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**The effects of psychodrama treatment on levels of assertiveness  
and locus of control in women who have experienced battering**

**Burger, Jeanne Ball, Ed.D.**

**The College of William and Mary, 1994**

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THE EFFECTS OF PSYCHODRAMA TREATMENT ON  
LEVELS OF ASSERTIVENESS AND LOCUS OF CONTROL IN  
WOMEN WHO HAVE EXPERIENCED BATTERING

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A Dissertation  
Presented to  
The Faculty of the School of Education  
The College of William and Mary in Virginia

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

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by  
Jeanne B. Burger  
May 1994

THE EFFECTS OF PSYCHODRAMA TREATMENT ON  
LEVELS OF ASSERTIVENESS AND LOCUS OF CONTROL IN  
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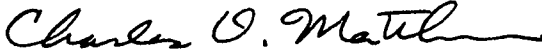
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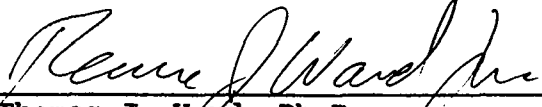
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## TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	v
LIST OF TABLES.....	vii
ABSTRACT.....	viii
CHAPTER 1. INTRODUCTION.....	2
Statement of the problem.....	2
Justification for the study.....	2
Theoretical Rationale.....	6
Definition of Terms.....	13
Research Hypothesis.....	14
Sample Description and general data gathering procedures.....	15
Limitations of the study.....	17
CHAPTER 2. REVIEW OF THE LITERATURE.....	19
Development of the theoretical concept.....	19
Locus of control.....	26
Assertiveness.....	32
Population of Battered Women.....	38
CHAPTER 3. COLLECTION OF DATA.....	44
Sample population.....	44
Data gathering method.....	45
Treatment method.....	46
Instrumentation.....	47
Research design.....	53
Specific hypotheses.....	53

CHAPTER 3 (continued)

    Statistical analysis.....54

    Ethical considerations.....54

CHAPTER 4. ANALYSIS OF RESULTS.....56

    Sample description.....54

    Analysis of differences between groups.....58

    Summary of hypothesis testing.....60

    Other findings.....62

CHAPTER 5. CONCLUSIONS.....64

    Summary of Findings.....64

    Discussion of results.....66

    Limitations .....71

    Recommendations for further research.....73

BIBLIOGRAPHY.....75

APPENDICES.....84

    A. Consent Form.....84

    B. Demographic Questionnaire.....86

    C. Psychodrama method.....88

    D. Leader Training .....91

    E. Letter to Colleagues.....95

    F. Tables.....97

VITA.....104

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LIST OF TABLES

Table	PAGE
4.1 Comparison of Demographic Frequencies Between Groups.....	97
4.2 Comparison of Pre-test Means, Standard Deviations and T-Tests Between Groups.....	101
4.3 Correlation Analysis of Variables Accross Groups.....	103

THE EFFECTS OF PSYCHODRAMA TREATMENT ON  
LEVELS OF ASSERTIVENESS AND LOCUS OF CONTROL IN  
WOMEN WHO HAVE EXPERIENCED BATTERING

ABSTRACT

The purpose of this study was to measure the effects of psychodrama treatment on assertiveness and locus of control for women who sought out-patient therapy to deal with the experience of having been battered. Subjects were required to have been out of their abusive relationships for at least two months.

Forty women completed the study. They were randomly assigned to an experimental group of psychodrama treatment or to a comparison group that received whatever treatment was available to them if the study were not taking place. Each of three sections of psychodrama experimental groups met for one eighteen hour weekend and for three, three hour evening meetings in the next three consecutive weeks.

Pre and post treatment measures of the Rathus Assertiveness Schedule and the Rotter I-E Scale were given to both groups. Findings indicated that although both the experimental group and the comparison group showed significant gains on assertiveness ( $t(39) = 1.39, p = 0.02$ ) during the pre to post time period, contrary to the first hypothesis, the experimental group did not show significantly more gains than the comparison group. Contrary to the second hypothesis, the experimental group did not show

significantly more change from external to internal orientation of locus of control. The changes in locus of control were not significant for either group. Assertiveness was found to be related significantly to internal locus of control on pre-testings ( $r = -0.47$ ,  $p = 0.02$ ) as predicted by the third hypothesis.

Positive changes for assertiveness, locus of control and depression were noted for both the experimental group and the comparison group but the results of this study did not show psychodrama to be significantly more effective than other treatments for increasing assertiveness or changing locus of control orientation. Limiting features of the study's design are discussed.

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**THE EFFECTS OF PSYCHODRAMA TREATMENT ON  
LEVELS OF ASSERTIVENESS AND LOCUS OF CONTROL IN  
WOMEN WHO HAVE EXPERIENCED BATTERING**

Chapter 1  
Introduction

Statement of the problem

The purpose of this study was to investigate the effects of psychodrama group treatment on levels of assertiveness and locus of control for women who seek out-patient therapy to deal with the experience of having been battered.

Justification for the study

Marital violence is a problem of enormous proportions and women are usually the victims. It is estimated that every thirty seconds a wife is beaten by her husband in the United States and that these victims total more than one million per year (Stacey and Shupe, 1983). In a study by Straus, Gelles and Steinmetz (1980), 28% of all couples interviewed reported violent incidents at least once in their marriage and the authors believe these figures to be a low estimate of the actual physical abuse between couples.

Domestic violence can result in deaths. Husbands have murdered wives while battering them and women have murdered husbands in defense. Twenty percent of all police fatalities occur during domestic dispute interventions (Hilberman, 1980).

Family violence passes from one generation to another. Straus et al (1980) found that one of four people who grew up in households where parents hit one another later use physical force

on their own spouses. In these households, child abuse is also likely to occur and the habit of family violence is likely to continue in the next generation when the children marry.

Thorman (1980) discusses how all members of families in which spouse abuse occurs suffer severe psychological effects. The victims suffer depression and anxiety accompanied by feelings of helplessness and hopelessness. Social isolation adds to the problem as families attempt to keep the violence a secret. Children are profoundly disturbed by witnessing the abuse. Their loyalties are confused, fear and feelings of helplessness are common. They become poor students and discipline problems. Male children, while feeling vulnerable and in need of love, often act out aggressively. Female children frequently think of themselves as being of little worth. They learn to distrust men and to fear sexual contact.

In spite of the severe consequences for spousal abuse, there has been little research to study effective treatment for the victims. Marital violence has occurred for centuries but it was largely ignored by mental health professionals until the late 1960s. Most of the research since then has delineated the degree of the problem in American society, described patterns of violence and investigated reasons why the victims stay in the relationship (Gelles, 1974, 1976, Rounsaville, 1978, Straus et al, 1980, Strube and Barbour, 1983). Other research has focused on describing psychological characteristics of the abuse victims (Star, Clark, Goetz and O'Malia, 1979, Rosenbaum and O'Leary, 1981).

The researchers cited above agree that depression, social

withdrawal, lack of assertiveness, low self-esteem and a perception of external locus of control are the most common characteristics that battered women share. The characteristics of low assertiveness, external locus of control and depression can be highly correlated for the general population of women (Culkin and Perotto, 1985 and Rude, 1986). Zielke (1984) and Drown (1986), each found that most battered women attribute life events to external control factors. Depression and low assertiveness frequently are related to this sense of helplessness.

Walker (1979) suggests that experience can explain much about the characteristics of domestic violence victims because repeated beatings coupled with the woman's unsuccessful attempts to control them lead to a conclusion of helplessness. The term "battered" is a description of an experience and not a diagnostic classification of women. Rosewater (1982) stresses that battered women should not be treated for personal pathologies such as masochism or severe developmental personality disorders when their symptoms have been induced by the experience of being abused. The treatment modality for traumatic experience should recognize a victim's competency and provide corrective experiences such as being in control, asserting rights and feeling and defining self as having more personal power.

In this study, psychodrama was investigated as a possible treatment for women who have experienced battering. Psychodrama includes the dramatization of problems and roles for the purpose of handling them more effectively. Moreno emphasized that psychodrama is the process of "doing, undoing and redoing", thus it can be a

way of redefining past experience and providing new experience to expand a person's self-perception (Shearon, 1975).

Studies have shown that battered women have learned to feel helpless and non-assertive (Myers-Abell and Jansen, 1980, Heppner, 1978, Ball and Wyman, 1978) and to believe in external locus of control (Young, 1983, Wilson, 1985, Zielke, 1984). Psychodrama has been suggested as a method for improving both locus of control (Rosenthal, 1976, Carpenter and Sandberg, 1985) and the behavioral component of assertiveness (Flowers and Booream 1980, Leaman, 1983). However there have been no reported studies of the effectiveness of psychodrama treatment with battered women.

In this study, psychodrama treatment was given to battered women and the resulting changes in pre-test, post-test scores on instruments of assertiveness and locus of control, as well as depression, were measured. Women who have had abusive relationships often seek therapy for themselves in order to regain their sense of personal power and in order to understand the experience of abuse in hopes that they will not repeat the pattern. Considering the high social and individual costs of domestic violence, there is a great need to study the effectiveness of treatment methods for the victims.

### Theoretical rationale

The theory used in this research study was psychodrama, which was conceived and developed by Jacob L. Moreno from 1908 to 1948. Moreno developed psychodrama as a philosophy and therapy based on empathy and experiential learning. Through a variety of techniques, problems are dramatized so that clients can explore issues and choices, try on new roles and behaviors, and thus, alter the way that they define themselves. Insight, catharsis and situational role-enactment are the corrective experiences that facilitate change. Moreno (1946) defined psychodrama as "the science which explores the truth by dramatic methods" (p. a).

Psychodrama theory is based on Moreno's triadic conceptualization of humanity which includes cosmic, social and individual theories. His cosmic theory presents human beings as having the potential for co-creativity with the Godhead and the ability to be in control of their own life. This is explained in his theory of spontaneity-creativity. His social theory, utilizing his theory of sociometry, presents human beings as products of their interactions with others. His individual or intrapersonal theory, called role theory presents the individual as an integration of somatic, social and psychodramatic roles learned and developed through experience (Buchanan, 1984).

The concept of spontaneity-creativity was first introduced by Moreno in 1914 and is the underlying theme of all of his works. He states in his 1964 introduction to the third edition of Psychodrama, I, "It was an important advance to link spontaneity to

creativity, the highest form of intelligence we know of, and to recognize them as the primary forces in human behavior." (p.X11).

Moreno (1946), considered human beings to be creative, at work with the men of the present, of the past and of the future in a continuous process toward the development of the world. He saw this co-creativity with the Godhead as what sets human beings apart from other creatures and he believed that it is this power to create our own lives and to choose those with whom we interact that determines our success in the world. He describes creativity as occurring when an individual can act in new and constructive ways to people and situations, producing new relationships which did not exist before. This theory is similar to belief in internal locus of control, that people can affect their own consequences.

Spontaneity is the catalyst or the motivating force for creativity and change. Moreno (1946) defined spontaneity as the ability to use one's resources "to respond with some degree of accuracy to a new situation or with some degree of novelty to an old situation" (p. X11). Spontaneity is the readiness factor and creativity is the response or act. When spontaneity is lacking, one is trapped in rigid and stereotyped patterns and anxiety is produced. In order to survive, one must be able to interact effectively and creatively with self, with others and with the environment. Spontaneity results from awareness of physical, cognitive and social aspects of self. It must be available to "the here and now situation" for creativity to occur. (Moreno, 1953).

"The problem is how to motivate men so that they all will give repeatedly and regularly, not only at one time or another, their maximum spontaneous participation." (Moreno, 1937a, p. 207).

Psychodrama was developed as a means of spontaneity training.

Sociometry, the measurement of groups, was developed by Moreno because of his interest in studying social interactions. Individuals comprise groups and are both controlled by groups and control groups. Thus, to measure groups is a way to study and measure man in a most fundamental dimension. (Moreno, 1946)

Moreno believed that man develops his identity through the roles he plays with those he chooses to have around him. He viewed society as being made up of small units of reciprocally chosen relationships between individuals which he named "social atoms". The communication channel of feelings between individuals in social atoms he called "tele". Tele becomes the "flow--to and fro--of affectivity between individuals" (Moreno, 1956, p.62) Moreno, (1959), compares tele to transference. He suggests that the feeling tone between individuals can occur even before anything has happened to cause a reaction to another person. Moreno concludes, "Tele is the fundamental factor underlying our perception of others. We see them not as they are, nor yet as we are, but as they are in relation to ourselves." (Moreno, 1956, p.275)

Moreno postulates that man is by necessity a social being. At birth, he is not capable of surviving on his own. He is dependant on caretakers and his first cry is a plea for interaction. Socialization is immediate and unavoidable as the child learns the

first roles demanded of him by the essential people in his life. The caretakers appear at first to the infant as extensions of his own body or as auxiliary egos. Moreno calls this early state of relationship the matrix of identity. He describes the following stages of development: (A) the other person is a part of the infant--spontaneous all-identity; (B) the infant centers attention upon the other, the stranger part of himself; (C) the infant lifts the other part from the continuity of experience and leaves all other parts out, including self; (D) the infant places himself actively in the part of the other and feels and acts the other role; (E) the infant acts the role of the other toward someone else, who in turn acts in the infant's role. Moreno related these stages as the basis for all future role processes. He saw the role-exchange of mother-giver and infant-receiver as the foundation for role expectancy between the infant and all future relationships. (Moreno, 1946).

