaded effects was rejected at the .05 level.

Neutral and loaded consequences thus appear to have differential effects upon the dependent variable criterion measure. The $F$ value for the main effects of treatment, however, was only marginally significant ($F(2,57) = 2.646, p < .08$), such that the hypothesis cannot be rejected. No real conclusion is possible regarding the differential effects of the three treatments, except to say that a difference as large as the one obtained could have occurred by chance (i.e., through random sampling error). The presence of an interaction ($p < .03$) warns that interpretation of the main effects must proceed with caution.

Interaction exists when the effect of one variable on another differs for different values of some third variable (Namboodiri, Carter, & Blalock, 1975). When it exists, very little in general can be said about the average effect of one variable upon the other. In the case of Hypotheses 1 and 2, a no-interaction hypothesis must be rejected with the conclusion that the resulting interaction could be expected to have occurred by chance only three times out of 100.

Table 2 shows the mean percentage of blame for self under neutral and loaded conditions, and Table 3 shows the mean percentage of blame across all ten trials.

One-way analysis of variance across the three treatment groups produces differential results depending upon which trials are involved in the analysis. For example, when the analysis includes all ten trials (i.e., both neutral and loaded scores), the $F$ value is equal to that produced under repeated measures analysis ($F(2,57) = 2.646, p < .08$).
Table 2

Mean Percentage Blame to Self on Neutral and Loaded Trials

<table>
<thead>
<tr>
<th></th>
<th>Neutral</th>
<th>Loaded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirror</td>
<td>69.11*</td>
<td>80.39</td>
</tr>
<tr>
<td>(N=20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turntable</td>
<td>67.14</td>
<td>76.06</td>
</tr>
<tr>
<td>(N=20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control</td>
<td>78.13</td>
<td>80.03</td>
</tr>
<tr>
<td>(N=20)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined</td>
<td>71.46</td>
<td>78.82</td>
</tr>
<tr>
<td>$\bar{X}$</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Neutral represents trials 1 - 5. Loaded represents trials 6 - 10.

*Mean percentage blame to self.
Table 3

Mean Percentage Blame to Self for All Ten Trials

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirror (N=20)</td>
<td>54.5*</td>
<td>64.2</td>
<td>85.1</td>
<td>64.25</td>
<td>77.5</td>
<td>76.35</td>
<td>87.65</td>
<td>89.7</td>
<td>78.4</td>
<td>69.85</td>
<td>74.75</td>
</tr>
<tr>
<td>Turntable (N=20)</td>
<td>56.2</td>
<td>59.0</td>
<td>77.7</td>
<td>66.7</td>
<td>76.1</td>
<td>60.5</td>
<td>90.35</td>
<td>83.05</td>
<td>76.95</td>
<td>69.45</td>
<td>71.60</td>
</tr>
<tr>
<td>Control (N=20)</td>
<td>66.35</td>
<td>82.25</td>
<td>86.65</td>
<td>73.35</td>
<td>82.05</td>
<td>64.5</td>
<td>90.6</td>
<td>87.6</td>
<td>81.1</td>
<td>76.35</td>
<td>79.08</td>
</tr>
</tbody>
</table>

*Mean percentage blame attributed by the S to himself.
See Table 4 for results. That being the case, the null could not be rejected, with the implication that $\mathcal{H}_1 = \mathcal{H}_2 = \mathcal{H}_3$.

However, when the one-way analysis is performed using only neutral consequences (i.e., trials 1-5), the $F$ value is highly significant ($F(2,57) = 3.856, p < .03$) as Table 5 shows. The Scheffe procedure at the .150 level was used to test for the significance of various contributions made to the sums of squares by differences among sample means. As Table 6 clearly shows, the control group had the significantly different mean when only neutral scores were considered. When only loaded scores were considered (Table 7), the $F$ value again is insignificant ($F(2,57) = 1.131, p < .329$). These results can be interpreted to mean that at least on the neutral trials, at least two of the three population means are not equal. The interaction of main effects consistently occurs when only neutral trials are analyzed.

Regardless of the statistical procedure utilized, some generalizations can be made regarding Hypotheses 1 and 2. Under all conditions the mean of the OSA group (the mirror condition) surpasses the mean of the SSA group (the turntable condition), as the theory predicts. But one-way and repeated measures analysis of variance both fail to show these means as being significantly different, as does a $t$-test for independent samples under all conditions (Tables 8, 9 and 10). Even for neutral consequences, results are unreliable ($t$,$38$ = 4.4, $p < .005$).

