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Anticipated Consequences of Self-Disclosure During Early Therapeutic Group Development

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ABSTRACT. This study categorized types of consequences associated with communicating self-disclosure messages anticipated by therapy group members during their first group meeting. Two hundred therapy group members responded to an inventory listing undesired consequences of communicating private information about oneself in a group setting. Members responded to the inventory at the conclusion of the first group meeting. Factor analysis of their responses identified six categories of undesired consequences. Categories exhibited moderate to high internal consistency reliabilities. Potential uses of the categories in group therapy practice and research are discussed.

SELF-DISCLOSURE IN THERAPEUTIC GROUPS describes communications whereby members reveal personal and private information to others in the group (Culbert, 1968; Jourard, 1971). The exchange of appropriate personal information generally is accepted as a necessary and desirable component of successful therapeutic groups. Members who frequently communicate appropriately structured and timed disclosures tend to be perceived more positively by other group members than do infrequent disclosers (Hurley, 1967; Weigel, Dinges, Dyer, & Staumfjord, 1972; Yalom, Houts, Zimerberg, & Rand, 1967). They are also more likely to experience therapeutic outcomes (Lieberman, Yalom, & Miles, 1973; Peres, 1947; Truax & Carkhuff, 1965; Yalom, 1975).

During the initial meetings of many groups, members do not communicate substantial self-disclosure messages at therapeutically meaningful levels. Bednar, Melnick, and Kaul (1974) observed that during early

group development, the environment is characterized by low levels of cohesion and interpersonal trust. In this environment, members have not had sufficient contact with one another to enable them to predict outcomes of communicating interpersonal messages. Thus, the unpredictability of others' responses to interpersonal messages contributes to members' evaluations of self-disclosures as high-risk communications. Bednar and his colleagues asserted that members tend to avoid communicating therapeutically significant information until group cohesion has increased and others' responses to their communications become more predictable. Earlier, Yalom and his associates (Yalom, Houts, Newell, & Rand, 1967) observed that members entering psychotherapy groups often avoided communicating emotionally significant personal information because they anticipated that communicating those messages might result in undesired reactions from others. Yalom and his associates, however, also found that members communicated greater amounts of therapeutically meaningful personal and interpersonal messages when they participated in early group discussions to identify and discuss their concerns about disclosing themselves to one another.

Theories of self-disclosure in interpersonal relationships (Egan, 1970; Powell, 1971; Steele, 1975) have asserted that persons avoid disclosing personal information when they believe their disclosures may communicate undesired images or adversely affect relationships with others. Adverse outcomes of self-disclosure may include rejection by others, inability to form meaningful relationships, and loss of self-esteem and the esteem of others. Empirical investigations generally have supported these theorized relationships between avoidance of self-disclosure and anticipation of undesired interpersonal outcomes. Barrell and Jourard (1976) found that when individuals liked, and desired to be liked by, others, they tended to avoid disclosing information that might harm their relationships with those persons and subsequently lower their self-esteem. Similarly, Rosenfeld (1979) observed that individuals avoided disclosing information about themselves that they believed would adversely affect their subsequent relationships. Rosenfeld also identified certain differences between men and women in reasons for avoiding self-disclosure in relationships. Generally, men tended to avoid disclosures in order to maintain control in relationships; women avoided disclosing in order to prevent relationships from being harmed and to avoid being hurt in relationships.

It appears, then, that anticipated consequences of self-disclosure during formative meetings of therapeutic groups strongly influence the frequency and quality of those messages. Leaders who are aware of the nature of members' concerns about self-disclosure might develop interven-

tions to help members identify and process their concerns during early group developmental stages.

This study classified types of undesired consequences of self-disclosure that were anticipated by therapy group members at the conclusion of their first group meetings. The study addressed three questions: Can anticipated consequences of self-disclosure be grouped into a few descriptive categories? Do male and female group members differ in the consequences they anticipate as a result of their disclosures? and Would derived categories exhibit internal stability when administered as scales to a second sample of group members?

Method

Group Participants

Participants were 112 female and 88 male members of therapy groups at a community counseling agency associated with a midwestern state university. Forty participants were undergraduate or graduate university students; the remaining 160 participants were community residents. The student participants ranged in age from 19 to 40 years (median age: 22 years), and community participants ranged in age from 23 to 56 years (median age: 35 years). Ten participants were Black; the remaining participants were White. Nearly all of the community participants (92.5%) had completed high school, and several participants had completed baccalaureate or advanced degrees (21.8%). These participants reported primary occupations in the following categories: professional, technical, or managerial occupations (15%); service occupations (25%); clerical occupations (20%); factory/processing (15%); labor (15%); farming (5%); and unemployed (5%).

Participants joined the groups in response to advertisements in local newspapers or by referrals from community mental health agencies and therapists in private practices. One hundred persons (57 women and 43 men) participated in the first phase of the research, during which anticipated consequences of self-disclosure were categorized, using factor analysis. An additional 100 group members (55 women and 45 men) participated in the second phase of the study, conducted to assess the internal consistency reliabilities and intercorrelations of factor/categories obtained during the first phase.

Groups

Groups were offered to help participants cope with interpersonal adjustment problems related to family, social, academic, and occupational functioning. Prospective participants were interviewed by 10 doctoral

students in counseling psychology to determine their suitability for the project. Prospective members were not assigned to groups if any of the following conditions were judged to exist: disorientation with regard to time, place, or person; presence of hallucinations or delusional thinking; severe depression or suicidal ideation; inability or unwillingness to attend all scheduled group sessions; and incompatibility of therapeutic needs or expectations with the groups' purposes. In addition to the 200 persons included in the research, 11 persons were interviewed and did not meet one or more of the above criteria. Those individuals were referred for more appropriate treatments.

Groups met once a week for 2-hour sessions over a period of 10 weeks. All groups were closed to new members after the first session. Meetings were conducted according to a cognitive-behavioral model that encouraged self-awareness and personal change through interpersonal learning. Group facilitators encouraged appropriate self-disclosure and behavioral feedback exchange through direct instruction, modeling, structured activities, and interventions intended to assist members in identifying and discussing interpersonal processes underlying group interactions.

Groups were cofacilitated by doctoral students in counseling psychology who had completed an introductory course on therapeutic group leadership and had led at least one previous group of the same type.

Instrument

The instrument provided space for group members to write in a self-disclosure message that they were currently unwilling to communicate in the group. In this space, group members were instructed to complete the sentence: "If I were to communicate this information about myself now, then. . . ." Below this were listed 41 statements describing potential consequences or outcomes of communicating disclosures. These consequence statements were developed during a 2-year period preceding the study by asking members of 32 earlier therapy groups to indicate the concerns that inhibited them from self-disclosing during initial group meetings. After deleting duplications, the authors identified 41 distinct consequences. Members were asked to rate the message they had written according to the degree to which they anticipated each consequence. Ratings were made on 7-point response scales (7 = *Strongly agree*, 1 = *Strongly Disagree*). Twelve statements were positively valenced, and 29 statements were negatively valenced to reduce possible response bias.

Procedure

The experimental procedure was repeated for Phase 1 and Phase 2 of the study. During both phases, the instrument was administered by the

facilitators, using written instructions, during the final 15 minutes of each group's first session. Participants were asked to bring to mind an item of personal information they desired to communicate in the group but were unwilling to communicate at that time. They were told that their disclosures could relate to a current or past behavior, attitude, or experience, personal characteristic, or personal concern that was significant to them in either a positive or negative way. Next, participants completed the anticipated consequence form. Participants were assured that they were not required to reveal the personal information they had written on the form nor show their responses to anyone in the group.