Moreno writes, "We consider roles and relationships between roles as the most significant development within any specific culture." (1946, p VI) He defines role as "...the functioning form the individual assumes in the specific situation in which other persons or objects are involved." He describes the three emerging stages of role development as: (1) psychosomatic roles such as the eater, the sleeper and the sexual being; (2) psychodramatic roles which are constructs of imagination such as Santa Claus, ghosts or authority figures; and lastly, (3) psychosocial roles recognized by society such as son or doctor.

Moreno (1946) said, "Roles do not emerge from the self but the self may emerge from roles." (p.11) "Every individual ... has a range of roles in which he sees himself and faces a range of counter-roles in which he sees others around him. (p.V)

According to Moreno's role theory, roles emerge from interaction and interdependence with others. Knowledge of the self, in turn, emerges from the roles that one plays. The psychodramatic process offers an opportunity for enacting a variety of roles such as teacher, mother, child, judge, lover or friend. As an individual identifies with these roles, he experiences an increased sense of empathy for others and an increased awareness of aspects of himself. As he experiences new responses in old situations and adequate responses in new situations, he increases his choices for behavior. As he re-experiences emotions and acts them out, he releases emotional tension and benefits from catharsis in a supportive environment (Starr, 1977).

Action is the very nature of psychodrama. As Moreno (1969) states, "Interpretation and insight-giving in psychodrama are of a different nature from those processes in verbal types of psychotherapy. In psychodrama one speaks of action insight, action learning... Interpretation may be questioned, rejected or totally ineffective, but action speaks for itself." (p.108) Moreno bases his ideas on the importance of man's creative process and the metaphysical concept that he calls "metapraxie". "Metapraxie" is derived from the word praxis which refers to the idea of practice rather than theory. It emphasizes Moreno's belief that life is more

an act than a state of being. Moreno expresses fear of complacency because it might destroy spontaneity which is man's best means of developing himself and his relationships (Moreno, 1983). Moreno believes that the therapeutic process is advanced most when the personality is expressed in terms of interaction and in relation to a specific situation.

Psychodramatist Marion Heisey (1982) cites the advantages of action for integrating body movement with cognition for use in the mental process of learning and relearning. He reminds us that "the organism is an integrated whole and memory cannot be separated from the anatomy and physiology of the body" (p.6). A person may learn to ride a bicycle when he is very young and may not use the skill for a long time. His body will remember how to balance and pedal even though he may not be able to verbally explain the process. Similarly the body retains emotional memory.

When a person becomes absorbed in the action, defenses are down and at this point the connection between emotional state and behavior is individually expressed. The physical expression of the emotion (twitching muscle, clenched fist, trembling voice) is experienced by the client and is seen and reacted on by the audience. The client can perceive the presence and the consequences of the behavior. The expression "here and now" was coined by Moreno to describe the process of experiencing these emotional and behavioral connections in the present (Blatner, 1973).

Psychodrama is described by Fenell and Weingold (1989) as a method for helping people to express their feelings, spontaneously

and dramatically, by role play. They state that because it involves many players, it is useful for group and family therapy, recognizing the importance of the social environment and action methods for both intrapersonal and interpersonal work.

The original thinking of Moreno as well as the importance of Moreno's contribution to experiential therapy is recognized by Eric Berne (1970) when he coined the "Moreno Problem"- "the fact that nearly all known 'active' techniques were first tried out by Dr. J. L. Moreno in psychodrama so that it is difficult to come up with an original idea in this regard." (p1520)

This study tested whether Moreno's theory of dramatizing experiences for corrective role identifications could help battered women who have developed roles of helplessness, external locus of control and low assertiveness to change those roles. Moreno's theory of spontaneity and creativity is based on personal choice and action in taking responsibility for outcome, thus the psychodramatic method was hypothesized to be a reasonable treatment modality for changing the related concepts of assertiveness and internal locus of control.

### Definition of terms

**Assertiveness:** "behavior which enables a person to act in his own best interests, to stand up for himself without undue anxiety, and to express his rights without destroying the rights of others" (Alberti and Emmons, 1974, p.2)

**Battered woman:** Defined for the purposes of this study as an adult (18 years or older) woman who reports that she has been intentionally physically and/or emotionally abused by an adult man with whom she resided in a relationship that involved sexual intimacy. Abuse was defined as partner behavior, defined by items on the Index of Spouse Abuse (ISA, Hudson and McIntosh, 1981), that measured scores of 10 or more for physical violence and 25 or more for non-physical violence. These scores were suggested as clinical cutting scores by the authors of the ISA instrument.

**Locus of control:** A construct that refers to the extent to which individuals view rewards as contingent on their own behavior. Internal locus of control refers to the view that reinforcers result from one's own actions, while external locus of control refers to the belief that reinforcers are the result of luck, fate or powerful others.

**Psychodrama:** a therapeutic process involving the enaction of certain roles and dramatic incidents which resemble those situations that produce problems or conflicts for the individual in

his daily life. Through this process, insight and corrective emotional experience are achieved, enabling more effective action in future situations. The following terms are particular to psychodrama and help to explain the therapeutic technique:

**Audience:** All other group members.

**Auxiliary ego:** Actor selected by the protagonist or the director to play a role (real, imagined or symbolic) in the enactment.

**Director:** Psychodrama group leader and therapist. **Protagonist:** The subject who has been selected to enact an issue.

**Role:** The characteristic functioning form that an individual takes in a situation. A role may represent both how he sees himself and how he is seen.

**Role-reversal:** The procedure of the protagonist changing roles with an auxiliary ego as a means of understanding the roles of significant others and of hidden aspects of self.

**Role training:** The process of rehearsing the protagonist to perform more adequately in roles.

**Structural phases of psychodrama:** **Warm-up:** The beginning process whereby group members are facilitated to meet one another emotionally and to select a theme **Action:** Enactment and working through of the issue. **Sharing:** Closure of the psychodrama through the relation of the group's personal feelings to the protagonist's experience.

### Research Hypotheses

1. The battered women groups which are treated by psychodrama will show a greater gain in assertiveness than will similar groups who do not receive psychodrama treatment.

2. The battered women groups which are treated by psychodrama will show more change from external to internal locus of control than will similar groups who do not receive psychodrama treatment.

3. There will be a positive correlation between assertiveness and internal locus of control in battered women on pretesting.

### Sample description and general data gathering procedures

Battered women (self-identified and referred) who had not been living with their abusers for at least two months and who had requested outpatient counseling were randomly assigned to one of two types of groups of equal original size (from 6 to 10 members each).

One type group received classical psychodrama therapy and the second type of group continued to receive the therapy that was available to them if the study had not taken place. Each of three psychodrama groups ran for one eighteen hour weekend (three hours Friday evening, eight hours Saturday and five hours on Sunday) and for three, three hour evening meetings in the next three consecutive weeks. A group of 9 met in July, 1993, a group of 7 met in September, 1993 and a group of 6 met in December, 1993. Comparison groups of subjects who did not receive psychodrama therapy were measured during the same time periods. The groups were

repeated until there were at least twenty women who received psychodrama therapy in the treatment group and twenty women who had not received the treatment in the comparison group. Psychodrama treatment was offered to the comparison group after the initial treatment period.

Before treatment, the women were given a demographic questionnaire, the Index of Spouse Abuse to determine levels of physical and nonphysical abuse, the Beck Depression Inventory, the Rathus Assertiveness Index and the Rotter I-E Scale for Locus of Control. The last three instruments were given again after the three weeks of treatment. The Eysenck Personality Inventory was also given as a post-test measure in order to use the lie scale as a screen for "faking good" responses (Eysenck and Eysenck, 1968).

The psychodrama therapists were licensed therapists who had received 400 or more training hours in psychodrama from the same internationally certified Trainer, Educator, Practitioner, Dr. Ella Mae Shearon, TEP. All were in private practice, had experience working with battered women and with the psychodrama treatment method.

The effects of psychodrama treatment on assertiveness, and locus of control were statistically computed by univariate analysis of change scores for each of the outcome variables. Assertiveness and locus of control and depression were also correlated on pre-test to determine the relationship between them.

### Limitations of the study

This study was designed to measure the effectiveness of psychodrama on assertiveness and locus of control. There was no attempt intended to compare psychodrama with other specific treatment modalities. The subjects may have received previous therapy but they had not received psychodrama previously.

This study was representational only of women who had sought outpatient treatment for past abuse. No attempt was made to seek out participants from the population of women who were currently in abusive relationships, who did not seek treatment or who sought shelter treatment only.

The fact that violence is the result of many factors and has many resulting consequences was not negated. The multiple and varied effects of psychodrama was also acknowledged. This study focused only on the specific effects of psychodrama on assertiveness and locus of control for women who had experienced previous abusive relationships.

Normative data is not available for the particular population of battered women for either the measurement of assertiveness or for locus of control. However, there were no significant differences on pretest measures of these characteristics between comparison groups and treatment groups.

No attempt was made to form groups with all socioeconomic levels or ethnic groups represented. Random assignment to treatment conditions created some inequalities in the distribution of these demographic characteristics but none were found to be significantly

different using Chi Square Test.

Although all the subjects for this study lived and were treated in one particular geographical area (Tidewater, Virginia), literature has shown that the dynamics of wife abuse are no different from North to South or from urban to rural (Straus et al, 1980, Stacy and Shupe, 1983).

Because of the specific nature of the instruments used, it was possible that subjects may have had some awareness of the focus of the study. However, both the experimental groups and the comparison groups were affected by this limitation. The "John Henry" effect of control subjects performing better because they were aware of being compared to another treatment group may have been cancelled by the "Hawthorn Effect" of the experimental subjects also being aware of being studied.

History and maturation are always intervening variables when there is treatment over time. Again, these factors were present for both treatment and comparison groups.

It must be acknowledged that therapist personalities may have an effect. Treatment groups were led by several different therapists in order to minimize this limitation.

When individuals are treated in groups, it is difficult to consider each individual as being independently treated because group members can and do influence one another. No group experience can be considered as the same as another because of interpersonal interactions. It is believed, however, that the psychodrama method has uniform benefits.

## Chapter 2

### Review of the Literature

#### Development of the theoretical concept

Psychodrama, as a therapeutic technique was introduced over sixty years ago when Moreno wrote about his work with the prostitutes in the streets of Vienna. Since then, thousands of clinicians have been trained to use Moreno's methods. The Moreno Academy operated for forty seven years in Beacon, New York. Currently training institutes operate from coast to coast in America and in many other countries including Germany, Japan, Australia, Argentina Sweden and France. (Buchanan, 1984)

Inspite of the growing use and enthusiasm for this therapeutic method, its practitioners have tended to rely on clinical experience to prove its efficacy and have produced a paucity of empirical research. Most of the literature consists of case studies and theoretical discussions in an attempt to support the use of psychodrama with varied populations and in different settings. (D'Amato and Dean, 1988, Kellerman, 1987, Kipper, 1978)

Psychodramatists often offer compatibility with other therapies as evidence of effectiveness. Blatner (1973, p.25) notes that dramatic doubling with a protagonist is very similar to Rogerian feedback. Behavioral practicing can be compared to Wolpe's reciprocal inhibition and other deconditioning techniques for the treatment of phobias (p.81). Blatner also reports the use of psychodrama by French psychoanalysts to illustrate the emergence of such psychodynamic themes as the Oedipal complex (p.127).

Psychodramatic enactment of intrapersonal conflicts has been used to illustrate the concept of splitting in object-relations theory, incongruent and autonomous body language in Gestalt theory and archetypes and complexes in Jungian theory. Kellerman (1987) mentions that psychodrama has similar treatment approaches to the fixed role therapy of George Kelly and the social model learning of Albert Bandura.

Recent articles in the journals further attest to the adaptability and usefulness of this model. Altner and Heakman-Lakanour (1987), used psychodrama for training counter-terrorist teams. Nordin (1987) reported success with psychodrama as treatment in a nursing home for the elderly. Newburger (1987) treated phobias with psychodrama. He reported that seven months after treatment, eight of the ten subjects remained symptom free.

In 1991, Little, Morgan and White reported positive results from using psychodrama with a life skills program for abusing and abuse-prone mothers. They found that they could examine the genesis of current problems through exploration of early experience and trauma. The women in this study were reported to have gained new roles for themselves. This study has strong implications for the use of psychodrama with abused women but unfortunately it shares the limitation of being anecdotal and using no control or comparison group to substantiate claims of efficacy.

Peter Kellerman (1987) researched and tabulated 23 outcome studies on classical psychodrama that were published between 1952 and 1985 and "adhered to a sufficiently rigorous research design"

(p.460). Although none of the studies included in this listing were specific for battered women, some of the outcome variables such as locus of control, self-esteem, attribution and overt behaviors were pertinent to this study.

In 1970, O'Connell and Hanson studied 176 hospitalized patients who participated in psychodrama in addition to other hospital programs. They found that the participants showed significant pre-to-post change toward internal locus of control as well as decreased psychological and somatic symptoms. They were also less defensive after psychodrama.

Locus of control was examined as an outcome of psychodrama by Rosenthal (1976) with his study of university students. He found positive feedback from his subjects on the helpfulness of psychodrama but he was not able to show significant changes on the locus of control measures.