The first half of Hypotheses 1 and 2 can be rejected with the implication that null in both cases is true, i.e., that $\mathcal{H}(OSA) = \mathcal{H}(SSA)$. In this population at least, an increase in objective self-awareness does not seem to significantly bolster the tendency for subjects to attribute causality to themselves. Nor does an increase in
### Table 4

One-way Analysis of Variance Across Treatment Groups

Using All Ten Trials

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>D.F.</th>
<th>Mean Squares</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between(^a)</td>
<td>564.1425</td>
<td>2</td>
<td>282.0710</td>
<td>2.646*</td>
<td>.079</td>
</tr>
<tr>
<td>Within</td>
<td>6077.0024</td>
<td>57</td>
<td>106.6141</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6641.1445</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^*p \leq .05\)

\(^a\)Main effects of treatment.
Table 5

One-way Analysis of Variance Across Treatment Groups
Using Neutral Trials

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>D.F.</th>
<th>Mean Squares</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between</td>
<td>1373.4300</td>
<td>2</td>
<td>686.7148</td>
<td>3.856*</td>
<td>.026</td>
</tr>
<tr>
<td>Within</td>
<td>10150.0603</td>
<td>57</td>
<td>178.0712</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11523.4883</td>
<td>59</td>
<td>178.0712</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P < .05

Main effects of treatment.
Table 6

Multiple Range Test:
Scheffe Procedure

<table>
<thead>
<tr>
<th>Subset 1</th>
<th>Turntable</th>
<th>Mirror</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>77.1400*</td>
<td>69.1100</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Subset 2</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>78.1299</td>
</tr>
</tbody>
</table>

Note: Ranges for the 0.150 level.

*For neutral consequences only.
### Table 7

**One-way Analysis of Variance Across Treatment Groups**

**Using Loaded Trials**

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>D.F.</th>
<th>Mean Squares</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between*</td>
<td>230.9770</td>
<td>2</td>
<td>115.4889</td>
<td>1.131*</td>
<td>.329</td>
</tr>
<tr>
<td>Within</td>
<td>5820.3899</td>
<td>57</td>
<td>102.1121</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6051.3672</td>
<td>59</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05

*Main effects of treatment.
Table 8

Comparison of Mirror and Turntable Means
on Neutral Trials

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Standard</th>
<th>T</th>
<th>2-tail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>Deviation</td>
<td>Error</td>
</tr>
<tr>
<td>Mirror</td>
<td>20</td>
<td>69.110*</td>
<td>15.591</td>
<td>3.486</td>
</tr>
<tr>
<td>Turntable</td>
<td>20</td>
<td>67.1400</td>
<td>12.840</td>
<td>2.671</td>
</tr>
</tbody>
</table>

Note: t-value represents pooled variance estimate.

*p < .05

*Mean percentage blame to self.
Table 9

Comparison of Mirror and Turntable Means on Loaded Trials

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mirror</td>
<td>20</td>
<td>80.3900*</td>
<td>9.381</td>
<td>2.09B</td>
<td>1.32*</td>
</tr>
<tr>
<td>Turntable</td>
<td>20</td>
<td>76.0600</td>
<td>11.243</td>
<td>2.514</td>
<td></td>
</tr>
</tbody>
</table>

Note: t-value represents pooled variance estimate.

*p = .05

*aMean percentage of blame to self.
Table 10

Comparison of Mirror and Turntable Means
on All Ten Trials

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Standard</th>
<th>T</th>
<th>2-tail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>Deviation</td>
<td>Error Value</td>
</tr>
<tr>
<td>Mirror</td>
<td>20</td>
<td>74.7500</td>
<td>11.161</td>
<td>2.500</td>
</tr>
<tr>
<td>Turntable</td>
<td>20</td>
<td>71.6000</td>
<td>10.825</td>
<td>2.421</td>
</tr>
</tbody>
</table>

Note: *t*-value represents pooled variance estimate.

*p < .05

^Mean percentage of blame to self.
subjective self-awareness significantly reduce the tendency for subjects to attribute causality to themselves. It can be said that the neutral-loaded variable does effect a differential response to the criterion measures.