Results

A preliminary analysis was conducted to determine whether the member-generated messages met criteria established for identifying self-disclosures. Two graduate students in educational psychology independently rated the messages on two criteria: Does the message clearly describe a behavior, attitude, experience, personal characteristic, or problem; and does the member clearly attribute the behavior, attitude, experience, personal characteristic, or problem to himself or herself. Messages were included in the analysis if both raters agreed that the inclusion criteria were satisfied. For Phase 1 of the study (factor analysis), 94 of the 100 disclosure messages (54 from women and 40 from men) were judged to satisfy both criteria. For Phase 2 of the study (reliability analysis), 96 of the 100 messages (53 from women and 43 from men) satisfied the criteria.

Phase 1: Factor Analysis

Using responses to the self-disclosure consequence form obtained from the 96 participants in Group 1, we performed factor analyses to identify categories of anticipated consequences. An initial factor analysis included the 94 male and female participants in Group 1. Next, responses of the 54 female and 40 male participants were factored separately. Each factor analysis was performed using a principle components procedure that employed iteration of the factor matrix to improve communality estimates (SPSS, Inc., 1983). Varimax rotation was used to derive terminal factor structures. Consequence statements loading at or beyond .40 on a factor were included in the interpretation of the factors.

Nine factors exhibiting eigenvalues of 1.0 or greater were obtained from the initial (unrotated) solution for all participants and for women, with a 10th factor extracted for men. Following rotation of the three initial solutions, all consequence statements loaded beyond .40 on at least one of the

first six factors, and each of the remaining factors included one or no statements loading beyond .40. The conceptualizations of relationships among consequence statements appeared to be most efficiently described by the first six factors, which were retained for further analysis.

The six factors accounted for 63.30% of the explained variance in the data for all participants (60.80% for women and 67.00% for men). Eigenvalues and proportions of explained variance associated with each factor for all Group 1 participants, women only, and men only are presented in Table 1.

Factor Descriptions

Terminal factor structures obtained for all participants and for women and men separately were nearly identical. Therefore, only results of the analysis for all participants are reported here. Table 2 presents items loading at or beyond .40 on the factors.

Two of the six factors appeared to describe anticipated consequences of an intrapersonal nature, that is, consequences arising from within disclosers. Effects on Self-Esteem/Coping Ability (Factor 1) included statements reflecting concerns that, had the disclosure actually been communicated, the discloser's self-worth would have diminished. Effects on Self-Control (Factor 5) appeared to describe concerns that communicating disclosures would result in the discloser's inability to cope with subsequent strong emotions or to control behavior.

The remaining factor/categories appeared to describe anticipated interpersonal consequences of self-disclosures. Effects on Others/Retaliation (Factor 2) appeared to reflect expectations that the disclosure would harm others, impede the progress of the group, and result in some form of retaliation by others. Effects on Relationships/Implicit Rejection

TABLE 1.—Eigenvalues (E) and Percentage of Explained Variance (PEV) of Anticipated Consequence Factors for All Participants, for Men, and for Women

	All participants		Women		Men	
Factor	E	PEV	E	PEV	E	PEV
1	12.04	29.40	12.10	29.50	12.00	29.30
2	4.83	11.80	4.82	11.80	4.82	11.80
3	3.03	7.40	2.90	7.10	3.09	7.50
4	2.83	6.90	2.82	6.90	2.82	6.90
5	1.75	4.30	1.24	3.00	2.41	5.90
6	1.43	3.50	1.02	2.50	2.30	5.60

TABLE 2.—Factor Loadings of Items, Anticipated Consequences of Self-Disclosure[a]

Item	Factor loading
Factor 1: Effects on Self-Esteem/Coping Ability	
9. I would continue to think as much of myself as a person as I did before I disclosed (reversed).	.40
14. I still would view myself as being as good a person as before I made the disclosure (reversed).	.78
18. I would have the same ability to control my actions in the group (reversed).	.42
26. I would have no more trouble living with myself after making the disclosure (reversed).	.63
30. I would be able to "hold myself together" as well as before I made the disclosure (reversed).	.40
33. My own image of myself would be poorer after I made this disclosure.	.59
34. I would begin to think of myself as a disgusting person.	.55
36. I would no longer feel able to help others in the group reach their goals.	.40
37. I would not see myself as an equal to other members anymore.	.62
Factor 2: Effects on Others/Retaliation by Others	
1. I would feel as if I had hurt the progress of the group.	.40
17. People would try to use me, to get their way later on in the group.	.48
29. I would make others in the group feel worse than they did before.	.41
32. Others in the group would be out to get me for what I said.	.72
38. Other group members would blame me for any problems with the progress of the group later on.	.69
40. The group members would decide I could not be helped.	.44
41. I would hurt the mental health of another person in the group.	.50
Factor 3: Effects on Relationships/Implicit Rejection	
1. I would feel as if I had hurt the progress of the group.	.66
2. I would not be able to form close relationships with others in the group.	.58
8. I would lose my ability to influence decisions made in the group.	.53
11. The people in the group would ignore me throughout the rest of the group meetings.	.40

TABLE 2.—(Continued)

Item	Factor loading
12. The people in the group would become afraid of me.	.45
16. I would be considered an outsider in the group by the other members.	.45
Factor 4: Attack/Explicit Rejection	
4. People in the group would still like me (reversed).	.56
11. The people in the group would ignore me throughout the rest of the group meetings.	.44
13. Others in the group would not act disgusted with me (reversed).	.40
20. No one in the group would hold what I said against me (reversed).	.46
22. People in the group would attack me with words.	.63
25. Some people in the group would not want to have anything to do with me anymore.	.60
39. I would be challenged by others in the group.	.63
Factor 5: Effects on Self-Control	
10. I would lose complete control of my emotions.	.72
15. I would start to cry and not be able to stop.	.70
19. I would become extremely angry.	.55
23. My thoughts would become very confused.	.40
30. I would be able to "hold myself together" as well as I did before my disclosure (reversed).	.40
Factor 6: Ridicule/Perceived Deviance	
5. People in the group would make fun of me.	.58
16. I would be considered an outsider in the group by the other members.	.43
24. People in the group would understand me (reversed).	.63
28. No one in the group would think I was strange (reversed).	.45
31. Others in the group would tell what I said to people who are not in the group.	.52
40. The group members would decide I could not be helped.	.40
Items Not Included on Any Factor/Category	
3. I would still feel comfortable talking in the group after this disclosure (reversed).	.21 (Factor 9)

TABLE 2.—(Continued)

Item	Factor loading
6. Others in the group would not use what I said to make me feel worse than before (reversed).	.29 (Factors 4, 6)
7. I would feel like I was going crazy.	.28 (Factor 5)
21. Someone in the group would physically attack me.	.24 (Factor 4)
27. I would become so unhappy, I might feel like harming myself.	.28 (Factor 1)
35. I would still be able to benefit from the group (reversed).	.29 (Factor 1)

[a]Computed on responses from Group 1.

(Factor 3) included statements reflecting expectations that the disclosure would result in being less able to form relationships in the group and experiencing subtle forms of rejection by others. Attack/Explicit Rejection (Factor 4) included expectations that the discloser would be verbally criticized or overtly shunned by others. Finally, the category Ridicule/Perceived Deviance reflected concerns that others would make fun of the discloser, fail to understand the disclosure, or consider the discloser to be odd or strange.

Phase 2: Category Means, Intercorrelations, and Reliabilities

Responses of the 96 group members included in Group 2 were used to compute intercorrelations among the six factor/categories for the entire sample, women only, and men only. Category intercorrelations are presented in Table 3.

