Running head: EFFICACY OF PSYCHODRAMA

The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents

Sally Singal
Department of Educational and Counselling Psychology
McGill University, Montreal

August, 2003

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment of the requirements of the degree of Ph.D. in Counselling Psychology.

Table of Contents

List of Tables

List of Figures

Abstract

This study attempted to validate psychodrama as a treatment for oppositional and defiant adolescents. Twenty-four high school students with conduct problems were randomly assigned to a psychodrama group or a waiting list control group. The treatment group received psychodrama therapy for 12 weeks. Personality and task performance tests were administered to the participants in both groups before and after treatment to estimate differences in impulsivity, empathy, and self-esteem. Parents' and teachers' rating scales were administered at the same two times to evaluate observable changes in the disruptive behaviours of the participants. Differences in the pre- and post-measures within and between groups were analysed and the results demonstrated statistically significant interaction effects in impulsivity scores and oppositional ratings.

Résumé

Cette étude tend à confirmer la vàlidité d'utilisation de la technique de psychodrame dans le traitement de l'opposition et de la défiance chez les adolescents. Nous avons sélectionné 24 étudiant(e)s de secondaire avec des problèmes de comportement pour un groupe en psychodrame et un autre sur une liste d'attente pour un groupe de contrôle. Pour une période de 12 semaines, nous avons prodiqués des sessions de psychodrame au group en traitement. Dans chacun des groupes nous avons administré des tests de personalité et de performance avant et après traitement afin d'évaluer la différence entre l'impulsion, l'empathie, et l'estime de soi. Les parents et les professeurs ont reçu des échelles d'évaluation en même temps que les groupes afin d'évaluer les changements dans le comportement perturbateur des participant(e)s. Les différences démontrées entre les mesures avant/après, à l'intérieur et entre les groupes, ont été analysées et les résultats démontrent statistiquement des différences perceptibles d'interaction en impulsivité et en classement oppositionnel.

Acknowledgments

I want to thank my parents, sister and brother-in-law for their devotion. I can't express my gratitude enough for all they've given me. I am also very grateful to friends and cousins for their untiring interest in my work.

My most sincere appreciation to Ted Maroun, my thesis supervisor, for his limitless support and guidance. I want to also thank the members of my advisory committee -- Michael Hoover, Anastassios Stalikas, Andrew Hum, and Angeles Toharia -- whose insights and encouragement enabled me to persist when the task seemed overwhelming. I am completely indebted to Diane Bernier who generously helped to simplify my life in the counselling psychology program.

I'd like to thank my co-workers and mentors at the Montreal Childrens' Hospital's Adolescent Treatment Program for allowing me the opportunity to practice my skills and refine my ideas over the years. Notably, I owe a great deal to Mark Zoccolillo and Margaret Carey for believing in me.

I want to thank Donald Reid at the English Montreal School Board for permitting the study to take place. I wish to extend special thanks to Karen Allen

who was instrumental in getting the project done. In addition, I wish to thank the entire Westmount High School staff for their cooperation throughout the study. However, nothing would have been possible without the adolescents themselves and their parents -- I am forever thankful for their participation.

Lastly, I am profoundly grateful to Tobi Klein for her expertise and sense of professionalism. I hope the completion of this thesis helps to spread the good word about the effectiveness of psychodrama.

I dedicate this thesis to my son, Jacob.

I. INTRODUCTION

Introduction to the Problem

Children make up one of the neediest populations in regard to mental health services (Weiss, Catron, Harris, & Phung, 1999). Child and adolescent psychotherapy research results indicate that alternative, not just mainstream, forms of psychotherapy for children and adolescents may prove efficacious in the treatment of childhood disorders; yet research studies in the area of alternative psychotherapies are extremely scarce (Achenbach & Edelbrock, 1978; Kazdin, Ayers, Bass, & Rodgers, 1990).

The lack of studies is particularly evident in the creative arts therapies. The attention that studies of treatments like art therapy or gestalt therapy have received is less that one percent of all studies conducted (Kazdin, et al. 1990). Music therapy, drama therapy, and psychodrama are frequently not even mentioned on lists of treatment forms that are investigated. A top priority for research is to attempt to identify effective treatments of emotional and behavioural disorders of children and adolescents (Robins, 1991). To do that, research studies examining both traditional and creative arts therapies must be

conducted.

One way to determine the efficacy of any treatment is to experimentally attempt to identify characteristics of a disorder that may be influenced by the treatment process. Very few studies have been conducted to make inferences about specific factors that contribute to treatment outcomes in relation to child and adolescent disorders (Kazdin, 1991, 2001). Outcomes of treatments are optimal to the degree that they target the specific deficits troubling the identified youth. The symptoms shown by the child, and the exact features associated with the deficit, should determine the type and manner of treatment that is administered (Kendall & Braswell, 1993).

Conduct/oppositional disorders. Conduct disorders and oppositional behaviours demand scientific attention because they represent a significant social and clinical problem. The prevalence rate of Conduct Disorder (CD) in 1986 was 11.6% among 12- to 16-year-old boys in Canada (Borduin, Henggeler, & Manley, 1995). The cost of adolescent delinquency to North American society runs into millions of dollars in terms of destruction and remediation expenses. In the United States, the yearly cost of school vandalism alone was estimated to be one-half billion dollars a decade ago

(Patterson, DeBaryshe, & Ramsey, 1989). Statistics are based on official records and represent only a fraction of the true offense rate -- and, therefore, the true cost -- because many juvenile crimes go unreported. Data on self-reported delinquent acts indicate that official police records account for only 2% of the actual juvenile law violations (Patterson, DeBaryshe, & Ramsey, 1989). It should be noted that the U.S. youth violence rate is about 10 times higher than in Canada (Garbarino, 1999).

Antisocial behaviour in adolescents continues to get worse, with immediate costs for services and for continued contact with the mental health system well into adulthood, undoubtedly exorbitant (Borduin, et al. 1995). Aside from the cost to society and to the victims, the behavioural disorders also cause pain to the children themselves, their families, and their peers. Children with behavioural problems are likely to experience serious adjustment problems in the areas of academic achievement and peer social relations (Kazdin, 1987). Aggression is the most common reason for referral in child psychiatry, and conduct/oppositional disorders are the most frequently diagnosed conditions in outpatient and inpatient mental health facilities for children (American Psychiatric Association, 1994; Caron & Rutter, 1991; Gérardin,

Cohen, Mazet, & Flament, 2002; Quevillon, Landau, Apple, & Petretic-Jackson, 1986; Robins, 1991; Zoccolillo & Rogers, 1991). Epidemiological studies reveal that disruptive behaviour problems (Oppositional Defiant Disorder [ODD], CD, & Attention-Deficit /Hyperactivity [ADHD]) affect 5-10% of children and adolescents and account for more than 50% of referrals to mental health clinics (Waschbusch, 2002).

Follow-up studies of antisocial children and adolescents show that, when untreated, disruptive children grow into adults who contribute disproportionately to the rate of substance abuse, violence, car accidents, job trouble, crime, financial problems, divorce, vagrancy, dependence on welfare support, antisocial behaviour, and mood problems (Robins, 1978; Rutter, 2000; Waschbusch, 2002). Only a handful of children with CD ever go on to achieve satisfactory social functioning as adults (Zoccolillo, Pickles, Quinton, & Rutter, 1992).

Aggression in youth is a persistent behaviour in the individual (Roberts, Schmitz, Pinto, & Cain, 1990; Robins & Price, 1991). Conduct disorders and oppositional behaviours are especially difficult to live with because of their persistence over time. The deviant behaviour begins early in childhood and continues into adolescence, then adulthood (Cicchetti &

Richters, 1993). In fact, adolescent or, for that matter, childhood aggression is considered to be as stable as IQ (Olweus, 1979). A current review by Waschbucsh (2002) showed that conduct problems are generally stable across development both for comorbid and noncomorbid children. Adults with symptoms of Antisocial Personality Disorder rarely lack a history of symptoms of Conduct Disorder in their childhood and youth (Robins, 1991). Even the slightest manifestation of CD before the age of 15 is associated with a higher rate of Antisocial Personality Disorder in adulthood (Robins & Price, 1991). To intervene during adolescence may be the final chance to prevent long-term social maladjustment and probable criminality.

Adolescent aggressivity is highly prevalent and costly to society. To the individual, it can be devastating. Even mild symptoms of aggression and negativism, occurring across multiple settings, must be examined and treated as a disorder that could develop into more severe and chronic problems in the future. According to the DSM-IV (American Psychiatric Association, 1994), Oppositional Defiant Disorder (ODD) is a developmental antecedent to Conduct Disorder (CD). Conduct Disorder and Oppositional and Defiant Disorder are listed in the DSM-IV (American Psychiatric Association, 1994) as separate diagnoses, but, in this

study, and according to many researchers, they are considered as a single unit representing a range of problems that are found in adolescents to different degrees; these problems represent more (CD) or less (ODD) severe expressions of the same syndrome (Achenbach & Edelbrock, 1978; Harrington, 1986; Smith, 1995; Tremblay, Vitaro, Bertrannd, LeBlanc, Beauchesne, Boileau, & David, 1992; Waschbusch, 2002; Werry, Methven, Fitzpatrick, & Dixon, 1983).

By focussing on adolescents demonstrating either ODD symptoms or very mild CD symptoms, it might be possible to arrest the maladaptive behaviour at this early, more manageable phase of the behavioural disorder. Part of the justification for undertaking this study is the assumption that effectively treating ODD reduces the risk for the emergence of CD (Kendall & Braswell, 1993; Loeber, Lahey, & Thomas, 1991). This is consistent with the hypothesis that ODD is a developmental precursor to CD in at least some children (Lahey, Loeber, Burke, Rathouz, & McBurnett, 2002). Early intervention may change the negative trend.

The other part of the rationale for the study is that adolescent aggression is a promising focus for research, intervention, and prevention because there is much that is already known about the pattern of aggressive behaviour (Robins, 1991). Delinquency is

somewhat predictable in many respects, such as child temperament, antisocial parents, unskilled grandparents, low SES and other stressors, and the tendency of mild symptoms to precede severe symptoms. In order to research, intervene, and prevent antisocial behaviour, specific factors that may account for it need to be targeted. The intervention employed in this study was chosen because it seemed suitable to treat those specific characteristics typically shown by negativistic and oppositional adolescents who were under investigation.

The dependent variables. Adolescents who demonstrate behaviour problems across multiple settings, who are disobedient, and who generally behave aggressively, often: 1) are impulsive (act without thinking); 2) lack empathy (do not respond to the emotional needs of another); and 3) have low self esteem (negative self-worth) (American Psychiatric Association, 1994; Carpenter & Sandberg, 1985; Pecukonis, 1990; Moffett & Bruto, 1990). It is hypothetical that these characteristics may represent essential components of the diagnostic criteria of ODD and CD; i.e., impulsivity may be predictive of symptoms of rule violation, lack of empathy may be predictive of aggressive and abusive behavioural symptoms and low

self-esteem may account for self-destructive behaviours and a pervasive hatred towards the whole world. Research has shown that the three characteristics may be interrelated. Several researchers have suggested that there is a negative correlation between impulsivity ('lack of control over one's own behaviour') and self-esteem ('self-efficacy') (Bandura, 1982), and between self-esteem and aggression (Aichhorn, 1935; Coopersmith, 1981; Fromm, 1947; Rosenberg, 1965). There is a significant negative relationship between aggression and empathy for 7-year-old boys (significant at the $p \leq .05$ level) (Feshbach & Feshbach, 1969).

In summary, there appears to be a compelling need for research to identify effective alternative therapies for the treatment of childhood and adolescent conduct and oppositional disorders. Part of the challenge of an experimental study in this area is to pinpoint the behavioural variables that are being directly changed by the treatment techniques.

Statement of the Problem

Psychodrama is at present not the treatment of choice for ODD/CD. The mainstream treatment is a problem-solving, cognitive-behavioural therapy combination with additional parent management training

(Kazdin, 1993). In schools, the most popular theoretical treatment modality is cognitive-behavioural (Shechtman, 2002). According to Shechtman (2002), the consensus that cognitive-behavioural therapy is more efficacious reflects the underrepresentation of other types of treatment in the research literature.

Even in mainstream therapy research, there are few outcome studies examining the precise mechanisms that account for change. Kazdin (2001) states that there is little in the way of theory that underlies current therapies for children and adolescents because there is no clear understanding of therapeutic change, no clear set of studies that explains why treatment works. Studies have not elaborated on the components that contribute to positive treatment outcome. What is it that promotes change in therapy? <u>If it works, why does it work?</u> In a review article, where the outcome evidence of psychotherapy for children and adolescents was represented, Kazdin (1991) emphasized that a more molecular level of analysis is needed in order to identify and evaluate the factors that contribute to positive outcomes (Kazdin, 2001).

Psychodrama could be considered a viable alternative treatment for ODD/CD. Firstly, group therapy is highly suitable for acting-out children and adolescents in a natural school setting (Shechtman,

2002). Secondly, psychodramatic techniques and methods are highly suitable for addressing issues such as impulsivity, lack of empathy, and low self-esteem. Psychodrama may help participants learn to restrain themselves at least long enough to consider consequences while dealing with emotionally charged situations, and to become aware of the effects, positive and negative, of their own behaviour on other people. In turn, practising more effective functioning within psychodramatic enactments, and participating in other self-empowering exercises, may exert a positive effect on the self-esteem of the participants. Thus, psychodrama may be successful in the treatment of ODD and CD because it may have a direct impact upon the underlying difficulties that are at the core of the maladaptive behaviour.

Psychodrama may be effective in affecting levels of impulsivity. The re-enactment during the second phase of the psychodrama session extends the moment, and for people who seem to forget the past and ignore the future, dramatic action connects present behaviour to its antecedents and consequences (Moffett & Bruto, 1990; Moreno, 1946). Salz, Dixon, and Johnson (1977) showed that impulsivity is reduced by training in fantasy activity that involves the techniques of play therapy and role playing. Role playing is a derivative

of psychodrama. Techniques like role playing and rehearsing more adaptive behaviours may provide the maladjusted adolescent with opportunities to learn strategies for long-term self-control (Cossa, 1992; Moffett & Bruto, 1990). However, an explicit connection between psychodrama and reduced impulsivity has never been established.

It has been postulated that the behaviour changes induced by psychodrama in children and adolescents result from the role reversal techniques, which facilitate an increase in empathic skills (Carpenter & Sandberg, 1985). In a study by Carpenter and Sandberg (1985), a sample of 21 delinquent adolescents, referred by probation officers or clinicians of the Wayne County Juvenile Court, were divided into an experimental and a control group. The treatment consisted of a combination of cognitive-behavioral techniques within a psychodrama group. Results indicated significant improvements in the participants' asocial index ($p \leq .01$), ego strength ($p \leq .05$), and introversion ($p \leq .01$). Clinical and empirical evidence links empathic responding to prosocial behaviour and lower aggression (Niec & Russ, 2002).

Frequently, CD and ODD adolescents come from emotionally damaging environments that serve to reinforce the negativistic and dysfunctional behaviour

(Farrington, 1993; Frick, Kamphaus, Lahey, Loeber, Christ, Hart, & Tannenbaum, 1991; Kazdin, 1993; Kendall & Braswell, 1993; Webster-Stratton, 1991; Widom, 1991). When the family life is dysfunctional, the adolescent often develops a negative self-concept and low self-esteem (Knittel, 1990). Additionally, adolescents who are labelled as offenders often have a bruised self-esteem and a negative self-concept (Kendall, 1993; Kipper, 1992). Much like cognitive therapy, psychodrama encourages self-empowerment and personal worth through role enactments.

Psychodrama might also work for the ODD/CD population because, through the psychodrama scenes, the therapist is able to meet each patient in the home, with friends, in the school, and within the community. According to Rutter (2000), it is the multifactorial influence of the psychosocial environment, defined as family, peers, school and community, interacting with the biological nature of the child, that creates the conditions for the aggressive behavioural problems to emerge and persist.

Behaviour therapy and psychodrama. Behaviour therapy (including cognitive behaviour therapy, and skills training approaches) has been the intervention of choice in many empirically based evaluations of

treatment programs focussing on conduct disorders (Glaser & Horne, 1994; Lochman, Burch, Curry, & Lampron, 1984; Kazdin, 1993; Kendall, 1993; Kendall, Reber, McLeer, Epps, & Ronan, 1990). In 1963, Jacob Moreno, the founder of psychodrama, described the similarities between psychodrama and behaviourism. Both are more concerned with a behavioural criterion of educational or therapeutic success than with criteria involving unconscious processes (Sturm, 1965). Psychodrama is a clearly non-analytically-based psychotherapy (Blatner, 1997). Behaviour therapy and psychodrama emphasize the learning of new behaviours and the reduction of maladaptive ones. Both these disciplines emphasize teaching clients problem-solving skills through practice in simulated problem situations (Fink, 1990). Behaviour therapy has been used to treat conduct disorders in highly controlled correctional environments as well as in school settings, and always utilizes role playing, among other techniques, to promote the learning experience (Glaser & Horne, 1994).

Psychodrama provides an ideal therapeutic setting in which behaviours can be learned or unlearned. Scenes in which a protagonist demonstrates his/her behaviours as if occurring in real life are performed in the psychodrama. The dysfunctional behaviours

inevitably emerge. The maladaptive behaviours are altered, then rehearsed until the original behaviours become more adaptive, or extinguished altogether. During the protagonist's psychodrama, as the scenes are being reenacted, the characteristics of the setting that are the pathogenic stimuli (cues), the behaviour (response) that is maladaptive, and the subsequent reward and punishment (reinforcement) become identifiable (Sturm, 1965). In terms of Moreno's classic definition of spontaneity, which is the key to mental health, the problem being investigated becomes more clearly defined as whether the protagonist needs to learn a new, more adaptive response to an old, inescapable and sick situation, or whether the protagonist needs to learn an adequate response, a good enough adaptation, to a new situation, i.e., to be able to face the novel situation at hand without decompensating (Blatner, 1997; Sturm, 1965; Moreno, 1972).

Role playing and related psychodramatic techniques are commonly used in a variety of individual and group therapies, including cognitive therapy and behaviour therapy (Blatner, 1997). In a recent study, psychodramatic and cognitive-behavioural techniques were integrated in an attempt to investigate the impact on the number of core beliefs and automatic thoughts,

and condition of affect of the participants (Boury, Treadwell, & Kumar, 2002). Depression scores did not improve; however, the authors attribute this to their use of students as participants in the study instead of a sample representative of a clinical population.

Introduction to the Study

The present study examined whether adolescents with ODD or mild CD, after participating in an intervention of approximately 24 hours of psychodrama for 12 weeks, would be different from adolescents with ODD never exposed to the intervention. Differences were operationally defined in terms of pre- and post-differences in scores on impulsivity, self-esteem, and empathy assessments. Observable changes in disruptive behaviours were recorded in the form of data from parent/teacher questionnaires.

The dependent measures were scores on tests reflecting the self-reported changes in three behavioural features of ODD/CD: impulsivity, lack of empathy and low self-esteem, as well as objective measures of behaviour problems associated with ODD/CD: oppositional, cognitive problems/inattention, hyperactivity, and ADHD DSM-IV criteria index. The study was aimed at investigating the effects of psychodrama on oppositional behaviours and,

specifically, on impulsivity, self-esteem, and empathy. Cognitive deficits and clinically diagnosed hyperactivity were not hypothesized to be treatable by psychodrama therapy and were not directly investigated. The independent measures were treatment status and time.

Purpose of the Study

The purpose of this study was to determine whether psychodrama is effective in helping adolescents who are oppositional and defiant to modify their aggressive behaviour, and to determine whether psychodrama specifically has an effect on their impulsivity, empathy, and self-esteem. The investigation was necessary because it is still not clear what interventions work with violence-prone adolescents (Mulvey & Cauffman, 2001). Cognitive-behavioural therapy, although strong in offering guidance and training, does not provide the essential outlet for self-expressiveness (Shechtman, 2002).

Results of group treatment based on cognitive-behavioural strategies have indicated that aggressive children do not change on all the dependent measures used in studies, and that some children don't improve at all (Lochman, et al., 1985). In a study comparing the effects of cognitive-behavioural therapy with those

of supportive/psychodynamic therapy for the treatment of CD, impulsivity scores (latency response and/or accuracy) did not change with either treatment (Kendall, Reber, McLeer, Epps, & Ronan, 1990). Interestingly, Kendall et al. (1990) concluded that gains would have been enhanced by greater focus on role-plays.