Carpenter and Sandberg (1985) found that locus of control did change significantly more internal for delinquent adolescents given psychodrama treatment than for a matched control group.

Wood, Del Nuovo, Bucky, Schein and Mickalik (1979) attempted to measure changes in personal adjustment among alcohol abusers after four weekly 3-hour psychodrama treatments. The pre/post change scores on the Comfrey Personality Scales and the Mini Mult version of the MMPI showed significantly more movement toward increased activity, trust and emotional stability for the clients treated by psychodrama than for the control group. The psychodrama group also showed movement away from denial.

Psychodrama was compared with anger therapy, values clarification, and decision making as a group treatment for adult males in a medium security prison by Schramski, Feldman, Harvey and Holliman in 1984. They found that the psychodrama treatment yielded higher gains than the other treatments for institutional adjustment as measured by the Correctional Institutions Environment Scale and for decreasing interpersonal sensitivity and increasing energy, hopefulness and personal autonomy on the Hopkins Symptom Checklist. The method in this study was well-defined. The authors suggest that it is probable that psychodrama was effective because the subjects were given new experiences in role training and could practice more appropriate responses to problematic encounters in the institution.

Psychodrama was used by Baumgartner (1986) to treat post traumatic stress syndrome in Vietnam veterans. Given pre and post tests for stress, treated subjects were shown to have significantly more reduction in stress scores than did the control group. Oral interviews were used to report the veterans' positive evaluations of the method.

Self-image and social adjustment changes were measured for deaf adolescents treated by psychodrama techniques in a 1986 study by Elizabeth Barret. The children who were in a once weekly social living class that used psychodrama methods showed significant gains on the Meadow/Kendall Social Emotional Assessment Inventory for the scales of social adjustment and self-image. The control group which did not participate in this class showed no change. Battered women and deaf adolescents share some similarities. Both suffer from long

term low self-esteem and both feel isolated in their social worlds.

Hickling (1989) researched the usefulness of psychodrama with chronically mentally ill patients in a Jamaican hospital from 1978 to 1981. He found that the 38 patients treated with psychodrama had greater decreases in medication dosage and lower psychosocial disability scores than did a matched group of patients who were not exposed to psychodrama. He also reported higher rates of improvement and higher discharge rates for the psychodrama group.

### Critique

None of the previous research has used battered women as the population of treatment. Some of the populations did, however, share problem characteristics that suggest treatment similarities. Baumgartner's (1986) veterans and Little et al's (1991) abusing mothers share histories of past trauma. Alcohol abusers as studied by Wood et al (1979) require treatment for denial and for low trust. All of the special populations cited have low self esteem and fixed role perceptions.

The studies use a variety of measures for outcome variables. Some such as the Correctional Institutions Environment Scale and the situation specific measures used by Little et al (1991), Baumgartner (1986) and Hickling are not generalizable.

The psychodrama studies that studied locus of control had differing results. Rosenthal (1976) suggested that his university students may have had relatively healthy attribution outlooks

before treatment, accounting for the lack of significant change.

O'Connell and Hanson (1970) studied hospital patients who had received psychodrama along with other human relations training. The Carpenter and Sandberg (1985) study of delinquent adolescents was better controlled and showed that psychodrama can be effective for changing locus of control.

The definition of what was being called psychodrama was unclear in the studies by Barret (1986) and Hickling (1989). When the psychodrama treatments are part of institutional programs, the effects are often confounded by the effects of adjunct therapies also in place.

D'Amato and Dean (1988) criticize psychodramatists for the lack of empirical evidence to support claims of therapeutic efficacy. D'Amato and Dean evaluate most psychodrama research as theoretical discussion or case study reports. They criticize the research methodology of the evaluative research. They question the claim that all who participate in psychodrama, including director, auxiliaries and audience, benefit from it (Moreno, 1964). They also question the broad context of psychodrama, they say, "...P.D is said to become what each specific individual needs. Such unsubstantiated claims have led many to question the face validity of the approach" (p.308).

The authors concede in a spirit of fairness that "other psychotherapeutic techniques suffer from a rather similar clinical foundation "(p.308) and they quote a defense from Moreno (1964), "psychodrama is human society in miniature, the simplest possible

setup for a methodological study of its psychological structure" (p.177).

In this research study battered women were treated by psychodrama and compared to similar groups who received no psychodrama. The psychodramatic techniques were defined and included the classical elements of group participation with warm-up, action, working-through and closure. The specific outcome variables of assertiveness and locus of control were measured by reliable and validated instruments. Battered women are a special population with specific treatment needs. It was important to investigate possible methods for specific outcomes. Blatner (1973) cautions that: "...Psychodrama is no panacea: any romanticizing of a single approach is dangerous, as it blinds one to the limits of the approach and the values of other methods." (p.4) The limits and the values of psychodrama deserve to be explored and reported in a credible way.

Review of the literature: Locus of control

Locus of control is a measure of generalized expectancy.

Rotter (1966) describes the locus of control construct as follows:

When a reinforcement is perceived by the subject as following some action of its own but not being entirely contingent upon this action, than in our culture, it is typically perceived as the result of luck, chance, fate, as under the control of powerful others, or as unpredictable because of the forces surrounding him. When the event is interpreted in this way by an individual, we have labeled this a belief in external control. If a person perceives that the event is contingent upon his own behavior or his own relatively permanent characteristics, we have termed this a belief in internal control."

(p. 1)

Locus of control is a social learning concept that is particularly salient to the problem of battered women, an important variable that links the woman's beliefs and behavior to the social system to which she relates. Phares (1965) found that people who have an internal locus of control behave quite differently from those that have an external locus of control. They are more likely to take action and use their available resources to deal with threatening conditions. Those who perceive external control tend to feel helpless and to not attempt to change their environment.

Several authors (Heppner, 1978, Hiroto, 1974, Walker, 1979) have noted the relationship between the construct of locus of control (Rotter, 1966) and the theory of Learned Helplessness developed by Martin Seligman. Learned helplessness is described by Seligman (1975) thus: "... a person or animal is helpless with respect to some outcome when the outcome occurs independently of all his voluntary responses" (p.16) "...the perception of uncontrollability causes significant deficits in three areas: the motivation to respond is sapped, emotionality is heightened, and the ability to perceive success is undermined" (p.44).

Hiroto (1975) corroborates the connection between the two concepts in his research. Hiroto (1975) used psychology students to investigate the interactions of internal-external perceptions of locus of control with escape-avoidance behavior toward inescapable noxious stimuli. He found externally focused students to have greater impairment of escapability than the internally focused students.

Many domestic violence investigators (Walker, 1979, Heppner, 1978, Hendricks-Matthews, 1978, Ball and Wyman, 1978) have discussed the battered woman's depression, helplessness and lack of assertiveness as resulting from her repeated but unsuccessful attempts to control the abuse that she receives. The theory of learned helplessness in combination with perception of control has been used by these authors to explain why battered women feel powerless and helpless to change their fate or to extricate themselves from the battering relationship. It has been suggested

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that increased perception of internal locus of control is necessary before battered women can feel empowered to act on their own behalf (Hendricks-Matthews, 1982, Harris, 1985, Wilson, 1985).

Some recent dissertations have focused on documenting locus of control in battered women. Zielke (1984) found that 42 shelter residents were more external in their locus of control than were the nonbattered comparison group subjects. She also found a positive relationship between self-perceived feminine role identification and external locus of control, lending credence to Walker's (1979) theory that the socialization of women to be passive, dependent and submissive may influence their sense of powerlessness or locus of control and render them vulnerable to learned helplessness.

Wilson (1985) used the Adult Nowicki-Strickland locus of control scale, the MMPI and the Tennessee Self-Concept Scale to measure psychological characteristics of battered women seeking shelter for the first time. She found the women to have low self-concept coupled with external locus of control.

In a similar study, Young (1983) found no significant difference for perception of locus of control among women who were currently battered, never battered and battered previously but not presently. She also found no difference in locus of control among currently battered subjects reporting more frequent, less frequent or stable violence. It may be pertinent to note that all subjects had sought some form of treatment for mental health problems and that the pre-treatment scores were significantly more external than

Rotter's national sample.

Harris (1985) showed that locus of control in battered women can be improved by treatment. He measured self concept by the Tennessee Self Concept Scale and locus of control by the Rotter Internal-External Locus of Control Scale before and after two treatment conditions, an in-patient shelter group and an out-patient group. He found a significant change for both treatment groups on internal locus of control and some measures of self-concept.

Locus of control was also shown to become more internal as a result of encounter group therapy in two studies by Diamond and Shapiro (1973) with graduate student subjects numbering 31 and 33 respectively. There was no significant gain for control subjects who received no treatment.

Gillis and Jessor (1970), Foulds (1971) and Lewis, Dawes and Cheney (1974) in three separate studies found brief (four to eight sessions) psychotherapy groups effective for changing locus of control to more internal beliefs. All three studies showed the greatest change for subjects who were most externally located before treatment.

Dua (1970) compared the effects of a behaviorally oriented action program and a psychotherapy reeducation program on the construct of internal-external control as well as emotionality and introversion-extroversion. Thirty students who sought counseling were assigned randomly to one of the treatment groups or to a control group. The action program, designed to create new behaviors

for dealing with situations of interpersonal anxiety, was found to be more effective than the reeducation program which focused upon cognitive processes and attitudes in changing locus of control to the more desirable internal focus.

Psychodrama has been investigated as a modality for changing locus of control. Rosenthal (1976) suggested that psychodrama goals of increased spontaneity as a construct of increased personal responsibility and freedom of action seem to be related to Rotter's (1966) internal locus of control construct. He was unable, however, to show psychodrama treatment to be any more effective than no treatment on measures of locus of control or on self-actualization.

In a study by O'Connell & Hanson (1970), 176 hospitalized patients participated in both psychodrama and human relations training emphasizing communication skills, problem solving and conflict resolution. Participants showed significant pre-to-post change toward internal locus of control as well as decreased somatic and psychological symptoms and defensiveness.

Carpenter and Sandberg (1985) found that psychodrama treatment for delinquent adolescents produced significantly more change toward internal locus of control than did no treatment for a matched control group.

### Critique

The studies cited above are based on the assumption that a belief in internal locus of control is desirable because it

promotes an individual's ability to take action in his own best interests (Phares, 1965). The researchers of the domestic violence problem agree that battered women need to take such action and locus of control is beginning to be investigated as a measure of the perceived helplessness that prevents the action of leaving a violent relationship (Zielke, 1984, Wilson, 1985, Young, 1983). These studies do not, however, address the question of treatment modalities to change locus of control.

The studies that found group psychotherapy to be effective in changing locus of control (Harris, 1985, Diamond & Shapiro, 1973, Gillis & Jessor, 1970, Lewis, Dawes & Cheney, 1974) made no attempt to compare modalities of group psychotherapy. Dua (1970) did compare a loosely defined action program to psychotherapy reeducation. This program was not specifically psychodrama.

Psychodrama studies (Rosenthal, 1976 and Carpenter and Sandberg, 1985) found different results for the effectiveness of psychodrama versus no treatment for their populations. Perhaps, the relative health of Rosenthal's graduate student subjects may explain why he found no significant change.

O'Connell & Hanson (1970) employed no control or comparison group, therefore, there can be no assurances that the observed changes were due to treatment and not to repeated testing or to the passage of time.

This study examined the effects of a specific treatment modality on changes in locus of control for a population that has been shown to need this change.

### Review of the literature: Assertiveness

The term, assertiveness, describes "...behavior which enables a person to act in his own best interest, to stand up for himself without undue anxiety, and to express his rights without destroying the rights of others" (Alberti and Emmons, 1974). It has been consistently demonstrated that assertiveness can be learned through training (Rathus, 1972, Rude, 1980) and that assertiveness can be correlated to other characteristics.

Assertiveness is positively correlated to self esteem, to verbal expression and to internal locus of control (Harris and Brown, 1979, Wilks and Coplan, 1977, DeMan and Green, 1988, Applebaum & Tuna, 1975). It has been shown to have an inverse relationship with depression (Myers-Abell and Jansen, 1980, Culkin and Perotto, 1985, Rude, 1986). Therefore, it would seem logical that abused women who are experiencing depression, low self-esteem and external locus of control as part of the learned helplessness syndrome may also experience low assertiveness.

Assertiveness training is described by Wolpe and Lazarus (1966) as a counterconditioning for the fear and anxiety that a person associates with certain interpersonal situations. The primary components of assertiveness training consist of role-play, modeling, mirroring, coaching and social reward through feedback. These are all components of psychodrama therapy.

Flowers and Booraem (1980) discuss psychodrama as a method for simulation of life problems, where "the client is systematically taught skills for use in the extratherapeutic or natural

environment" (p. 173). They describe the original work by Moreno as assertive skill development for delinquent girls. They suggest that assertiveness can best be trained by the simulation and role-playing methods in psychodrama groups.

Psychodrama methods were also shown to be effective by Leaman (1983) in a group for psychiatrically disturbed adolescent inpatients. Hospital staff reported improvements in social adjustment that included clearer and more assertive communication.