**Hypothesis 3**

Subjects judged to be child-focused by a therapist will show less objective self-awareness under all conditions than subjects judged to be more self-aware, and this should operate for both neutral and loaded consequences.

There were no significant differences between subjects judged to be child-focused and those judged to be more self-aware. On neutral trials only, $t(58) = 0.79, p < .216$. On loaded trials only, $t(58) = -0.70, p < .243$. Tables 11 and 12 compare child-focus means for first neutral and then loaded consequences, and Table 13 gives a breakdown of the child-focused groups on mean percentage of blame to the self for all ten trials.

Since the probability in all cases is larger than the chosen significance level of .05, the null hypothesis is not rejected, and it is assumed that $\mathcal{H}_1 = \mathcal{H}_2$. A real-world, clinical assessment of child-focus does not appear, in this case, to discriminate successfully among the broader variables that motivated the clinic parents to accept responsibility for blame under experimental conditions.

**Further Analysis**

Of the three experimental groups in the investigation, the control group stands out as having the highest percentage of self-blame.
Table 11

Comparison of Child-focus Means for
Neutral Trials

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No Child Focus</td>
<td>31</td>
<td>70.0774</td>
<td>14.236</td>
<td>2.557</td>
<td>-0.79*</td>
<td>58</td>
<td>0.433</td>
<td>0.216</td>
<td></td>
</tr>
<tr>
<td>Child Focus</td>
<td>29</td>
<td>72.9379</td>
<td>13.785</td>
<td>2.560</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: t-value represents pooled variance estimate.

*p .05
Table 12

Comparison of Child-focus Means for
Loaded Trials

<table>
<thead>
<tr>
<th></th>
<th>Standard N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Error</th>
<th>T</th>
<th>Value</th>
<th>D.F.</th>
<th>Prob.</th>
<th>2-tail</th>
<th>1-Tail</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Child Focus</td>
<td>31</td>
<td>77.9352</td>
<td>9.991</td>
<td>1.795</td>
<td>-0.70*</td>
<td>58</td>
<td>0.486</td>
<td>0.243</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Focus</td>
<td>29</td>
<td>79.7793</td>
<td>10.358</td>
<td>1.923</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: t-value represents pooled variance estimate.

*p < .05
Table 13

Mean Attribution to Self on All Ten Trials
for Child-focus Groups

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>Combined</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Focus (N=29)</td>
<td>58.21*</td>
<td>69.10</td>
<td>84.07</td>
<td>69.28</td>
<td>84.03</td>
<td>64.24</td>
<td>90.59</td>
<td>90.45</td>
<td>77.17</td>
<td>76.45</td>
<td>76.36</td>
</tr>
<tr>
<td>No Child Focus (N=31)</td>
<td>59.77</td>
<td>67.90</td>
<td>82.29</td>
<td>67.00</td>
<td>73.42</td>
<td>68.81</td>
<td>88.55</td>
<td>83.35</td>
<td>80.35</td>
<td>67.61</td>
<td>74.01</td>
</tr>
</tbody>
</table>

*Mean percentage blame attributed by the S to himself.
Theoretically, the objectively self-aware (mirror) group should have the highest mean percentage of blame to the self; the subjectively self-aware (turntable) group should have the lowest; and the control group should fall somewhere in the middle.

It could be that by chance a disproportionately large number of subjects of a certain characteristic got allocated to the control group. The excess in the observed mean score for the control group over the other groups might then be due, at least in part, to causal factors not included in the experiment, and not solely to the treatment differences.

If this is the case, then it can be said that the experimental treatments in fact had no real effect on the dependent measures, and that the loaded conditions only served to elevate the percentage of self-blame across treatment groups which were drawn from the same population.

Cross-tabulation of child-focus, sex, age, therapist and treatment variables underscore the possible characteristics differentiating the control group from the other treatment groups. Inspection of the contingency table data (Appendices E, F and G) shows that the three groups are equal on all variables except therapist (Table 14). A marginally significant Chi Square ($X^2 = 5.42, p < .06$) on the therapist variable across treatment groups suggests that to be one important difference.

However, comparison of the individual means of Therapist A group versus Therapist B group (Tables 15 and 16) indicates no difference between them on either neutral or loaded trials. For neutral trials only, $t (58) = -0.31, p < .73$; and for loaded trials only, $t (58) = 0.40, p < .69$. 