Various researchers have documented the importance of more effective investigations into therapeutic prevention and intervention for the case of CD (Robins, 1991; Tremblay, Vitaro, Bertrand, Beauchesne, Boileau, & David, 1992). The research literature provides strong support for the assumption that childhood aggression left untreated is a significant risk factor for maladaptive outcomes (Lochman, 1992). If ODD behaviour is first identified, treated and modified it might not evolve into severe CD behaviour short term and Antisocial Personality Disorder in the long run.

Definitions of Terms

Action. An act done. The Greek meaning of 'drama'.

Action Sociogram. A symbolic representation of the dynamics of one's relationships using auxiliaries or objects such as puppets or chess pieces to represent the significant persons in the relationships.

Action Insight. Through the dramatic process, the individual is confronted with his or her unconscious fantasies and with the outside reality, which results in insight.

Antagonist. The auxiliary playing opposite to the protagonist.

Audience. The others not immediately involved in the psychodramatic enactment. Members take on various active roles in helping the protagonist's examination of his or her situation as the psychodrama unfolds; as well, audience members are helped by witnessing the subject on the stage.

Auxiliary Ego. Or 'auxiliary'. Anyone besides the protagonist who takes part in a psychodrama. Usually the auxiliary ego plays someone in the protagonist's life. Special roles played by an auxiliary include being a 'double'.

Creativity. The function of inventing and re-inventing spontaneous moments/states and the manifestation of spontaneity.

Director. A therapist who guides the clients by applying the psychodramatic method to help each protagonist examine his or her problem throughout the psychodrama.

Double. The alter ego of the protagonist as personified by an auxiliary who, standing directly

behind the protagonist, verbalizes unexpressed emotions and thoughts of the protagonist during the psychodrama.

Empty Chair (or Auxiliary Chair). A technique in which the client acts out problems by imagining his or her antagonist seated in an empty chair on the stage, interacting with this imaginary being, and even reversing roles with the imaginary being in the empty chair.

Enactment. The therapeutic acting out of a situation, whether it's about pretending to be in a role, re-enacting a past scene, living out a currently pressing problem, creating life onstage, or rehearsing one's behaviour for the future.

Magic Shop. An exercise in which clients' unwanted and dysfunctional qualities can be magically transformed or exchanged for desired or beneficial ones.

Play Therapy. A psychotherapeutic treatment modality that emphasizes the use of puppets and dolls, for their distancing effect, in the diagnosis and treatment of clients.

Protagonist. The subject of the psychodramatic enactment who is portraying his or her own life situation.

Psychodrama. An action-oriented psychotherapeutic

treatment modality that uses dramatic methods to explore the psychological dimensions of human experience and allows clients to work through conflicts by acting them out instead of just talking about them.

Psychodrama. An enactment; a reliving of a personal situation from a protagonist's life. Presented in the action stage of the session.

Re-enactment. Rehearsing alternative and more effective approaches to a general problem within the psychodrama. Re-enacting past scenes.

Role Play. The therapeutic experimentation with and personification of roles and situations.

Role Reversal. Two individuals change roles during the enactment, enabling the experiencing of the world from the other's perspective, and the experiencing of oneself from the other's perspective.

Sociodrama. An enactment where the focus is on real-life issues that pertain to the group, rather than on an individual's personal situation.

Sociogram. A symbolic representation of the dynamics of one's relationships depicted with paper and markers.

Spontaneity. An individual's adequate response to a novel situation, or new response to an old situation. Spontaneity releases creativity.

Turn Your Back. In case of shame, the protagonist is allowed, for a limited time, to turn his or her back to the group and to act as if he or she were alone.

II. REVIEW OF THE LITERATURE

Theory

The following section contains a description of key theoretical underpinnings of psychodrama and a discussion of its beneficial effects on adolescents. Finally, the theoretical dilemma of the existence of one or two syndromes of adolescent aggressive behaviour will be presented.

Psychodrama. Psychodrama is a therapy that uses theatrical conventions as participants act out their problems (D'Amato & Dean, 1988). Guided dramatic action is utilized to examine problems or issues raised in a group. In this study, psychodrama was used as an approach for rehearsing and learning the solutions to problems relating to Oppositional Defiant Disorder. The participants presented scenes depicting problems from their lives that may have resulted from their having an impulsive way of thinking, not being able to feel for others, and not experiencing self-worth.

Psychodrama rests on five elements: 1) the therapist, who is the catalyst and the director of the re-enactment; 2) the protagonist, who emerges during the warm-up phase of the session to become the 'star' of his/her re-enactment; 3) the auxiliaries, who are

those group members chosen to perform supporting roles that serve the needs of the protagonist in his/her re-enactment; 4) the rest of the group, who comprise the audience and participate as 'doubles'; and 5) the stage, an empty space, where the protagonist has complete control over time and space (Moreno, 1946, 1965).

The key concepts in psychodrama are: 1) spontaneity (bringing novelty to a familiar situation, or reacting adequately to a new situation); 2) creativity (breaking frozen patterns of behaviour and 'deconserving' one's spontaneous energy. Creativity is as much a function of self-expression as it is a function of self-control.); 3) situation (setting the scene -- including the protagonist introducing his or her auxiliary characters to the group by using role reversal techniques); 4) tele (a two-way empathy); 5)action catharsis (extinguishing a maladaptive, conditioned emotional response by encouraging its release in the nonthreatening and protective setting of the psychodrama); and 6) action insight (gaining understanding and making interpretations through dramatic action) (Moreno, 1965, 1989).

Scenes in the re-enactment are described by the protagonist and arranged by the therapist/director.

The protagonist confronts himself or herself, and the relationships in his or her life, by acting out unresolved conflicts or wishful situations. In the re-enactment, the protagonist confronts his or her maladaptive behaviours and cognitions that are habitual, compulsive, and rigid - that have become conserved (Moreno, 1972).

Effects of psychodrama on adolescents.

Psychodrama is group psychotherapy in action. Psychodrama may be effective with adolescents because they prefer to communicate interactively rather than introspectively (Mishne, 1986; Lippe, 1992). Group work, in general, may be a more natural choice for adolescents because they are exceedingly influenced by their peer culture and crave belonging to cliques (Mishne, 1986). Adolescents value the group experience because they feel less isolated, they are stimulated to try new ways of coping with problems, and they develop new skills in interpersonal relations (Corder, 1994).

Psychodrama can be especially suitable for adolescents because it fits with their typically egocentric and narcissistic disposition (Mishne, 1986). Elkind (1974) suggested the following:

> The adolescent is continually constructing, or reacting to, an imaginary audience. It is an

> audience because the adolescent believes that he or she will be the focus of attention, and it is imaginary because, in actual situations, this is not usually the case. (p.91)

In this regard, the stage is not a metaphor for life -- it is life. The adolescent perceives that he or she is living on stage, centre stage, and may act out in an attempt to fulfill the dramatic intensity of any given moment. Psychodrama provides the adolescent with the therapeutic conditions that can help him or her to distinguish between real and imagined audiences, and the true self from the self that is acting a role (Mitchell, 1996). It provides adolescents with their own therapeutic stage, one with structure and safety, on which it becomes possible to resolve conflicts and rehearse novel behaviours that are both rewarding and socially acceptable.

In trying to discover an identity, a role in life, an adolescent spends a lot of energy trying to predict the reactions of others in social situations. Adolescents are constantly preoccupied with how they look to others (Knittel, 1990). The focus of psychodrama is on the exploration of the individual in relation to the collective social situation. Two things are important: 1) the individual's subjective perceptions; and 2) the collective and consensual

reality. In psychodrama, the exploration of the private and the collective components of the self are combined. This may be especially useful for adolescents who, in forming their identities, are constantly working at the developmental task of discovering how they fit into the greater social framework with which they will soon interact as adults. In doing so, adolescents employ a process of reflection and observation of what they perceive to be the way in which others judge them and how they perceive themselves in comparison to others (Erikson, as cited in Lopez, 1992).

Psychodrama emphasizes that every individual presents and integrates both a collective and an individual component. Psychodrama, unlike mainstream psychotherapy, is able to directly explore the collective component, which includes all those aspects that are shared by members of a particular sociocultural milieu (e.g., family, friends, work, school, clubs, etc.) through the technique of reenactment. This may be especially relevant for the treatment of adolescent aggression because it is often the result of multiple psychosocial stressors. The function of the therapist in psychodrama is to enter the root of the problem via the social world and bring shape and order into it (Moreno, 1972). By means of the reenactment, the therapist is able to get at those motivating factors that reinforce the dysfunctional

behaviour. Psychodrama proposes that the self emerges from roles (Moreno, 1972). A changed self, a healthier self emerges from experiencing new, more adaptive roles.

In summary, the dramatic context in a group format may be an ideal therapeutic medium for adolescents because of their unique developmental stage in life. The processes and techniques of psychodrama seem to address the behavioural symptoms of adolescent aggression that are being measured in this study (Battegay, 1990; Corder, Haizlip, Whiteside, & Vogel, 1980; Moffett & Bruto, 1990; Stallone, 1993).

Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) -- adolescent aggression. ODD and CD include a wide range of acting out behaviours that are aggressive and antisocial (see Appendix A). The diagnostic criteria overlap so much that it is uncertain whether the two diagnoses represent two distinct clinical entities (Harrington, 1986). In an article regarding the taxonomy of disruptive child behaviour, Waschbusch (2002) makes a distinction between hyperactive-impulsive-attention problems and conduct problems that entail oppositional behaviours, defiance, aggression, and disregarding the rights of others. He does not differentiate between ODD and CD.

Whether a separate, independent syndrome of oppositional behaviour really exists is controversial. Awaiting the publication of the DSM-IV (American Psychiatric Association, 1994), Kendall and Braswell (1993) anticipated that changes in the criteria for ODD and CD might involve the creation of a new diagnosis, e.g., Disruptive Behaviour Disorder, that would include ODD and CD. The DSM-IV was published stating that ODD and CD were distinct disorders. According to Robins (as cited in Smith, 1995), there is a single syndrome of antisocial behaviours, and research has found many intercorrelations between the classifications of childhood deviance, and between the forms of childhood deviance and total adult deviance. In fact, behaviours appearing under oppositional disorder correlate with and are part of a conduct disorder factor (Achenbach & Edelbrock, 1978). According to the 10th International Classification of Diseases (ICD-10), ODD is one diagnostic subtype specified under the concept of CD (Gérardin et al., 2002).

The two diagnoses are probably expressions of an underlying continuum because disruptive behaviour in childhood is strongly correlated with later delinquent behaviour (Tremblay et al., 1992). Combining ODD and CD actually improves reliability of DSM diagnoses (Werry et al., 1983). The question of whether there

exists one or two syndromes of aggressive behaviour in adolescence, however, is still open to debate and research.

When ODD and CD symptoms are compared and examined, it becomes apparent that less serious problems emerge first and more serious problematic behaviours later. ODD emerges early, mild CD symptoms afterwards, and serious symptoms emerge much later. There is evidence that ODD symptoms actually predict later CD symptoms or the probability of a diagnosis of CD (Loeber, Lahey, & Thomas, 1991). According to Tremblay (2000), physical aggression is clearly antecedent to less serious forms of aggressive behaviour, such as verbal aggression or indirect aggression.

An important issue in the decision to keep or drop the distinction between ODD and CD is whether this distinction is relevant with regard to treatment. Reviews of treatment studies of CD have shown that successful reduction of CD symptoms is uncommon and the few reports of success are often not replicated (Kazdin, 1987). On the other hand, some evidence has suggested that treatment is more effective for children showing lower levels of aggression, such as ODD behavioural symptoms (Kazdin, 1991; Loeber et al., 1991). The disappointing results of the interventions

for CD may be explained by the fact that children start to pile up negative experiences as they grow older, personalities become more fixed, and behaviours become more resistant to treatment. It, therefore, makes sense to intervene when personalities are more plastic and less intractable. This implies the need to intervene with the earliest oppositional/conduct problems, such as ODD behaviours (Kazdin, 1991).

The salient issue is that ODD symptoms must be viewed as warning signs of potential violence, because even though not everyone with ODD goes on to develop CD, nearly everyone who meets criteria for CD also meets the criteria for ODD. This occurs in the same way that almost all adults with Antisocial Personality Disorder demonstrate CD before the age of eighteen, while only 33% of adolescents with CD ever develop chronic Antisocial Personality Disorder as adults (Zoccolillo, Pickles, Quinton & Rutter, 1992).

In summary, whether ODD as a diagnosis is eliminated in favour of CD as a single entity, with distinct developmental phases, or the two syndromes retain their independent status, ODD behaviours warrant identification and intervention. The personality of the adolescent at this early stage of the entire chronic disorder is more malleable, and this facilitates the modification of the disruptive

behaviour.

Research

Efficacy of psychodrama. Psychodrama was first offered as a psychotherapy in 1923. Since its introduction, there have been believers and nonbelievers. Psychodrama continues to be practised as a therapeutic technique internationally although few empirical evaluations of the method have appeared (Blatner, 1997; D'Amato & Dean, 1988). There are approximately seven thousand certified practitioners worldwide (Blatner, 1997).

Research studies on therapeutic strategies and articles featuring case illustrations in this domain have been problematic (D'Amato & Dean, 1988). Sometimes, there is a lack of generalizability, as well as inconsistent results, or else the definition of psychodrama differs between studies, or there is no definition at all (Kipper, 1978). Psychodrama is underrepresented in psychotherapeutic research and, when studies are conducted, the results are equivocal. There is a clear need for empirically based research on the method of psychodrama that could offer empirical support for its efficacy (Kane, 1992; D'Amato & Dean, 1988). Furthermore, researchers in psychodrama appear to assume that therapy will affect everyone the same

way, despite evidence of an interactional effect between subjects and treatments (D'Amato & Dean, 1988). Perhaps psychodrama is differentially efficacious in the treatment of specific disorders and specific populations. Psychodrama research studies must be designed to focus on issues such as suitability of technique to population (Kane, 1992).

Efficacy of psychodrama on aggression. Drama-based, action-oriented therapeutic approaches like psychodrama have frequently been used to help prisoners and released prisoners adjust to their environments. In a recent meta-analysis, positive treatment effects across multiple outcome measures, including self-esteem and anger, were found for the use of group psychotherapy with incarcerated offenders (Morgan & Flora, 2002). Psychodrama, in particular, seems effective in facilitating significant improvement in offenders' attitudes towards the correctional facility, a significant reduction in distressing symptomatology, and a significant increase in interpersonal sensitivity (Schramski, Feldman, Harvey, and Holiman, 1984). Theatre workshops with prisoners and ex-offenders seem to be more successful, both in the short term and in preventing recidivism, than any other of the many programs in the correctional systems across the U.S.

(Melnick, 1984). Specific therapies like 'The Cell Block' and 'Skills through Drama', which were created for the transient population in detention centres, use improvisations based on conflict where participants are not allowed to use violence or walk away (Melnick, 1984).

The process of working through conflict situations presented as scenes with characters who in real life are threatening and antagonistic seems to help aggressive individuals to increase their awareness, see the effects of their actions on other people, and consider the consequences (Melnick, 1984). This is what can be achieved in a psychodrama session -- the protagonist may learn a new, more adaptive response to a familiar and destructive situation recurring in his/her life. Jacob Moreno effectively used psychodrama therapy in helping institutionalized prisoners return to life in the outside society (Haskell, 1974). One study, conducted in Germany for six years with over one hundred prisoners, showed psychodrama to be more effective in treating criminal behaviour than traditional methods of psychotherapy (Melnick, 1984).

Although most of the outcome research on psychotherapy with conduct disordered children has been reported since 1970, one early example of the success

of incorporating dramatic methods to treat aggressive children occurred in 1942. According to Kendell and Braswell (1993), in 1942, G.E. Chittenden conducted an experiment to measure and modify assertive behaviour in young children. He used age-matched groups, a control group, and follow-up testing. The treatment contained elements of play-acting therapy and problem-solving training. Dolls were used to play out social problem situations. The children practised, through their dolls, how to take turns, share, and cooperate. At posttest, the trained children demonstrated significantly more cooperative behaviour and less dominant behaviour than at pretest.

In 1987, Goldstein and Glick researched a treatment program for incarcerated aggressive youth called 'Aggression Replacement Training'. The intervention uses the technique of role playing in modelling prosocial behaviour by the therapists and in rehearsing prosocial behaviour by the group members. The training consists of three parts: social skills, anger management, and moral reasoning. During the first part of the program, each group member enacts a hypothetical scene in which he or she rehearses the behavioural steps involved in each of the 10 basic social skills.

Psychodramatic techniques like improvisation, role

playing, and rehearsing, in addition to the behavioural technique of modelling, were used by Sarason and Sarason (1981) in their treatment of students in a secondary school with high delinquency rates. They intervened by targeting the participants' cognitive processes and their behaviours as they improvised actual, personal situations. This is similar to what occurs in a session of psychodrama -- the therapist meets the protagonist in real-life situations that are recreated by the group. The Sarasons' intervention involved 13 class sessions, with the first and the last sessions devoted primarily to assessment. The program emphasized a problem-solving approach to problematic situations via modelling, role playing, and rehearsing adaptive behaviours. The results of the Sarason and Sarason study showed that social skills and cognitive skills of low-achieving high school students seem amenable to change through drama techniques.

Psychodramatic methods seem to work for aggressive adults and adolescents with a disruptive behaviour disorder. Having the opportunity to act as part of a therapy modality may diminish the need to act out. Yet, psychodrama is not considered the treatment of choice for acting-out behaviour. This study attempts to examine whether psychodrama is a viable therapy for oppositional and defiant adolescents.

Much of the psychotherapy research investigating conduct/oppositional problems is on adolescents who have severe symptoms of CD. However, in this study, it is hypothetical that it may be more efficacious to intervene at an earlier point, when the child is experiencing some academic, familial, and social impairment but has not yet committed severe criminal actions. Kazdin (1991) suggests that the greater the level of child aggression, the less effective is the treatment. The benefits of therapy may be greater for the adolescent with ODD or mild CD symptoms than for the adolescent with severe CD.

Aggression is often triggered through the way in which environmental events are perceived and processed. This is especially true for adolescents with conduct problems, who tend to misperceive the intentions of others as more hostile and threatening than is the reality (American Psychiatric Association, 1994). In psychodrama, the protagonist is able to conduct a reality check either with the auxiliary role player in the scene or with the audience. He or she is then given the opportunity to rehearse new, more reality-based and adaptive behaviours in the same scene.

In summary, this study suggests that an impulsive thinking style, low empathy, and low self-esteem contribute to the oppositional adolescent misreading

social cues, jumping to erroneous conclusions regarding the intentions of others, and reacting aggressively. This study also suggests that these three characteristics may be positively affected by psychodrama.

The main thrust of the study tested hypotheses about three characteristics or possible determinants of ODD and CD. Advances in treatment of childhood and adolescent mental disorders depend upon an analysis at a molecular level of how change is accomplished (Kazdin, 1991). This study examined three elements that may contribute significantly to the disordered behaviour. At the same time, identifying effective therapies requires evaluation of the impact of the conditions that influence their outcomes (Kazdin, 1993). This study examined the impact of psychodrama that contributes to positive changes in behaviour, relative to no treatment.

Research on the Efficacy of Psychodrama on Specific Behavioural Variables

Psychodrama and impulsivity. Children who meet the criteria for either ODD or CD commonly manifest problems stemming from impulsivity that results in reckless behaviour (American Psychiatric Association, 1994). These children display poor judgement, and the

presence of impulsivity has to be addressed (Kendell & Braswell, 1993). Juvenile delinquents tend to make impulsive decisions to engage in aggressive acts, without enough thought to the probable consequences of their behaviour (Zarb, 1992). Either they don't bother to stop and analyse the situation or they use poor analysis based on erroneous or insufficient information.

One of the advantages of using psychodrama for acting-out participants is the opportunity for the participant/protagonist to witness an actual demonstration of his or her behaviour, in role reversal with an auxiliary player. Psychodrama provides the participant with an opportunity to experience, first-hand, the effects of his or her own impulsive behaviour on others (Moffett & Bruto, 1990). The protagonist, with the support of the group, may then process the information, make changes and try new, more reflective responses in reaction to familiar, trigger situations.