In 1977 Percell, Benwick and Biegel found that self concept increased and anxiety decreased as assertiveness was increased by training. An assertiveness scale, a self-acceptance scale and an anxiety measure were administered to 100 psychiatric outpatients. In pre-tests, both men and women showed a positive relationship between assertiveness scores and scores on the self-acceptance inventory. A negative correlation between anxiety and assertiveness was shown for the women subjects only. After treatment by assertiveness training and by a relationship-control group therapy, the subjects who received the experiential assertiveness training showed significant gains in assertiveness and self-acceptance and significant decreases in anxiety relative to the other group. Both groups were given didactic information on assertiveness, explored the subjects' own behaviors and discussed how to behave more effectively. However, only the assertiveness training group used the techniques of role-reversal and behavioral rehearsal. The authors suggest that the study demonstrates the effectiveness of action techniques to increase assertiveness.

Stake and Perlman (1980) found that assertiveness training is a viable technique for improving low performance self-esteem among women. Performance self-esteem is a construct developed by the authors to denote self-perception of job performance and ability. A sample of 121 women were assigned to twelve treatment groups of assertiveness training or to a control group. Performance self-esteem and assertiveness increased significantly in the training group but not in the control group both at immediate follow-up and after one year. Another interesting finding of this research was that the women who signed up for assertiveness training had lower performance self-esteem scores on pretest than did the control group, suggesting that "the approach seems to be particularly attractive as well as effective for low performance self-esteem women." (p.281)

Black high school students were given assertiveness training in an attempt to bolster self-esteem in a study by Stewart and Lewis (1986). Assertiveness was measured pretest and posttest by the Rathus Assertivenss Scale. Additional posttest scores were derived for the experimental group from a situational behavior test designed by the authors. Changes toward improved self-esteem for the experimental group were in the positive direction but not statistically significant. Differences in assertiveness were found to be significant only for the women subjects who received the training. The male subjects actually decreased assertiveness scores with treatment. The authors suggest that this difference may have to do with culturally expected aggressive behavior for black males.

Rude (1980) found depressed women to improve their scores on the Beck Depression Inventory after cognitive therapy combined with assertiveness training was given. Although there was significant improvement for treated subjects over control subjects when both assertiveness and cognitive therapy was given, there was no difference for the midpoint measurement of assertiveness or cognitive treatment alone. This indicates that behavioral rehearsal without cognitive insight may not be sufficient for improving depression. Psychodrama is unique in its inclusion of both.

In a single case study, improvement was shown on depression as well as assertiveness after assertiveness training was given to a battered woman (Meyers-Abell and Jansen, 1980). This is the only reported study which measures the effects of assertiveness training on the battered woman population although several investigators have suggested that it would be useful (Walker, 1979, Heppner, 1978 and Straus et al, 1979). This study was designed to test differences in a shelter assertive therapy group and a shelter-services-only group but difficulty in follow-up assessment precluded any statements about effectiveness. The subject in the case example showed an increase of assertiveness and a decrease in depression on measurement as well more assertive behavior in outside situations. The subject eventually divorced her husband.

### Critique

None of the reported research is concerned with psychodrama treatment for assertiveness training with battered women.

Flowers and Booraem (1980) and Leaman (1983) discuss the use of psychodrama for increasing assertiveness in other populations but they offer no empirical evidence by testing. While Flowers and Booraem offer only a theoretical discussion, Leaman relies on observer reports by hospital personnel to declare his inpatient population to be more assertive.

Percell et al (1977) provide the most controlled study for supporting action techniques as an effective treatment to increase assertiveness. However, The Lawrence Interpersonal Behavior Test used to measure assertiveness has poorly established validity and reliability for the assertiveness construct. Also, testing of 100 subjects revealed that men and women were significantly different on correlations of assertiveness and anxiety with only women demonstrating a negative correlation. Twelve subjects of both genders were randomly assigned to the two types of groups. Because of the gender imbalance, they may not have been equivalent groups. When the male subjects are subtracted from the sample, the sample becomes very small, only five women were included in the assertiveness training group and seven were in the relationship-control therapy group. Stewart and Lewis (1986) shared this problem of gender difference in response to assertiveness measures.

Stake and Perlman (1980) used a smaller control group (n=20) than experimental group (n=76). Because the subjects selected and paid for the treatment group and were shown to be lower in self-esteem pretests than the control group, groups were not randomly assigned and may have been unequal.

Limitations of the Myers-Abell and Jansen single-case study with assertiveness training for battered women have already been discussed.

This study will attempt to measure gains in assertiveness on the Rathus Assertiveness Index following psychodrama group treatment for randomly assigned battered women who have been referred for outpatient therapy.

### Review of the literature: Population of battered women

Although spouse abuse has occurred for centuries, it has been largely ignored by mental health professionals until the late 1960's (Gelles, 1976). Over the past fifteen years, the enormous proportions of the problems of battered women have emerged from the sanctums of the home to public scrutiny and disapproval. Increasingly the medical, legal, mental health and law enforcement agencies have become involved in providing services. In the 1970's, the shelter programs concentrated on identifying the victims and providing for basic physical needs in a safe and confidential environment. Only recently, have programs begun to address treatment for the psychological needs of the battered women.

Most of the research to date has focused on identifying the frequency and nature of battering, causes and patterns of abuse, family history of generational violence and investigating reasons why the victims stay in these relationships (Gelles, 1974, 1976, Rounsaville, 1978, Walker, 1979, Straus, Gelles and Steinmetz, 1980, Strube and Barbour, 1983). Researchers in the last decade have also begun to describe psychological characteristics of the abuse victims (Star, Clark, Goetz and O'Malia, 1979, Rosenbaum and O'Leary, 1981, Wilson, 1985). Recent investigators have considered the abused woman's psychological functioning as a result, not a cause of her victimization (Gellen, Hoffman, Jones and Stone, 1984, Mitchell and Hodson, 1983, Walker, 1984).

All of these studies have important implications for developing treatment strategies, the next step for aiding battered

women. Treatment must help battered women to explore why they stay in abusive relationships and help them to leave. One of the important factors cited is the reality of economic dependency. Women who lack job skills and personal income and who are caring for young children have "objective dependency" according to Kalmuss and Straus (1982) and they are less likely to leave the relationship. In a study by Strube and Barbour (1983) only 18% of women who stated economic problems left violent relationships while 73.3% of women who claimed economic independence left.

Women may also fear retaliation (Rounsaville, 1978) or they may attribute the spouse's behavior to a temporary external condition such as alcohol or job pressure (Snyder and Fructman, 1981, Pfouts, 1978, Ferraro and Johnson, 1983).

Another external factor involves society's tolerance for husbands to physically control their wives and a reluctance to invade marital privacy and provide wives with legal protection (Straus et al, 1980, Lloyd, Cate and Conger, 1983, and Gentemann, 1984).

Sometimes, abused women seem to passively stay in a violent relationship even when, externally, it seems possible to leave. Some researchers (Walker, 1979, and Mitchell and Hodson, 1983) have proposed that Seligman's learned helplessness theory might provide an explanation for this situation. Seligman (1975) says, "When an organism has experienced trauma it cannot control, its motivation to respond in the face of later trauma wanes" (p.22). Thus, women who are subjected to unpredictable and uncontrollable violence

learn that their behaviors do not affect the outcomes. Mitchell and Hodson, 1983, proposed that this cognition is likely to diminish coping efforts and decrease self-esteem while increasing depression. In the study by these researchers, 60 women in shelters were assessed by questionnaires to determine levels of violence, personal resources of education and income, social support systems, institutional responses (police, lawyers or therapists) and their coping measures. Self-concept and perception of control were found to be indirectly related to violence levels and directly related to social support, institutional responses and effective coping techniques.

Gellen, Hoffman, Jones and Stone, (1984) using the MMPI were able to distinguish between 10 abused women and 10 non-abused women. They found a profile that they likened to Seligman's learned helplessness construct, particularly that abused women were significantly more depressed, more prone to hypochondriases and more socially introverted than non-abused women. They concluded that these women could not be expected to demonstrate goal directed, logical or independent behavior under the circumstances.

These findings were supported by Star et al (1979) who used the Sixteen Personality Factor Questionnaire and the Clinical Analysis Questionnaire by Raymond Cattell to show that a sample of 80 abused women showed a lack of self-esteem, a lack of self-confidence and a tendency to withdraw. Mullen, Romans-Clarkson, Walton and Herbison (1988) also found that psychiatric diagnoses of depressive and anxiety disorders were more frequent among abused

women.

Wilson (1985) assessed and described 16 battered women by interview and questionnaires which included the Tennessee Self-Concept Scale, the MMPI and the Adult Nowicki-Strickland locus of control scale. She found the subjects to be depressed, low in self-concept and high in external locus of control. In addition, the women described themselves as functioning at a low level of competence, and as passive and dependent.

Many researchers have proposed group counseling as the most effective type of therapy for abused women (Rounsaville, 1978 and Hartman, 1983). It provides social contacts for a population who feel isolated. It allows women who perceive themselves as helpless to problem solve for one another. Sharing similar situations and reactions helps to normalize the victims. By listening to other stories and telling their own, battered women can begin to understand the pattern of abuse and to feel less at fault. They can begin to feel in control (Hartman, 1983). The effectiveness of group counseling for changing locus of control and self-concept in battered was investigated by Harris (1985) in a comparison of a shelter group program and an outpatient battered women's group. From his literature review, he determined that the central issues for battered women are low self-esteem, a sense of isolation and a pronounced belief of powerlessness in controlling life events. The pretest scores for the Rotter I-E Scale revealed that the subjects perceived themselves before intervention as being externally controlled. After counseling both sheltered and

nonsheltered subjects had changed significantly toward internal locus of control. The pretest scores of the Tennessee Self-Concept Scale showed an overall low self-concept for both sheltered and nonsheltered groups. There was no significant difference in self-concept after intervention but there was a general tendency toward improved self-concept for both groups. Harris suggests that this may be due to the change toward internal locus of control.

### Critique

The research cited indicates that battered women can be identified. The psychological characteristics that result from battering victimization seem to be fairly consistent and can be attributed to the experience of abuse. Studies that question why women stay in abusive relationships seem to lead the conclusions of poor self-esteem and external locus of control. The characteristics of low assertiveness and external locus of control have both been measured with interview and questionnaires and have been identified as problem areas that may benefit from treatment.

Most of the research to date has consisted of measuring the domestic violence and suggesting rationale for its existence and persistence. Studies for measuring program effectiveness are extremely sparse. Most importantly, none of the studies have compared specific treatment methods.

The study by Harris, comparing in shelter and out of shelter

support groups, was the only study found that evaluated program effectiveness in an empirical manner. This study also had problems. It used a small sample and uneven numbers of participants per group (16, 7 and 4). A large number of subjects did not complete the study. The completion rates averaged 36%

This study attempted to measure by reliable instruments, the effectiveness of one specific group treatment (psychodrama) for the improvement of assertiveness and internal locus of control. These characteristics have been shown to be the most identifiable deficiencies for the population of battered women.

### Chapter 3

#### Collection of Data

##### Sample Population

Forty-six adult (over 18) women who voluntarily sought outpatient therapy for having experienced domestic violence in the community of Hampton Roads were referred by advertisement or therapists to participate in this study. These women had to have been out of the battering relationship for at least two months. Some were in therapy or had been in therapy in the past but had not experienced psychodrama therapy. Therapists for outpatient groups from hospitals, battered women shelters and family service agencies as well as private therapists were invited to refer appropriate and willing clients to this treatment study. Participants were invited to refer appropriate friends and a small announcement was placed in a local newsletter for addiction and co-dependency recovery. A copy of the letter inviting therapists to refer clients to this study can be found in Appendix F. Referred and consenting subjects were randomly assigned to a comparison waiting group or to a psychodrama treatment group.

There were no selection criteria of race, income, education, occupation, religion, number of children or number of years of being battered but a demographic questionnaire (Appendix B) was used to gather this data. The degree of abuse was also not a selection criteria but was assessed by the Index of Spouse Abuse (ISA, Hudson and McIntosh, 1981) as part of the pretesting procedure.

### Data gathering method

All participants were informed about the nature of the groups and were randomly assigned to either a waiting comparison group, continuing with existing treatment, or to a psychodrama group created for this study. All participants were given the following paperwork to complete before beginning treatment: the research consent form (Appendix A); the demographic questionnaire (Appendix B); the Rotter IE Scale for Locus of Control (I-E Scale, Rotter, 1966); Rathus Assertiveness Schedule (RAS, Rathus, 1973); Index of Spouse Abuse (ISA, Hudson & McIntosh, 1981) and the Beck Depression Inventory (BDI, Beck & Steer 1987). The total time of pretesting was forty minutes.

Participants were randomly assigned to either a psychodrama group or to a comparison group of equal original size (from 6 to 10 members each). Each psychodrama group met for 27 hours, including one 18 hour weekend and three, weekly, three hour evening meetings. A group of 9 met in July, 1993 a group of 7 met in September, 1993 and a group of 6 met in December, 1993. After the four week treatment interval, the psychodrama participants and the comparison group subjects were given the Rotter Internal-External Scale and the Rathus Assertiveness Schedule as post-tests. The Beck Depression Inventory and the Eysenck Personality Inventory (EPI, Eysenck and Eysenck, 1968) were also given as post-tests. Comparison group subjects were offered the opportunity to be included in the next psychodrama group.