### Table 14

Crosstabulation of the Therapist Variable by Treatment Groups

<table>
<thead>
<tr>
<th></th>
<th>Mirror</th>
<th>Turntable</th>
<th>Control</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist A</td>
<td>9(^a)</td>
<td>11</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>37.5(^b)</td>
<td>45.8</td>
<td>16.7</td>
<td>40.0</td>
</tr>
<tr>
<td></td>
<td>45.0(^c)</td>
<td>55.0</td>
<td>20.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>15.0(^d)</td>
<td>18.3</td>
<td>6.7</td>
<td></td>
</tr>
<tr>
<td>Therapist B</td>
<td>11</td>
<td>9</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td>30.6</td>
<td>25.0</td>
<td>44.4</td>
<td>60.0</td>
</tr>
<tr>
<td></td>
<td>55.0</td>
<td>45.0</td>
<td>80.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18.3</td>
<td>15.0</td>
<td>26.7</td>
<td></td>
</tr>
<tr>
<td>Column Totals</td>
<td>20</td>
<td>20</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td></td>
<td>33.3</td>
<td>33.3</td>
<td>33.3</td>
<td>100.0</td>
</tr>
</tbody>
</table>

\(^a\)Count

\(^b\)Row percent

\(^c\)Column percent

\(^d\)Total percent
Table 15

Comparison of Therapist Means
for Neutral Trials

<table>
<thead>
<tr>
<th></th>
<th>Standard</th>
<th>Standard</th>
<th>T</th>
<th>2-tail</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>Deviation</td>
<td>Error</td>
</tr>
<tr>
<td>Therapist A</td>
<td>24</td>
<td>70.7000</td>
<td>15.748</td>
<td>3.215</td>
</tr>
<tr>
<td>Therapist B</td>
<td>36</td>
<td>71.9666</td>
<td>12.869</td>
<td>2.145</td>
</tr>
</tbody>
</table>

Note: t-value represents pooled variance estimate.

*p  .05
Table 16

Comparison of Therapist Means for Loaded Trials

<table>
<thead>
<tr>
<th>Therapist</th>
<th>N</th>
<th>Mean</th>
<th>Standard Deviation</th>
<th>Standard Error</th>
<th>T Value</th>
<th>D.F.</th>
<th>Prob.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist A</td>
<td>24</td>
<td>79.4749</td>
<td>10.898</td>
<td>2.225</td>
<td>0.40*</td>
<td>58</td>
<td>.69</td>
</tr>
<tr>
<td>Therapist B</td>
<td>36</td>
<td>78.3944</td>
<td>9.714</td>
<td>1.619</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: *t*-value represents pooled variance estimate.

*p < .05*
If a two-way analysis of variance is performed on neutral trials using time in therapy as the dependent variable (i.e., total number of hours in therapy prior to the experimental manipulation), the main effects for treatment are reliable \( F(2,54) = 3.761, p < .03 \). As Table 17 shows, however, the therapist variable is not significant.

If, instead, a one-way analysis of variance is performed using time as the dependent variable (Table 18), the results are not reliable \( F(2,54) = .15, p < .86 \), unless the therapist factor is controlled for, whereas the results then become reliable \( F(2,21) = 3.85, p < .05 \) for Therapist A only (Table 19).

Results suggest that the mean hours in therapy for control subjects are much greater for Therapist A subjects than for Therapist B subjects. This is an interesting finding because, as Table 20 shows, while there were only four from the Therapist A group in the control group, the mean hours in therapy for those four was high \( (\bar{X} = 40.25 \text{ hours}) \). This indicates that time in therapy is in fact an important variable in the process of attribution, suggesting that self-blaming may well be a learned process. The assignment of subjects high in mean hours of therapy was the result of random error, causing the control group to vary significantly in the direction of greater self-blame.