The psychodrama techniques themselves are therapeutic. To perform a role reversal, or to enact a role, requires self-control, retraining, and/or reconditioning of arousal that is lacking in the delinquent whose capacity for self-restraint is weak. According to Moreno (1965), in these methods lies a greatly underestimated and disregarded application of

psychodrama -- the treatment of impulsivity in delinquency.

Another likely benefit that psychodrama offers in the treatment of impulsivity is the chance to replay past events that involved impulsive and reckless behaviour in order to relive the sequence of actions that preceded and followed the reckless decision to act out. In the context of the psychodrama, it becomes possible to act out alternate behaviours and then play out their consequences. The adolescent thereby learns to consider the cause and effect relationships that exist in daily living.

The research attention that has been directed toward identifying and describing impulsivity is due to the work of Jerome Kagan and his colleagues (Cohen, Swerdlik, & Smith, 1992). These researchers observed the differences in children's tendencies to adopt either reflective or impulsive approaches to solving problems that required the analysis of several simultaneously available response alternatives (Kagan, 1966; Kagan, Rosman, Day, Albert, & Phillips, 1964). Although reflective vs. impulsive style has been shown to be stable over time, there is a tendency for reflection to increase as the individual gets older (Kagan, 1966).

The reflective-versus-impulsive conceptual tempo

is defined as the consistent tendency to demonstrate slow or fast response times in problem situations with high response uncertainty (Kagan, 1966). Those with a reflective style spend more time examining the problem, considering alternative solutions, and check for the accuracy and completeness of each alternative solution. Those with an impulsive style tend to make quick decisions and to respond with what comes to mind rather than with an analytical examination. This is especially true when the child is confronted with a degree of ambiguity (Kendell & Braswell, 1993).

It is not a coincidence that, especially in ambiguous situations, aggressive adolescents often do not process information accurately. In social situations where there may be a moderate degree of uncertainty, they often 'jump the gun', so to speak. They frequently misperceive the intentions of others as more hostile than is the case in these uncertain situations, and so they respond with aggression that they then feel is justified (American Psychiatric Association, 1994). The psychodrama group provides the perfect opportunity for clarity, which reduces ambiguity and impulsive aggression. On the psychodrama stage, the protagonist is encouraged to explore the reality of any scene from his or her life, and to rehearse more adaptive ways of looking at, and reacting

to, situations.

Cognitively, impulsive boys are reported to be more distractible and overactive relative to reflective boys (Kendell & Braswell, 1993). Behaviours considered to be partly a function of impulsivity that are frequently observed with ADHD adolescents include such delinquent acts as vandalism, theft, assault, substance abuse, and use of weapons; these behaviours frequently lead to a diagnosis of Conduct Disorder (Van Hasselt & Hersen, 1995). An unruly adolescent's behaviour is often the result of a lack of planning and of impulsive thinking -- not thinking of the consequences. This leads to the adolescent's being caught by parents, school authorities, and police for various acting-out behaviours that may include annoying impulsive conduct like verbal interruptions, physical intrusions, and lying.

Similar to the cognitive-behavioural therapy of training impulsive children to talk to themselves, in psychodrama therapy, the individual acting as the protagonist can be encouraged to rehearse self-talk as the critical scene is being played out, for example, in the form of a soliloquy, in order to control impulsive urges (Meichenbaum & Goodman, 1971; Nelson & Birkimer, 1978). But more than this, like Meichenbaum's self-talk method, the idea behind role-play in general is to

separate thought from action in order to prevent inappropriate emotional responses through automatic behaviour (Fink, 1990).

In psychodrama, the adolescent's pattern of behaviour becomes evident as scenes from the protagonist's life are being replayed over and again, step by step, while the protagonist is receiving feedback from therapists and peers. According to Moffett and Bruto (1990), psychodrama provides each group member with an opportunity to learn to become more reflective, to think before acting. Once the protagonist recognizes his/her impulsive behaviour and understands the consequences of it, he/she can try out different more appropriate ways of behaving.

Psychodrama and empathy. Research suggests that empathy is a key factor in the development of social understanding and prosocial behaviour (Mead, 1934; Pecukonis, 1990; Piaget, 1932). The strong presence or absence of empathy seems to, respectively, inhibit or increase the risk for antisocial behaviour patterns (Saltaris, 2002). Past theorists have stated that empathy is acquired through role-playing behaviour, and that role-taking ability is the key variable in social and moral development (Piaget, 1932; Mead, 1934; Kohlberg, 1969; 1976). Psychodrama promotes learning

and practising role-playing skills that enable one to take on the role and emotional perspective of another.

Developmentally, as children learn to decentre, to become less egocentric, their ability to anticipate, identify, and understand what another may be thinking or feeling increases. That is what the psychodramatic technique of role reversal does -- it demands that the protagonist decentre and look through another's eyes. Operationalizing this view, Chandler (1974) found that training delinquent adolescents in taking perspective, and in being less subjective, was instrumental in decreasing egocentric thought.

Role play and role reversal are effective techniques in developing empathy and improving relationships (Weil, Pascal, Kaddar, & Luboshitzky, 1990). Firstly, role playing in a group lets each person view his or her situation as others do. This allows the protagonist to do a reality check by evaluating group consensus. Secondly, because an aggressive adolescent's hostile behaviour results from a tendency to misperceive what others think of him or her (American Psychiatric Association, 1994), the assuming of different roles lets the individual investigate different perceptions in a nonthreatening situation. Finally, in psychodrama, adolescents are put in touch with processes that give them direct ideas

of how others think and feel. They get to experience what it's like to be in the other person's shoes.

Aggression and empathy are inversely related (Feshbach & Feshbach, 1969; Hogan, 1973; Mehrabian & Epstein, 1972). In fact, empathy is positively correlated with altruism and cooperation, nonegocentric thought, and the internalization of moral values and moral development (Chandler, 1972; Hogan, 1973; Kohlberg, 1969; Roe, 1980). Although empathy itself is not a sufficient condition for inhibiting aggression altogether, differences in empathic tendency do make a difference in aggressivity (Feshbach & Feshbach, 1969).

The literature indicates that levels of empathy are influenced by separate cognitive and affective factors (Mehrabian & Epstein, 1972; Pecukonis, 1990; Hogan, 1973). The cognitive factors are those that guide the ability to recognize another's emotion, while the affective factors guide the ability to share another's emotion (Mehrabian & Epstein, 1972). Aggression, which is at the root of CD and ODD, may be regulated by the affective component of empathy, and not necessarily by the cognitive part (Feshbach, 1975).

Delinquents have been found to be deficient in affective role-taking, or affective empathy, but not necessarily in cognitive empathy (Rotenberg, 1974). This combination allows the delinquent to manipulate

others without distress (Moffett & Bruto, 1990). In other words, the adolescent can recognize and predict what the victim is feeling, but does not, or cannot, experience what the victim feels. Past findings demonstrate that therapy, in the form of training, can increase the level of affective empathy (Pecunokis, 1990; Feshbach, 1975).

Individuals with ODD and CD characteristically damage people or objects and cause pain, usually without remorse. Sometimes even empathic, 'normal' individuals may purposefully hurt others; however, the observation of the noxious consequences evokes distress in the empathic observer, even if he or she is the instigator of the aggressive act (Feshbach & Feshbach, 1969). The person would probably retreat and govern him/herself accordingly.

A significant inverse relationship has been found between empathy and aggression in boys. Teachers rate high-empathy boys as significantly less aggressive than low-empathy boys (Feshbach & Feshbach, 1969). Empathy may function as a control of aggressive behaviour. Aggression in children, in terms of its deviant social connotations and its often impulsive quality, is seen as an immature moral behaviour (Hogan, 1973). Empathy, on the other hand, especially in terms of its role-taking component, is seen as related to the emergence

of higher moral development (Hogan, 1973).

The vicarious emotional experience of the pain and distress that the injured person experiences, taking the affective role of the victim -- affective empathy -- may inhibit the aggressive act. One would hypothesize that those high in empathy will manifest less aggression than those low in empathy. Evidence supports this proposition (Feshbach and Feshbach, 1969, Feshbach, 1975; Mehrabian & Epstein, 1972).

Mehrabian and Epstein (1972) conducted an experiment in which 91 participants, undergraduates acting as 'teachers', were instructed to punish 'pupils' for wrong answers by administering electric shocks. A significant effect ($p \leq .05$) was found for immediacy of pupil/victim and empathic tendency. The study showed that the teacher/aggressor with high empathy used significantly less aggression (i.e., fewer shocks), when the pupil/victim was of closer proximity. Low empathy 'teachers' aggressed with the same intensity against an immediate as a nonimmediate 'pupil', that is, a 'pupil' situated farther away from the 'teacher'.

In conclusion, it would be reasonable to expect that aggressive adolescents, as they increase their capacity for affective empathy become less aggressive, less oppositional and defiant. This may be achieved by

using psychodrama techniques.

Psychodrama and self-esteem. Self-esteem involves the positive or negative evaluation that humans attribute to their self-concept and self-worth (Coopersmith, 1981; Sarbin, 1952; Smith, 1960); that is, once they have built concepts of themselves, to what degree can they accept and approve of themselves? Self-concept refers more to one's intellectual beliefs about oneself. Self-esteem constitutes one's feelings about oneself. It is reasonable that, since thoughts and feelings are integrated, so are self-concept and self-esteem.

In a study of adolescents, Coopersmith (1981) investigated a variety of schools and families and concluded that children with high self-esteem have expectations of success and confidence in their judgements, engage in more group and social interactions, form interpersonal relationships more easily, and are not preoccupied with personal problems. Self-esteem is a set of attitudes and beliefs that prepares one to face the world and to respond according to expectations of success, acceptance, and personal strength. Children with low self-esteem are not successful, feel isolated, and are more likely to manifest deviant behaviour patterns (Coopersmith,

1989). They may engage in violence of a non-confrontational nature. This describes ODD behaviour of perpetrating violence against property and avoiding direct confrontation. According to Coopersmith (1981), an adolescent with low self-esteem, although defiant, is in no position to directly confront his or her adversary. Aggressive adolescents with low self-esteem seem to commit the covert incidents of disorderly conduct typical of ODD. Self-esteem appears to become more stable in late adolescence (Coopersmith, 1989; Harrington, 1986). If left untreated, the older the antisocial child, the more ingrained is his/her negative self-view, and the more likely he or she will continue to act out in destructive ways.

According to the theoretical view of Cooley (1998, 1964), self-esteem is considered as originating with the individual's perception of how significant others view the self. It is only through the interaction with one's social environment that the self is formed.

Cooley (1964) recognized that the foundation of hostility lies in social self-feeling. One person attributes to another person an injurious thought regarding something which is valued as a part of the self. It makes no difference whether this is true, or in the imagination, as long as the aggressor believes that the other person harbours the disparaging idea.

Psychodrama gives the person who has a distorted view and a poor self-image the opportunity to clearly see himself or herself as others do.

An aspect of self-esteem, as examined by Mead (1934), is that one often sees oneself as others do; self-concept develops from social experience. The difference between Cooley and Mead in this respect is that Mead proposes that a judgement about oneself is preceded by an actual phase of experience. In other words, one had to have experienced oneself in the way one is being judged. Psychodrama gives the person who is rejected by his or her peers and has a low self-esteem the opportunity to receive constructive and caring feedback about what he or she does that offends and annoys others; this becomes evident as the personal scenes are enacted. The information is necessary for the person to begin having positive experiences by making changes in how he or she ultimately relates to others.

Another perspective on the association between aggression and self-esteem, according to Fromm (1947), is that the way one experiences others is not different from the way one experiences oneself. Acceptance of self leads to acceptance of others. Developmental theorists concur that high-self esteem is basic to self-acceptance and acceptance of others; you cannot

like other people if you do not like yourself (Coopersmith, 1981; Rosenberg, 1989).

It may be that self-esteem influences the degree of empathy one demonstrates; self-esteem and empathy may be positively correlated. If either trait is modified through therapy, then the other may change as a result; if both traits are improved because both are targeted, as in this study using psychodrama, then the benefit may be synergistic.

Aichhorn (1935), a pioneer in the area of delinquent behaviour, believed that aggressive, antisocial behaviour is caused by low self-esteem. The delinquent personality possesses an insecure core which is surrounded by a tough facade. The mask of toughness is a defence against actual weakness and personal dissatisfaction, and it is an attempt to get illicitly what is not believed to be attainable by less destructive ways of living. In any case, for children whose conduct disturbance is characterized by high levels of aggressive behaviour, prior research has indicated that they display poorer self-esteem (Lochman, Lampron, Burch, & Curry, 1985).

Carl Rogers (1961) stated that discrepancies between one's perceived sense of self and one's desired or ideal sense of self affect self-esteem and consequently behaviour. He shared in the inference

that self-esteem influences behaviour.

Psychodrama may be an efficacious intervention to increase self-esteem and improve behaviour. Psychodrama contains many self-empowerment techniques, like standing on a chair to give a sense of high stature, or reenacting a scene in which one experiences a corrective emotional ending. These are used in combination with positive, constructive, and caring feedback from one's peers, who make up the group membership. Psychodrama also promotes a sense of self-worth through role enactments of adaptive behaviour that are rehearsed. Therefore, one's self-esteem may be positively influenced through exposure to psychodrama therapy.

According to Moreno (1999), everyone is potentially omnipotent in the degree that one is creative in one's life. In a sense, the psychodramatic reenactment makes it possible for the protagonist to play god. The protagonist who feels helpless and trapped by life's experiences, and has a deflated self-esteem, may be encouraged by the director to play the role of god and seize control of his or her life. As god, protagonists have the possibility to immediately realize all of their aspirations. Protagonists may gain courage to be more creative in managing their real lives, and liberate themselves from self-destructive

choices and situations.

To build self-esteem in the school, Coopersmith (1989) recommended that a child be given an opportunity to play out different roles that reveal alternative ways in which he or she might act in the face of difficulty. He considered it essential that schools integrate self-esteem programs that help students deal with problems effectively by opening up new, alternative ways of acting that are not part of the child's usual strategy. This is precisely the purpose of creating spontaneity in psychodrama.

Significance of the Study

It is hypothesized that psychodrama is effective for adolescents with oppositional/conduct problems when administered once a week for three months. The findings of this research project could have direct implications for the treatment of disorderly conduct in adolescents, as well as for the application of psychodrama. Mental health professionals would focus therapy on the impulsivity, empathy, or self-esteem of a child to improve behaviour. Psychodrama, a creative arts therapy and a group method, would be administered to adolescents in the treatment of ODD, or mild CD, because of its positive effects on improving impulsivity, self-esteem, empathy, and disruptive

behaviour. In a study investigating the effectiveness of traditional child psychotherapy, relatively little support was found for conventional individual methods of child-oriented psychotherapies in the treatment of internalizing and externalizing disorders (Weiss, Catron, & Harris, 2000).

Hypotheses and Research Questions

This study addressed the problem of treating syndromes of aggressive behaviour in youth. Will adolescents with aggressive behavioural problems benefit from the treatment of psychodrama? The general hypothesis of the study was that, if adolescents with behavioural difficulties participate in a short-term psychodrama therapy program, they will behave less impulsively, feel more empathic, and make greater gains in self-esteem than if they had never received the treatment.

There were four main hypotheses. They are as follows:

1) If oppositional and defiant adolescents are treated with short term psychodrama therapy, levels of impulsivity will significantly decrease as compared to pretreatment levels and to oppositional and defiant adolescents who were not treated.

2) If oppositional and defiant adolescents

are treated with short term psychodrama therapy, levels of empathy will significantly increase as compared to pretreatment levels and to oppositional and defiant adolescents who were not treated.

3) If oppositional and defiant adolescents are treated with short term psychodrama therapy, levels of self-esteem will significantly increase as compared to pretreatment levels and to oppositional and defiant adolescents who were not treated.

4) If oppositional and defiant adolescents are treated with short term psychodrama therapy, their maladaptive behaviours (especially oppositional behaviours) will significantly decrease as evaluated by their parents (part 1) and teachers (part 2), compared to pretreatment levels and to oppositional and defiant adolescents who were not treated.

III. METHOD

Characteristics of the students recruited as participants are presented in this chapter, as well as the procedure employed to recruit them. In addition, technical details of the instrumentation used to measure the behaviours and personality characteristics of the adolescents before and after the psychodrama therapy, the intervention itself, and types of statistical analyses used are described.

Participants

The sample of students was selected from all grades (7-11) in one high school in Montreal. The school was chosen because it is representative of central city and suburban students. Approximately 50 students, identified by the guidance counsellor and vice principal as the most disruptive and aggressive in the school, were referred to the treatment study. The referral was based on 1) students meeting the Oppositional Defiant Disorder diagnostic criteria from DSM-IV (American Psychiatric Association, 1994)(see Appendix A), 2) accounts of suspensions and detentions, and 3) teacher recommendations.

Generally, most of the youth with mental disorders present with comorbid symptoms (Newman, Moffitt, Caspi,

and Silva, 1998). For children with externalizing behaviours, having two or more primary diagnoses is the rule, not the exception (Lambert, Wahler, Andrade, & Bickman, 2001). As in this study, children with ODD/CD are likely to display ADHD symptoms (Hinshaw, 2002). Behavioural studies have found that ADHD is a significant predictor of the future development of ODD (Clarke, Barry, McCarthy, & Selikowitz, 2002). The decision made here was to target ODD/CD problems for treatment.

Procedure

The first 24 students who fit the criteria for ODD and were willing to participate were selected from the 50 referred students. The sample consisted of 18 females and 6 males. The mean age was 14.5 years, ranging from 12-17 years. The SES ranged from middle to lower economic status. The participants came from mostly single-parent families. The children, parents, and teachers agreed about the nature and extent of the conduct problems. There was no age, gender, or ethnicity quota in the sample. Brief interviews with each student determined his/her willingness to participate in the study. All procedural details were arranged with the school according to it's regulations and requests.

Parents and participants were asked to sign consent forms that stated each child's intention to participate in the study (see Appendix B). The consent form contained information regarding a therapeutic safety net which was established to handle any crises that should emerge at all times during the course of the study.

Participants were randomly divided into experimental and control groups. Thirteen participants (10 females, 3 males) were randomly assigned to the psychodrama group. Eleven participants (8 females, 3 males) were randomly assigned to the waiting-list control group. The experimental group was bolstered by two more participants to safe guard against a potential drop-out situation due to the nature of the sample and the fact that attendance in the psychodrama sessions was voluntary. (None of the participants withdrew from the study.) The groups were matched with respect to gender. The control and experimental group were virtually the same in terms of age and asociability scores (see Table 1).

With respect to the validity of the ODD diagnosis, the Asocial Index (AI) on the Jesness Inventory (JI) (Jesness, 1996) showed that both the psychodrama group and the control group rated themselves as slightly delinquent. According to Jesness (1996), an AI score

of 66 is the cut-off point for distinguishing delinquents from nondelinquents for all ages. (AI scores can range from 25-90.) The Asocial Index reflects a general predisposition to resolve social or personal problems in ways that demonstrate a disregard for social customs or rules. The JI was given solely at pretest to validate the conduct disordered nature of the sample.

Table 1

Age and Asocial Index (Jesness Inventory) of Sample

	Experimental Group (10 females, 3 males)			Control Group (8 females, 3 males)		
Variable	M	SD	Range	M	SD	Range
Age	14.308	1.182	12-16	14.727	1.555	12-17
AI	65.923	6.639	54-76	69.154	13.184	48-90

The homogeneous nature of the groups was necessary to ensure replicability and validity of the study. Both groups were assessed at the same times to ensure that experimental changes were not due to confounding influences. The primary comparisons of interest in

this study were differences between therapy group and control group, and between the pre- and post-measures within each group. Changes in participants, before and after the 12-week intervention, were examined statistically. A review by Kellerman (1987) concluded that long exposure to psychodrama is a relatively unimportant factor influencing outcome and that many studies included 10-week exposures to psychodrama were able to produce positive results.

Participants were told that they would be participating in a group experience aimed at: 1) controlling one's own urges in order to assess the consequences of one's behaviour; 2) understanding, and caring more for, other people; and 3) feeling worthwhile. Participants assigned to the control group were placed on a waiting-list for future treatment.

The psychodrama group met once every week for 12 weeks for the psychodrama session. The sessions lasted 1-2 hours and included three phases: 1) a warm-up; 2) a reenactment; and 3) a closure phase. The rules governing the psychodrama group, for example, confidentiality rules, as well as all issues pertaining to participation in the study, were discussed during the first session and a hand-out was distributed (see Appendix B). The group was directed by an accredited psychodramatist and psychotherapist, with the author

of the study as assistant to the director. The psychodrama sessions were audiotaped. Juice and snacks were available at each session.