### Treatment Method

The psychodrama groups followed Moreno's (1946) classical methods (described in Appendix C) and included warm-ups, action dramas and sharings. These groups were each led by two licensed therapists who are trained and experienced in the psychodrama method. The experimenter was also present at each group meeting. Dr. Ella Mae Shearon, conducted a special training session for the group leaders regarding the phenomena of spouse abuse. Warm-up procedures and methods for dealing with abuse trauma were designed. Appendix D contains a summary of the leader training.

Although a total of forty-six subjects were recruited, data from four experimental subjects was dropped because the subjects did not complete the group meetings and/or post-tests. Data from two subjects in the comparison groups was dropped due to incompleting post-tests. There were a total of 19 experiential subjects and 21 comparison subjects.

Each of the three psychodrama groups followed the same format. The Friday night meeting included structured warm-ups around names and commonalities and an exercise in doubling. Some mini-dramas were enacted. These sessions were designed to build group cohesion and to familiarize the participants with the psychodramatic method. On Saturday mornings, there was discussion about abuse and a soft lifesized dummy was labeled with descriptions of abusers. Participants were invited to psychodramatically address this "abuser". The remaining sessions focused on protagonist-centered dramas that emerged spontaneously from the group.

### Instrumentation

Six paper and pencil instruments were used in this research. Two, the demographic questionnaire (Personal Questionnaire) and the Index of Spouse Abuse (ISA) were given on pre-test only for purposes of subject description. They were used to assess significance between group differences before treatment. The standardized instruments, Rotter's Internal-External Locus of Control Scale (I-E) Scale and the Rathus Assertiveness Schedule (RAS), were the outcome measures for this study. The Beck Depression Inventory (BDI) and the Eyesenck Personality Test (EPI) were included in order to detect severe depression and "test-faking" tendencies.

The Personal Questionnaire (Appendix B) is a nine question checklist designed by the researcher for obtaining basic demographic information: age, race, marital status, number of years in the relationship, number of children, employment, education, religion and income.

The Index of Spouse Abuse was developed in 1978 by Sally McIntosh and Walter Hudson for use in clinical settings to evaluate the degree or severity of both physical and nonphysical partner abuse as perceived by female respondents. This scale was chosen as preferable to the more commonly used Conflict Tactics Scale (CT) (Straus 1979) because the CT scales focus on violence within the family as a whole, while the ISA was developed specifically to measure the perceived abuse that is inflicted upon women by their partners. The ISA is easily understood by the respondents and can

be completed in approximately 5 minutes. This is a 30-item self-report scale that yields two different scores. Items are weighted according to severity of abuse and are scored separately to reflect physical or nonphysical abuse. Cutting scores for the two scales have been recommended by the authors as a tool for classifying abuse. This instrument has been shown to have an internal consistency reliability of .90 for the physical abuse factor and .91 for non-physical abuse factor. Concurrent criteria validity for the physical and nonphysical abuse factors was determined to be .73 and .80 (Hudson and McIntosh, 1981). The ISA was used in this study to assess the level of violence for participants.

The I-E Scale was developed by J. B. Rotter (1966) to measure differences in a generalized expectancy or belief in personal control. The test is self-administered with most subjects completing it in 4 to 8 minutes. The scale consists of 29 forced choice items, six of which are fillers and are not scored. The items each have two statements, one of which is to be selected as being more similar to the respondent's beliefs. One of the statements suggests internal orientation or belief in outcome being attributable to one's own action while the accompanying statement suggests external orientation or belief in outcome being attributable to luck, fate or the action of powerful others. The scale yields a single score which describes the degree of externality. Low scores, therefore, indicate an "internal" locus of control or belief that one controls one's own outcomes.

Reliability and validity of the I-E Scale are reported from

a variety of studies by Rotter in a 1966 monograph. He found that measures of internal consistency taken from four samples (total of 1600 subjects) yielded an average reliability coefficient of .71. Test-retest reliabilities that were retested after two months averaged .75 for two samples. This was corroborated by a study by Hersch and Scheibe (1969) who found reliability coefficients ranging from .48 to .84 over a 2 month interval.

Good discriminant validity was reported by Rotter (1966) with his findings of low correlations with such variables as intelligence, social desirability and political affiliations. Hersch and Scheibe (1969) supported the findings by comparing three different measures of intelligence with the I-E Scale and finding nonsignificant correlations.

Tyre, in his 1972 review of locus of control literature, says, "a fairly substantial body of literature has accumulated regarding the development of the internal construct. Reliability and discriminate validity appear to support a fairly consistent amount of predictive capacity for the I-E instrument" (p.34).

Construct validity has been demonstrated frequently in studies that measure attempts to control the environment. Strickland (1965) found that "internals" were more likely to choose to participate in civil rights activities. Tubercular hospital patients who were measured to be "internal" and thus would be expected to perceive more personal control over their lives were, indeed, found to know about more about their health and to question hospital staff about their condition than did "externals" (Seeman & Evans, 1962).

The Rathus Assertiveness Schedule (RAS, Rathus, 1973) is a 30 item self-report inventory for measuring assertiveness or social boldness. Respondents are asked to rate the degree that the 30 statements are characteristic of them on a 6 point Likert scale ranging from "very uncharacteristic of me-extremely nondescriptive" (-3) to "very characteristic of me -extremely descriptive (+3). The test yields possible scores of minus 90 to plus 90 with higher scores indicating a higher degree of assertiveness.. Most subjects complete the test within nine minutes.

The RAS has been found to have high test-retest reliability at .78 ( $p < .01$ ) over a period of 2 months for 68 male and female college undergraduates and good split-half reliability at .77 for male and female subjects ranging from 15 to 70 years of age (Rathus, 1973). Futch, Scheire and Lisman (1982) also found the instrument to be highly reliable as well as having construct validity for current definitions of assertiveness.

Rathus (1973) tested validity by having raters define people they knew well in terms of assertiveness and comparing this to RAS scores. He found significant positive correlations for boldness, outspokenness assertiveness, aggressiveness and confidence and found no significant correlations for intelligence, happiness or fairness. In a second study, he correlated raters scores of responses to situational questions describing assertiveness to RAS scores and found a validity coefficient of .70 ( $p < .01$ ).

Applebaum and Tuna (1975) found that locus of control as measured on the Rotter I-E Scale (1966) covaries with

assertiveness. They found that internals are more assertive than externals and that this relationship does not vary with social desirability. This study supports the hypothesis that assertiveness may be a behavioral manifestation of locus of control.

Harris and Brown (1979) supported validity for the RAS in assessing assertiveness by comparing RAS scores to related measures on the CPI. They found significant positive relationships for the Class 1 scales of dominance, capacity for status, sociability, self-acceptance, sense of well-being and social presence. They concluded that the RAS was a valid predictor for poise, ascendancy and self-assurance and could be useful for identifying clients who needed to increase assertive behavior.

The Beck Depression Inventory (BDI, Beck & Steer 1987) was used in this study to screen for dangerous levels of depression before and after treatment. It was developed as a structured interview in 1961 and revised in 1971 by Aaron Beck (Sunberg, 1992). Beck and Steer published the manual in 1987. It is a well-known and frequently used instrument to detect depression and to assess its severity. The self-report measure consists of 21 items with four choices per item. It is expected to take the average person 5 to 10 minutes to respond.

In an extensive review article, Beck, Steer & Garbin (1988) published reliability and validity data. Content validity is substantiated by comparing items to the criteria for depression in the American Psychiatric Association's Diagnostic and Statistical Manual on Mental Disorders. The internal consistency rated by

Cronbach's alpha for 25 students ranged from .73 to .95 (Beck, Steer & Garbin, 1988) When compared to clinical ratings, the MMPI depression scale and other depression instruments, the mean correlations for concurrent validity ranged from .60 to .76. It is noted that test-retest reliability ranged from .60 to .86 for non-psychiatric samples and .48 to .86 for psychiatric samples. This could be due to the variability of a person's experience of depression. (Conoley, 1992)

The BDI has been used to classify different levels of depression and to predict suicidal behavior (Emery, Steer & Beck, 1981). The BDI has been found to be particularly sensitive for women, who tend to have slightly higher scores than men. Hammen & Padeski (1977) tested 1300 female college students and found a mean score of 6.34 with a SD of 5.58.

The Eysenck Personality Inventory (EPI, Eysenck & Eysenck, 1968) was used in this study only for the lie (L) scale to detect faking good. The inventory Form A that was used consists of 57 items in a yes/no format with 9 of these items making up the lie scale. The authors of the test report that the lie scale is comparable to the MMPI L scale and purports to indicate a "faking good" profile. The authors found a mean score of 3.8 on a norming sample of 1003 American college students. In a study assessing the effects of being asked to fake good responses, Braun and Gomez (1966) obtained scores of 7.27 which were reduced to 5.94 when subjects were asked to conceal their faking. The cut-off score for faking good was suggested to be 4 or 5 when using Form A.

### Research Design

This study employed the Pretest-Posttest Control Group Design (Campbell & Stanley, 1963).

R O1 X O2

R O3 O4

Participants were randomly assigned to one of the conditions and measured before and after treatment on two variables. This design controls for history, maturation, testing, instrumentation, regression, selection, mortality and selection-maturation interaction. Because both the experimental group and the control condition group received some intervention, it is expected that the interaction effects of selection and treatment and the reactive effects of experimental arrangements were minimized. The interaction effects of testing and retesting were not controlled.

### Specific Hypotheses

The following null hypotheses were tested:

1. There will be no significant difference in gains on assertiveness as measured by the Rathus Assertiveness Schedule between the treatment groups and the comparison groups.
2. There will be no significant difference in changes from external to internal locus of control as measured by the Rotter I-E Scale between the treatment groups and the comparison groups.

3. There will be no significant relationship between assertiveness as measured by the Rathus Assertiveness Schedule and locus of control as measured by the Rotter I-E Scale for battered women on pretesting.

### Statistical analysis

Demographic variables were examined by Chi Square Test to determine if there was group equivalency.

Means and standard deviations were determined for all instrument scores and were tested for normal distribution.

Pearson product-moment correlations were done on all variables, as data were normally distributed, in order to describe significant correlations.

The effects of psychodrama treatment on the outcome variables of assertiveness and locus of control were statistically tested by computing univariate analysis of gain scores for each of the outcome variables. Additionally, to test for the third hypothesis, pretest scores of assertiveness and locus of control were correlated to determine the relationship between these constructs.

### Ethical Considerations

Approval for this research was sought from the Committee for the Protection of Human Subjects of The College of William and Mary. Referrals and advised consent were also obtained from the directors of the battered women's shelters and directors of other referring agencies. These professionals were provided with the

results of the study.

Subjects were informed about the nature of the study, the testing procedures and about the treatment modality before they signed the required consent forms. They were told that they would be randomly assigned to one of the two groups and that they could withdraw at any time.

Confidentiality was assured. Subjects were identified by an assigned number on the research instruments. The list of subjects and names will only be available to the researcher for the purpose of matching pre and post test scores and will be destroyed after the post-tests are completed. Only group means were reported.

Any subject who was upset or had questions about the instruments or the treatment were be counseled by the investigator or one of two other licensed therapists. Any subject who requested information about her scores, were given the scores and interpretation of them following post-testing. If a subject's score on the Beck Depressin Inventory or the Spouse Abuse Index had indicated physical danger, the subject would be appropriately counseled or recommended for shelter. If at any time during the testing or treatment, a subject or a therapist determined danger to self or others, the normal measures were taken to ensure safety.

## Chapter 4

### Analysis of Results

The purpose of this study was to measure the effects of psychodrama treatment on the levels of assertiveness and locus of control for women who seek out-patient therapy to deal with the experience of having been battered.

#### Description of the sample

The sample size for this study was forty. Of the forty-six subjects originally referred and selected, nineteen experimental group subjects and twenty-one comparison group subjects completed the study. Four experimental subjects were dropped from data analysis; one subject could not attend all of the psychodrama sessions because of a death in her family, one subject moved away from the area before post-test data was collected, one subject had missing data on post-test and one subject was not included because she was disassociative at the time of post-testing. Two of the comparison subjects failed to complete post-test data.

Originally, the study was planned as a lagged treatment design, allowing subjects to participate as experimental subjects after they had first served as comparative subjects. Because only three comparison subjects elected to take part in the psychodrama groups after the "control " period, the lagged design method was abandoned.

Age. For those studied in this sample (n=40), the age range was between 21 and 66 years. Sixty-three percent of the subjects

were between the ages of 30 and 50 years old, 22% were younger and 15% were older.

Marital Status. The most common marital status was divorced (42.5%) with separated being represented at 32.5% and married at 20%. Only 5% were single.

Length of Relationship. Most subjects had been in an abusive relationship between 5 and 14 years (55%), with 27.5% in the relationship a shorter period of time and 17.5% a longer period of time. The subjects had been out of the relationship for varied periods of time: 30% for less than one year, 18% for 1 to 3 years, 10% for four to seven years, 8% for 7 to 10 years and 34% for more than 10 years.

Religious Affiliation. The most frequently indicated religion was Protestant, (50%) in this sample. Catholics comprised 25% of the sample and "other" religions made up 15%. Subjects who claimed "none" for religious affiliation made up 10% of the sample. There were no Jewish subjects.

Racial Representation. Racial representation was 90 % caucasian. African- American subjects made up 5% and 5% of the sample was made up of "other" racial groups (Hispanic and Asian).

Number of Children. Most of the subjects had no children at home (51%), while 18% had one child and 31% had two to three children at home. No subject had more than three children at home but one subject had five grown children living away from home.