**Summary**

Hypotheses 1 and 2 were rejected at the .05 level of significance. Repeated measures analysis of variance resulted in a highly significant \( F \) value for paired comparisons, indicating that the neutral-loaded condition had a significant impact on the dependent variable criterion measures. Loaded scores served to significantly
Table 17

Two-way Analysis of Variance Using Time as
the Dependent Variable and Treatment
and Therapist as Factors on
Neutral Trials Only

<table>
<thead>
<tr>
<th>Source of Variance</th>
<th>Sum of Squares</th>
<th>D.F.</th>
<th>Mean Squares</th>
<th>F</th>
<th>Significance Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Effects</td>
<td>1416.526</td>
<td>3</td>
<td>472.175</td>
<td>2.519</td>
<td>.06</td>
</tr>
<tr>
<td>Treatment</td>
<td>1393.425</td>
<td>2</td>
<td>696.713</td>
<td>3.761*</td>
<td>.03</td>
</tr>
<tr>
<td>Therapist</td>
<td>43.062</td>
<td>1</td>
<td>43.062</td>
<td>0.232</td>
<td>.63</td>
</tr>
<tr>
<td>Interaction</td>
<td>104.793</td>
<td>2</td>
<td>52.397</td>
<td>0.283</td>
<td>.75</td>
</tr>
<tr>
<td>Residual</td>
<td>10002.129</td>
<td>54</td>
<td>185.225</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11523.449</td>
<td>59</td>
<td>195.313</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Multiple R Squared = .123.

*p .05
### Table 18

One-way Analysis of Variance Using Time as the Dependent Variable

<table>
<thead>
<tr>
<th>Source of Variance</th>
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<th>Mean Squares</th>
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*p .05

*Main effects of treatment.
Table 19

One-way Analysis of Variance Using Time
as the Dependent Variable with
Therapist A Subjects Only

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*P < .05

aMain effects of treatment.
Table 20

Comparison of Mean Hours in Therapy for Therapist Groups

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*Mean hours in therapy prior to experimental manipulation.
elevate the self-blaming responses of subjects under all treatment conditions.

Hypothesis 3 was also rejected at the .05 level of significance. There were no significant differences between subjects judged to be child-focused and those judged to be more self-aware under all conditions.

It would seem that the process of attribution of causality is differentially affected depending upon the characteristics of the experimental population. In a population of parents of child psychiatric patients, the child-focus phenomenon seems to interfere with the usual process of attribution of causality in some significant ways.
Chapter 5
Summary, Conclusions, Limitations
and Recommendations

Chapter 5 will provide a summary of the study and interpretation of results, followed by conclusions, limitations, and recommendations for further study.

Summary

The Theory of Objective Self-Awareness by Duval and Wicklund (1972) addresses itself to the nature of the conditions that cause consciousness to focus on the self, and it provides a general model relating focus of attention to attribution of causality. Its central notion that the person will evaluate himself when he focuses on himself provides an empirical bridge to the as yet largely theoretical notion of the child-focus phenomenon, which describes a mechanism through which the anxiety of marital discord is defused by way of projection of the problem to a "special" child. To the extent that a person focuses attention upon one object or area in the environment to the exclusion of other areas, objective self-awareness theory predicts that he will tend to attribute causality for any event to that object or area.

A test of the theory on a highly focused population (N=60) of parents of child psychiatric patients called for a manipulation of the person's focus of attention towards one or another object. Subjects were randomly assigned to two experimental conditions and one control condition and were asked to imagine themselves in ten hypothetical situations involving
negative outcomes, where either the subject or another person might be "at fault". Five of the hypothetical situations involved neutral consequences for the subject, where the outcomes were considered to be situationally ambiguous enough to be perceived by the subject as nonthreatening. The remaining five situations involved loaded consequences, where the outcomes were both relevant to the subject and situationally similar to some of his own experiences, such that they could be perceived by him as threatening.

As the psychiatric literature demonstrates, a highly child-focused population seems to have relatively stable attributions regarding the locus of blame for problems, and their focus is clearly external to themselves when they come with their child to the mental health setting. The literature thoroughly defines the rigid parameters of child-focus and the salient systems dynamics behind it. It suggests that it serves as a system-preserving, anxiety-reducing, self-protective maneuver designed to restore equilibrium to a dysfunctional family unit. But while the survival of the family unit may be the primary goal, it seems to occur at the expense of the child who is focused upon in the process.

The empirical manipulation of this study served to test the theory of objective self-awareness against the dimensions of such a clinical phenomenon. Its central hypothesis was that the attribution of causality would be in the direction of focus of attention in spite of the bias of the child-focus.