The self-report and performance measures, described under Instruments, were administered, and behavioural ratings were completed by parents and teachers two weeks before the first, and after the final, psychodrama session (see Appendix B). The control group was assessed at the same times as the psychodrama group but did not receive any treatment until after their final testing. Three teachers (English, math, and French)and one parent or guardian of each participant completed the Conners' Rating Scales - Revised (Conners, 1997), a brief questionnaire, at the same two times.

Instruments

The Jesness Inventory (Jesness, 1996) was administered to provide a pre-treatment level of aggression. The other instruments selected measured the three dependent variables being investigated: Impulsivity via the Matching Familiar Figures Tests (MFFT) (Kagan, 1965); empathy via the Balanced Emotional Empathy Scale (BEES) (Mehrabian, 1996); and self-esteem via the Self-Esteem Inventory (SEI) (Coopersmith, 1989). To address the need for multiple

informant assessment in research on adolescents with behavioural disorders (Institute of Medicine, as cited in Kendall & Braswell, 1993), the Conners' Rating Scales - Revised (CRS-R) (Conners, 1997), parent and teacher versions, were distributed to provide scores on objective observations of the adolescents' disruptive behaviour problems.

The Jesness Inventory (JI). The Jesness Inventory (Jesness, 1996) was developed with institutionalized delinquents to assess personal and interpersonal functioning. It is composed of 80 items, each of which is rated on a 5-point scale. Scores on 11 factor-analytically derived and three rationally derived scales are obtained; these include friendliness versus hostility, enthusiasm versus depression, and sociability versus poor peer relations (Goldstein & Glick, 1987; Van Hasseslt & Hersen, 1995).

The JI was administered to assess the level of antisocial traits. The inventory is equipped to classify adolescents and provide scales helpful in marking progress, and is used for children ages 8-18. It provides 11 scales: social maladjustment, value orientation, immaturity, autism, alienation, manifest aggression, withdrawal, social anxiety, repression, denial, and asocial index.

The JI is often used in research to evaluate the effects of various intervention modalities. Significant changes pre-to-post were found in one study, using both the MMPI and the JI, that attempted to determine the effects of a behavioural/cognitive treatment program (Roberts, Schmitz, Pinta, & Cain, 1990). Carpenter and Sandberg (1985) confirmed their hypothesis that behavioral-cognitive techniques within a psychodramatic framework would reduce delinquent tendencies as measured by the JI. The inventory is also used to predict delinquency and to distinguish delinquent from nondelinquent individuals (Jesness, 1996). In this study, the JI was administered at the outset to determine the delinquent profile of the sample.

The Matching Familiar Figures Test (MFFT). The MFFT (Kagan, 1965) was first developed as an instrument to research the reflective-impulsive dimension in children aged 5-12. Although primarily used in research with children, investigations of Kagan's formulations with adolescents and adults have been conducted (Cohen, Swerdlik, & Smith, 1992). There are two versions of the task-oriented performance measure -- one for children and one for adolescents and adults. The test is standardized for children from

5-12 years old. According to Kagan (personal communication, August 30, 2000), the test is appropriate for adolescents.

The MFFT consists of 12 items that represent familiar objects (such as lamp, graph, and leaf) and two sample items. The participant is presented with a standard picture and six almost identical pictures, of which only one is truly identical to the standard. The subject is instructed to select the identical copy. Scores are based on the mean response latency (MFFT-Latency) and on the mean number of errors produced (MFFT-Error) across the 12 items.

Those with fast response times and many errors earn scores indicative of impulsivity, while others with longer response times and a low number of errors are designated as reflective. It has been demonstrated that high negative correlations exist between response time on the MFFT and the number of errors produced; that is, test-takers who respond quickly tend to make more errors than those who respond more slowly (Kagan, 1965).

Variations in cognitive style as measured by the MFFT may be related to different types of pathology. Campbell (1974) showed that boys who externalize their conflicts and show aggressive, antisocial behaviour tend to score high on impulsivity.

The MFFT has been criticized for a lack of normative data (over the age of 12), and there are no data on reliability and validity (Kagan, 1985). Still, the test has provided useful information in many research projects for over 30 years with participants of all age groups, including studies exploring how impulsivity might be modified (Cohen, Swerdlik, & Smith, 1992; Kagan, 1985; Meichenbaum & Goodman, 1971).

The Balanced Emotional Empathy Scale (BEES). The BEES measures an individual's vicarious emotional response to the perceived emotional experiences of others (Mehrabian, 1998). This scale replaces The Emotional Empathic Tendency Scale (EETS) co-authored by Mehrabian and Epstein (1972). Much of the item content on the two instruments is similar (Johnson, 1998). Mehrabian (1998) considers the BEES to be superior to the EETS. The test can be helpful in elucidating a wide range of behaviours, including social skills. According to Mehrabian (personal communication, August 24, 2000), the test is suitable for individuals 12 years of age and older.

The BEES has adequate internal consistency, or internal reliability of .87, as measured by the Cronbach's alpha coefficient. This is evidence of homogeneity, internal consistency and construct

validity, which means that the test adequately measures empathy. Most of the validity for the BEES has been derived from studies conducted on the EETS because, according to Mehrabian (1996), the two tests are highly correlated (r=.77). The subscale intercorrelations on the EETS are all significant at the .01 level.

The split-half reliability coefficient for the test is .84 (Mehrabian, 1996). To obtain split-half reliability, two pairs of scores obtained from equivalent halves of the test are correlated after a single administration of the test. It is a useful measure of test-retest reliability estimates (Cohen, Swerdlik, & Smith, 1992).

Individuals who rate high on the affective empathy test are more likely to show empathy in their relationships with others and to show more arousal of their autonomic nervous system in response to emotional stimuli than those who score low on the test (Mehrabian & Epstein, 1972). Individuals with high scores have shown less aggressiveness, more altruism, and a greater probability to volunteer to help others. The BEES is viewed as an adequate measure of emotional empathy for research purposes (Urbina, 1998).

The Self-Esteem Inventory (SEI). The SEI (Coopersmith, 1989) assesses levels of self-esteem of

children and adults in familial, social, academic, and personal contexts. It is a self-report questionnaire measuring self-attitudes in four areas (social self-peers, home-parents, school-academic, and general-self) related to academic functioning and personal satisfaction in school or adult life. The total-self score was used in this study.

The SEI is frequently used for classroom screening, and pre-post evaluations in research studies. There are two existing forms: School (8-15) and Adult (16 years and over) (Harrington, 1986). The test has concurrent and predictive validity as well as high reliability regarding internal consistency, and test-retesting (Coopersmith, 1989; Peterson & Austin, 1985; Sewell, 1985). Internal consistency by Kudor Richardson 20 range between .87 and .92 (Sewell, 1985).

The Coopersmith inventories are reliable and stable and there is a vast amount of information bearing on their construct validity (Peterson & Austin, 1985). The test has demonstrated convergent validity with other self-report measures of self-esteem including the Rosenberg Self-Esteem Scale for adolescents (Chubb, Fertman, & Ross, 1997; Peterson & Austin, 1985).

The SEI is among the best known and most widely used of all the tests measuring self-esteem over the

past two decades, and it comes highly recommended for use in research (Peterson & Austin, 1985; Sewell, 1985). This is primarily why the test was chosen, and because it is based on a theory that relates self-esteem to effective functioning (Sewell, 1985).

The Conners' Rating Scales-Revised(CRS-R). The CRS-R evaluate problem behaviours and psychopathology in children and adolescents by obtaining reports from teachers and parents. The scales are useful in measuring treatment changes. The CRS-R were normed on several large samples of children and adolescents from schools in the U.S. and Canada (Conners, 1997).

The Conners' scales assess Attention-Deficit/ Hyperactivity Disorder (ADHD), conduct disorders, cognitive/inattention problems, family problems, emotional problems, anger control problems, and anxiety problems (Conners, 1997). Although the Teacher's Report Form by Achenbach & Edelbrock (1986) also provides internalizing and externalizing subscales, the Conners' test was chosen because it tapped more specifically into the variables that are being tested in this study. For example, the data results from the oppositional disorder subscale provided information on the efficacy of treatment on the precise behaviour targeted. In addition, the data from the oppositional

subscale corroborated the pre-test results of the Jesness Inventory. The information from the hyperactive subscale of the CRS-R complemented the results of the MFFT (Kagan, 1965). The availability of both parent and teacher forms also suited the purpose of this study.

The internal reliability, as measured with the Cronbach's alpha coefficient, ranges from .73-.96 across all forms of the CRS-R (Conners, 1997). Test-retest reliability coefficients ranged from .47-.92, from medium to high, across the subscales. In support of the validity of the CRS-R, the tests seem to correlate with other measures believed to measure the same construct (convergent validity) and do not correlate with measures believed to measure different constructs (Conners, 1997). Additionally, factor analysis seems to offer support for the factors given by the scales.

Two versions, short and long, are available for both forms. Conners (1997) recommends the use of the short versions of the instruments when administration time is limited or where multiple administrations over time are required. Both versions yield comparable results. The short version of the test was employed for this study. The subscales consisted of oppositional problems, cognitive/

inattention problems, hyperactivity, and ADHD (DSM-IV) index. The oppositional behaviours of the adolescents that are rated by parents are: anger and resentment, arguing with adults, losing one's temper, irritability, defiance and refusal to comply with adults' requests, and being deliberately annoying to others. The oppositional behaviours that are rated by teachers are: defiance, actively refusing to comply with adults' requests, being spiteful and vindictive, arguing with adults, temper outbursts, and explosive and unpredictable conduct.

Rationale for the use of multimodal reports. The decision to use self-reports was based upon the realization that young people are frequently overlooked as a major source of information about themselves (Marchant & Ridenour, 1998). When an attempt is made to identify behaviours, perceptions, and even personality, records are consulted and parents and teachers are usually questioned about their objective observations. There are few studies designed to solicit responses from children (Marchant & Ridenour, 1998). There is a need to use self-reports for adolescents, especially in light of evidence that a weak agreement often exists between parent and child reports (Achenbach, 1995; Achenbach, McConaughty, &

Howell, 1987; Marchant & Ridenour, 1998).

It should be noted that in a survey of over 100 members of the Society for Research in Child and Adolescent Psychopathology by Loeber, Green, and Lahey (1990), results demonstrated that there are variations in the reliability of informants across different types of problems. For gathering data on the description and frequency of impulsive behaviour and externalizing problems, self-reports were not considered as important as teacher and parent ratings. Multiple sources of information were therefore required for the present study.

Intervention

The Psychodrama Session

The following is a description of a typical psychodrama session. It illustrates the format that was used in the present study. The session is made up of three stages: the warm-up (15%), the action (60%), and the closure (25%).

The warm-up. The main objective of the warm-up is not to turn the clients into actors, but rather, to stir them up to be on the psychodrama stage more deeply and explicitly than they appear to be in daily existence (Moreno, 1972). The warm-up exercises

increase the level of readiness of the group members to become involved in the psychodrama. They also serve to determine the most pressing problem of each member of the group (Carpenter & Sandberg, 1985), and produce a protagonist for the next stage.

There are various psychodrama warm-up exercises; a newly formed group might start with early warm-ups such as: introduction dyads, self-presentations, and the empty chair. Later warm-ups might include improvisations with objects or other members, the magic shop, the mask boutique, turn your back, portrayal of a dream, and the sociogram (Blatner, 1989; Emunah, 1994).

The director is the first to warm up. He/she sets the scene for psychodrama by moving around the room, setting up chairs, talking and improvising, presenting a basic introduction: the format of the session, how long the group will last, confidentiality issues, etc. The director is developing spontaneity in him/herself. The therapist/director is the most spontaneous one in the group (Moreno, 1966). His/her warming up begins to allow the group to know and trust him/her. Few things are more counter-productive to a group's warming up than a therapist who talks with the group from a sitting position (Blatner, 1989).

The therapist's behaviour also models for the group the norms of self-disclosure, spontaneity,

acceptance of humour, tolerance of some distance (i.e., the acceptability of some reserve on the part of the group members and a respect for some unwillingness to engage in significant disclosures at first), and the acceptability of action and forceful expression. The therapist is interacting with the group members and developing a level of tele, or empathic communication with them (Blatner, 1989).

The action stage. The action stage contains the psychodrama. It begins at the moment that a protagonist has emerged from the warm-up. The scenes take place 'in the here and now' regardless of when the actual incident being played out occurred, or may yet occur, or was fantasied (Moreno, 1989).

This stage of the psychodrama session includes three connected segments. The first segment depicts the role playing of the protagonist's complaint, or conflict -- the portrayal of the presenting problem. This is followed by a section of explorations and clarifications - scenes in which the presenting problem is being investigated. Moreno demanded that his patients show him, in action, how they had reached their current impasse (Moreno, 1989).

The protagonist is directed to confront, and then to reverse roles with, the auxiliary actors, group

members who are cast by the protagonist to portray real people from his/her life. This is designed to bring the protagonist's conflicts into sharper focus (Blatner, 1989). Through role reversal, the protagonist is helped to depict the distortions of his or her interpersonal perceptions by acting out what he or she believes others think (i.e., his/her own projections).

The last segment is the rehearsing and searching for alternatives -- the enactment of solutions for the problem. The protagonist is directed to throw away his/her old script because it hasn't worked very well (Moreno, 1966). Instead, he/she is provided with several variations on the theme. In this way, the protagonist develops more effective responses to a stressful situation. The action simulation takes place in a safe context. There is continual feedback regarding the effectiveness of trial behaviours until some degree of satisfaction is achieved.

Generally, there are two kinds of scenes -- key scenes and connecting scenes (Blatner, 1989). A connecting scene might consist of a brief soliloquy (pacing and talking aloud) by the protagonist (and perhaps an auxiliary) to elicit his or her feelings and cognitions either before or after a key scene. A typical action stage will have about four key scenes

and 2-3 connecting ones. Blatner (1989) posits it is the shift from one scene to another that sometimes produces the therapeutic effect, not the excessive exploration of one scene. For example, after the protagonist has finished a key scene in which he/she fights with a parent at the breakfast table, the director might freeze the action and ask the protagonist to speak about the feelings and thoughts that are in his/her mind this morning in a soliloquy to the audience (connecting scene); the director would then set the next key scene at the protagonist's school when he/she gets a detention for defying a teacher's request.

The therapist uses a variety of techniques to keep up the pace in the action phase: scene changes, role reversals, standing on chairs, mirror technique, observations from the audience, amplification (of gesture or voice), death scenes, rebirth scenes (into anybody). The therapist continually speaks in the present tense, reinforcing the protagonist's immersion in the here-and-now (Blatner, 1989).

The therapist/director must be aware of his/her own needs so as not to impose biased views on the needs of clients (Moreno, 1966). The director must put him/herself into an experiential, subjective relationship with the protagonist. The therapist/

director also assists the protagonist to focus on action and interaction. Instructions, according to Moreno (1966), are stated in simple terms: For example, "Here we do not talk about how we feel, here we act out how we feel. It is happening now, here. Let's live it through, together. Show me, do not tell me" (p. 217). The participants must feel free to act out parts of their worlds -- positive, negative, real, or fantasized. Each participant must have the freedom to feel at home in the psychodrama.

Closure. Closure is a period of discussion and rarely contains role playing. It is a time when the group members share their experiences (subjective views of a collective experience) with 'Joe' the protagonist. Each member is asked, "What have you experienced that relates to Joe's situation?" This is the time when an attempt is made to bring the experience-based learning to a meaningful integration so the protagonist (and any other member) can use it in everyday life.

Planning the next session, giving support (self-esteem building technique), any unfinished business, and closing rituals are also part of closure. For example, at the end of each session, the members might be asked to form a standing circle and say goodbye while making eye contact with each person.

The therapeutic ingredients in the sequence of behaviour change are: disinhibition (becoming spontaneous), enactment (being creative), catharsis and insight(both affective and cognitive), and retraining (or searching for alternatives). Old, inauthentic roles are exposed and discarded and a large spectrum of new roles is released from which the protagonist may choose freely. The protagonist who is rigid, 'conserved', who repeats his/her old type of behaviour to no avail, is offered an opportunity to try out a new set of behaviours and skills, here, now.

Data Analysis

Data analysis consisted of two stages. The first stage, the intercorrelation matrix, explored the associations between the dependent and independent variables, including age and gender, of the students.

The second stage identified the statistically significant effects and interactions between the psychodrama and control groups and time (trial) with regard to dependent measures: impulsivity (response time and error scores of the MFFT), empathy (BEES), and self-esteem (SEI). Analyses were run on the maladaptive behaviours (oppositional, cognitive problems/ inattention, hyperactivity, ADHD index) as rated by parents and teachers on the CRS-R:S.

The selection of statistical procedures was based on the relationship between groups, sample size, and the scale characteristics of the variables. Systat was used to compute all quantitative analyses, with the exception of the intercorrelation matrix, which was performed using SAS. The study employed a pretest-posttest, control-group design. The data were analysed using Repeated Measures Analyses of Variance (RM-Anovas) in combination with one-way univariate Analyses of Variance (ANOVAs). According to Heppner, Kivlighan, and Wampold (1999), when testing the efficacy of treatment against a control group, it is appropriate to test only whether the treatment is more effective than no treatment. The repeated measures univariate approach was used because it is more powerful than the multivariate approach when the N is small (Stevens, 1996). The effects of two types of independent variables, group and time (trial), were investigated. Treatment status represented the between variable, while trial the within variable.

The CRS-R:S parent and teacher scores were examined statistically using four repeated measures ANOVAs, one for each of the subscales on the short-form Conners' test. The Conners' report for teachers was completed pre- and posttest by three core-subject (English, math, and French) teachers for each

participant. In order to obtain a single measure of the teachers' impressions, the mean of the three teachers' scores was used in the following analysis.

Summary

The purpose of this study was to examine the treatment effects of psychodrama on adolescents selected for their oppositional and defiant behaviour. To this end, students were randomly divided into experimental and control groups. The experimental group was exposed to psychodrama for 1-2 hours weekly for 12 weeks. Each group was tested pre- and post-treatment. As well, parents and teachers completed rating scales assessing changes in four areas of maladaptive behaviour. Once the methodology for this study was implemented, the data resulted in pre- and post-measures of impulsivity, empathy, self-esteem, oppositional behaviour, cognitive and inattention problems, hyperactivity, and ADHD indexes for the psychodrama group and the control group.

IV. RESULTS

Statistical Analysis

This chapter presents the results of the data analyses pertaining to the four experimental hypotheses listed at the end of chapter 2. In this section, 1) an intercorrelation matrix showing the relationships between the variables will be presented, and 2) a statistical description of each of the dependent measures will be outlined and the effects of the psychodrama treatment will be explored via a series of Repeated Measures ANOVAs (RM-ANOVAs). A summary will be included at the end of the chapter.

Correlations Between Variables

Given that the behavioural variables tested in this study were expected to be separate yet interrelated symptoms of Oppositional Defiant Disorder, a correlation matrix was employed to highlight the degree of association among the measures being investigated. Due to the large number (105) of correlations computed for this matrix, there is a high probability of an inflation of Type 1 error. Care must be taken in the interpretation of any significant results. A Bonferroni correction would have resulted in an intolerably stringent criterion such that

no correlation of less than .999 would have been significant. Therefore, the results of this correlation matrix should be interpreted for descriptive purposes only.

As shown in Table 2, there was a slightly significant correlation between the oppositional subscale on the CTRS:R-S (Conners, 1997) and the latency scores on the MFFT (Kagan, 1965). There was a significant relationship between the oppositional subscale on CPRS:R-S and the error scores on the MFFT. As well, there was a significant negative correlation between the two parts, latency and error, of the MFFT. Among the other measures, there was an unexpected negative association between the SEI (Coopersmith, 1989), and the latency scores on the MFFT. There were many significant associations between the subscale variables contained in Conners' parents' and teachers' scales, including one between the oppositional subscales, and between the oppositional and hyperactivity subscales.