Based on the responses of Group 2, internal consistency reliabilities of the six factor/categories for all participants, women, and men were computed using coefficient alpha (Cronbach, 1951). Separate independent sample t tests were used to compare mean scores obtained by men and women on each category. Mean scores for men were significantly greater than mean scores for women on Category 1 ($t = 4.82$, $p < .01$) and Category 2 ($t = 3.76$, $p < .01$). The mean score for women was significantly greater than the mean score for men on Category 5 ($t = 2.89$, $p < .01$). Observed differences between mean scores obtained by men and women on the remaining categories were nonsignificant. Category means, stan-

TABLE 3.—Category Intercorrelations for All Participants, for Men, and for Women, Anticipated Consequences of Self-Disclosure[a]

Category	1	2	3	4	5	6
All participants						
1. Effects on Self-Esteem/ Coping Ability	—	.46	.47	.42	.48	.42
2. Effects on Others/Retaliation		—	.38	.30	.38	.29
3. Effects on Relationships/ Implicit Rejection			—	.22	.39	.43
4. Attack/Explicit Rejection				—	.33	.24
5. Effects on Self-Control					—	.14
6. Ridicule/Perceived Deviance						—
Men						
1. Effects on Self-Esteem/ Coping Ability	—	.51	.44	.40	.51	.38
2. Effects on Others/Retaliation		—	.33	.27	.32	.36
3. Effects on Relationships/ Implicit Rejection			—	.25	.32	.41
4. Attack/Explicit Rejection				—	.26	.18
5. Effects on Self-Control					—	.16
6. Ridicule/Perceived Deviance						—
Women						
1. Effects on Self-Esteem Coping Ability	—	.49	.50	.44	.43	.46
2. Effects on Others/Retaliation		—	.40	.33	.32	.23
3. Effects on Relationships/ Implicit Rejection			—	.18	.35	.45
4. Attack/Explicit Rejection				—	.47	.30
5. Effects on Self-Control					—	.15
6. Ridicule/Perceived Deviance						—

[a]Computed on responses from Group 2.

dard deviations, and internal consistency coefficients for all participants, men, and women are presented in Table 4.

Discussion

Results of this study indicated that anticipated consequences of self-disclosure during early group development may be classified into internally stable categories. The observed stability of these categories and the fre-

TABLE 4.—Category Means, Standard Deviations, and Internal Consistency Reliabilities of Anticipated Consequences of Self-Disclosure

Category	Number of items	Sample			Men			Women		
		M	*SD*	α	*M*	*SD*	α	*M*	*SD*	α
1. Effects on Self-Esteem/ Coping Ability	9	24.18	13.20	.82	26.05	12.62	.78	22.66	13.47	.83
2. Effects on Others/ Retaliation	7	20.22	12.58	.81	21.59	11.69	.86	19.11	12.74	.77
3. Effects on Relationships/ Implicit Rejection	6	18.05	11.56	.72	17.87	10.79	.71	18.11	11.81	.70
4. Attack/Explicit Rejection	7	23.11	13.98	.75	24.15	13.90	.79	22.76	14.22	.70
5. Effects on Self-Control	5	12.29	7.96	.63	10.86	8.33	.60	12.77	6.84	.66
6. Ridicule/Perceived Deviance	6	20.86	10.94	.69	20.15	11.61	.66	21.09	8.95	.72

quencies with which they were reported by the respondents support earlier assertions (Yalom, Houts, Newell, & Rand, 1967) that therapy group members tend to harbor specific types of concerns about the outcomes of their interpersonal messages in the absence of factual knowledge regarding those outcomes.

Some of the six consequence factor/categories were substantially intercorrelated. In particular, the category Effects on Self-Esteem was substantially correlated with each of the four categories of anticipated interpersonal consequences. Given the strength of this factor relative to the four interpersonal factors, a possible explanation for their intercorrelations is that anticipated decreases in self-esteem are consistently associated with anticipated negative reactions to disclosures from other group members. That is, members who hesitate to communicate particular disclosures may believe that their disclosures will result in undesired responses from others, which, in turn, would cause them to devalue themselves. Although the types of interpersonal consequences anticipated may vary among members, self-devaluation may be a consistently anticipated second-order outcome. This interpretation is similar to Barrell and Jourard's (1976) observation that, as disclosers' liking for prospective recipients increases, they may fear that their disclosures will result in negative interpersonal consequences and, subsequently, a reduction in self-esteem. A similar conceptual relationship between the four interpersonal factors and the factor Effects on Self-Control is also likely.

In this study, we observed some differences between men and women in mean scores on the six anticipated consequence categories. Male group members obtained greater mean scores than female members on the categories Effects on Self-Esteem/Coping Ability and Effects on Others/Retaliation by Others. Female members obtained a greater mean score than male members did on the category Effects on Self-Control. Rosenfeld (1979) found that men who reported that they often lacked control over their disclosures avoided disclosing because they did not want their disclosures to be "used against them," whereas men who reported having control over their disclosures avoided disclosing because they did not want to hurt another person. The dimension of perceived control over disclosures was not investigated directly in this study, but it is possible that male group members who felt they had little control over their decisions to self-disclose tended to anticipate consequences involving retaliation by other group members. The men who believed they maintained control over their disclosures in their groups may have been more disposed to anticipate consequences related to the negative effects of their disclosures on others. Also, given Rosenfeld's observation on the importance to men of maintaining control in relationships, male therapy group members in this study

may have anticipated negative effects on their self-esteem as a result of losing control in relationships because of their disclosures. In contrast to Rosenfeld's findings with a general population, it appeared that the men and women in the group did not differ substantially in anticipating consequences from their disclosures on their relationships with other group members. In the groups studied in this investigation, members were overtly encouraged to develop relationships with one another as a means of achieving their therapeutic goals. Given the importance placed on developing relationships in these groups, it is likely that both men and women were particularly concerned about how their disclosures would affect those relationships.

The categories of anticipated consequences derived in this study are similar to those identified in a recent study investigating anticipated consequences of communicating corrective feedback messages during initial sessions of counseling groups (Robison, Stockton, Morran, & Uhl-Wagner, 1988). The similarity of consequence typologies is not surprising if we consider the conceptual similarity of self-disclosure and feedback. Appropriately structured behavioral feedback messages also disclose communicators' personal reactions to recipients' behaviors. Thus, feedback in a therapeutic group can be conceptualized as a specific type of self-disclosure that is communicated to effect change in recipients' behaviors.

The observed magnitudes of intercorrelations among certain categories relative to their reliabilities could be taken as a basis for justifying a further reduction of categories. We believed, however, that the amount of nonoverlapping variance among the categories was sufficient to treat them as independent types of expectations. The retention of six categories also appeared to provide more precise descriptions of concerns that inhibited members from producing therapeutically significant disclosures. By retaining more categories, we believed that they could be used more effectively to develop scientific interventions to help members discuss and evaluate specific concerns. Further research may lead to reductions or modifications of categories when applied to other types of groups and client populations.

This study was intended only to develop a general classification of consequences associated with self-disclosure and, with the exception of gender differences, did not investigate the numerous other variables that may affect members' initial expectations of consequences to their disclosures. For example, consequences anticipated by various group participants may vary according to outcomes of personal disclosures they have experienced in other contexts before joining a group, their perceptions of a group's purposes, and their initial impressions of the group therapist and other members. Moreover, anticipated consequences may vary according to the type

of disclosure communicated (i.e., behavioral, attitudinal, emotional), the immediacy of the disclosure (e.g., an event occurring in the past versus an event occurring within the group), and the discloser's feelings regarding the disclosure (e.g., disclosures about which the member has positive feelings versus those about which the member experiences negative feelings).