Statistical treatment of the data consisted of repeated measures analysis of variance in a posttest-only control group design. One-way analyses of variance were performed to determine differential treatment effects on neutral versus loaded trials, and t-tests for significance
of independent sample means were used to determine the effects of child-focus and therapist variables across treatment groups. All three hypotheses were tested at the .05 level of significance.

Conclusions

Conclusions concerning the relationship between focus of attention and attribution of causality in a child-focused population will be presented in this section by hypothesis.

**Hypotheses 1 and 2**

The research hypotheses that (1) an increase in objective self-awareness would bolster the tendency for subjects to attribute causality to themselves and (2) an increase in subjective self-awareness would reduce the tendency for subjects to attribute causality to themselves were rejected at the .05 level of significance. Values of F in a repeated measures analysis of variance with percentage of blame to the self as the dependent measure showed that the experimental treatments were not effective in altering the process of attribution. One significant finding was the consistency with which loaded outcomes elicited a marked elevation in attribution of causality to the self across the treatment groups.

The finding of an interaction (p < .03) is theoretically interesting in light of Duval and Wicklund's (1973) findings, and similar earlier findings by Feather (1969). These authors reported no differential attribution of causality to the self as a function of the favorability of consequences or either success or failure on a task. Liebling and Shaver (1973), however, introduced a high evaluation component into a replication of a study (Wicklund and Duval, 1971) to test this idea and found that subjects in the low evaluation condition performed
significantly better in the presence of a mirror in contrast to those in the high evaluation condition who did worse. The finding of an interaction in essence fails to support the theoretical notion that the person's location of causality is solely determined by the direction and focus of his attention.

With regard to the various treatment conditions, previous research has found that the person's image in a mirror serves to bring his attention inward. This is based on the postulate that any element in the environment that reminds the person of his status as an object will cause attention to focus upon the self to the exclusion of other parts of the environment. Previous research has also demonstrated that imposing a task on the subject while he estimated the causality of an event resulted in decreased attribution of causality to the self. Theoretically, this decreases a person's ability to focus attention upon him or herself.

The results of the present study suggest that the child-focus phenomenon interferes with the usual process of attribution of causality in some significant ways. The experimental paradigm assumes that the objective state may be brought about by external stimuli which cause the person to perceive himself as an object. In the case of the child-focused parent, the child appears to be an external focus, and the logical prediction is that this focus serves to take the parent (the subject) out of the objective state. In the usual child-focused situation the parent is clearly "acting upon" the child through his constant over-involvement with him. The fact that this focus does not seem to take the parent out of the objective state implies the opposite, that it serves to keep him in the objective state. If this is so, then one
possible interpretation could be that the effect of the child-focus resembles a mirror or a T.V. camera or even one's own tape-recorded voice in its ability to remind the person of himself. Or it could be hypothesized that the child-focus effect carries with it the same significance as the presence of another person.

Such a speculation is interesting in that it opens up the possibility that there may be some intangible elements in the environment which serve, like mirrors and television cameras do, to move the person in and out of the objective state. The intangibility of the child-focus phenomenon, with its underlying tension and anxiety, could be said to create so great a reminder of the self that self-blaming is the natural consequence. In this case the parent may carry around with him like so much excess baggage the interdependent tensions of marital discord and child over-concern which, taken together, supersede any subjective self-awareness producing qualities in the environment.

Thus, while the child-focus can be seen as an attempt on the part of the parent to take himself out of the objective state and to distract himself from anxious concerns, it appears to function in quite the reverse. In a pathological family system, the family members are locked into a self-defeating pattern that is not open to change. The more concentrated the focus becomes, the more exaggerated the relationship patterns become, and the greater the sense of loss of control and loss of freedom on the part of the focused parent. And apparently the greater his self-awareness becomes.

Eventually the parent comes with the child to a mental health setting for help, the child-focus a camouflage for the underlying anxieties he may well be experiencing. Therapeutic involvement in such
a setting, paradoxically, may even exacerbate the already existing high level of objective awareness to the point of interference in any task (i.e., requiring differential attribution). In light of the above it is not difficult to see why some clients disengage themselves prematurely from the therapeutic setting, if what they experience is only increased anxiety and self-blame. As Liebling and Shaver (1973) conclude, extreme self-awareness must be debilitating. In that therapy can be said to encourage learned self-blaming, the implication for clinical work with families is great. This speaks well for the validity of the brief therapy movement (i.e., Erickson, 1976; Haley, 1963b, 1973, 1976) which accepts the family's problem as it is presented and finds ways of remedying it without focusing on the intrapsychic and self-blaming elements of pathological forms of relating and communicating in families.