Among the independent variables, gender correlated significantly and negatively with BEES (Mehrabian, 1996), CTRS-R:S oppositional, and hyperactivity scores. As well, gender correlated significantly with group. Age correlated significantly positively with latency scores and negatively with error scores on the

ble 2

tercorrelations Between Variables

easures	1. Gp	2. Ge	3. Age	4. Trial	5. Imp-L	6. Imp-E	7. Emp	8. S.E.	9. P-O	10. T-O	11. P-C	12. T-C	13. P-H	14. T-H	15. P-A	16. T-A
Group	--															
Gender	.74**	--														
Age	.19	.13	--													
. Trial	0	0	0	--												
5. Imp-L	-.19	.07	.28*	.10	--											
6. Imp-E	-.05	.11	-.38*	-.38*	-.53**	--										
7. Emp	.08	-.38*	.05	0	.15	-.25	--									
8. S.E.	-.07	.19	-.21	.07	-.28*	.23	-.03	--								
9. P-Opp	-.21	-.05	-.01	-.13	-.23	.32*	.03	.08	--							
10.T-Opp	-.24	-.31*	-.39*	.06	-.28*	.13	-.01	.18	.36*	--						
11.P-Cog	.03	-.07	-.04	-.09	-.16	.05	.06	.01	.36*	.22	--					
12.T-Cog	.14	-.08	-.13	.07	-.15	.23	.17	.12	.21	.21	.12	--				
13.P-Hyp	-.25	-.13	-.01	-.04	-.08	.09	.07	.10	.46*	.35*	.35*	.21	--			
14.T-Hyp	-.11	-.33*	-.50*	.03	-.24	.32*	.22	.36*	.36*	.66**	.21	.55**	.41*	--		
15.P-Adhd	-.84	-.12	-.13*	.06	-.17	.10	.19	-.02	.53**	.36*	.78**	.18	.64**	0	--	
16.T-Adhd	-.09	-.20	-.40*	.02	-.23	.22	.05	.39*	.30*	.64**	.18	.71**	.44*	.90**	.40*	--

*p ≤ .05 **p ≤ .001

MFFT. Age was shown to have a significant, negative association with CTRS-R:S oppositional subscale.

Outcome Measures and Treatment Effects

It was anticipated that, by the end of the psychodrama therapy, students assigned to the experimental condition would improve their self-reported problematic behaviours and personality characteristics with respect to levels of impulsivity, empathy, and self-esteem. At the same time, it was expected that these improvements would be noted by parents and teachers as they rated the maladaptive behaviours of the adolescents before and after the 12 weeks of psychodrama.

RM-ANOVAs were performed on the dependent variables to investigate the extent to which therapy influenced posttest behaviour. The intervention was successful in the predicted direction. Supplementary analyses in the form of *t*-tests were used for paired variables following statistically significant RM-ANOVA results. The breakdown of the means and standard deviations for the dependent variables that were measured using self-reports to test Hypotheses 1-3 is presented in Table 3.

Table 3

Descriptive Statistics of Outcome Measures -- Self-Reports

	Pretest		Posttest	
Variables	M	SD	M	SD
Impulsivity (latency response)*				
exp.	22.942	10.679	30.964	17.418
control	21.632	18.652	19.519	17.757
Impulsivity (error)				
exp.	1.885	0.661	1.191	0.601
control	1.695	0.898	1.217	0.825
Empathy				
exp.	37.538	37.832	44.077	38.487
control	49.727	22.419	42.455	27.754
Self-esteem				
exp.	53.538	18.150	58.154	14.200
control	53.455	21.375	53.636	18.129

* $p \leq .05$

Hypothesis 1. The first hypothesis predicted that levels of impulsivity would significantly decrease in ODD adolescents exposed to psychodrama therapy as compared to pre-psychodrama levels and to ODD adolescents not exposed to psychodrama. To this end, the Matching Familiar Figures Test (MFFT) (Kagan, 1965) was administered to the adolescents pre- and post-psychodrama.

Before the intervention, neither the psychodrama group (pretest M=22.942 s, SD=10.679 s) nor the control group (pretest M=21.632 s, SD=18.652 s) scored in the impulsive range on the latency aspect of the MFFT (less than 15 seconds is considered impulsive). Regarding the error rate of the test, both the psychodrama group (pretest M=1.885, SD=0.661) and the control group (pretest M=1.695, SD=0.898) barely rated as reflective -- more than 2 errors is considered impulsive (Kagan, 1965).

After the treatment, the psychodrama group improved in response latency (posttest M=30.964 s, SD=17.418 s). The control group actually accelerated its response time by the end of the study (posttest M=19.519 s, SD=17.757 s). Interestingly, both groups demonstrated a reduction in errors at the final testing with the psychodrama group (pretest M=1.885, SD=0.661, and posttest M=1.191, SD=0.601), outperforming the

control group (pretest M=1.695, SD=0.825, and posttest M=1.217, SD=0.828).

As presented in Table 4, results demonstrated that the psychodrama group's improvement in mean scores with respect to the latency response aspect of impulsivity was statistically significant, $F(1,22)=7.687$, $p<.05$. Accordingly, the pretest-posttest t-test results for the psychodrama group was $t(12)=-2.516$, $p=.027$, and $t(10)=1.720$, $p=.116$ for the control group.

Table 4

Repeated Measures Analysis of Variance Results for MFFT Scores (latency response)

Measure	Source	df	MS	F	P
Impulsivity (latency response)					
Between	Group	1	484.699	0.991	.330
	Error	22	489.345		
Within	Trial	1	104.015	2.613	.120
	Trial X Group	1	305.970	7.687	.011*
	Error	22	39.806		

* $p \leq .05$

Paradoxically, there was a statistically significant effect for Trial regarding the error scores on the impulsivity test, $F(1,22)=7.687$, $p<.05$ (see Appendix C). It is noteworthy that, although there was not a significant interaction effect, the experimental group improved significantly, $t(12)=4.687$, $p=.001$, while the control group did not, $t(10)=1.564$, $p=.149$.

These results did not support the first hypothesis with respect to the accuracy aspect of impulsivity. However, the results did support hypothesis 1 regarding the latency measure of impulsivity.

Hypothesis 2. The second hypothesis stated that levels of empathy would significantly increase in ODD adolescents exposed to psychodrama therapy, as compared to pre-psychodrama levels and to ODD adolescents not exposed to psychodrama. To this end, the Balanced Emotional Empathy Scale (Mehrabian, 1998) was employed.

The psychodrama group (pretest $M=37.538$, $SD=37.832$) scored in the slightly unempathic range, below 45, coming into the study, and the control group (pretest $M=49.727$, $SD=22.419$) scored in the slightly empathic range, above 45. After the intervention, the psychodrama group almost placed in the nondeviant range, with a posttest mean of 44.077 ($SD=38.487$). The control group, meanwhile, became less empathic and

scored in the unempathic range (posttest M=42.455, SD=27.754). The results of the empathy scores showed a trend in the direction of the hypothesis but they were not statistically significant, F(1,22)=1.778, p=.196 (see Appendix C). Hypothesis 2, that psychodrama would significantly strengthen the presence of empathy in oppositional adolescents, was not confirmed by these results.

Hypothesis 3. The third hypothesis claimed that self-esteem would significantly increase in ODD adolescents exposed to psychodrama therapy, as compared to pre-psychodrama levels and to ODD adolescents not exposed to psychodrama. To this end, the Self Esteem Inventory (Coopersmith, 1989) was employed.

At the outset, both the psychodrama group (pretest M=53.538, SD=18.150) and the control group (pretest M=53.455, SD=21.375) rated as having lower than average self-esteem, below 67. After the intervention, the psychodrama group increased its mean score by 4.616 points (posttest M=58.154, SD=14.200) and the control group also increased its mean score but only by a margin of .181 of a point (posttest M=53.636, SD=18.129); both groups remained in the low range of self-esteem. The results were not statistically significant, F(1,22)=.558, p=.463 (see Appendix C).

Hypothesis 3, that psychodrama would significantly elevate self-esteem in oppositional adolescents, was not supported by these results.

Hypothesis 4. Hypothesis 4 dealt with objective ratings of misconduct. Table 5 contains a breakdown of the descriptive statistics for the objective measure used in part 1 -- the Conners' Parent Rating Scale - Revised: Short form (CPRS-R:S)(Conners, 1997).

The first part of the fourth hypothesis predicted that maladaptive behaviours (especially oppositional behaviours) would significantly decrease in ODD adolescents exposed to psychodrama therapy, as evaluated by their parents, compared to pre-psychodrama levels and to ODD adolescents not exposed to psychodrama. At the outset, the parents' objective measure of oppositional behaviour, in both the psychodrama group (pretest M=8.923, SD=4.786, 95th percentile) and the control group (pretest M=5.364, SD=3.501), rated as highly oppositional according to the CPRS-R:S (82nd percentile)(Conners, 1997). After the intervention, the psychodrama group improved to a statistically significant degree (posttest M=6.077, SD=3.095, 88th percentile), while the control group's oppositional problems increased (posttest M=6.273,

Table 5

Descriptive Statistics of the Outcome Measures - Objective Reports - CPRS-R:S for Parents

	Pretest		Posttest	
Variables	M	SD	M	SD
Oppositional*				
exp.	8.923	4.786	6.077	3.095
control	5.364	3.501	6.273	3.690
Cognitive problems/Inattention				
exp.	9.000	5.416	8.000	4.340
control	9.182	4.708	8.455	5.279
Hyperactivity				
exp.	4.692	4.553	3.923	2.397
control	2.364	2.378	2.636	2.976
ADHD Index				
exp.	16.769	9.400	15.231	7.201
control	12.636	5.626	13.636	8.078

* $p \leq .05$

SD=3.690, 88th percentile), F(1,22)=6.069, p<.05 (See Table 6). The pretest-posttest t-test results for the psychodrama group and the control group were t(12)= 2.813, p=.016, and t(10)= -0.792, p=.447, respectively.

Table 6

Repeated Measures Analysis of Variance Results for CPRS-R:S (Oppositional Subscale)

Measure	Source	df	MS	F	P
Oppositional Subscale					
Between	Group	1	33.706	1.494	0.234
	Error	22	22.558		
Within	Trial	1	11.178	1.615	0.217
	Trial X Group	1	42.012	6.069	0.022*
	Error	22	6.923		

* $p \leq .05$

At the start of the study, parents rated the psychodrama group as being in the 95th percentile for cognitive and inattention problems (pretest M=9.000, SD=5.416). They rated the control group as also being in the 95th percentile (pretest M=9.182, SD=4.708). At the end of the study, the parents observed a slight

decrease in cognitive and inattention problems in the psychodrama group (posttest M=8.000, SD=4.340) as well as in the control group (posttest M=8.455, SD=5.279) enough to move both groups into the 94th percentile. However, these results were not significant, F(1,22)=.038, p=.847 (see Appendix D).

At the outset, parents rated their children assigned to the psychodrama group as highly hyperactive, in the 97th percentile (pretest M=4.692, SD=4.553), and as having a correspondingly high ADHD index in the 95th percentile (pretest M =16.769, SD=9.400). The children assigned to the control group were rated as slightly less hyperactive (92nd percentile, pretest M=2.364, SD=2.378), with a pretest mean ADHD index of 12.636 (SD=5.626), which put them in the 90th percentile.

After the psychodrama treatment, the data indicated a nonsignificant decrease in the level of hyperactivity in the psychodrama group (posttest M=3.923, SD=2.397, 96th percentile), and a slight increase in the control group (posttest M=2.636, SD=2.976, unchanged percentile), F(1,22)=.567, p=.460 (see Appendix D). The pattern continued as parents' ratings of the psychodrama group showed a similar nonsignificant decrease in the ADHD index (posttest M=15.231, SD=7.201), while the control group's

index level increased (posttest M=13.636, SD=8.078), F(1,22)=1.474, p=.238 (see Appendix D).

The second part of the fourth hypothesis predicted that maladaptive behaviours (especially oppositional behaviours) will significantly decrease in ODD adolescents exposed to psychodrama therapy, as evaluated by their teachers, compared to pre-psychodrama levels and to ODD adolescents not exposed to psychodrama. To this end, the Conners' Teacher Rating Scale - Revised: Short form (CTRS-R:S)(Conners, 1997) was employed. Table 7 contains breakdowns of the descriptive statistics for the Conners' scales for teachers.

At the start of the study, the teachers rated the psychodrama group as being in the 96th percentile (pretest M=6.077, SD=3.546) with respect to oppositional behaviour. The control group was rated as being in the 90th percentile (pretest M=2.727, SD=2.054). At the end of the study, the teachers noted a reduction in oppositional behaviour in the participants of the psychodrama group (posttest M=4.923, SD=3.427, 94th percentile). At the same time, the teachers recorded an increase in the oppositional behaviour in the control group (posttest M=4.909, SD=4.036, 94th percentile). This proved to be a

Table 7

Descriptive Statistics of Outcome Measures - Objective Reports - CTRS-R:S for Teachers

	Pretest		Posttest	
Variables	M	SD	M	SD
Oppositional*				
exp.	6.077	3.546	4.923	3.427
control	2.727	2.054	4.909	4.036
Cognitive problems/Inattention				
exp.	6.077	1.605	6.615	2.434
control	7.091	3.936	7.273	3.636
Hyperactivity				
exp.	5.846	3.848	5.692	3.351
control	4.545	4.251	5.273	4.245
ADHD Index				
exp.	15.000	5.212	15.308	4.697
control	13.636	6.265	14.727	7.016

* $p \leq .05$

significant effect for the Group by Trial interaction, $F(1,22)=11.826$, $p<.05$ (see Table 8). However, the reciprocal side illustrating the positive effects of psychodrama was revealed in these results. The control group deteriorated in a statistically significant manner, $t(10)=-3.068$, $p=.012$, while the experimental group improved nonsignificantly from a statistical viewpoint, $t(12)=1.752$, $p=.105$.

In the initial testing, teachers rated the experimental group as being in the 91st percentile with regard to cognitive and inattention difficulties

Table 8

Repeated Measures Analysis of Variance Results for CTRS-R:S (Oppositional Subscale)

Measure	Source	df	MS	F	P
Oppositional Subscale					
Between	Group	1	33.705	1.704	.205
	Error	22	19.785		
Within	Trial	1	3.148	1.123	.301
	Trial X Group	1	33.148	11.826	.002*
	Error	22	2.803		

* $p \leq .05$

(pretest M=6.077, SD=1.605). They rated the control group as being in the 92nd percentile (pretest M=7.091, SD=3.936). At the final testing, teachers reported that the cognitive and inattention problems increased both in the psychodrama group (posttest M=6.615, SD=2.434, 92nd percentile) and in the control group (posttest M=7.273, SD=3.636, unchanged percentile). The psychodrama group's problems increased by a slightly greater margin, 0.538 points, than the 0.182-point increase for the control group. The results were not significant, F(1,22)=.211, p=.650 (see Appendix E).

Teachers rated the hyperactivity level in the psychodrama group starting at a mean of 5.846 (SD=3.848), 94th percentile, and finishing at one of 5.692(SD=3.351), the same as the pretest percentile. The control group had a pretest mean of 4.545 (SD=4.251), 92nd percentile, that increased at the end (M=5.273, SD=4.245), 94th percentile. However, the results were not significant, F(1,22)=1.132, p=.299 (see Appendix E).

The teachers rated the psychodrama group as having an ADHD index in the 94th percentile (pretest M=15.000, SD=5.212) and the control group as having one in the 93rd percentile (pretest M=13.636, SD=6.265). The psychodrama group's ADHD index increased at posttest (M=15.308, SD=4.697, unchanged percentile), as

did the control group's (posttest M=14.727, SD=7.016, 94th percentile). The psychodrama group showed a smaller increase (0.308 points) compared to the control group (1.091). The results were not significant F(1,22)=.537, p=.471 (see Appendix E).

Hypothesis 4, that psychodrama would have a significant impact on maladaptive behaviours (especially oppositional behaviours), was supported by the results of both the parents' and teachers' ratings. Although there were no significant findings in the other areas of disruptive behaviour problems (hyperactivity and inattention), the study did yield statistically significant results concerning the changes in oppositional behaviours of the groups.

Summary of the Results

The purpose of this study was to examine specific effects that psychodrama therapy has on adolescents manifesting oppositional and defiant conduct problems. Three subjective dependent variables, one with two measures, were investigated by way of self-reports: 1)impulsivity (response latency and accuracy), 2)empathy, and 3)self-esteem. Objective reports were based on four areas of misconduct, as observed by parents and teachers: 1) oppositional behaviour,

2) cognitive problems/inattention, 3) hyperactivity, and 4) ADHD (DSM-IV) criteria index.

The results of the RM-ANOVAs showed the following statistically significant differences:

1. Impulsivity

Posttest improvements in latency scores on the MFFT (Kagan, 1965) were significant, and hypothesis 1 was confirmed (see Figure 1). A statistically significant Trial by Group interaction effect was found on changes in latency scores for the experimental group. In other words, the psychodrama group as a whole took more time deliberating before responding,

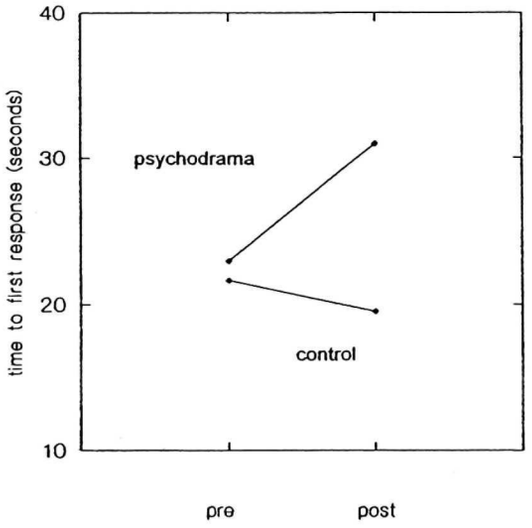

Figure 1. MFFT impulsivity (response latency) results for psychodrama and control groups at pretest and posttest.

becoming more reflective than before the treatment. The control group actually sped up its response time, making it more impulsive than when the study began.

2. Oppositional Behaviour (as observed by parents)

As predicted by part 1 of hypothesis 4, the parents' ratings of the oppositional behaviour of some of their children indeed showed statistically significant pretest-posttest improvements (see Figure 2). The experimental group improved by reducing the number of oppositional behaviours over the course of the psychodrama intervention. The control group's oppositional misconduct increased.

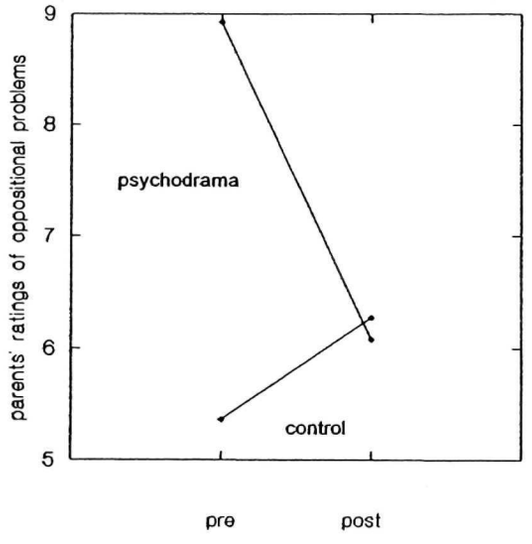

Figure 2. CPRS-R:S results of number of oppositional problems for psychodrama and control groups at pretest and posttest.

3. Oppositional Behaviour (as observed by teachers)

The teachers' ratings reflected those of the parents. Supporting part 2 of hypothesis 4, a statistically significant Trial by Group interaction effect was detected on changes in scores for the oppositional subscale on the CTRS-R:S (see Figure 3).

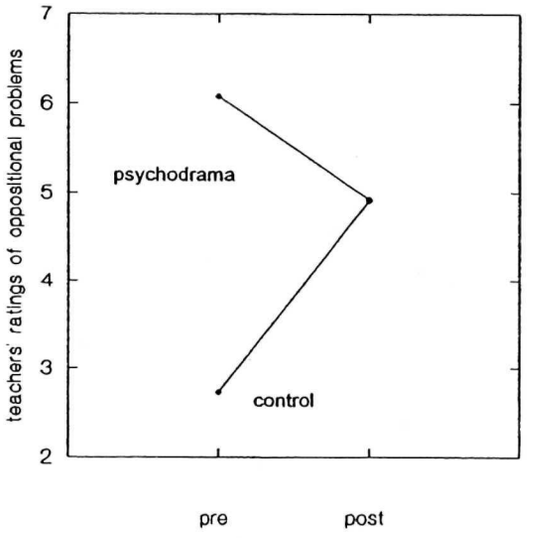

Figure 3. CTRS-R:S results of number of oppositional problems for psychodrama and control groups at pretest and posttest.