The categories obtained in this study have implications for future research on the functions of self-disclosure in therapeutic group development. Bednar, Melnick, and Kaul (1974) suggested that anticipated responses to interpersonal messages were largely speculative during early group development. With increased group cohesion, members can more reliably predict others' responses to their messages and associate less risk with personally significant communications. Participants in this study reported anticipated consequences of self-disclosure near the conclusion of their groups' first session, at a point when cohesion probably was at low levels and group norms governing the exchange of therapeutic communications were not well established. By assessing members' expectations about the outcomes of their personal messages at various times during group development, group leaders could assess the types and strength of emerging group norms pertaining to giving and receiving personal messages. Furthermore, the therapist could use observed changes in consequences of disclosure anticipated by members to measure indirectly the development of the group and the level of cohesion among members.

Previous research (Bednar & Battersby, 1976; Crews & Melnick, 1976; Evansen & Bednar, 1978) has indicated that leader-imposed structuring of early group activities tends to increase the frequency of therapeutically meaningful self-disclosure messages. Crews and Melnick (1976) observed, however, that, although early group structure increased therapeutic interactions, some group members reported increased anxiety. In subsequent research, Evansen and Bednar (1978) found that members disinclined to social risk taking tended to evaluate group experiences more negatively when therapeutic communications were structured. These findings may indicate that, although early group structure increases the frequencies of certain communications such as feedback, self-disclosure, and group confrontation, members less inclined toward risk maintain their concerns about undesired consequences of communicating such messages. Negative attitudes about self-disclosure may be reduced and frequency of disclosure increased by encouraging members to discuss and evaluate their concerns about undesired consequences they associate with self-disclosure. After assessing members' anticipated consequences, therapists might encourage discussion and activities to help them clarify and evaluate their specific concerns as part of structuring interventions. The effectiveness of such interventions would be evaluated by periodically measuring the frequency

and therapeutic quality of subsequent disclosures and measuring changes in members' attitudes toward disclosing in the group.

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Rematrixing an Experience with Abortion

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ABSTRACT. This paper repeats the use of reconciliation as a method for rematrixing traumatic experiences in a person's past, in this case, abortion. It describes a session in individual psychodrama in which this technique was successful and the steps taken to achieve this.

ABORTION IN BRAZIL is illegal and therefore a criminal act, although it is rarely punished. The law tends to turn a blind eye to abortions as indicated by the number of physicians who perform abortions and are rarely prosecuted. There exists a significantly high mortality rate among mothers, especially among those from the lower classes where laypeople tend to perform abortions. Brazil, considered the largest Catholic nation, has a large population of baptized Catholics who, for the most part, describe themselves as nonpracticing.

Rematrixing is a process whereby the original trauma is changed by substituting the original situation with a new one or by reframing, i.e., changing the meaning attributed to the first one. The session described in this study illustrates one form of rematrixing a traumatic experience. It is generally agreed that the original feelings of a situation are intimately tied to the experience itself. Reliving a traumatic experience provides the catharsis that elicits an abreaction that may be followed by a rematrixing.

Psychodrama is one methodology that provides a rematrixing process. It possesses a very privileged position because through the dramatizations there is the possibility of rematrixing experiences on a more concrete level.

Inner Psychodrama and the Interpolation of Resistance

Although rematrixing in psychodrama is done on a concrete level, it is also possible to do this in what is termed internal or inner psychodrama. This is a technique whereby a person relives the traumatic experience in the

mind's eye: He or she is directed to lie down on the stage and relax (exercises that will help him physically relax are very helpful), and he is directed to enact the trauma through imagery. The patient is asked to describe the details of the imaged trauma and led through the different stages of dramatization.

This technique is especially helpful in situations where living out the original traumatic experience is very difficult to do on a concrete level, such as experiences with rape, incest, violence, or sensitive issues that pertain to sexual relationships. In this manner, the patient does not feel as exposed or vulnerable as she or he would doing it in a group setting or privately at a concrete level.

Interpolation of resistance is a term used to describe the introduction of elements that did not exist, or were not apparent, in the original situation (Rojas-Bermudez, 1979). Christian inner healing often employs this technique (although it is defined in other words) by introducing the figure of Jesus to heal the original memory. In the session reported in this paper, the introduction of the mother's forgiveness was an interpolation that obviously did not exist in the original scene.

Rematrixing and Reconciliation

Our therapeutic work over the last 8 years has been guided by a proposal of repairing relationships, the technical term for what theologians tend to call reconciliation.

We believe that resolving relationships leads to greater mental health. Bustos (1979) wrote that Moreno stated that a "man without relationships does not exist." We find it important, therefore, to help people develop healthy relationships at three basic levels: with himself or herself, with his or her neighbor (interpersonal relationships), and with a Superior Being (more commonly acknowledged as God). Because it is possible to put any one of the internal images of these relationships on the psychodramatic stage, we can work on the repairing or rematrixing of any of these situations at a concrete level.

Reconciliation is one of the ways of effecting the rematrixing of a relationship. There are other forms, but this one is perhaps one of the most efficient. It provides a catharsis for the relationships and heals the memory, as well. Usually, when a person is not willing to forgive, it is because of the following:

1. He or she is not ready to do so and has not exhausted all of the feelings tied to the reliving of the experienced trauma or memory, which is necessary to help the individual complete his or her catharsis.

2. Sometimes, the individual is unconsciously tied to the other by the feeling itself. If someone forgives another, he or she will "lose" that person and lose the only tie that maintains the linkage to the other. It is usually fairly easy to identify this situation if you ask what would happen between the two if the individual decided to forgive the other. From the answer, one can perceive the direction to be taken.

3. Sometimes it is necessary to let the victim make the other one "pay" for what was done to her or him (or what that person perceives as having been harmful). Once again, the psychodramatic stage permits the individual to express vengeful feelings as a way to purge onself. After the catharsis is effected, the individual can offer forgiveness.

Case Study

In the following case study, the protagonist, Emily, demonstrates a healthier way to maintain this link instead of hanging on to the anger, resentment, or hate because these repressed feelings tend to be detrimental to the person. Emily* was 34 years old when she finally decided to approach the matter of her abortion. She had been married for several years and had two children when she found out that she was pregnant again. In a few days, she had "fixed" the pregnancy. At that time, she was already in individual psychotherapy. Because she and her husband were not getting along well, she had sought help. At the time of the abortion, she told her story as if it had happened to somebody else, and even though it was a very painful subject that was highly charged with emotion, she waited a considerable period of time until she mentioned it again.

A year and a half later, she joined a therapy group. There were two women who, a short time afterwards, became pregnant, almost simultaneously. Emily began to get nervous without any apparent reason. Things with her husband had improved remarkably, she had gone back to work at a job she really enjoyed, the children were doing fine. . . .

One day, however, she came in complaining about the children's grades and their abruptly changing behavior. "I don't understand what's happening to me—I'm always irritated with them. I don't seem to have any patience. I don't seem to be able to control myself, and I'm usually not like that."

She was not chosen to dramatize that night and asked for an individual session at the end, to try to work things out more quickly.

*This is not her real name. Other identifying traits have also been changed. We are grateful to the client for her permission to publish this story.

Before this session began, an auxiliary ego on the staff (Andre) and I commented on Emily's difficulty in handling the present situation. It was obvious that the things that were going on in her life at that time did not justify the amount of suffering that she was going through ever since her group colleagues had announced their pregnancies. Moreover, Emily had clearly stated in the last session that she could not figure out what was happening to her.

For this individual session, she arrived very nervous, almost in tears. She made some small talk and then interrupted herself, "That's not what I came here to talk about today."

We investigated a little further, looking for clues. Finally, at the end of the session, I asked her very gently, "How do you feel about your colleagues' pregnancies?"