From such a perspective, the goal of therapy would be to change the sequence of behavior in family relationships such that the focus is interrupted. This serves to put the adult back in control of his environment, albeit in more direct confrontation with the issues of marital discord. But the approach assumes that more normal ways of communicating increases the adult's competency in dealing with the issues at hand, which then frees the child from his uncomfortable, pivotal role in the matrix of family relationships.

Hypothesis 3

This hypothesis explored the relationship between a real-world, clinical assessment of child-focus and the more general term applied to any parent who comes to a mental health setting with their focus on the child. It was hypothesized that a therapist's judgment, of which
subjects were more self-aware, could effectively discriminate between these two groups, but t-values for both neutral and loaded trials showed no significant differences ($p < .24$).

This finding provides further support for the assumption of objective self-awareness behind the child-focus phenomenon in general. Perhaps it could be said that the one judged to be more self-aware has less to risk by his so openly acknowledging it.

**Limitations**

This study represents a first step in the application of objective self-awareness theory to an area of clinical inquiry.

The primary disadvantages associated with the study include the nonrandom selection of subjects, limited generalizability of the findings, and the problems of internal validity inherent in the instrumentation.

Any experimental manipulation of objective self-awareness faces several difficulties, such as (1) the incorporation of non-manipulated stimuli which tend to increase objective self-awareness for subjects (Duval & Wicklund, 1973), which has the effect of making control subjects as self-conscious as the experimental subjects; and (2) the avoidance of objective self-awareness stimuli by subjects, which has the effect of reducing the differential impact of the manipulations.

An effort was made in the design of this study to minimize as many as possible of the non-manipulated objective self-awareness producing qualities of the experimental setting. First, the experimenter was visually screened from the subjects during the manipulation to eliminate the self-awareness producing effect of his gaze. Second, the study was not presented as an experiment per se, but rather as a cooperative
effort between the experimenter and the subject to test the validity of a new parent questionnaire. This served to direct the evaluation component away from the subject and towards the instrumentation instead.

Third, possible avoidance of the mirror was prevented by seating the subject in a chair opposite a three-sided mirror which reflected his image within the limits of normal peripheral vision. The space which contained the chair and mirror was small and difficult to maneuver in once the subject was seated. Fourth, the ten hypothetical attribution items were presented orally to the subject by the experimenter from behind a screen to decrease competition for the subject's visual attention and to prevent the subject from distracting his attention by focusing on a written list of items. And fifth, those in the turntable condition were led to believe that the rotation of the turntable was important to a later manual dexterity activity, such that it had the effect of fixing their attention and concentration on the task at hand.

**Recommendations**

In light of the rather curious finding of increased self-blame in the control group, the first recommendation for further study is that time in therapy be more adequately controlled for. Since it is probable that increased self-blaming is a learned outcome of traditional therapies and that it seems to increase over time in treatment, the design should incorporate control groups containing differential combinations of time-in-treatment.

Further exploration into the therapist variable might discriminate among those therapeutic approaches most supportive of change in the sequence of behavior in family relationships which allows for the interruption of the child-focus. Results should predictably demonstrate
a significant decrease in objective self-awareness in subjects no longer under the systematic control of the child-focus.

A final area of inquiry for further study is associated with Shaver's (1970) concept of defensive attribution, which refers to systematic distortions of the links between possible causal agents and the outcomes of some event, as perceived by an observer. Shaver specifies situational and personal relevance as requirements for the arousal of defensive tendencies in attribution, such that "when subjects are asked to consider the responsibility of a person whose imputed personal characteristics are similar to their own, they are more lenient both in the attribution of responsibility and in other judgments of the situation than when the characteristics imputed to the stimulus person are different from their own" (Shaver, 1970, p. 108). The results of the present study suggest a need to clarify this defensive posture in light of the motivational effects of the child-focus phenomenon. The loaded consequences utilized in this study apparently had the opposite effect.
APPENDICES
### APPENDIX A

#### SUBJECT DATA SHEET

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<th>Green</th>
<th>Yellow</th>
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**Residence:**
- Williamsburg
- York County
- James City County
- Poquoson