The t-tests revealed that, in this instance, the psychodrama group improved non-significantly and the control group deteriorated to a significant degree.

There was a significant effect for Trial on the error scores of the MFFT, with both groups improving at

posttest -- a practice effect, perhaps. Further analysis revealed that only the psychodrama group improved significantly.

There were no other statistically significant findings in this study. The data did not support the claim that empathy (hypothesis 2) and self-esteem (hypothesis 3) would significantly increase as a result of short-term psychodrama intervention in the case of adolescents who are oppositional and defiant. There were no statistically significant results in the objective ratings of the cognitive and inattention problems, hyperactivity levels, or ADHD indexes of these adolescents. It is not surprising that parents' and teachers' reports showed results that contradicted each other on the cognitive problems/inattention subscale because this feature of conduct problems was not directly addressed in the current study. However, there was a trend of hyperactivity in the predicted direction, by both parents' and teachers' ratings, without reaching statistical significance.

V. DISCUSSION

The purpose of this chapter is to summarize and interpret the results of the hypotheses testing and to integrate the findings with research in the field. Specifically, this chapter presents: a discussion of significant research findings and a summary of nonsignificant results, the study's contribution to research, an analysis of its theoretical and clinical implications, a description of its limitations, suggestions for future research, and, finally the study's contribution to knowledge.

Research Findings

The present study sought to investigate four hypotheses concerning treatment efficacy of psychodrama for adolescents exhibiting aggressive misconduct such as Oppositional Defiant Disorder. Three of the hypotheses concerned predicted changes in specific characteristics that constitute the cornerstone of the disorder. At the same time, problems with impulsivity, empathy, and self-esteem seemed to be fitting targets for the specific treatment being investigated -- psychodrama. The last hypothesis concerned objective ratings by parents and teachers regarding posttreatment changes in disruptive behaviour. To test these

hypotheses, quantitative analyses were applied to the scores on the tests, inventories, and rating scales administered prior to, and after, the 12-week psychodrama intervention.

The two hypotheses (1 and 4) that were supported by the data are discussed first. Hypothesis 1 predicted an improvement in the impulsivity of the participants in the experimental group. Treatment effects were determined by changes in latencies to response, and number of errors committed. The psychodrama therapy was expected to create an opportunity for the participants to adopt a more reflective conceptual tempo. This hypothesis was formed on the basis of theoretical and research literature indicating that impulsive behaviour is associated with defiant and aggressive actions (American Psychiatric Association, 1994; Kendall & Braswell, 1993; Tremblay, 2000; Zarb, 1992). Impulsivity and conduct problems co-occur at a rate greater than chance (Waschbusch, 2002).

Research has already shown that psychodrama and drama-based therapies can be effective in dealing with problems of adult aggression (Haskell, 1974; Melnick, 1984; Schramski et al., 1984). Kellermann's (1987) findings demonstrated psychodrama to be a valid alternative to other therapeutic approaches in

facilitating behaviour change with antisocial disorders. There is also research evidence that demonstrates the efficacy of drama-based therapies in treating severe adolescent aggression (Goldstein and Glick, 1987; Kendall & Brasewell, 1993; Lochman et al., 1984); Sarason & Sarason, 1981). However, research has not been conducted to examine specifically whether psychodrama is effective in improving aggressive behaviour in adolescents by reducing impulsivity.

This study found that adolescents who participated in the psychodrama therapy succeeded at significantly increasing their reaction time to the first solution hypotheses for items on the MFFT (Kagan, 1965). The experimental group's significantly longer response time was accompanied by nonsignificant lower error scores. This condition implies that it is likely that the participants in the psychodrama group learned to actively reflect over alternative solution hypotheses.

Although accuracy is part of the overall impulsivity measurement, Kagan's view is that MFFT response time is the primary and sufficient basis for measuring individual differences in reflection-impulsivity (Block, Block, & Harrington, 1974). Incidentally, an increase in latency response does not refer to delay that is the result of fear of failure, timidity, or inability to generate any solution (Kagan

& Messer, 1975). Reflection is defined as the consideration of alternative solution hypotheses (e.g., problem-solving sequences) when many are available simultaneously under conditions of response uncertainty. This is what is lacking in the aggressive adolescent who impulsively acts out, often in ambiguous situations where the intentions of the 'other' are not immediately obvious (American Psychiatric Association, 1994). This study showed that psychodrama can help the aggressive adolescent, who is often at the mercy of his or her impulses, to slow down and consider the consequences of his or her actions. In turn, by slowing down reaction time, it was predicted that oppositional and aggressive behaviours would decrease.

The correlation results did point to a connection between the positive changes in this sample in impulsivity and oppositional behavior. Impulsivity and oppositional scores were significantly associated, albeit slightly and in a descriptive manner, as were oppositional and hyperactivity scores. As well, in the RM-ANOVA results, the hyperactivity scores, although nonsignificant, seemed to reflect the improvement in impulsivity (latency) in the psychodrama group and its worsening in the control group, according to both parents and teachers. Impulsivity is a major problem, along with higher levels of inappropriate activity and

inattention, that is demonstrated by most hyperactive children. If not treated, impulsivity appears to be relatively stable in the individual, persisting into adulthood (Hetherington & Parke, 1986; Swann, Bjork, Moeller, & Dougherty, 2002).

Hypothesis 4 was supported by the data as well, in both the realms of improvement and prevention. The study demonstrated that oppositional behaviours of adolescents at home significantly decreased at the end of the psychodrama therapy, and, at school, the same group avoided a change for the worse and showed a near-statistically significant improvement. It may be that the parent and teacher results complement rather than copy each other because 'catching the kid being good' is more easily done at home than in a classroom with 25 other students.

Hypothesis 2, the expectation of an improvement in the affective empathy of the participants in the experimental group, was not supported by the data. Treatment effects were determined by changes in scores on the BEES (Mehrabian, 1996). It was predicted that, as empathy increases by way of psychodramatic techniques, aggressive behaviour would be inhibited (Mehrabian & Epstein, 1972; Weil et al., 1990). Through playing more adaptive roles, and assuming different perspectives in role reversal exercises

(e.g., the victim's perspective), adolescents who behaved aggressively were expected to acquire new, more empathic outlooks in their attempts to change the pattern of dysfunctional behaviour (Battegay, 1990; Lippe, 1992). Although there were no significant findings in the posttreatment results of the psychodrama group it did increase its empathy scores while the control group's mean decreased which reflects a trend in the hypothesized direction.

Hypothesis 3 claimed that self-esteem would be positively affected by the psychodrama intervention. By being exposed to alternative social experiences in the psychodramatic process, psychodrama was to help produce new self views and new models of identification. As self-esteem increased, so would self-acceptance and acceptance of others (Rosenberg, 1965). It was expected that empathy and self-esteem would be positively correlated, and that as aggressive adolescents would experience an increase in their self-worth because of their exposure to psychodrama, they would become less destructive because they would care more for themselves and others (Coopersmith, 1981). This finding did not emerge.

In the end, both the psychodrama group and the control group displayed nonsignificant increases in self-esteem. Perhaps the positive attention that the

entire sample received by being selected to participate in the study was sufficient to increase the evaluation that these adolescents attributed to their self-concept and self-worth. The psychodrama group ended the treatment with a larger increase than the control group; however, both groups remained in the deviant range of self-esteem, as suggested by normative comparisons.

It may be that improvements in empathy and self-esteem are more complex changes that would require more time to manifest themselves in a significant manner. Impulsivity and oppositional conduct are behaviours, whereas empathy and self-esteem are personality characteristics. Wolpe (1982) suggested that attitudes and feelings are changed by first changing behaviour. It may be that as the adolescent practices more reflective and less oppositional behaviours, consequent positive experiences -- the rewards and benefits of prosocial behaviour -- will promote significant improvements in empathy and self-esteem over time.

Finally, in this study, psychodrama did not produce significant effects on the conduct problems, other than oppositional, as measured via the Conners' Rating Scales (1997). The Conners' test is designed to tease apart overlapping disruptive behaviour disorders. In this investigation, the target item of interest on

the Conners' scale was oppositional behaviour. Cognitive/inattention problems, hyperactivity, and the ADHD index subscales, which are often part of the ODD/CD profile, were not considered primary measures of treatment efficacy. They were not hypothesized to be especially treatable by psychodrama. (Pharmacotherapy is an example of an effective treatment for ADHD and inattention problems [Hetherington & Parke, 1986].) Likewise, the students were selected specifically for their oppositional problems and not necessarily for existing comorbid disorders such as ADHD. So it is not surprising that psychodrama did not improve either participants' inattention problems or their ADHD indexes.

In conclusion, psychodrama helped the adolescents in the experimental group practice and learn to spend more time examining problems and checking various solutions before acting. The adolescents learned to attend more responsibly to external cues and guides and make decisions based on analytical examination rather than acting, as before, on any impulse. This new, more reflective style seemed to cut down on the aggressive, oppositional behaviours that were partly a function of lack of planning and impulsive thinking. According to Tremblay (2000), many, if not most, aggressive behaviours are impulsive behaviours that were not

intended. In turn, psychodrama seemed to protect the experimental group from displaying worse -- more oppositional -- behaviour in the classroom.

Contribution to Research

Children who are disruptive are often the objects of preventive and corrective interventions that are guided more by instinct than by empirically grounded knowledge. Ethical considerations would suggest that the choice of these interventions be based on evidence of their effectiveness, which can be established only by experimental processes (Tremblay, 2000). The present study contributed to empirical research on childhood conduct problems by providing experimental evidence that a treatment program, psychodrama, has had beneficial effects in treating oppositional and defiant adolescents. Furthermore, it identified an effective ingredient associated with the change: that the specific format and techniques of psychodrama have an influence in increasing the time the child takes before responding to an impulse.

Results also revealed an overall positive trend in the outcome measures. The study yielded non-statistically significant posttreatment improvements in the experimental group in empathy (an almost-significant interaction effect), and in hyperactivity

(consistent scores by parents and teachers in the hypothesized direction).

Child and adolescent group psychotherapy research is still in its infancy, and is based mostly on methodologically questionable case studies (Shechtman, 2002). This empirical study contributed to child and adolescent group psychotherapy research by demonstrating that psychodrama, a group method, is efficacious when treating a population in great need of therapy in the school -- aggressive adolescents.

Theoretical Implications

The study contributed to the Kagan (1966) argument that conceptual tempo is an important cognitive style underlying children's general behavioural differences (Egeland, Bielke, & Kendall, 1980). The data contributed to theory that links psychodrama to the treatment of adolescent aggression. As well, the results implied a link between psychodrama and the treatment of impulsivity. Furthermore, the data illustrated a connection between a reduction in impulsivity and a reduction in oppositional behaviour.

Clinical Implications

The results of this study indicated that psychodrama is an effective treatment modality for

significantly reducing impulsivity in oppositional and defiant adolescents, for significantly reducing oppositional behaviours, as observed by parents, and for significantly preventing oppositional behaviours from becoming worse, as observed by teachers. This has important implications for clinicians and educators regarding remediation procedures for children with behavioural problems. Clinicians should attempt to identify and modify levels of impulsivity when working with oppositional and defiant adolescents. Psychologists now have another tool, short-term psychodrama, when working to decrease impulsiveness and oppositional behaviour in the home.

Individual treatment of disturbed children does not help schools deal with far-reaching problems of violence (Twemlow, Fongay, & Sacco, 2001). What is especially appealing about the results of this study is that psychodrama, being a group method, is more cost-effective to administer in schools where the number of counsellors and psychologists has decreased. Currently, more child and adolescent therapy groups are needed in schools because the school is a highly suitable and effective setting for practising group work (Shechtman, 2002). School-based mental health services have been shown to be more effective than clinic or hospital-based programs (Evans, 1999). The

results of this study suggest that school clinicians should be cognizant that psychodrama is an effective group method when working with aggressive adolescents to try to ameliorate and prevent their impulsive and oppositional behaviour.

Limitations

1. The major limitation of this study is that the parents of the adolescents were not directly included in the actual treatment process. They were indirectly involved via parental reports. A growing consensus among reviewers is that to be potentially effective, treatments of conduct disorders should include work with the family (Rutter, 2000). The positive changes resulting from the psychodrama intervention might have been enhanced by concurrent parents' group psychotherapy, or family therapy.

2. This analysis used a sample of convenience, which compromises the generalizability of the results. The participants were not randomly selected from the population. However, random selection does not typify research in counselling; available samples are "good enough for our purpose" (Heppner et al., 1999, p.324). In fact, the current approach in counselling research favours field studies with actual clients (Heppner et

al., 1999). Nonetheless, this potential confound was accounted for by the use of random assignment to treatment groups, similarity of the control group, and pretest standardized mean differences (Shadish, Matt, Navarro, & Phillips, 2000).

3. The relatively small sample size compromises the generalizability of the results. The small sample size also inflates Type 2 error. In a larger-scale study, one might find more statistically significant improvements due to therapy than were found in the present study. For example, the present study, conducted with a larger sample size, might have yielded statistically significant results in empathy scores that already came very close to significance.

4. The study took place in the school attended by the participants, which may have affected their level of disclosure and participation in the psychodrama group. It is difficult to distinguish between typical adolescent resistance to disclose personal information in therapy and an actual confound of the experiment. Although confidentiality was discussed, some group members expressed a resistance to disclose certain events or details of their personal lives because they feared reprisals such as rumours. (No such incident

was ever reported.)

On the other hand, the setting contributed to the ecological validity of the study. The measures assessed the impact of change on the participants' everyday functioning in a real-world context (Kazdin & Weisz, 1998). The most valid answers to the questions how, why, and with whom are more likely to come from within the context of genuine practice, rather than from research with samples seen in laboratory conditions (Weisz, 2000).

5. The likely comorbid nature of the sample (ODD, CD, and ADHD) may have rendered it less responsive to treatment. However, screening out comorbid cases to focus on pure cases may yield results that cannot be generalized (Newman et. al.,1998).

6. The author of the study collected the data, which was scored by two graduate students. Therefore, experimenter bias was unavoidable, due to funding and time constraints. While experience suggests that no one will do the same quality of work as the researcher most directly affected, and investigators should not conduct studies in absentia (Heppner et al., 1999), future research should attempt to use different experimenters for the different levels of the

independent variables.

Future Research

Future research in this area should, as this study did, try to meet the standards set by Chambless and Hollon (1998). This study employed a group design involving random assignment, and the psychodrama sessions were directed by a licensed psychodramatist who was trained by J.L. Moreno which serves as evidence of uniform therapist training and of therapist adherence to prescribed procedures (Chambless & Hollon, 1998). Also, in this study, unmodified classical psychodrama was administered to the participants. As well, future research should select adolescents in need of therapy. Finally, future research should employ multimethod outcome assessment in the same way that this study employed multiple informants and included in one of its tests, the MFFT (Kagan, 1966), a task performance test.

The criterion delineated by Chambless and Hollon (1998) not met here was assessment of long-term outcomes beyond treatment termination. Unfortunately beyond the scope of this study, long-term outcomes should be part of future investigations on this topic. It would be valuable to collect data on a few occasions over months following treatment, to identify the

function or course of change once treatment has terminated (Kazdin & Weisz, 1998). This would validate the assumption that if ODD behaviour is treated successfully it does not develop into CD. Longitudinal studies enable the collection of data on treatment effects that take longer to manifest themselves -- for example, in personality traits such as empathy or self-esteem. Longitudinal experiments assess more adequately for a sleeper effect, where treatment children show benefits only over the course of several years as they gradually develop and apply what they learned in treatment (Weiss et al., 2000).

Although this study investigated mild aggression, future research on any treatment for aggression should include a significant long-term impact on the most socially feared form of aggression. According to Tremblay (2000), research should attempt to use physical aggression as an outcome, and target physical aggression, rather than globally defined aggression, anger control problems, or disruptive behaviour.

Future research should include studies to determine whether psychodrama outperforms other treatments for aggression. Finally, future research using psychodrama in the treatment of aggression in younger children should be conducted in order to explore a developmental perspective on its efficacy and

application.

Contribution to Knowledge

The present study is necessary and relevant because it contributes to a zeitgeist -- a recent interest in moving to more specific knowledge about child and adolescent psychotherapy by identifying concretely those techniques that have support for specific clinical problems (Kazdin & Weisz, 1998). This study contributes to establishing a basis for investigations of less conventional modes of treatment for child and adolescent aggression, such as creative arts therapies.

Specifically, the study provides data supporting the efficacy of psychodrama in the treatment of oppositional and defiant adolescents. Psychodrama helped adolescents to become more reflective. The intervention ameliorated oppositional behaviour at home and prevented oppositional behaviour from worsening at school. Furthermore, the study contributes evidence for the association between reflection-impulsivity and psychological dysfunction of the acting-out or delinquent variety (Glenwick, Croft, Barocas, & Black, 1979).

Although psychodrama was formulated over 75 years ago, it has not generated many significant predictions

about therapeutic efficacy that are amenable to empirical research (Kipper, 1997). The consensus indicates that groups for children and adolescents are effective, but this general appraisal is no longer satisfactory (Shechtman, 2002). The present empirical study validates the efficacy of psychodrama and contributes to a higher stage of knowledge, in which the question, "Which type of group is effective for which problem?" (Schechtman, 2002, p. 294) is answered when it comes to the treatment of oppositional and defiant conduct problems. After years of neglect, it is vital that the effectiveness of different modalities of child and adolescent psychotherapy continues to be the focus of considerable research.

VI. REFERENCES

Achenbach. T.M. (1995). Empirically based assessment and taxonomy: Applications to clinical research. *Psychological Assessment, 7,* 261-274.

Achenbach, T.M., & Edelbrock, C.S. (1978). The classification of child psychopathology: A review and analysis of empirical efforts. *Psychological Bulletin, 85,* 1275-1301.

Achenbach, T.M., & Edelbrock, C.S. (1986). *Teacher's Report Form.* Burlington, VT: Author.

Achenbach, T.M., McConaughty, S.H., & Howell, C.T. (1987). Child/adolescent behavioural and emotional problems: Implications of cross-informant correlations for situational specificity. *Psychological Bulletin, 101,* 213-232.

Aichhorn, A. (1935). *Wayward youth.* New York: Viking Press.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Bandura, A. (1982). Self-efficacy mechanism in human agency. *American Psychologist, 37,* 122-147.

Battegay, R. (1990). New perspectives on acting out. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 42*(4), 204-212.

Blatner, A. (1989). *Acting in.* New York, NY: Springer Publishing Co.

Blatner, A. (1997). Psychodrama: The state of the art. *The Arts in Psychotherapy, 24*(1), 23-30.

Block, J., Block, J.H., & Harrington, D.M. (1974). Some misgivings about the Matching Familiar Figures Test as a measure of reflection-impulsivity. *Developmental Psychology, 10*(5), 611-632.

Borduin, C.M., Henggeler, S.W., & Manley, C.M. (1995). Conduct and Oppositional Disorders. In Van Hasselt, V.B. & Hersen, M. (Eds.), *Handbook of adolescent psychopathology; A guide to diagnosis and treatment* (pp.349-383). Lexington Books: New York.

Boury, M., Treadwell, T., & Kumar, V.K. (2002). Integrating psychodrama and cognitive therapy - an exploratory study. *International Journal of Action Methods: Psychodrama, skill training, & role playing, 45*(1), 13-37.

Butt, D.S. (1978). Review of The Jesness Inventory. In

O.K. Buros (Ed.) *The eighth mental measurements yearbook*. Highland Park, N.J: Gryphon Press.

Campbell, S. (1974). Cognitive styles and behaviour problems of clinic boys. *Journal of Abnormal Child Psychology, 2*, 307-312.

Caron, C., & Rutter, M. (1991). Comorbidity in child psychopathology: Concepts, issues, and research strategies. *Journal of Child Psychology and Psychiatry, 32*(7), 1063-1080.

Carpenter, P., & Sandberg, S. (1985). Further psychodrama with delinquent adolescents. *Adolescence, 20*, 599-604.

Chambless, D.L., & Hollon, S.D. (1998). Defining empirically supported therapies. *Journal of Consulting and Cinical Psychology, 66*, 7-18.