She replied, "I don't feel good about it at all. . . . I keep remembering the abortion I had some time ago, and I feel very guilty about it. It really bothers me. I pray for the child every night."

I asked her if she would like to return and work these things out because it was obvious that she was very upset about this matter. "Maybe you have things that you would like to say to this child. Maybe you would even like to say good-bye because there was no funeral. It seems that there are a lot of loose ends. . . ."

Emily cried and agreed to return as quickly as possible. A few days later she was back. Without much ado, we began the session. Emily was extremely anxious. "This isn't something I particularly want to do, but I know that it needs to be done. I don't want to have to try to resolve this when I'm 50."

So I gave instructions. Andre would be her "baby," and Emily would have a conversation with the child on stage. She could say whatever she wanted. I explained to her that in psychodrama everything was possible, everything happened "as if it were." We could call in anyone or anything that we desired. She agreed. The two sat down on the stage, and Andre reclined in fetal position.

When Emily looked at her baby, she burst into tears. Emily sat on her legs as if she were in an upright fetal position and cried into her hands. After a few minutes, she began to talk to the baby. "I just wanted you to know that I didn't want to kill you. I just think it's awful to have to own up to it all, but I just couldn't have you at the time. My life was a mess; I wasn't getting along well with my husband. I thought we were going to wind up separating, and I just couldn't cope with it all. I guess I feel even worse because during my other pregnancies things weren't roses either. He was unemployed when I got pregnant with the second child. Even so, I never thought of doing with them what I did with you. But when you turned

up, everything was different. Things were too confused inside of myself, and everything was in disarray inside. You just didn't fit inside of me."

She continued to cry as I gently asked her to exchange roles with the baby. She took a deep breath and changed places. I took her place as Emily, and she took the role of the child. I repeated the last words of Emily's conversation.

Emily as Baby: Yes, but you didn't even give me the chances that other children have, the chance to live, to come into the world. I'm very mad at you. I didn't deserve what you did to me. . . ."

Therapist as Emily: You're right. . . . You're absolutely right, but I'm trying to explain to you what was happening to me at the time. It wouldn't have been good for you either. I can understand what you're saying to me, and I feel very guilty. I pray for you every night."

Baby: (still very angry) "What's the good of explaining all of this to me? It's not going to do me any good. It won't bring me back to life. It doesn't change anything. What do you want with me now? I can't come back!"

Emily: Well, I guess I called you here to ask you to forgive me. See if you could do that. Maybe if you could forgive me, I could live a little better, without this horrible guilty feeling. I know that it won't change anything for you; I can't undo what's been done. But it would change things for me."

Baby: (a little less angry) "Well, you're right, it won't change anything for me. Pretty sight, isn't it? You botch things up and then come running to ask for my forgiveness!"

Emily: You're right again, but still, I want you to consider it. Maybe that way, instead of being an abortion in my life, you could be the child I was unable to have, a miscarriage of sorts. We could make an agreement, a secret one: you could be my third child, the child I was unable to have. That way, instead of being a thing in my life, an abortion, you could be somebody, a person, a child. . . ."

Baby: (remains silent for a long time and then takes a deep breath) "Well, if it's going to change things for you, maybe I could forgive you. I guess it would feel a lot better to be your child than to be your abortion. (Another deep breath.) All right, all right, let's do it. I'll forgive you, what you did to me, and become a child in your life, the child you never had. Maybe that way I can at least have a mother for myself."

Stepping out of the role of Emily, I asked her to return to the original places: Andre as the baby and she as Emily. The "baby" repeated the words of forgiveness to her. Emily cried again as she heard the "child" speaking and accepted the forgiveness that was offered to her.

We finished the dramatization and shared a little about the session. When I asked Emily how she was feeling, she answered, "Well, everything is hurting a whole lot still, but I guess I'm better. I think that now I can cope with it all. I know it's still going to hurt for a while, but the worst is over."

We shared some things with her: She really had been unable to have the child, a child that "did not fit inside of her" so much so that it had resulted in the abortion. We also mentioned the importance of forgiveness in human relationships, especially with regard to situations where the guilt feelings are due to the transgression of an individual's value system, which was Emily's case. We also tied this session to the information she had earlier furnished about her past: How her mother had gotten married when she became pregnant with Emily, and how she had often suspected that her mother had made some abortion attempts at that time, which Emily's mother had always denied.

We ended the session, and, when we saw her the following week, she was significantly calmer. The children were better at home, and she looked very relieved. A few weeks later, reading over this manuscript, she mentioned, a bit awed, how much her relationship with her very difficult mother had improved after this session.

Comments

As we said earlier, it is possible in psychodrama to create situations that never existed. This is what happened in Emily's case. The therapist introduced a proposal for seeking forgiveness from the "baby" (Emily) as a way of finding out how far the reconciliation process might progress. We did not know how the baby would react—only Emily could inform us. Since the baby was willing to move toward forgiving Emily, the scene ended with Emily being able to receive the forgiveness offered to her by the child and effecting a reconciliation. It is important to note here that it is useless to try to force a reconciliation just because we think that happy endings are better. To be considered a true reconciliation, the patient must take on this option and live it out as being his or her own choice. Therefore, therapists must take special care not to lead the patient into their endings.

If the baby (Emily) had not agreed to the mother's (therapist's) proposal of forgiveness, we could have investigated and found out what the baby would have liked to have done with her mother. It is probable that she would have punished her in some way, taking advantage of the opportunity to have her revenge. Once the baby's anger had been vented, perhaps it would have been possible to propose a reconciliation: "Now that your mother has paid for what she did to you, maybe the two of you could reach some sort of agreement over the situation."

In some situations, the individual prefers not to kiss and make up. So be it. One cannot force anyone into forgiveness or reconciliation. The therapist can suggest it and bide his or her time. Usually, the suggestion will be repeated later in another form until it becomes obvious to the patient that unless he or she resolves the situation, he or she will continue to live under its torment. The patient comes to realize that the situation hurts *himself.* After that, reconciliation is usually a matter of time. The therapist, however, must respect the patient's timing and rhythm. If he or she cannot do it now, it is because he or she cannot do it now.

This case touches on a situation that deals with what we could call *true guilt* (as opposed to *false guilt*, which tends to appear with greater frequency in therapy). Paul Tournier, in his classic, *Guilt and Grace* (1985), makes a brilliant exposition about this difference and the function of each. Even Freud talked about moral guilt—those situations where an individual feels guilty because he has gone against his own values.

This situation is different from those that deal with false guilt, where a person feels guilty for things that he did not do or that had nothing to do with him. In these situations, however, once the psychodramatic situation is properly structured, the individual tends to shove the guilt out of his life and off the stage. In cases of real guilt, this is impossible because this person sincerely believes that the guilt is justified and that he or she deserves all of the suffering that the guilt is causing.

In this case, even though Emily was not an especially religious person (she had been raised a Catholic), having an abortion was something that went against her own moral code. She had only done it because of the despair in which she found herself at the time that she became pregnant. Osborne (1985) mentions the fact that in the face of true guilt, an individual will consciously or, more likely unconsciously, handle it in one of two ways—either by punishment and doing the penance necessary to make amends or by forgiveness.

Specifically in Emily's case, she felt true guilt. She felt she had done something that was morally wrong. Her guilt feelings, her irritability, her taking things out on her children were all forms of punishing herself because she did not deserve to be happy, having done such an awful thing.

Conclusion

Finally, on the matter of the abortion itself, rematrixing is not playing the Pollyanna syndrome of looking on the bright side of things. There are no arguments against facts: Once an abortion has been performed, there is little the therapist can do to change such facts. On the other hand, we do not believe in "unforgivable sins," but in the relief of real and neurotic

suffering. What is the use of maintaining a person under the burden of these feelings if there is nothing that can be done to change the past? Therein lies the importance of rematrixing: The facts cannot be changed, but their perception can be modified. In rematrixing one's past, a person can come to terms with himself, with his past, with his behavior and thereby free himself to live new and better alternatives in his life.