Employment and Income. Seventy percent of this sample was employed outside of the home. Income levels were distributed evenly

across the sample with annual incomes that varied from less than \$7400 (7.5%) to more than \$50,000 (12.5%). Income levels of \$7500 to \$11,900 were representative of 12.5% of the subjects, \$12000 to \$19,900 representative of 22.5%, \$20,000 to \$29,900 of 22.5% and \$30,000 to \$50,000 of 22.5%.

Education. Most of the subjects were educated beyond high school. Only 15% of the sample population had not graduated high school, 42% of the subjects listed high school as the highest degree achieved, 15% had 2 year college degrees, 15% had 4 year college degrees and 13% of the subjects had graduate degrees.

#### Analysis of differences between groups

Preliminary analyses were conducted to determine if the experimental group and the comparison group were significantly different from one another on the demographic variables or on pre-test scores. Table 4.1 summarizes these data.

Chi Square Test determined that demographic variables were distributed without significant differences between the two groups for age (Chi Square Test, 2-tailed=0.513), marital status (0.494), length of relationship (0.546), years out of relationship (0.530), number of children (0.410), employment outside of the home (Chi Square Test, 2-tailed 1.00, left= 0.710, right= 0.554), education (0.165), race (0.488), religion (0.457), and income (0.115).

To assure that the control and experimental groups were comparable at baseline, t-tests were done for tests given only once, the Index of Spouse Abuse and the Eysenck Lie Scale as well

as for pre-test scores for the Rathus Assertiveness Schedule, the Rotter I-E Scale of Locus of Control, and the Beck Depression Inventory. There were no differences between groups for any of the pre-test scores. Table 4.2 shows these values.

There were no differences between groups for the ISA physical abuse scale ( $t(38)=0.29$ ,  $p=0.77$ ), the ISA non-physical scale ( $t(38)=1.07$ ,  $p=0.29$ ), the Lie scale ( $t(38)=1.52$ ,  $p=0.14$ ), and for pre-tests of the IE scale ( $t(38)=-0.94$ ,  $p=0.360$ , the Rathus ( $t(38)=1.39$ ,  $p=0.17$ ) and the Beck ( $t(38)=0.003$ ,  $p=1.00$ ).

Index of Spouse Abuse. The ISA scores showed subjects from both groups had indeed been physically abused as the mean for the comparison group and the experimental group respectively were 22.9 and 22.2, well above the cut-off score of 10 that was suggested by the authors of the instrument. No single subject's minimum score was below 10 for either group.

Eysenck Lie Scale. The Lie scale showed that no subject was faking responses. The mean scores of 3.18 for the comparison group and 2.47 for the experimental group were well below the suggested cut-off scores of 4 or 5 that might indicate "faking good" responses.

Beck Depression Inventory. All variables were found to have normal distribution except for the Beck Depression Inventory, which was slightly skewed in the direction of higher depression (Skewness=1.25;  $p,0.006$ ) for both comparison and experimental groups. The mean scores for the Beck were 18.90 for the comparison group and 18.89 for the experimental group, indicating moderate

levels of depression. According to the literature, this is consistent with the appearance of other battered women.

Rotter Index of Locus of Control. The Rotter I-E scores were normally distributed but indicated that subject's were moderately externally oriented to locus of control. The mean scores of 11.5 (comparison) and 13.2 (experimental) are slightly less internal than the mean score of 8.68 that Rotter found for his normative population of college students (Rotter, 1966). Again this is consistent with the literature regarding characteristics of battered women.

The Rathus Assertiveness Schedule. The RAS measured both groups to be low on assertiveness. The mean for the comparison group was -4.6 and the mean for the experimental group was -14.42. There was a large standard of deviation for both groups (SD= 24 and 20.4 respectively). The range of scores for the Rotter is -90 to +90, indicating that the scores for this study are mildly low but within normal limits.

The sample was determined to be appropriate for the study and equivalent between groups for demographics and for pre-test variables.

### Summary of Hypothesis Testing

The major findings of this study were based on several principal hypotheses.

Hypothesis 1. The first experimental hypothesis was that there would be a significant gain on assertiveness, as measured by

the Rathus Assertiveness Schedule, between the experimental and the comparison groups at the end of the treatment period. Specifically, the experimental group was expected to make the greatest gain.

Research results actually confirmed a null hypothesis of no difference between the groups. On the basis of an alpha level of  $p < .05$ , there was no difference between experimental group change scores and comparison group change scores ( $M = -7.1$  and  $M = -4.71$ , respectively,  $t(38) = 0.25$ ,  $p = 0.81$ ).

Both groups made changes toward more assertiveness equally. Paired t-tests were calculated for change scores collapsed for groups on the Rathus Assertiveness Schedule. Differences were found between pre and post test scores ( $M = -5.85$ ) for both groups on the RAS ( $t(39) = -2.55$ ,  $p = 0.02$ ).

Hypothesis 2. The second experimental hypothesis was that experimental subjects would show an increase in internal locus of control orientation relative to comparison subjects. Again, study results actually found no differences on the I-E scale between groups, supporting the null hypothesis. There was no difference between experimental group change scores ( $M = 0.62$ ) and comparison group change scores ( $M = 0.42$ ) for the Rotter I-E Score as determined by the Student's t-test ( $t(38) = 1.39$ ,  $p = 0.17$ ). The difference between pre and post test scores ( $M = 0.53$ ) for the I-E Scale were found to be insignificant for both groups ( $t(39) = 1.32$ ,  $p = 0.19$ ).

Hypothesis 3. The third experimental hypothesis was that there would be a significant relationship between assertiveness as measured by the Rathus Assertiveness Schedule and locus of control

as measured by the Rotter I-E scale for battered women on pre-testing.

This hypothesis was proven valid. A Pearson Product Correlation Coefficient of  $-0.47$  ( $p= 0.002$ ) was shown by the study for the relationship between the scores for the Rotter I-E Scale and scores for the Rathus Assertiveness Schedule. This finding indicates, as expected, that decreased assertiveness was associated with increased external locus of control among battered women at pre-testing.

#### Other Findings

While it was not a primary hypothesis, the study findings also indicated that the Beck Depression Inventory scores showed significant changes between testing times when change scores were collapsed for both the experimental group and the comparison groups ( $M= 3.6$ ,  $t(39)= 3.52$ ,  $p= 0.001$ ). Both groups became significantly less depressed. However, there was no significant difference ( $t(38)= 0.43$ ) in the relative changes of the experimental group ( $M=4.38$ ) compared to the changes made by the comparison group ( $M=2.74$ ). Also, the BDI was found to be significantly related to both assertiveness and locus of control. Correlations using pre-test scores ( $N=40$ ) found increased depression to be associated with decreased assertiveness ( $r= -0.45$ ,  $p= 0.003$ ) and increased external locus of control ( $r= 0.47$ ,  $p= 0.002$ ). It has already been noted from discussion about the third hypothesis that locus of control and assertiveness are related so that decreased assertiveness

correlates with more external locus of control ( $r= 0.47$ ,  $p= 0.0021$ ). Changes in the desired direction for these three related constructs occurred equally for the experimental group and for the comparison group.

Relationships concerning the constructs of depression, assertiveness, locus of control and demographic variables are shown in Table 4.3. Many of these follow expected associations and support earlier findings regarding battered women.

Age was related negatively ( $r= -0.62$ ,  $p= 0.0001$ ) to Beck scores in this sample, revealing that the older the subject, the less her depression. Assertiveness was positively associated ( $r= 0.54$ ,  $p= 0.001$ ) so that the older the subject, the higher her scores of assertiveness on the Rathus. The inverse relationship of age to I-E scores indicate that the older the subject, the more internal is her locus of control.

The more children a woman had related to less assertiveness ( $r=-0.34$ ,  $p= 0.03$ ) and to more external locus of control ( $r= 0.46$ ,  $p= 0.003$ ). Depression was not significantly related to number of children.

Physical abuse was significantly related to depression ( $r=0.37$ ,  $p= 0.019$ ) but not to assertiveness or to locus of control. The number of years (length) in the abusive relationship was also only significantly associated with depression ( $r= -0.38$ ,  $p=0.01$ ). Contrary to expectations, the number of years a subject had been out of her relationship was not related to depression, assertiveness or locus of control.

## Chapter 5

### Conclusions

#### Summary of Findings

The purpose of this study was to investigate the effects of psychodrama treatment on levels of assertiveness and locus of control for women who had experienced battering and were seeking out-patient therapy. The problem of battering has reached crisis levels in recent years. It is known that it affects generations of families and it can be lethal. There is evidence to suggest that the victims of battering are often left with lowered self-esteem, depression, lack of assertiveness and a perception of external locus of control (Walker, 1979, Star et al, 1979, Ball and Wyman, 1978, and Zielke, 1984).

Although there has been a great deal of research about battered women since the 1960's, most of it has focused on identifying what causes violence in relationships, what characteristics can be identified for battered women, and why women stay in these relationships. The present study attempted to address the question of treatment for these victims of violence. The "battered woman syndrome" is not a diagnosis of the victim but it is a result of a traumatic experience. Psychodrama, an experiential therapy developed by J. L. Moreno and his wife Zerka, was chosen as a possibly effective treatment because it addresses past experience while also validating self-worth and offering supportive interpretation within the therapeutic environment of a caring

small group. The enactment of certain roles and dramatic incidents allows insight and corrective emotional experiences, enabling more effective action in future situations. Psychodrama has been suggested as an effective way to deal with past traumatic experiences (Baumgartner, 1986), teach more assertive behavior (Flowers and Booraem, 1980, Leaman, 1983) and promote more internal locus of control (Carpenter and Sandberg, 1985).

A sample of forty -six women who requested out-patient therapy because of previous experiences in physically abusive relationships were assigned randomly to either an experimental group of classical psychodrama therapy or to a comparison group that did not receive the psychodrama therapy. Out of the forty six subjects who began the study, a total of forty women completed the study, nineteen experimental subjects and twenty-one comparison subjects.

Before treatment, both groups were asked to complete demographic questionnaires, a measure of physical spouse abuse and pre-tests of The Beck Depression Inventory, the Rathus Assertiveness Schedule, and The Rotter Scale of Internal-External Control. As had been expected from review of the literature, the battered women in this study were measured to be moderately depressed ( BDI Score M= 18.9), moderately oriented toward external locus of control (IE Score M= 12.1) and mildly non-assertive (RAS Score M= -9.5). The groups were found to be equivalent when compared on demographic variables and pre-test scores. In support of one of the hypotheses, the measures of depression, locus of control and assertiveness were found to be significantly related to

one another on pre-testing. Decreased assertiveness was found to be related to increased external locus of control ( $r = -0.47$ ,  $p = 0.002$ ). Depression increased as assertiveness decreased ( $r = -0.45$ ,  $p = 0.003$ ) and as locus of control was more external ( $r = 0.47$ ,  $p = 0.0021$ ).

The experimental subjects were given psychodrama treatment in three sections. Each group section met for a total of 27 hours, including an intensive weekend workshop of 18 hours and three, weekly, three hour evening meetings. A group of 9 met in July, 1993, a group of 7 met in September, 1993 and a group of 6 met in December, 1993. After the treatment phase of four weeks, the experimental subjects and like numbers of comparison subjects were given post-tests on the measures of depression, assertiveness and locus of control.

Contrary to the research hypothesis, psychodrama treatment had no significant differential effect on changes in assertiveness or locus of control in this study. It also had no effect on changes in depression levels. Locus of control changes from pre to post tests were not significant for either experimental or comparison groups. While both groups showed significantly less depression ( $t(39) = 3.52$ ,  $p = 0.001$ ) and more assertiveness ( $t(39) = 1.39$ ,  $p = 0.02$ ) from pre-test to post-test, the gains for the experimental subjects were not significantly greater than the gains for the comparison subjects on depression or assertiveness.

### Discussion of Results

Data from the demographic questionnaire described a sample of women who ranged in age from 21 to 66 years with an approximate mean age of 35 years. Most (76% ) were separated or divorced, caucasian (90%) and Christian (75%). Most of this sample was employed outside of the home (70%) and were educated beyond high school (53%). Most (51%) had no children at home. Income levels were primarily in the range of \$20,000 to 50,000 (45%). T h e subjects had all been out of their abusive relationship for at least three months as a condition of the study. The majority (70%) had been out for longer than a year. All were seeking treatment. The demographics are consistent with the literature regarding what might be expected of women who have successfully left abusive situations.

Most studies of battered women have used a sample of sheltered women who were still in the process of leaving. Snyder and Fructman studied 119 sheltered women in 1981. The demographic profile for their sample was younger (mean age of 29), more racially diverse (only 34% of the subjects were Caucasion), had more children (79% had children with them) and was less educated (mean level of education was 11 years) than the women in the present study. Only 28% of the women in the sheltered sample had been employed outside of the home and 41% were receiving public relief. The study of fifty women in shelters by Star et al in 1979 reported these demograhics: mean age of 32;, 70% Caucasion; 64% Christian; 72% had education less than high school; and 40% had two or more children.

The factors of safety and economic independence are often cited in the literature as the factors that determine whether a battered woman can leave her abusive relationship (Strube and Barbour, 1983 and Kalmuss and Straus, 1982). Therefore, it is expected to find these factors improved in a sample of women who have successfully left their relationships.