**Age:**

**Sex:**

**Race:**

**Occupation:**

**Income:**
- Less than $5000
- $5000 to $10,000
- Over $10,000

**Marital Status:**
- Married
- Divorced
- Widowed
- Single
- Separated

**Education:**
- 0 - 3 yrs.
- 4 - 7 yrs.
- 8 - 10 yrs.
- 11 - 12 yrs.
- College

**Number of Children:**
- Child-focus
- No child-focus

### ATTRIBUTION RESPONSES

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### APPENDIX B

**COMPUTER-GENERATED RANDOM NUMBER LIST (1-60)**

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APPENDIX C

ORIGINAL LIST
of Attribution of Responsibility Items

Neutral Consequences

1. You’re driving down the expressway when suddenly the woman in front of you slams on her brakes and you run right into the back of her.

2. You pull up behind a bus that’s stopped at a stop sign and you want to turn right at this intersection. After waiting for 1½ or 2 minutes, the bus hasn’t moved. Finally, not knowing what he’s going to do, you decide to pull out around him and have to cut back in front of him to turn right at the corner. Just as you do, he pulls out and runs right into you.

3. You bought a new shirt about a week ago. You’ve worn it a few times so it needs washing. There are directions on the material from the manufacturer telling how to launder it so you go ahead and wash it like you usually do. Afterwards when you put it on, it’s three sizes too small and the colors have faded.

4. You have a book checked out of the library and it’s due in about 2 days. A friend of yours wants to borrow it, so instead of returning it, you let him use it. About 3 months later, you receive a note that the book has never been seen and you owe a huge fine.

5. You forgot to get gas and you find that your car has run out of gas on the interstate. You’re about 14-miles from the exit ramp to the Exxon station and you could walk it in 20 minutes. But you’ve been working all day and you’re tired, so you decide to hitchhike. Instead of taking you to Exxon, the guy who picks you up takes all your money and credit cards and drops you off in Richmond.

Loaded Consequences

6. You’re driving down the street about 5 miles over the speed limit when a little kid suddenly runs out chasing a ball and you hit him.

7. You park your car on a steep grade and leave your child in the car while you step into the nearby drugstore to fill a prescription. While you’re gone the child releases the brake and the car rolls down the hill and crashes into a 1976 Cadillac. There is considerable damage to both cars and your child suffers some head injuries.

8. You left a bottle of a prescription drug on the kitchen counter on your way out of the house after a rushed lunch. Your child gets home before you do and swallows two of the tablets, thinking they were aspirin. He gets very sick and has to be taken to the hospital to get his stomach pumped.
9. The phone is ringing when you walk in the door. You put the groceries down on the stairs instead of on the kitchen counter and you relax with a cigarette while you talk for an hour with your friend on the phone. Your two children come rushing down the stairs laughing and chasing after each other. One trips over the groceries and lands on his face on the floor and breaks two front teeth.

10. You have been intending to throw away some spoiled food that's been in the refrigerator, but you haven't had the time to do it yet. Your child, who is on a very strict diet, sneaks the spoiled food and eats it while you're gone and gets violently sick from food poisoning.
APPENDIX D

RANDOM ORDERING
of
Attribution of Responsibility Items

The following represents a computer-generated random ordering of the numbers 1-10:

9 3 5 4 8 6 2 1 10 7

The ten attribution of responsibility items were presented to the subjects in the above random order so as to eliminate the contaminating effects of a neutral versus loaded response set. The original order was taken from the preceding list of attribution of responsibility items which ordered them 1-5 (neutral) and 6-10 (loaded).
## APPENDIX E

Crosstabulation of the Child-focus Variable by Treatment Groups

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\(^a\)Count  
\(^b\)Row percent  
\(^c\)Column percent  
\(^d\)Total percent
## APPENDIX F

**Crossstabulation of the Sex Variable**

by Treatment Groups

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<sup>a</sup> Count

<sup>b</sup> Row percent

<sup>c</sup> Column percent

<sup>d</sup> Total percent
APPENDIX G

Crosstabulation of the Age Variable
by Treatment Groups

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\(^a\) Count
\(^b\) Row percent
\(^c\) Column percent
\(^d\) Total percent
References
References


Haley, J. Marriage therapy. Archives of General Psychiatry, 1963, 8, 25-46. (a)


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Place of Birth Grand Rapids, Minnesota

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