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Prevention of Cigarette Smoking: Effect of Information about the Negative Social Effects of Smoking

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ABSTRACT. Adolescents who are contemplating beginning to smoke may not be aware of the social disadvantages of being a smoker. It was hypothesized that adolescents, given the opportunity to learn about and experience the negative social effects of smoking, would be less likely to intend to begin smoking. Middle school students participated in a smoking prevention program using role playing of scripts dealing with the negative social effects of smoking. These intervention-group students were compared with a control group of students before the intervention, immediately following the intervention, and 5 weeks following the intervention. The students in the intervention group showed more negative beliefs about the social consequences of smoking and were less likely to plan to start smoking than the students in the control group at both immediate posttest and at the 5-week follow-up.

SMOKING IS THE MOST important preventable cause of illness and death in the United States (U.S. Department of Health, Education and Welfare, 1979). Smoking prevention programs tend to focus on young adolescents (Oei & Fea, 1987) because individuals tend to begin smoking just as they leave childhood (Barton, Chassin, Presson, & Sherman, 1982).

Smoking prevention programs with some evidence of effectiveness include health education approaches (e.g., Andrews & Hearne, 1984; Murray, Swan, & Clark, 1984) and approaches involving training in decision making and peer-pressure resistance (e.g., Schinke & Gilchrist, 1983; Worden, Flynn, Brisson, Secker-Walker, McAuliffe, & Jones, 1987). After reviewing published etiology and prevention studies, Oei and Fea (1987) concluded that anti-smoking attitudes and beliefs are important

factors in the onset of smoking, that these generally remain constant over many years, and that encouraging stronger anti-smoking attitudes among youngsters is an important part of primary prevention of smoking.

Beliefs about the social effects of smoking have rarely, if ever, been addressed in smoking prevention programs. These consequences include being less liked (Polivy, Hackett, & Bycio, 1979), being perceived as not "socially OK" (O'Rourke, Smith, & Nolte, 1984), being less desired as a friend (Barton et al., 1982), being disfavored for dating and marriage (Malouff, Schutte, & Kenyon, 1988), and being less likely to be hired to work (Weis & Fleenor, 1981).

Malouff et al. (1988) found that college students rated their own social preference for nonsmokers significantly higher than the preference they thought people generally have. Hence, they appeared to underrate the actual social disadvantage of being a smoker. Young people who are considering whether to start smoking may be even less knowledgeable about the social disadvantages of being a smoker. In fact, Pederson and Lefcoe (1985) and Bloom and Greenwald (1984) found that young smokers tend to believe that smoking helps them socially.

We therefore hypothesized that attitudes against beginning to smoke could be strengthened by providing young adolescents with information about the negative social consequences of smoking. We chose young adolescents because they are at a prime age for beginning to smoke and because they appear to be very socially conscious (Barton et al., 1982).

The intervention included discussion and didactic psychodrama (Moreno, 1969) in the form of role-playing scripts dealing with the negative social effects of smoking. Role playing was included because it is unusual and arousing for children and should therefore tend to be remembered (Deffenbacher, 1983; Pillemer, 1984) and because it has been shown to lead to changes in cognitions and behavior (Irwin, Levy, & Shapiro, 1973; Janis & King, 1969), including smoking behavior (Mann, 1967; Mann & Janis, 1968).

Method

Subjects

The 102 subjects included 16 fifth graders, 24 sixth graders, 33 seventh graders, and 29 eighth graders. The 45 male and 57 female subjects had a total mean age of 12.27 years, $SD = 1.17$.

Procedure

Subjects in the four grades were randomly assigned by class to either an intervention group or a control group. Subjects in Grades 5 and 8 were as-

signed to the intervention condition; subjects in Grades 6 and 7 were assigned to the control group.

Subjects in both conditions completed all four measures just before the intervention began and 6 weeks later. At the end of the intervention, all subjects also completed three scales: the social consequences of smoking, personal preference for smokers, and the intention to smoke.

Intervention

Subjects in the intervention condition participated in discussion and a brief psychodrama regarding the social effects of smoking. The usual classroom teacher led the intervention according to a manual provided by the researchers.

The teacher began the intervention by reading a description of the negative social effects one smoker experienced before he quit. The teacher then stated some of the negative social consequences found by prior research: smokers tend to be liked less and to be disfavored for friendship, dating, marriage, and employment for a variety of reasons. Next, the teacher passed out three-person role-playing scripts relating to the social effects of smoking. The students took about 15 minutes to rehearse their roles. The scripts were designed to capture the interest of young teen-agers; they focused on the possible negative effects of smoking on friendship, dating, and employment. The entire session took 45 minutes.

On the following day, the subjects acted out the scripts in front of the class. The subjects then discussed the role plays and the social effects of smoking. This session lasted 45 minutes.

Subjects in the control group did not participate in any intervention regarding smoking. It is possible, however, that they learned from intervention-group subjects some of the material covered in the intervention.

Measures

The Social Consequences of Smoking Scale was developed by the researchers on the basis of prior research findings, mentioned previously, which showed that nonsmokers tend to be liked more and to be favored with regard to dating, marriage, and employee selection. The scale contains 10 items about the extent to which the respondent perceives a preference by others in these regards. The scale consists of items such as "Most people want to date smokers." Subjects used a 5-point scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*) to express how much they agreed with the items. Scores can range from 10 to 50, with high scores indicating the strong view that smoking has negative social consequences. The scale

had adequate reliability for research purposes, as shown by Cronbach's alpha, which was .85 (N = 98) at pretest.

The six-item intention to smoke scale was previously found by Barton, Chassin, Presson, and Sherman (1982) to have adequate reliability for research purposes. For each of the six items, respondents express how much they agree with a statement of whether they intend to smoke at a certain time in the future. Scale scores can range from 6 to 30, with higher scale scores indicating a stronger disinclination to smoke in the future. The smoking-behavior item, based on an item developed by Barton et al. (1982), asks respondents to state whether they smoke more than once a week.

Results

An analysis of variance showed that there were no significant differences between the two conditions with regard to sex, age, or pre-intervention scores on any of the three outcome measures.

Pearson correlation coefficients showed a significant correlation between beliefs about smoking and intention to smoke at all three assessment times. At pre-assessment, it was $r(96) = .35$, $p < .0001$; at posttest, it was $r(84) = .31$, $p < .002$; and at follow-up, it was $r(84) = .54$, $p < .0001$.

Examination of subject responses on the smoking behavior item at pretest showed that only one of the subjects was smoking at the time. Because of the statistical impossibility of showing a significant group decrease in smoking after the intervention, this variable was abandoned. The other two variables, beliefs about smoking and intention to start smoking, showed adequate variance at pretest, although there was somewhat of a ceiling effect with regard to intentions in that the subjects generally expressed a strong inclination not to start smoking.

In order to determine whether the intervention changed beliefs about the social effects of smoking, the two conditions were compared with regard to changes in their beliefs. A 2 × 3 (Condition × Test: pre-, post-, and 5-week follow-up) repeated measures ANOVA on social consequences of smoking scores showed a significant interaction between conditions and repeated measures, $F(2, 66) = 6.18$, $p < .003$, suggesting that the intervention changed beliefs about the social effects of smoking.