Chandler, M.J. (1972). Egocentrism and antisocial behavior. The assessment and training of social perspective-taking skills. *Developmental Psychology, 10*, 546-553.

Chandler, M.J. (1974). The assessment and training of role-taking and referential communication skills in institutionalized emotionally disturbed children. *Developmental Psychology, 10*, 546-553.

Cicchetti, D., & Richters, J.E. (1993). Developmental

considerations in the investigation of conduct disorder. *Development and Psychopathology, 5,* 133-344.

Chubb, N.H., Fertman, C.I., & Ross, J.L. (1997). Adolescent self-esteem and locus of control: A longitudinal study of gender and age differences. *Adolescence, 32*(125), 113-129.

Clarke, A.R., Barry, R.J., McCarthy, R., & Selikowitz, M. (2002). Children with attention-deficit/hyperactivity disorder and comorbid oppositional defiant disorder: an EEG analysis. *Psychiatry Research, 111,* 181-190.

Cohen, R.J., Swerdlik, M.E., & Smith, D.K. (1992). *Psychological testing and assessment: An introduction to tests and measurements* (2nd ed.). Mountain View, California: Mayfield Publishing Company.

Conners, C.K. (1997). *Manual for the Conners' Rating Scale-Revised.* Toronto: Multi-Health Systems, Inc.

Cooley, C.H. (1964). *Human nature and the social order* (4th ed.). New York: Schocken Books.

Cooley, C. H. (1998). *On self and social organization* (H.J. Schubert, Ed.). Chicago: University of

Chicago Press.

Coopersmith, S. (1959). A method for determining types of self-esteem. *Journal of Abnormal and Social Psychology, 59*, 87-94.

Coopersmith, S. (1981). *The antecedents of self-esteem* (2nd ed.). Palo Alto, California: CPC, Inc.

Coopersmith, S. (1985). Coopersmith Self-Esteem Inventories. In J.D. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook*, (pp.395-398). Lincoln, NB: The Buros Institute of Mental Measurements.

Coopersmith, S. (1989). *Coopersmith Self-Esteem Inventories* (rev.). Palo Alto, CA: Consulting Psychologists Press, Inc.

Corder, B.F. (1994). *Structured adolescent psychotherapy groups*. Sarasota, Fl: Professional Resource Press.

Corder, B.F., Haizlip, D.T., Whiteside, R., & Vogel, M. (1980). Pre-therapy training for adolescents in group psychotherapy: Contract, guidelines, and pre-therapy preparations. *Adolescence, 59*, 700-706.

Cossa, M. (1992). Acting out: A pilot project in drama therapy with adolescents. *Arts in Psychotherapy,*

19(1), 53-55.

D'Amato, R.C., & Dean, R.C. (1988). Psychodrama research therapy and theory: A critical analysis of an arrested modality. *Psychology in the Schools, 25*(3), 305-314.

Dunne, P.B. (1988). Drama therapy techniques in one-to-one treatment with disturbed children and adolescents. *Arts in Psychotherapy, 15*(2), 139-149.

Egeland, B., Bielke, P. & Kendall, P.C. (1980). Achievement and adjustment correlates of the Matching Familiar Figures Test. *The Journal of School Psychology, 18*(4), 361-372.

Elkand, D. (1967). Egocentrism in adolescence. *Child Development, 38*, 1025-1034.

Elkind, D. (1974). *Children and adolescents: Interpretive essays on Jean Piaget* (2nd ed.). New York: Oxford Press.

Emunah, R. (1994). *Acting for real: drama therapy process, technique, and performance*. New York: Brunner/Mazel Publushers.

Evans, S.W. (1999). Mental health services in schools: Utilization, effectiveness, and consent. *Clinical Psychology Review, 19*(2), 165-178.

Farrington, D.P. (1993). Motivations for conduct disorder and delinquency. *Development and Psychopathology, 5*, 225-241.

Feshbach, N.D. (1975). Empathy in children: Some theoretical and empirical considerations. *The Counseling Psychologist, 5*(2), 25-30.

Feshbach, N.D. & Feshbach, S. (1969). The relationship between empathy and aggression in two age groups. *Developmental Psychology, 1*, 101-107.

Fink, S.O. (1990). Approaches to emotions in psychotherapy and theatre: Implications for drama therapy. *The Arts in Psychotherapy, 17*, 5-18.

Frick, P.J., Kamphaus, R.W., Lahey, B.B., Loeber, R., Christ, M.A., Hart, E.L., & Tannenbaum, L.E. (1991). Academic underachievement and the disruptive behavior disorders. *Journal of Consulting and Clinical Psychology, 59*, 289-294.

Fromm, E. (1947). *Man for himself*. NY: Rinehart.

Garbarino, J. (1999, December). Some kids are orchids. *Time Magazine*, p. 35.

Gérardin, P., Cohen, D., Mazet, P., & Flament, M.F. (2002). Drug treatment of conduct disorder in young people. *European Neuropsychopharmacology, 12*, 361-370.

Glaser, B.A., & Horne, A.M. (1994). A treatment program for children with conduct disorder. In C. LeCroy (Ed.), *Handbook of Child and Adolescent Treatment Manuals*. New York: Lexington Books.

Glass, G.V. & Hopkins, K.D. (1984). *Statistical methods in education and psychology* (2nd ed.). Needham Heights, Massachusetts: Alyn and Bacon.

Glenwick, D.S., Croft, R.G.F., Barocas, R., & Black, H.K. (1979). Cognitive impulsivity and social status in predelinquent preadolescent males. *Social Behavior and Personality*, 7(2), 209-215.

Goldstein, A.P., & Glick, B. (1987). *Aggression replacement training: A comprehensive intervention for aggressive youth*. Champaign, Illinois: Research Press.

Greenberg, I.A. (1974). *Psychodrama: Theory and therapy*. N.Y.: Behavioral Publications.

Haen, C., & Brannon, K. (2002). Superheroes, monsters, and babies: Roles of strength, destruction and vulnerability for emotionally disturbed boys. *The Arts in Psychotherapy, 29*, 31-40.

Hare, A.P. (1992). Moreno's sociometric study at the Hudson School for Girls. *Journal of Group*

Psychotherapy, Psychodrama, and Sociometry, 45(1), 24-39.

Harrington, R. G., (Ed.). (1986). *Testing Adolescents: A reference guide for comprehensive psychological assessments*. Kansas City: Test Corporation of America.

Haskell, M.R. (1974). The contributions of J.L. Moreno to the treatment of the offender. *Group Psychotherapy and Psychodrama, 27*(4), 147-156.

Heppner, P.P., Kivlighan, D.M., & Wampold, B.E. (1999). *Research design in counseling* (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Hetherington, E.M., & Parke, R.D. (1986). *Child psychology: A contemporary viewpoint* (3rd ed.). New York: McGraw-Hill, Inc.

Hinshaw, S.P. (2002). Preadolescent girls with attention-deficit/hyperactivity disorder: I. Background characteristics, comorbidity, cognitive and social functioning, and parenting practices. *Journal of Consulting and Clinical Psychology, 70*(5), 1086-1098.

Hogan, R. (1969). Development of an empathy scale. *Journal of Consulting and Clinical Psychology, 33*(3), 307-316.

Hogan, R. (1973) Moral conduct and moral character: A psychological perspective. *Psychological Bulletin, 79*, 217-232.

Hug, E. (1997). Current trends in psychodrama: Eclectic and analytic dimensions. *The Arts in Psychotherapy, 24*(1), 31-35.

Jesness, C. (1996). *The Jesness Inventory* (rev.). Toronto: Multi-Health Systems, Inc.

Jesness, C. (1978). The Jesness Inventory. In O.K. Buros (Ed.) *The eighth mental measurements yearbook*. Highland Park, N.J: Gryphon Press.

Jesness, C. (1972). The Jesness Inventory. In O.K. Buros (Ed.) *The seventh mental measurements yearbook*. Highland Park, N.J: Gryphon Press.

Jesness, C., & Wedge, R.F. (1984). Validity of a revised Jesness Inventory I-Level classification with delinquents. *Journal of Consulting and Clinical Psychology, 52*(6), 997-1010.

Johnson, R.W. (1998). Review of The Balanced Emotional Empathy Scale. In J.C. Conoly & J.J. Kramer (Eds.), *The thirteenth mental measurements yearbook*, (pp. 77-78). Lincoln, NB: The Buros Institute of Mental Measurements.

Kagan, J. (1965). *The Matching Familiar Figures Test.* Cambridge, Mass.: Jerome Kagan.

Kagan, J. (1966). Reflection-impulsivity: The generality and dynamic conceptual tempo. *Journal of Abnormal Psychology, 71*, 17-24.

Kagan, J. (1985). Matching Familiar Figures Test. In J. D. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook*, (pp.908-909). Lincoln, NB: The Buros Institute of Mental Measurements.

Kagan, J., & Messer, S.B. (1975). A reply to "Some Misgivings about the Matching Familiar Figures Test as a Measure of Reflection-Impulsivity". *Developmental Psychology, 11*(2), 244-248.

Kagan, J., Rossman, B.L., Day, D., Albert, J., & Philips, W. (1964). Information processing in the child: Significance of analysis and reflective attitudes. *Psychological Monographs, 78*, 1-37.

Kane, R. (1992) The potential abuses, limitations, and negative effects of classical psychodramatic techniques in group counselling. *Journal of Group Psychotherapy, Psychodrama, & Sociometry, 44*(4), 181-189.

Kazdin, A.E. (1987). Treatment of antisocial behavior in children: Current status and future directions.

Psychological Bulletin, 102, 187-203.

Kazdin, A.E. (1991). Effectiveness of psychotherapy with children and adolescents. *Journal of Consulting and Clinical Psychology, 59*(6), 785-198.

Kazdin, A.E. (1993). Treatment of conduct disorder: Progress and directions in psychotherapy research. *Development and Psychopathology, 5*, 277-310.

Kazdin, A.E. (2001). Bridging the enormous gaps of theory with therapy research and practice. *Journal of Consulting and Clinical Psychology, 31*(1), 59-66.

Kazdin, A.E., Ayers, W.A., Bass D., & Rodgers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology, 58*(6), 729-740.

Kazdin, E., & Weisz, J.R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66*(1), 16-36.

Kellerman, P.F. (1987). Outcome research in classical psychodrama. *Small Group Behavior, 18*, 459-469.

Kendall, P.C. (1993). Cognitive-behavioral therapies

with youth: Guiding theory, current status, and emerging developments. *Journal of Consulting and Clinical Psychology, 61*(2), 235-247.

Kendell, P.C., & Braswell, L. (1993). *Cognitive behavioral therapy for impulsive children.* NY: The Guilford Press.

Kendall, P.C., Reber, M., McLear, S., Epps, J., & Ronan, K.R. (1990). Cognitive-behavioral treatment of conduct-disordered children. *Cognitive Therapy and Research, 14*(3), 279-297.

Kipper, D.A. (1978). Trends in the research on the effectiveness of psychodrama: Retrospect and prospect. *Group Psychotherapy, Psychodrama and Sociometry, 31*, 5-18.

Kipper, D.A. (1992). Psychodrama: Group psychotherapy through role playing. *International Journal of Group Psychotherapy, 42*(4), 495-521.

Kipper, D.A. (1997). Classical and contemporary psychodrama: A multifaceted, action-oriented psychotherapy. *The International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing, 50*(3), 99-107.

Knittel, M. (1990). Strategies for directing psychodrama with the adolescent. *Journal of*

Group Psychotherapy, Psychodrama and Sociometry, 43(3), 116-120.

Kohlberg, L., (1969). Stage and sequence: The cognitive-developmental approach to socialization. In D.A. Gosling (Ed.), *Handbook of socialization theory and research*. Chicago: Rand McNally.

Kohlberg, L., (1976). Moral stages and moralization: The cognitive-behavioral approach. In T. Lickona (Ed.), *Moral development and behavior: Theory, research, and social issues*. New York: Holt, Rinehart, & Winston.

Lahey, B.B, Loeber, R., Burke, J., Rathouz, P.J., & McBurnett, K. (2002). Waxing and waning in concert: Dynamic comorbidity of conduct disorder with other disruptive and emotional problems over 7 years among clinic-referred boys. *Journal of Abnormal Psychology, 111*(4), 556-567.

Lambert, E.W., Wahler, R.G., Andrade, A., & Bickman, L. (2001). Looking for the disorder in Conduct Disorder. *Journal of Abnormal Psychology, 110*(1), 110-123.

Lippe, W.A. (1992). Stanislavski's affective memory as a therapeutic tool. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 45*(3),

102-111.

Lochman, J.E. (1992). Cognitive-behavioral intervention with aggressive boys: Three-year follow-up and preventive effects. *Journal of Consulting and Clinical Psychology, 60*(3), 426-432.

Lochman, J.E., Burch, P.R., Curry, J.F., & Lampron, L.B. (1984). Treatment and generalization effects of cognitive-behavioral and goal-setting interventions with aggressive boys. *Journal of Consulting and Clinical Psychology, 52*, 915-916.

Lochman, J.E., Lampron, L.B., Burch, P.R., Curry, J. F., & Lampron, L.B. (1985). Client characteristics associated with behavior change for treated and untreated aggressive boys. *Journal of Abnormal Psychology, 13*(4), 527-538.

Loeber, R., Green, S., & Lahey, B. (1990). Mental health professionals' perception on the utility of children, mothers, and teachers as informants on childhood psychopathology. *Journal of Clinical Child Psychology, 19*, 136-143.

Loeber, R., Lahey, B.B., & Thomas, C. (1991). Diagnostic conundrum of oppositional defiant disorder and conduct disorder. *Journal of*

Abnormal Psychology, 100(3), 379-390.

Lopez, F.G. (1992). Family Dynamics and Late Adolescent Identity Development. In Brown, S. D. & Lent, R. W. (Eds.), *Handbook of counseling psychology* (2nd ed., pp. 251-284). New York: John Wiley & Sons, Inc.

Marchant, G.J. & Ridenour, T.A. (1998). Review of The Inventory for Youth. In O.K. Buros (Ed.) *The thirteenth mental measurements yearbook*. Highland Park, N.J: Gryphon Press.

Mead, G.H. (1934). *Mind, self and society*. Chicago: University of Chicago Press.

Mehrabian, A. (1998). The Balanced Emotional Empathy Scale. In J.C. Conoly & J.J. Kramer (Eds.), *The thirteenth mental measurements yearbook*, (pp. 77-79). Lincoln, NB: The Buros Institute of Mental Measurements.

Mehrabian, A. (1996). *The Balanced Emotional Empathy Scale*. Monterey, CA: Author.

Mehrabian, A. & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality, 40*, 525-543.

Meichenbaum, D.H. & Goodman, J. (1971). Training impulsive children to talk to themselves: A means

of developing self-control. *Journal of Abnormal Psychology*, 77, 115-126.

Melnick, M. (1984). Skills through drama: The use of professional theatre techniques in the treatment and education of prison and ex-offender populations. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 37*(3), 104-116.

Mitchell, J.J. (1996). *Adolescent vulnerability.* Calgary: Detselig, Enterprises Ltd.

Mishne, J.M. (1986). *Clinical work with adolescents.* New York: Free Press, MacMillan Inc.

Moffett, L.A., & Bruto, L. (1990). Therapeutic theatre with personality-disordered substance abusers: Characters in search of different characters. *Arts in Psychotherapy, 17*(4), 339-348.

Moreno, J.J. (1999). Ancient sources and modern applications: The creative arts in psychodrama. *The Arts in Psychotherapy, 26*(2), 95-101.

Moreno, J.L. (1946). *Psychodrama.* New York: Beacon.

Moreno, J.L. (1963). Behavior therapy. *American Journal of Psychiatry, 120*, 194-196.

Moreno, J.L. (1972). *Psychodrama: Volume 1* (4th Edition). McLean, VA: Beacon House, Inc.

Moreno, J.L. (1993). *Who Shall Survive?* Student

Edition. McLean, VA: ASGPP

Moreno, Z.T. (1965). Psychodramatic rules, techniques and adjunctive methods. *Group Psychotherapy, 18*, 73-86.

Moreno, Z.T. (1966). Practical aspects of psychodrama. *Group Psychotherapy, 22*, 213-219.

Moreno, Z.T. (1989). Psychodrama, role theory, and the concept of the social atom. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 42*(3), 176-186.

Morgan, R.D., & Flora, D.B. (2002). Group psychotherapy with incarcerated offenders: A research synthesis. *Group Dynamics: Theory, Research, and Practice, 6*(3), 203-218.

Mulvey, E.P., & Cauffman, E. (2001). The inherent limits of predicting school violence. *American Psychologist, 56*(10), 797-802.

Nelson, W.J., & Birkimer, J.C. (1978). Role of self-instruction and self-reinforcement in the modification of impulsivity. *Journal of Consulting and Clinical Psychology, 46*, 183.

Newman, D.L., Moffitt, T.E., Caspi, A., & Silva, P.A. (1998). Comorbid mental disorders: Implications for treatment and Sample Selection. *The Journal*

of Abnormal Psychology, 107(2), 305-311.

Niec, L.N. & Russ, S.W. (2002). Children's internal representations, empathy, and fantasy play: A validity study of the SCORS-Q. *Psychological Assessment, 14*(3), 331-338.

Olweus, D. (1979). Stability of aggressive reaction patterns in males: A review. *Psychological Bulletin, 86*, 852-875.

Patterson, G.R., DeBaryshe, B.D., & Ramsey, E. (1989). A developmental perspective on antisocial behavior. *American Psychologist, 44*(2), 329-335.

Paul, G.L.(1967). Outcome research in psychotherapy. *Journal of Consulting Psychology, 31*, 109-118.

Pecukonis, E.V. (1990). A cognitive/affective empathy training program as a function of ego development in aggressive adolescent females. *Adolescence, 25*(97), 59-76.

Peterson, C. & Austin, J.T. (1985). Review of Coopersmith Self-Esteem Inventories. In J.D. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook*, (pp.396-397). Lincoln, NB: The Buros Institute of Mental Measurements.

Piaget, J. (1932). *The moral judgement of the child.* New York: Harcourt.

Quevillon, R.P., Landau, S., Apple, W.B., & Petretic-Jackson, P., (1986). Assessing adolescent conduct disorders and oppositional behaviors. In Robert G. Harrington (Ed.), *Testing adolescents: A reference guide for comprehensive psychological assessments* (pp. 263-300). Kansas City: Test Corporation of America.

Roberts, G., Schmitz, K., Pinto, J., & Cain, S. (1990). The MMPI and Jesness inventory as measures of effectiveness on an inpatient conduct disorders treatment unit. *Adolescence, 25*(100), 989-996.

Robins, L.N. (1978). Sturdy childhood predictors of adult antisocial behaviour: replications from longitudinal studies. *Psychological Medicine, 8*, 611-622.

Robins, L.N. (1991). Conduct disorder. *Journal of Child Psychology and Psychiatry, 32*, 193-212.

Robins, L.N. & Price, R.K. (1991). Adult disorders predicted by childhood conduct problems: Results from the NIMH Epidemiological Catchment Area project. *Psychiatry, 54*, 116-132.

Roe, K.V. (1980). Early empathy development in children and the subsequent internalization of moral values. *Journal of Social Psychology, 110*, 147-

148.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston: Houghton Mifflin.

Rosenberg, M. (1989). *Society and the adolescent self-image*. Middletown, CT: Wesleyan Press.

Rotenberg, M. (1974). Conceptual and methodological notes on affective and cognitive role taking (sympathy and empathy): An illustrative experiment with deliquent and nondeliquent boys. *Journal of Genetic Psychology, 125*, 177-185.

Rutter, M (2000). *Environmental influences on child psychopathology -- some challenges and some solutions*. Paper presented at Concordia University's Miriam Roland Biannual Lecture in Psychology, Montreal, Quebec.

Rutter, M., & Smith, D.J. (Eds.) (1995). *Psychosocial disorders in young people: Time trends and their causes*. W. Sussex, England: Wiley & Sons.

Saltaris, C. (2002). Psychopathy in juvenile offenders; Can temperament and attachment be considered as robust developmental precursors? *Clinical Psychology Review, 22*, 729-752.

Saltz, E., Dixon, D., & Johnson, J. (1977). Training

disadvantaged pre-schoolers in various fantasy activities: Effect on cognitive functioning and impulse control. *Child Development, 48,* 367-380.