The characteristics of low assertiveness, external locus of control and depression have been found in women still in shelters but the priorities of physical and economic survival must be addressed before victims of abuse can seek or devote energy to the more psychological issues. It is only after safety and economic independence have become more stable that the treatment goals of changing assertiveness and locus of control may be addressed.

The treatment of psychodrama was not measured to be effective for significantly changing assertiveness, depression or locus of control. Although subjects from both treatment and comparison groups made significant changes in the desired direction for depression and assertiveness, changes for the experimental group were not significantly greater than those for the comparison group. There were no significant changes for either group on the locus of control measure.

The improvement on assertiveness and depression for the comparison group may be attributable to maturation, effects of testing or the effect of hopefulness following the initial contact for therapy. As was discussed earlier, subjects for this study had a readiness to seek help and the coping skills for finding it.

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Mitchell and Hodson (1983) discuss the importance of social support for enhancing the coping skills of women stressed by abuse. They found that helpfulness of an "institutional response" (police, lawyers or therapists) significantly ( $p < .01$ ) increased active cognitive coping and decreased depression ( $p < .05$ ), more than support from family or friends. The contact that subjects received from the researcher for the purpose of obtaining data may have been perceived as supportive "institutional response". This help may have taken the form of a cathartic experience during assessment, or from validation and increased attention to the subject and her problems. According to O'Hanlon (1989), just the suggestion that problems can be addressed by treatment, instills hope and decreases depression. Assessment and interviewing are intervention; clients and therapists co-create definitions for problems and expectations for therapy. Binder (1976) states that it may not be possible to include a truly untreated control group when doing psychotherapy outcome research.

The action of testing and re-testing may have introduced the phenomena described by Orne (1969) as "demand characteristics" responses from both groups. It is not difficult to detect what the Beck Depression Inventory or the Rathus Assertiveness Schedule is measuring. Perhaps the subjects were able to ascertain what improvement was expected and their high motivation to improve, affected their responses.

The results of this study fail to show psychodrama to be effective for improving assertiveness and locus of control in

battered women. The changes for the treated subjects were not significantly greater than the changes for the comparison subjects although all changes were in the desired direction. The subjects who received psychodrama treatment were, however, reported feeling better and were enthusiastic about the process. Ten of the nineteen experimental subjects requested to be in an ongoing psychodrama group as their treatment of choice. Others, after attending psychodrama sessions, expressed interest in attending more psychodrama weekends.

It is possible that the outcome measures that were used in this study were insensitive to the particular benefits of psychodrama. Zax and Klein, (1960) report that a research problem exists in using external measures as a criteria in phenomenological self-reports. They discuss the difficulty of developing criteria which represents a broad area of functioning and yet is specific enough to be measured with validity. In his article about outcome research in psychodrama, Kellerman (1987) discusses the problem of selecting outcome measures and quotes Moreno as having recommended using only the tests that were specifically designed for testing psychodrama benefits, such as spontaneity and creativity tests, role tests and social atom tests. While these tests may be useful to measure the behavioral changes of psychodrama treatment, they may not be considered valid for addressing the broader areas of psychological phenomenon.

The outcome measure of locus of control may require more time for changes to be measurable. In this study, there were only four

weeks between pre-testing and post-testing. Rosenthal reported that the timing of his post-test measures (two weeks) may have been a limiting feature of his study of psychodrama effects on locus of control in which he, also, found no significant effects. It was hoped that the intensive weekend in this study would eliminate the problem of insufficient exposure to treatment. Psychodrama is considered to be a brief therapy treatment. Hall (1977) compared the difference between an intensive weekend psychodrama experience and six spaced (weekly) sessions and found that the intensive group had significant effects for relieving anxiety and depression while the weekly groups did not. Locus of control, however, may be a cognitive construct that requires more time to change. The studies by White, Rosenblatt, Love and Little (1982), and Carpenter and Sandberg (1985) showed psychodrama to be effective in changing locus of control with treatment periods of 19 weeks and 12 weeks respectively. Harris (1985) reported changes toward more internal locus of control for sheltered and outpatient battered women after a treatment period of fifteen months.

#### Limitations of this study

There were several limitations to this study. The following represent areas of caution regarding the findings:

1. The subjects in this study represent only women who have successfully left an abusive relationship and have sought treatment. Characteristics and responses might be quite different

for women who remain in physically abusive relationships, are in the transitional stage of being sheltered, or who do not seek treatment after leaving.

2. The treatment method of psychodrama is a group method. There were three different groups of experimental subjects which met during different time periods and with different therapists. When individuals are treated in groups, it must be acknowledged that group members do influence one another and that personal interactions create different experiences. The psychodrama method was applied in this study as uniformly as possible. The therapists were chosen for the similarity of their skill level in psychodrama theory and methods. It was hoped that by using different therapists, the variable of therapist personality would be minimized in favor of the constant variable of the method. The three groups were not significantly different in demographics or in results.

3. Only the outcomes of assertiveness, locus of control and depression were measured. There may have been unmeasured benefits to the treatment.

4. Because of the specific nature of the instruments used, it is possible that the subjects may have had some awareness of the focus of the study. The effects of demand characteristics, the John Henry effect for the control subjects and/or the Hawthorn effect for experimental subjects may have created some of the "good performance" improvement.

5. The practice effect of repeated testing may affect outcome.

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6. There was no control over the variable of therapy for women who did not receive the psychodrama treatment. Some may have experienced very effective individual or group treatment during the time period of pre-test to post-test.

#### Recommendations for further research

Further study is needed to learn how we can help women who have been in physically abusive relationships to recover from the depression, low self-esteem, low assertiveness and external locus of control that have been consistently shown to be results of this violence. It is no longer enough to ask what is wrong with these women and why they don't leave their abusive relationships. Research and experience have shown repeatedly that safety, economic viability and social support are the primary factors that affect the ability to leave. These are important social problems that must be addressed. However, the question for psychotherapy evaluation is to determine what treatment modalities actually help with the psychological results of abuse.

This study investigated only one treatment modality, psychodrama, for treating the women victims of abuse. Other treatment modalities have also been shown to be helpful for relieving depression and increasing assertiveness and internal locus of control. Other studies might investigate the relative efficacies of some of these therapies, such as cognitive restructuring, bibliotherapy or reality therapy. Therapies could be compared one to another in order to control for the intervening

variable of the unknown and differing treatment experiences for the comparison group.

There has been considerable discussion in the literature about the superior benefits of group therapy over individual therapy for battered women (Hartman, 1983, , Hilberman, 1980, Rounsaville et al, 1979). The authors cite social support, validation, and opportunity to help others as being therapeutically beneficial for this population. Groups help to counteract the effects of isolation and self-doubt. To date, however, there has not been an empirical study to measure relative effectiveness of group therapy versus individual therapy.

This sample was relatively small and was restricted only to women who had already left their relationships and were seeking therapy. Consequent studies might use survey methods to include more subjects as well as those with more diverse situations.

A longer follow-up period may produce different results. Women who have the corrective experience of psychodrama therapy may retain gains on assertiveness and lesser depression more than untreated subjects over time. Locus of control orientation may also show changes after treatment and with time for integration.

A study of the effects of the psychodrama treatment on levels of assertiveness, depression and locus of control after a year of treatment will be attempted by this researcher, using the subjects who may be still available from this study.

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## Appendix A

### CONSENT FORM

The purpose of this form is to obtain your signed consent to participate in a research study to be conducted while you are involved in outpatient counseling. Please read the form carefully to understand what the study is about and sign the last line to indicate your permission to be included.

This study is about treatment for women who have been involved in abusive relationships. If you are willing to participate, you will be randomly assigned to one of two types of treatments. Both types of treatment should be helpful to you. One type of treatment will involve an action therapy called psychodrama, where you participate in experiential group therapy acting out incidents and feelings. The psychodrama treatment will be free and involve one weekend and three weekly evening meetings. The other treatment will be whatever group or individual treatment that you would receive if psychodrama were not being offered. If you are assigned to the other treatment group, you will be offered the opportunity to experience psychodrama the next time it is offered.

You will be asked to complete four questionnaires before beginning treatment. After the treatment period of three weeks, you will be asked to complete two questionnaires. This should take approximately thirty minutes the first time and twenty minutes the second. You will not be asked to put your name on any of the questionnaires so that your response will be confidential.

We know of no significant risks involved in this study. You may take the opportunity to discuss any of the questionnaires or

feelings that are raised by the questions with this researcher or with your therapist.

If you give your consent to participate in this research, you are free to withdraw your consent and stop participating at any time. If you decide not to participate, this will not affect your treatment in any way.

You will be given a copy of this agreement. If you are interested in results of this study you may contact:

Jeanne Burger, L.P.C., Researcher  
4053 Taylor Road, Suite J  
Chesapeake, Va. 23505 (804) 483-6404

If you have complaints about the study you may contact:

Dr. Stan Hoegerman,  
Chair, Committee for the Protection of Human Subjects  
The College of William & Mary  
Williamsburg, Va. 23187

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE STATEMENT ABOVE AND THAT I MAY WITHDRAW MY PARTICIPATION IN WHOLE OR IN PART AT ANY TIME. I CERTIFY THAT I AM AT LEAST EIGHTEEN YEARS OF AGE AND THAT I CONSENT TO PARTICIPATE IN THIS STUDY.

-----

Subject's signature

Date

-----

Researcher's signature

Date

I.D. \_\_\_\_\_

**APPENDIX B**  
**PERSONAL QUESTIONNAIRE**

It is helpful to know how you are similar or different from other women who answer this questionnaire. This information is confidential. Please check the answer that best describes you.

Your age (check one)

- |                           |                    |
|---------------------------|--------------------|
| 1) 20 years and under ( ) | 4) 41-50 ( )       |
| 2) 21-30 ( )              | 5) 51-60 ( )       |
| 3) 31-40 ( )              | 6) 60 and over ( ) |

Your present marital status

- |                  |                                      |
|------------------|--------------------------------------|
| 1) Single ( )    | 4) Married (1st time) ( )            |
| 2) Separated ( ) | 5) Married (2nd time) ( )            |
| 3) Divorced ( )  | 6) Married (3rd time ( )<br>or more) |

Years in the abusive relationship

- |                        |                    |
|------------------------|--------------------|
| 1) 0-Less than one ( ) | 4) 10-14 years ( ) |
| 2) 1-4 years ( )       | 5) 14-20 years ( ) |
| 3) 5-9 years ( )       | 6) 20 + years ( )  |

How long have you been out of this relationship?



## Appendix C

### The Method of Psychodrama

As a method, psychodrama has structure and terminology. There are three phases of a classic psychodrama: the warm-up, the action and the sharing. The warm-up is a preparation period to mentally cue group members to the task at hand. It is a time for getting acquainted with group members on an emotional level, for establishing group norms and for building group cohesion. A sociodrama or action exercises may be used to warm up the group and to identify an individual who is to be the subject of the psychodrama (termed the protagonist). The therapist (termed the director) warms himself up to the feelings of the protagonist and elicits information to establish the setting. As the director leads the protagonist to the area where the action will take place (termed the stage), the time, place, details and emotional climate are reviewed. Other persons who will be involved in the psychodrama (termed auxiliaries) are chosen by the director or the protagonist. Any one else who is present is called audience.

During the second phase of psychodrama (the action), the problem of the protagonist is dramatized. Scenes from the past may be reenacted for the purposes of catharsis and insight. New scenes may be enacted for the purpose of rehearsal for the future. The enactment is likely to continue until the protagonist achieves a shift in perception of the problem or he has tested a new effective method for approaching it (Heisey, 1982). Dr. Moreno is quoted by Blatner (1973, p.63) as saying, "We don't tear down

the protagonist's walls; rather, we simply try some of the handles on the many doors, and see which one opens."

Sharing, closure or integration is the third and final phase of psychodrama. Audience and auxiliaries tell the protagonist how the scene affected each of them. They are encouraged not to intellectualize or analyze and not to give advice but to identify their own feelings or to tell of similar feelings and experience. This is a crucial time of support for the protagonist (Heisey, 1982).

Some of the most common techniques that a director may use in psychodrama for enhancing the emotional experience and for broadening the protagonist's perception are the aside, the soliloquy, the double, and role reversal.

The aside is the technique of having a player turn away from the action and verbalize thoughts while the scene continues. It is used when the player does not want the action to be affected by his thoughts or when it is too threatening for him to say them directly to an auxiliary.

The soliloquy is the technique of having a player walk around and think out loud. It may be used when more information is needed to warm up the scene properly or when the protagonist needs to express his expectations, hope and fears before or after an enactment.

The technique of doubling is when an auxiliary stands near the protagonist and gives voice to thoughts which the protagonist is having but for some reason is unable to vocalize. This may be useful when the protagonist is resistant or blocked. Doubling is

helpful when an obviously rich role is being depicted in a shallow manner, when the protagonist cannot be heard or when there is a wide discrepancy between verbal and non-verbal messages. It may help when the protagonist's thoughts are too fragmented or ambivalent to express, or are too threatening or painful to acknowledge. They may not be at his conscious level of awareness. When the statements are made by an effective auxiliary, the protagonist often experiences relief at being understood and the elements of his struggle are concretized and can more easily move toward integration and resolution.