The mean scores for the intervention and control groups showed that the intervention subjects, relative to the control subjects, came to believe more strongly in the negative social effects of smoking after the intervention and maintained their stronger beliefs throughout the 5-week follow-up. The means for the intervention group were 38.91, SD = 5.79, (N = 45) at pretest; 42.19, SD = 5.85 (N = 39) at posttest; and 41.23, SD =

6.19 (N = 39) at 5-week follow-up. The means for the control group were 39.06, SD = 6.00 (N = 53) at pretest; 39.40, SD = 7.03 (N = 42) at posttest; and 36.40, SD = 8.72 (N = 47) at 5-week follow-up.

In order to determine whether the intervention affected intention to smoke, a 2 × 3 (Condition × Test) repeated measures ANOVA was done on intention to smoke scores. The analysis showed a significant interaction between conditions and repeated measures, $F(2, 69) = 3.59$, $p < .03$.

The mean scores for the intervention and control groups showed that the intervention subjects maintained their initially high disinclination to start smoking throughout the 5-week follow-up. The control subjects, however, showed a decrease in their initially high disinclination to start smoking. The means for the intervention group were 25.82, SD = 4.59 (N = 44) at pretest; 25.15, SD = 5.68 (N = 44) at posttest; and 25.82, SD = 4.76 (N = 39) at 5-week follow-up. The means for the control group were 26.55, SD = 5.09 (N = 51) at pretest; 24.05, SD = 6.00 (N = 43) at posttest; and 23.09, SD = 6.77 (N = 6.77) at follow-up.

Unbeknownst to the researchers, the fifth-grade class also participated during the time of the intervention in a presentation by the American Lung Association that included information on the physiological effects of smoking. In order to assess whether that influenced the subjects, the fifth- and eighth-grade classes were compared with regard to changes on the belief and intention measures. There were no significant differences between the two classes.

Discussion

The study provided evidence that information about the possible negative social consequences of smoking leads to a change in beliefs about the consequences of smoking among young adolescents. Information about the social consequences of smoking also seems to make it less likely that young teens will plan to start smoking. These findings, along with the consistently significant correlation between the belief that smoking leads to negative social consequences and lessened intention to smoke, support the conclusion of Oei and Fea (1987) that beliefs about smoking are one of the factors that influence the decision to smoke.

Because adolescents tend to have inaccurate perceptions of the consequences of smoking (Bloom & Greenwald, 1984; Malouff et al., 1988; Pederson & Lefcoe, 1985) and because they are quite concerned about their social standing (Barton et al., 1982), an approach such as the one described in this study might be an effective component in smoking prevention programs.

The results of the present experiment should be interpreted cautiously, however, because of certain methodological limitations. First, subjects were used as the unit of analysis, although random assignment was of classes. The generalizeability of the findings, therefore, may be limited (Murray et al., 1987). Hence, the need for replication of the findings is greater here than with studies that use dozens of classes.

Second, the intervention appeared to prevent an increase in inclination to smoke in the experimental group, such as that experienced by subjects in the control group. There was, however, no evidence of a significant decrease in inclination to smoke among subjects in the experimental group. That might be due to a ceiling effect in that, prior to the intervention, subjects in both groups generally expressed a strong disinclination to start smoking.

Third, there were not enough smokers among the subjects for it to be statistically possible to demonstrate an effect on smoking behavior, in addition to smoking attitudes. Attitudes do predict behavior (Fishbein & Ajzen, 1975), including starting to smoke (Oei & Fea, 1987), but it is not known to what extent the changes in belief and intention produced by the intervention will lead to an actual change in future smoking behavior.

Fourth, the physical health education program provided to the fifth-grade subjects at about the same time as the social-consequences intervention may have had some effect on the subjects' attitudes toward smoking. A comparison of their attitude outcomes, however, with those of the other intervention class, the eighth graders, provided no evidence of that.

Future research could build on the present findings by examining (a) the long-term efficacy of a similar intervention with other children and (b) the importance of the didactic-psychodrama component of the intervention.

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Improving Oral Exams— An Application of Morenean Sociometry

RORY REMER

ABSTRACT. Oral examinations of various types are part of many training programs, as well as other life situations (e.g., job interviews). Usually, assumptions are made about orals that are more consistent with their being seen as psychometric procedures. Because of their essential interactive nature, however, such examinations also have sociometric aspects. In this article, the problems and ambiguities caused by the conflicting demands of psychometric and sociometric procedures are discussed. On the basis of the analysis, conclusions and recommendations regarding future use of oral examination procedures are offered.

ALTHOUGH ORAL EXAMINATIONS are usually thought of as academic exercises, many other situations could be termed oral examinations. In addition to the traditional oral situations, such as doctoral dissertation defenses or class examinations and presentations, presentations at conferences, to business associates, and at case conferences, as well as panel interviews where a group questions an individual and instances where factual information is presented and the presenter questioned fall into this category. Oral examinations, in this general sense, are much more common than we generally recognize.

Given the prevalence of these generic oral examinations, it is interesting to note that so little has been written about them. A review of three of the main social science data bases—Psychological Abstracts, ERIC, and Business Abstracts—for the last 10 years revealed only a few articles that were even tangentially related to the topic (Birkel, 1981; Crawford, 1984; Hare, 1985; Ingenkamp & Wolf, 1982; Maag, 1980; Sawa, 1986; Schechtman, 1983; Watson, 1984; Yang & Laube, 1983) and only one comprehensive treatment (Aiken, 1979) that pertained directly to the oral examination situation.

Aiken (1979), in his review of literature over the last 20 years dealing with the oral examination, indicated that the oral examination is not held

in very high esteem by either American students or instructors and is viewed "as anachronistic and to some extent pro forma" (p. 1). Although it is acknowledged that the oral examination produces results different from, and in some ways often more informative than, written measures (Aiken, 1979), most articles focused on the failings of and problems with the oral examination process, particularly their "inefficiency and subjectivity" (Crowl & McGinitie, 1974; Platt, 1961). If viewed differently, however, the oral examination not only can be strengthened with regard to its ostensible primary purpose, the testing of the examinee's command of a knowledge area, but also can be used to enhance the examinees' effective use of information.

The present discussion will focus on improving the oral examination by delineating, emphasizing, and enhancing the positive aspects inherent in oral examination situations. The Morenean conceptualization of sociometry will be used as the basis for this exploration because of its unique relevance and utility, an applicability not generally known or recognized.

What Makes Oral Examinations Different? Interpersonal Dynamics

The major criticisms leveled at oral examinations focus on their lack of psychometric rigor. Students feel that the examinations are unfair measures of subject matter, knowledge, and understanding; professionals fault them for their lack of objectivity, reliability, and validity (Aiken, 1979). Accordingly, most efforts at improvement (e.g., Yang & Laube, 1983) are geared toward enhancing the psychometric properties.

The advantages of oral examinations are their potential breadth and flexibility—the interactive social situation they provide (Aiken, 1979), the communication and social interaction (Peterson, 1974), and the possibility of asking for explanation, defense, or elaboration of answers (Glovrozov, 1974; Platt, 1961). These advantages, however, tend to be vague qualities and seem to be disquieting to most psychometric practitioners, most of whose efforts toward improvement of oral tests are focused on eliminating these very advantages (e.g., Deitz, 1961; Green, 1975; Guerra, Abramson & Newmark, 1964).

From a psychometric perspective, these strengths are, in fact, weaknesses. The interactive, group dynamic aspect leads to subjectivity, less reliability, and thus, in a psychometric sense, less validity. The goal, therefore, has been to make oral examinations comparable to written examinations. Doing so, however, fails to recognize that the two types of examinations measure different aspects of performance (Aiken, 1979). What is being suggested here is that these two aspects—the psychometric and the interactive—be distinguished. An attempt must be made to enhance both, if

possible, or separate them so they will not engender confounding if total separation is not possible.