Sarason, I.G., & Sarason, B.R. (1981). Teaching cognitive and social skills to high school students. *Journal of Consulting and Clinical Psychology, 49,* 908-918.

Sarbin, T.R. (1952). A preface to a psychological analysis of the self. *Psychological Review, 59,* 11-22.

Schramski, T.G., Feldman, C.A., Harvey, D.R., & Holiman, M. (1984). A comparative evaluation of group treatments in an adult correctional facility. *The Journal of Group Psychotherapy, Psychodrama, and Sociometry, 36*(4), 133-147.

Sewell, T.E. (1985). Review of Coopersmith Self-Esteem Inventories. In J.D. Mitchell, Jr. (Ed.), *The ninth mental measurements yearbook,* (pp.396-397). Lincoln, NB: The Buros Institute of Mental Measurements.

Shadish, W.R., Matt, G.E., Navarro, A.M, & Phillips, G. (2000). The effects of psychological therapies under clinically representative conditions: A meta-analysis. *Psychological Bulletin, 126*(4),

512-529.

Shechtman, Z. (2002). Child group psychotherapy in the school at the threshold of a new millennium. *Journal of Counseling & Development, 80*, 293-299.

Smith, D.J. (1995). Youth crime, and conduct disorders: Trend patterns, and causal explanations. In Rutter, M., & Smith, D.J. (Eds.), *Psychosocial disorders in young people: Time trends and their causes* (pp.389-489). W. Sussex, England: Wiley & Sons.

Smith, P. (1960). A factor analytical study of the self concept. *Journal of Consulting Psychology, 24*, 191.

Stallone, T.M. (1993). The effects of psychodrama on inmates within a structured residential behavior modification program. *Journal of Group Psychotherapy, Psychodrama, and Sociometry, 46*(1), 24-31.

Stevens, J. (1996). *Applied multivariate statistics for the social sciences.* New Jersey: LEA

Sturm, I.E. (1965). The behavioristic aspect of psychodrama. *Group Psychotherapy, 18*, 50-64.

Swann, A.C., Bjork, J.M., Moeller, F.G., & Dougherty, D.M. (2002). Two models of impulsivity:

Relationship to personality traits and psychopathology. *Biological Psychiatry, 51,* 988-994.

Tremblay, R.E. (2000). The development of aggressive behavior during childhood: What have we learned in the past century? *International Journal of Behavior Development, 24*(2), 129-141.

Tremblay, R.E., Vitaro, F., Bertrand, L., LeBlanc, M., Beauchesne, H., Boileau, H., & David, L. (1992). Parent and child training to prevent early onset of delinquency: The Montreal longitudinal-experimental study. In McCord, J. & Tremblay, R.E. (Eds.) *Preventing antisocial behavior: Interventions from birth through adolescence* (pp.117-139). New York: The Guilford Press.

Twemlow, S.W., Fonagy, P., & Sacco, F.C. (2001). An innovative psychodynamically influenced approach to reduce school violence. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(3), 377-379.

Urbina, S. (1998). Review of The Balanced Emotional Empathy Scale. In J.C. Conoly & J.J. Kramer (Eds.), *The thirteenth mental measurements*

yearbook, (pp. 78-79). Lincoln, NB: The Buros Institute of Mental Measurements.

Van Hasselt, V.B., & Hersen, M. (Eds.) (1995). *Handbook of Adolescent Psychopathology: A Guide to Diagnosis and Treatment*. Lexington Books: New York.

Waschbusch, D.A. (2002). A meta-analytic examination of comorbid hyperactive-impulsive-attention problems and conduct problems. *Psychological Bulletin, 128*(1), 118-150.

Webster-Stratton, C. (1991). Strategies for helping families with conduct disordered children. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 32*(7), 1047-1062.

Weil, F., Pascal, M., Kaddar, Y., & Luboshitzky, D. (1990). The place of verbal games in the framework of in-patient group psychotherapy with late adolescents. *Journal of Group Psychotherapy, Psychodrama and Sociometry, 43*(3), 128-138.

Weintraub, S.A. (1972). Review of The Jesness Inventory. In O.K. Buros (Ed.), *The seventh mental measurements yearbook*. Highland Park, N.J: Gryphon Press.

Weiss, B., Catron, T., & Harris, V. (2000). A 2-year

follow-up of the effectiveness of a traditional child psychotherapy. *Journal of Consulting and Clinical Psychology, 68*(6), 1094-1101.

Weiss, B., Catron, T., Harris, V., & Phung, T.M. (1999). The effectiveness of traditional child psychotherapy. *Journal of Consulting and Clinical Psychology, 67*(1), 82-94.

Weisz, J.R. (2000). Agenda for child and adolescent psychotherapy research: On the need to put science into practice. *Archives of General Psychiatry, 57*, 837-838.

Werry, J.S., Methven, R.J., Fitzpatrick, J., & Dixon, H. (1983). The reliability of DSM-III in children. *Journal of Abnormal Child Psychology, 11*, 341-354.

Widom, C.S. (1991). Avoidance of criminality in abused and neglected children. *Psychiatry, 54*, 162-174.

Wolpe, J. (1982). *The Practice of Behavior Therapy* (3rd ed.). New York: Pergamon Press.

Zarb, J.M. (1992). *Cognitive-behavioral assessment and therapy with adolescents*. New York: Brunner/ Mazel, Inc.

Zoccolillo, M., Pickles, A., Quinton, D., & Rutter, M.

(1992). The outcome of childhood conduct disorder: implications for defining adult personality disorder and conduct disorder. *Psychological Medicine, 22*, 971-986.

Zoccolillo, M., & Rogers, K. (1991). Characteristics and outcomes of hospitalized adolescent girls with conduct disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 30*(6), 973-981.

Appendixes

APPENDIX A

ODD and CD DSM-IV Diagnostic Criteria

Diagnostic criteria for 313.81 Oppositional Defiant Disorder (American Psychiatric Association, 1994, pp. 93-94):

A. A pattern of negativistic, hostile, and defiant behavior lasting at least 6 months, during which four (or more) of the following are present:

1) often loses temper
2) often argues with adults
3) often actively defies or refuses to comply with adults' requests or rules
4) often deliberately annoys people
5) often blames others for his or her mistakes or misbehavior
6) is often touchy or easily annoyed by others
7) is often angry and resentful
8) is often spiteful or vindictive

B) The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C) The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder

D) Criteria are not met for Conduct Disorder, and, if

the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Diagnostic criteria for 312.8 Conduct Disorder (American Psychiatric Association, 1994, pp. 90-91):

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals

1) often bullies, threatens, or intimidates others
2) often initiates physical fights
3) has used a weapon that can cause serious harms to others (e.g., a bat, brick, broken bottle, knife, gun)
4) has been physically cruel to people
5) has been physically cruel to animals
6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7) has forced someone into sexual activity

Destruction of property

8) has deliberately engaged in fire setting with the

intention of causing serious damage

9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

10) has broken into someone else's house, building, or car

11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

Serious violations of rules

13) often stays out at night despite parental prohibitions, beginning before age 13

14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

15) is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

APPENDIX B

Letters of Correspondence

Letter to Parents or Guardians

Please accept this letter as a request for your permission to allow your son/daughter, _____, to participate in a voluntary study involving psychodrama beginning February 2001. Psychodrama is a method that uses dramatic action to examine problems or issues raised in a group. The goal of the study is to help adolescents with mild conduct problems increase their self-understanding, improve relationships, and control impulsive behaviour. The study is the subject of a doctoral dissertation.

_____ will be assigned either to a 12-week, two-hour-a-week, psychodrama group, or to a waiting list group that will not participate in any therapy immediately but will be offered short-term therapy at a later date. Either way, he/she will be expected to complete four brief personality tests before the first session and after the twelfth session. You will also be required to complete a short questionnaire evaluating your child's behaviours. The results of the study, in the form of group results, will be available upon request. The psychodrama sessions will be audiotaped.

The tapes will be destroyed upon completion of the study.

Psychodrama is as risk-free as any psychotherapy. Issues that emerge during each psychodrama session should be resolved within the session. However, as a precaution, you and your child will be able to contact me and Dr. Ted Maroun at McGill University during the day for the duration of the study. Ms. Karen Allen, at the school will be associated with this project. Dr. Kathleen Myron, a psychiatrist at the Jewish General Hospital, will be 'on-call' for the duration of the study. After the study, if you and your child so want, you will be given a referral to the Adolescent Treatment Program, an excellent outpatient service at the Montreal Children's Hospital, for continued therapy.

Confidentiality will be maintained by the researcher and therapist. Please do not expect to be told anything that your child says or does during the study unless he/she is being threatened by anyone, or unless he/she expresses a threat to him/herself, or (a threat) to anyone else. Any information revealed by you or your child will not be available to anyone other than myself, Tobi Klein (psychodramatist), and Dr. Myron, without written permission.

You and your child are invited to a brief

information meeting, at your convenience, to discuss the project. If you have any questions, you may contact Karen Allen, at your school, or Dr. Ted Maroun, my supervisor at McGill University (398-2449).

Thank you for your interest in reading this letter.

_____

Sally Singal, Researcher

Consent Form for Parents or Guardians

Project Title: The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents

I have read the description of the project entitled The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents. I have understood the request for my son/daughter to participate in the study.

. I understand the purpose of the research and the conditions of participation.

. I understand that my child may withdraw from the study at any time without penalty or prejudice.

. I understand how confidentiality will be maintained during the study.

. I understand that the psychodrama sessions will be audiotaped.

I have discussed this with my son/daughter and

_____ I give permission for my son/daughter to participate

_____ I DO NOT give permission for my son/daughter to participate.

Name of Student:_____

Name of Parent of Guardian:_____

Signature of Parent or Guardian:_____

Date:_____

Letter to Participants

I would like to invite you to participate in a voluntary study involving psychodrama, beginning February 2001. Psychodrama is a method that uses dramatic action to examine problems or issues raised in a group. The goal of the study is to help adolescents with mild conduct problems increase their self-understanding, improve relationships, and control impulsive behavior. The study is the subject of a Ph.D. thesis.

You will be assigned either to a 12-week, two-hour-a-week, psychodrama group, or to a waiting list group that will not participate in any therapy immediately but will be offered short-term therapy at a later date. Either way, you will be expected to complete four short personality tests before the first session and after the twelfth session. The results of the study, in the form of group results, will be available upon request. The psychodrama sessions will be audiotaped. The tapes will be destroyed upon completion of the study.

Psychodrama is as risk-free as any psychotherapy. Issues that come up during each psychodrama session should be resolved within the session. However, as a precaution, you will be able to contact me and Dr. Ted Maroun at McGill University during the day for the

duration of the study. Ms. Karen Allen, at the school will be available for you to talk to about this project. Dr. Kathleen Myron, a psychiatrist at the Jewish General Hospital, will be 'on-call' for the duration of the study. At the end of the 12 weeks, if you want, you will be offered a referral to the Adolescent Treatment Program, an excellent outpatient service at the Montreal Children's Hospital, for more therapy.

Confidentiality will be maintained by the researcher and therapist. No one will be told what you say or do unless you are being threatened by anyone, or unless you express a threat to yourself, or (a threat) to anyone else. Any information revealed by you will not be available to anyone other than myself, Tobi Klein (psychodramatist), and Dr. Myron, without your written permission.

I would like to meet with you and your parent(s) or guardian, at your convenience, to discuss the project. If you have any questions, you may contact Karen Allen, at your school, or Dr. Ted Maroun, my supervisor at McGill University (398-2449).

Thanks for reading this letter.

_____

Sally Singal, Researcher

Consent Form for Participants

Project Title: The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents

I have read the description of the project entitled The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents. I have understood the request for my participation in the study.

. I understand the purpose of the research and the conditions of participation.

. I understand that I may withdraw from the study at any time without penalty or prejudice.

. I understand how confidentiality will be maintained during the study.

. I understand that the psychodrama sessions will be audiotaped.

I have discussed this with my parent(s) and

_____ I agree to participate

_____ I DO NOT agree to participate.

I freely consent and voluntarily agree to participate in this study.

Name of Participant:_____

Name of Parent or Guardian:_____

Signature of Participant:_____

Date:_____

Letter to Teachers

MEMO TO: Westmount High School Teachers
FROM: Sally Singal, researcher
DATE: Feb. 9, 2001

I'd like to take this opportunity to thank you for your cooperation in allowing me access to students during class time. I believe Mr. Dansereau had announced that I would be conducting a research project in the school entitled 'The Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents'. I am in the process of collecting students' self-reported data, parents' questionnaires, and I also require objective ratings from teachers. Enclosed please find the Conners' Teacher Rating Scale - Revised. Kindly complete the form and return it to the guidance department.

I am using a pretest posttest research design; therefore I'd like to be able to call on you again near the end of May, if I may. The first psychodrama group starts March 1.

Thanks for your attention to this matter.

Very truly yours,

Handout to Participants in the Psychodrama Group

HANDOUT

PSYCHODRAMA
- 'MIND IN ACTION'
- GROUP METHOD

3 PARTS
1) WARM-UP
2) ACTION
3) SHARING

5 PERSONAE
1) PROTAGONIST = THE STAR OF THE DRAMA
2) AUXILIARY EGO = SUPPORTING CAST
3) DOUBLE (STANDS BEHIND THE PROTAGONIST AND SAYS WHAT THE PROTAGONIST MAY BE THINKING AND FEELING BUT NOT SAYING)
4) DIRECTOR (THERAPIST)
5) AUDIENCE

SCENE SETTING
- HERE AND NOW (DRAMA TAKES PLACE IN THE PRESENT TENSE)
- SURPLUS REALITY (SUSPENDING REALITY)

KEY ELEMENTS IN PSYCHODRAMA
1) SPONTANEITY
   - BEING ABLE TO RESPOND IN A NEW, BETTER WAY TO A FAMILIAR SITUATION OR
   - BEING ABLE TO RESPOND IN AN ADEQUATE WAY TO A NEW SITUATION
2) CREATIVITY

SECRECY AND CONFIDENTIALITY AND RESPECT
- WHAT HAPPENS IN THE GROUP MUST REMAIN A SECRET
- DO NOT DISCUSS WHAT HAPPENS WITH ANYONE OUTSIDE THE PROGRAM
- TREAT THE GROUP WITH RESPECT
- EXPECT RESPECT FROM THE GROUP
- DO NOT DISRUPT/SPEAK WHILE SOMEONE IS PERFORMING
- FEEDBACK MUST BE CARING AND HELPFUL

APPENDIX C

Repeated Measures Analysis of Variance for Pre-, Post-Trial Changes by Treatment Group in Dependent Measures (Self-Reports)

Measure	Source	df	MS	F	P
1. Impulsivity (latency response)					
Between	Group	1	484.699	0.991	.330
	Error	22	489.345		
Within	Trial	1	104.015	2.613	.120
	Trial X Group	1	305.970	7.687	.011*
	Error	22	39.806		
Impulsivity (error)					
Between	Group	1	0.081	0.101	.753
	Error	22	0.801		
Within	Trial	1	4.097	13.218	.001*
	Trial X Group	1	0.142	0.457	.506
	Error	22	0.310		
2. Empathy					
Between	Group	1	332.623	0.180	.675
	Error	22	1847.607		
Within	Trial	1	1.606	0.005	.944
	Trial X Group	1	568.273	1.778	.196
	Error	22	319.623		

Measure	Source	df	MS	F	P
3. Self-esteem					
Between	Group	1	63.078		.736
	Error	22	541.856		
Within	Trial	1	68.560	0.654	.427
	Trial X Group	1	58.560	0.558	.463
	Error	22	104.880	39.806	

* $p \leq .05$

APPENDIX D

Repeated Measures Analysis of Variance for Pre-, Post-Trial Changes by Treatment Group in Dependent Measures (CPRS-R:S, Parents' Reports)

Measure	Source	df	MS	F	P
1. Oppositional Subscale					
Between	Group	1	33.706	1.494	0.234
	Error	22	22.558		
Within	Trial	1	11.178	1.615	0.217
	Trial X Group	1	42.012	6.069	0.022*
	Error	22	6.923		
2. Cognitive problems/Inattention Subscale					
Between	Group	1	1.206	0.028	0.869
	Error	22	43.194		
Within	Trial	1	8.888	1.527	0.230
	Trial X Group	1	0.222	0.038	0.847
	Error	22	5.822		
3. Hyperactivity Subscale					
Between	Group	1	38.846	2.202	0.153
	Error	22	16.736		
Within	Trial	1	0.654	0.123	0.729
	Trial X Group	1	3.001	0.567	0.460
	Error	22	5.296		

Measure	Source	df	MS	F	P
4. ADHD Index Subscale					
Between	Group	1	97.722	0.909	0.351
	Error	22	107.504		
Within	Trial	1	0.864	0.066	0.799
	Trial X Group	1	19.197	1.474	0.238
	Error	22	13.028		

* $p \leq .05$

APPENDIX E

Repeated Measures Analysis of Variance for Pre-, Post-Trial Changes by Treatment Group in Dependent Measures (CTRS-R:S, Teachers' Reports)

Measure	Source	df	MS	F	P
1. Oppositional Subscale					
Between	Group	1	33.705	1.704	.205
	Error	22	19.785		
Within	Trial	1	3.148	1.123	.301
	Trial X Group	1	33.148	11.826	.002*
	Error	22	2.803		
2. Cognitive problems/Inattention Subscale					
Between	Group	1	8.322	0.524	.477
	Error	22	15.894		
Within	Trial	1	1.546	0.862	.363
	Trial X Group	1	0.379	0.211	.650
	Error	22	1.792		
3. Hyperactivity Subscale					
Between	Group	1	8.816	0.309	.584
	Error	22	28.565		
Within	Trial	1	0.980	0.480	.496
	Trial X Group	1	2.313	1.132	.299
	Error	22	2.043		

Measure	Source	df	MS	F	P
4. ADHD Index Subscale					
Between	Group	1	11.259	0.177	.678
	Error	22	63.666		
Within	Trial	1	5.828	1.713	.204
	Trial X Group	1	1.828	0.537	.471
	Error	22	3.402		

* $p \leq .05$

APPENDIX F

Certificate of Ethical Acceptability

RECEIVED DEC 11 '20

MCGILL UNIVERSITY
FACULTY OF EDUCATION

CERTIFICATE OF ETHICAL ACCEPTABILITY FOR FUNDED AND NON FUNDED RESEARCH INVOLVING HUMANS

The Faculty of Education Ethics Review Committee consists of 6 members appointed by the Faculty of Education Nominating Committee, an appointed member from the community and the Associate Dean (Academic Programs, Graduate Studies and Research) who is the Chair of this Ethics Review Board .

The undersigned considered the application for certification of the ethical acceptability of the project entitled:

Title: Efficacy of Psychodrama in the Treatment of Oppositional and Defiant Adolescents (Amended research proposal)

as proposed by:

Applicant's Name: Sally Singal — Supervisor's Name: Dr. Ted Maroun, Dr. Anastassios Stavlikas

Applicant's Signature: Sally Singal — Supervisor's Signature: _____

Degree / Program / Course: PhD / Counseling Psych. / Thesis — Granting Agency: _____

The application is considered to be:

A Full Review: ✓ — An Expedited Review: _____

A Renewal for an Approved Project: _____ — A Departmental Level Review: _____ Signature of Chair / Designate

The review committee considers the research procedures and practices as explained by the applicant in this application, to be acceptable on ethical grounds.

Prof. E.A. Stringer
Department of Educational and Counselling Psychology
_____
Signature / date

4. Prof. Lise Winer
Department of Second Language Education
Lise Winer 17 Jan. 2001
Signature / date

2. Prof. John Leide
Graduate School of Library and Information Studies
John Leide 01/17
Signature / date

5. Prof. Claudia Mitchell
Department of Educational Studies
[illegible] 22 Jan 2001
Signature / date

3. Prof. René Turcotte
Department of Physical Education
René Turcotte 01/01/19
Signature / date

6. Prof. Kevin McDonough
Department of Culture and Values in Education
[illegible] 17 Jan. 01
Signature / date

7. Member of the Community W.B. Wilson
W.B. Wilson 22 Jan 2001
Signature / date

Mary H. Maguire Ph. D.
Chair of the Faculty of Education Ethics Review Committee
Associate Dean (Academic Programs, Graduate Studies and Research)
Faculty of Education, Room 230
Tels: (514) 398-7039/398-2183 Fax: (514) 398-1527

Mary Maguire
Signature / date

(Updated January 2000)