When a protagonist and an auxiliary exchange places, the technique is called role reversal. This may be done to help the auxiliary to get a better idea of the person that he is playing and to help the protagonist to "try on" the perspective of the other person. It is also useful when only the protagonist can supply the information that he solicits and can be used to break up unproductive or dangerous aggression to the other person. It sometimes helps the protagonist to assess the effect of his behavior on others or to broaden his perspective of a difficult situation.

## APPENDIX D

### LEADER TRAINING BY DR. ELLA MAE SHEARON, T.E.P.

1. Methodology was explained and discussed.
2. Leaders/directors were paired and locations decided.
3. Leaders/directors were introduced to assessment measures.
4. Theoretical position of battering as an experience that produces a characteristic syndrome of learned helplessness was discussed.
5. The constructs of assertiveness and locus of control were discussed as they pertained to battered women. Assertiveness was introduced as a behavioral way of valuing self and learning to identify and to speak for one's needs. It was compared to Moreno's concept of role identity. Locus of control was introduced as a continuum of attribution cognition. The internal locus of control cognition (happenings are affected by one's own actions) is similar to Moreno's ideas about spontaneity-creativity. It is important to realize that the extreme of perceiving an illusion of control when none exists can be as harmful as believing there is no control over salient life events.
6. Leaders/directors were warmed up psychodramatically to the theme of abuse. Each person present talked about their own experiences of abuse. One person took on the composite role of abuser, incorporating the researched characteristics of a battering perpetrator: low self-esteem, macho persona, need for control, poor impulse control and rageful. All others present were invited to tell "him" what they thought of his actions and to tell what they would like to do to him. Next, participants were paired off

and each person took a turn at acting out abuser and victim. It was noted that every person had a different way of reacting to the roles. For example, as abusers some participants felt powerful, some felt vulnerable because they realized that the power could not be maintained, some felt shame, some felt trapped to act tough, others felt that anger came from having been abused themselves. As victims, some participants reacted with feelings of helplessness, some with terror and others with anger. Some "victims" ran away, some cowered in place and others fought back.

7. Goals for therapy with this population were identified and prioritized. The first goal is confirmation for the self. Shame can be turned to support by trust and sharing. Connections (tele) made with one another through shared experience are validating. Another goal is empowerment, achieved by the experience of seeing oneself in new roles (role theory) and experiencing the replacement of ineffective patterns with new and effective behavior patterns (spontaneity). Catharsis is another goal. Polarities must be identified and experienced in order that this take place. Some of the polarities of abuse were identified. The abuser feels helplessness within his control; there is tenderness within his toughness; the pain of his own father's emotional unavailability may underly the rage he expresses. The victim is actually a survivor; she may experience power to control others by her helplessness. Wherever there is cold, there must be warmth; where there is toughness and anger, there must be tenderness and compassion; where there is danger, there must be protection. The final goal is to enable the battered woman to develop a healthy

sense of self and to facilitate healthier future relationships.

8. Principles of psychodrama that will be most helpful to obtaining the goals were discussed. Development of cohesiveness and trust will be essential to the main goal of confirming the self. The psychodramatic principle of tele will be emphasized, especially at the beginning of the group. Connections can be made through sharing of similar experiences and through the technique of doubling. Sharing can help change the feelings of isolation to feelings of belonging. Role reversal will be essential for empowerment. It will allow the victim to see the action from the abusers point of view, to obtain catharsis by acting out the abuser role and to recognize the duality of the abusers feelings of power and insecurity. In role reversal, the technique of playback can be used and the victim can be replaced by a double so that she is never retraumatized by the violence scenes. In her own role, she can say to the abuser what she has not been able to say and can decide how she wants to psychodramatically overpower her abuser.

9. Possible warm-up techniques for the sessions were suggested. During the first few hours of the group meetings, the warm-ups will be for connecting. First, some name warm-ups: Do you like your name, who named you, have you ever been called something different, do you have any other associations to this name, would you like to choose a different name? One person in the group will try to recall the names, others can help. Next, further introduction warm-ups will be used such as asking participants to tell of their favorite family roles (mother, sister, aunt, etc.). A warm-up to explain doubling may be done by having dyads double each other to introduce

themselves to the rest of the group. Connection warm-ups will follow: Who do you feel drawn to, what do you like about her, what do you have in common, does she remind you of anyone, who could be supportive for you here? Therapists will summarize by emphasizing connecting themes. The next warm-up will be to create a sense of caring and safety. Participants will draw names of person to whom they will be "a secret guardian angel" for the weekend. Warm-up questions will be: What does a guardian angel do, who has been one in your life, who would you like to have, in what situation did you need one? This will probably lead to a full drama and perhaps a few vignettes. The purpose is to introduce support. The weekend can be used for the cathartic dramas. Some suggested warm-ups for the abuse situation are: 1. Sculpturing the Batterer- allow a therapist to take on the characteristics of batterer as described by the group members, allow each member to tell what she thinks of him, wants to say to him and wants to do to him; 2. Surplus Reality Dramas such as the playing of favorite heroines and playing out situations using heroine powers, or terrorist/prisoner scenes or sultan/slave scenes with a therapist as the victim and the group working together to to rescue the victim; 3. Playback Theatre with a group member showing how she escaped her abusive relationship; 4. Future Projection Scenes depicting what the protagonist would like to see herself doing five years from now.

10. It was agreed that the leaders/directors would be briefed again by the researcher before the therapy groups met.

## Appendix E

May 24, 1993

Dear Colleagues,

Beginning in July of 1993, as part of my doctoral dissertation, I will be offering free psychodrama group therapy to women who have experienced being battered by spouses or live-in boyfriends. The women must have been out of this relationship for at least two months. The first weekend will be held at CARE Psychotherapy during the weekend of July 16, 17 and 18. There will also be two follow-up meetings. Other weekends will be held in September and in December. Two licensed therapists will be joining me as therapists. Further details will be provided if you are interested.

I am hoping that you will see the value of this experiential weekend and follow-up as an adjunct to the therapy that you are providing as well as a resource for clients who may not be able to afford private therapy. There is no problem with clients who are referred to this study continuing in their present therapy without interruption.

When you refer a client who fits this description to me, I will administer the pre-tests of the Rotter I-E Scale for Locus of Control and The Rathus Assertiveness Schedule. I will also ask her to complete a consent form, a demographic information form and The Beck Depression Index. The Spouse Abuse Inventory will be used to measure the level of violence. If you and your client wish for me to share this information and a report of the results, I will be

happy to do this.

Clients will be randomly assigned to psychodrama group or to a waiting group. Any control subjects who wish to experience the psychodrama group will be offered that opportunity after a control period of one month. Groups will consist of 7 to 12 members and will be run consecutive months until at least 20 women have received psychodrama treatment.

As you can see, this is a big undertaking. I will be appreciative of any help that you can give me. I need subjects as soon as possible - women who can serve as controls or waiting subjects as well as women who are able to participate in the July workshop. I do care that women have experienced the violence of being battered and I would like to help you with their empowerment to recovery.

Please call me with questions or referrals. Thank you for your attention to this long and complicated request.

Sincerely,

Jeanne B. Burger, R.N., L.P.C.

Telephone (h) 622-4986 or (w) 483-6404

Appendix F

Table 4.1

Comparison of Demographic Frequencies Between Groups

DEMOGRAPHIC CHARACTERISTICS	COMPARISON (n=21)	EXPERIMENTAL (n=19)	CHI SQUARE TEST
<u>AGE IN YEARS</u>			<u>0.51</u>
21-30	4	5	22.5%
31-40	5	7	30.0%
41-50	9	4	32.5%
51-60	2	3	12.5%
60+	1	0	2.5%
<u>MARITAL STATUS</u>			<u>0.49</u>
SINGLE	1	1	5.0%
SEPARATED	7	6	32.5%
DIVORCED	11	6	42.5%
MARRIED (1st)	1	4	12.5%
MARRIED (2nd or more)	1	2	7.5%
<u>RELATIONSHIP LENGTH (years)</u>			<u>0.55</u>
1-4	4	7	27.5%
5-9	8	3	27.5%
10-14	6	5	27.5%
14-20	1	2	7.5%
20+	2	2	10.0%

Table 4.1 (continued)

Comparison of Demographic Frequencies Between Groups

DEMOGRAPHIC CHARACTERISTICS	COMPARISON (n=21)	EXPERIMENTAL (n=19)	CHI SQUARE TEST
<b>LEVEL OF EDUCATION</b>			<b>0.165</b>
9-11th GRADE	5	1	15%
HIGH SCHOOL GRADUATE	9	8	42.5%
2 YEARS COLLEGE	2	4	15%
4 YEARS COLLEGE	4	2	15%
GRADUATE WORK	1	4	12.5%
<b>RACE</b>			<b>0.49</b>
CAUCASIAN	18	18	90%
BLACK	2	0	5%
HISPANIC	0	1	2.5%
ASIAN	1	0	2.5%
<b>RELIGION</b>			<b>0.46</b>
CATHOLIC	5	5	25%
PROTESTANT	9	11	50%
OTHER	5	1	15%
NONE	2	2	10%

Table 4.1 (continued)

Comparison of Demographic Frequencies Between Groups

DEMOGRAPHIC CHARACTERISTICS	COMPARISON (n=21)	EXPERIMENTAL (n=19)	CHI SQUARE TEST
<u>YEARS OUT OF RELATIONSHIP</u>			<u>0.53</u>
0-1	7	5	30%
1-3	3	4	17.5%
4-7	1	3	10%
7-10	2	1	7.5%
10+	8	6	35%
<u>NUMBER OF CHILDREN</u>			<u>0.39</u>
0	13	7	51.3%
1	3	4	18%
2 or 3	5	7	30.7%
<u>EMPLOYED OUTSIDE OF HOME</u>		<u>LEFT= 0.7, RIGHT= 0.6</u>	
YES	15	13	70%
NO	6	6	30%

Table 4.1 (continued)

Comparison of Demographic Variables Between Groups

DEMOGRAPHIC CHARACTERISTICS	COMPARISON (n=21)	EXPERIMENTAL (n=21)	CHI SQUARE TEST
<b>LEVELS OF INCOME</b>			<b>0.12</b>
\$7400 or less	3	0	7.5%
\$7500- 11,900	2	3	12.5%
\$12,000- 19,900	5	4	22.5%
\$20,000- 29,900	2	7	22.5%
\$30,000- 50,000	7	2	22.5%
\$50,000 or more	2	3	12.5%

Table 4.2

Comparison of Pre-Test Means, Standard Deviations and T-tests  
Between Groups

TESTS	EXPERIMENTAL (n=19)	COMPARISON (n=21)	T-test DF=38
<u>Index of Spouse Abuse</u>			0.29
Mean	22.22	22.90	p=0.77
Standard Deviation	7.4	7.3	
Minimum	12	11	
Maximum	37	40	
<u>Lie Scale of Eysenck Personality Inventory</u>			1.49
Mean	2.47	3.18	p=0.14
SD	1.3	1.7	
Minimum	0	1	
Maximum	4	7	
<u>Rotters I-E Scale of Locus of Control</u> <u>Pre-tests</u>			0.94
Mean	12.8	11.5	p=0.36
SD	4.1	5	
Minimum	6	2	
Maximum	19	20	

Table 4.2 (continued)

Comparison of Pre-test Means, Standard Deviations and T-Tests  
Between Groups

TESTS	EXPERIMENTAL (n=19)	COMPARISON (n=21)	T-test DF=38
<u>Rathus Assertiveness Schedule</u>			1.39
Mean	-14.42	-4.57	p=0.17
SD	20	24.0	
Minimum	-51	-48	
Maximum	22	50	
<u>Beck Depression Inventory Pre-tests</u>			0.003
Mean	18.89	18.90	p=0.99
SD	9.6	12.2	
Minimum	3	5	
Maximum	35	51	

Table 4.3

Correlation Analysis of Variables Across Groups

DEMOGRAPHIC VARIABLES (N=40)	BECK	IE	RATHUS
AGE	r= -0.62 p= 0.0001	-0.49 0.0035	0.54 0.0009
LENGTH IN RELATIONSHIP	r= -0.38 p= 0.015	-0.17 0.30	0.21 0.19
LENGTH OUT OF RELATIONSHIP	r= -0.30 p= 0.08	-0.33 0.05	0.32 0.06
NO. OF CHILDREN	r= 0.18 p= 0.26	0.46 0.003	0.33 0.036
ISA-PHYSICAL ABUSE	r= 0.37 p= 0.019	0.04 0.78	-0.05 0.73

## Vita

Jeanne Ball Burger

Birthdate: February 26, 1945

Birthplace: Hampton, Virginia

### Education:

1985- 1989 The College of William and Mary  
Williamsburg, Virginia  
Educational Specialist, Counseling

1980- 1985 Old Dominion University  
Norfolk, Virginia  
Master of Education

1965- 1967 The University of Virginia  
Charlottesville, Virginia  
Bachelor of Science, Nursing

1963-1965 Mary Washington College  
Fredericksburg, Virginia

### Professional Licensure and Certification:

1967 Registered Nurse, State License #0001-081305  
1989 National Certified Counselor #22203  
1990 Virginia Licensed Professional Counselor #0701-001522  
1994 Certified Practitioner of Psychodrama, Sociometry and  
Group Psychotherapy

### Professional Memberships:

1991 Clinical Member of American Association for Marriage and  
Family Therapy  
1991 C. G. Jung Society of Tidewater