Sociometry, the Forgotten Component

Oral examinations are, perforce, exercises in group dynamics because of their interactive nature. This group dynamic aspect was labeled sociometry by Moreno (1951, 1953, 1985), who developed specific terminology for discussing the theory involved and dealt extensively with methods for enhancing the chances of reaching the positive sociometric goals. His focus was on assessing and increasing the spontaneity in such situations. He defined spontaneity specifically as the production of an adequate response in a novel situation or a creative response in an old situation. This definition coincides well with the advantages that are sought from oral examinations. The essence of spontaneity is not only the demonstration of having knowledge but also the demonstration of recognizing its appropriate application.

Spontaneity is not, however, a unitary construct. Spontaneity is a process that combines the use of knowledge, as a base, with innate interpersonal communication ability, developed skills at assessment, and attention to group interaction. The knowledge base is termed *conserves*; the innate communication is called *tele*; and aspect of group interaction is called *sociometry*. The complex interplay of these different factors can create confusion and inconsistency in an oral examination situation, but they also produce the sense of depth and reality—the mercurial essense of approximating true-life situations that the oral examination is designed to capture.

Although efforts at standardizing oral examinations stress the attempt to distill the psychometric aspect, the sociometric components are neglected. Oral examinations are not only tests of knowledge but also role tests (ways to assess the ability to perceive roles accurately and to act within them appropriately), spontaneity tests (methods for judging conserve acquisition and their flexible application), and sociometric tests (procedures to measure and employ the affinities that are developed and that change between members of a group) (Moreno, 1951, 1953, 1985). To use oral examinations effectively, examiners must address their multidimensional nature. The sociometric aspects cannot be ignored but must be recognized, dealt with, and, if possible, enhanced.

How to Improve Orals: Discussion and Suggestions

Although, as already noted, most efforts toward improving oral tests have been aimed at structuring them to approximate written examinations, some authors have offered other suggestions. Suchman (1966) and Taba

(1967) have developed methods to aid examiners in probing a student's knowledge and understanding. Hitchman (1964) attacks what is perceived as the primary problem, the examiners. Still, these efforts are focused on the psychometric component.

Although Hitchman (1964) may have correctly identified the focal point, he has missed the appropriate direction for change. The goal should not be to turn examiners into machines but to capitalize on the unique advantages inherent only through spontaneous social interaction.

Aiken (1979) reported successfully improving effectiveness of oral examinations by recognizing the mixed feelings and apprehension of students and by making special efforts to establish rapport with examinees. He also suggested eliminating "evaluators' favoritism and other subjective influences." No assistance is offered regarding how to attain these aims, however. These observations and suggestions again point to sociometric aspects being the key to improving oral tests.

Moreno (1951, 1953, 1985) provides an extensive exposition of sociometric theory, much of which is relevant to the present problem. The theory, better recognized through one of its components, psychodrama, was developed specifically to address interpersonal, group dynamics. Sociometric theory provides just the approach required at present. The term sociometric theory is employed here, rather than Moreno's term sociometry, because sociometry has become defined as "measuring the social affinities in a group." While Moreno's conceptualization includes this aspect, sociometric theory goes beyond simply measuring to suggest methods for using such information.

This distinction between Moreno's conceptualization of sociometry and the popular definition is important. Failing to acknowledge the more general, subsuming nature of Moreno's original view leads to needless limitation and consequent diminution of its power, at least in the present instance. For example, in the confined usage, sociometric questions (of choice) must always be stated in the future tense (Hart, 1980). Also, for full impact, the choices must always be implemented (Moreno, 1953). Meeting these requirements is neither possible nor necessary, if they were to be applied to generic oral examinations. In a broader tense, the sociometry of a group, like any other existential phenomenon, can exist only in the present, the here-and-now, because tele is an existential phenomenon. The existential perspective is more applicable and helpful in the present case.

The first step in applying sociometric theory is deciding or delineating what the goal or goals of the examination are, that is, what is to be accomplished. Based on this preliminary analysis, the situation can be structured accordingly, separating the various aspects as much as possible to ensure that there will be no confusion. The chances for preventing difficulties are

better if all those involved understand the expectations, criteria for evaluation, the methods for conducting the examination, the amount of emphasis being given to different components of the examination, and any other similar factors effecting the outcome. Preventing problems is more likely to produce adequate results than any attempts at remediating the problems after they occur.

To assess and weigh the different components of an oral test, these must be recognized and their influences acknowledged. Three of the components of Morenean sociometry—role theory, sociometric theory, and psychodramatic theory—can be employed to accomplish these ends. Role theory provides a framework to examine the reciprocal interactions and expectations stereotypically assigned to participants in the specific situation; sociometric theory aids in recognizing and adjusting for the affinities participants engender in each other; and psychodramatic theory helps in optimizing the process of interpersonal interactions (enactments). The techniques developed in each of these three areas can be employed to promote the positive social interactions indicated by Aiken (1979), Peterson (1974), and others as the reasons for conducting oral examinations.

Foremost, the sociometric approach highlights group dynamics. Concentrating on either the examinee or the evaluators (examiners), although perhaps helpful, misses the most important difference between oral examinations and written tests, that is, the outcomes of oral examinations are the product of interpersonal interaction. Sociometric techniques emphasize heightening the spontaneity of *all* group members by influencing their warm-ups (mental, physical, social preparations for interacting).

"Basic sociometric procedure depends upon the methods of creating the motivation to more adequate participation . . . the project becomes a cooperative effort. . . . Because the method is giving full consideration to the nature of the warming up process of human beings it is able to elicit the maximum spontaneity and cooperation of the participating subjects" (Moreno, 1951, p. 20 ff).

Moreno (1951) expounds on a number of general principles that can serve as guidelines for structuring sociometric procedures or for promoting group dynamics. Applying these principles to an oral test situation produces the following suggestions:

1. All those involved should be motivated to take the oral as seriously as the examinee does.
2. The examination should take precedence over other demands on the examiners, as well as the examinee.
3. A structure/schedule should be established and maintained so that the warming-up process will not be unnecessarily interrupted.

4. The first part of the examination process should address the techniques used for the group's warm-up.
   a. The start of the process should be clearly indicated
   b. Everyone present should be involved, and everyone to be involved present
   c. The specific criteria to be employed for evaluation should be stated and, if necessary, negotiated
   d. The secret and official needs of the group should be made overt and reconciled, if at all possible
   e. The private and collective aspirations of all involved (e.g., any distractions drawing energy from attending to the situation at hand) should be made manifest and dealt with.
5. If there is any doubt that the warming-up process is inadequate, perhaps because it was disrupted, the doubt should be voiced.
6. In the case of some problem, the examination should be continued only if all judge there is a reasonable chance the process can be adequately re-engaged. This should be a group responsibility.
7. The focus should not be on the examinee alone but on the sociometry and process of the entire group.
8. Every attempt should be made to help the group overcome or use their conserves (preconceptions, predispositions) regarding how an examination should be conducted constructively.
9. The opportunity for all members of the committee as well as the examinee to share reactions and give and obtain/feedback should be provided, inducing an optimal learning experience for all involved *in situ*.
10. The closure should receive equal stress with other aspects of the process.
11. Contradictory evidence (e.g., observations made in other, perhaps more representative, situations) should be examined, weighted, and incorporated.
12. Enough time and resources should be allotted to ensure the process eventuates in its totality.

Although being future-oriented (in the sense of structuring the group sociometry ahead of time through sociometric choice/assessment) would certainly help, it is usually not feasible. Not only are committees normally constituted without regard to sociometric criteria, but also the sociometry of the group changes over time. The suggestions presented here are geared more toward dealing directly with the sociometry *in situ* because they delineate the parameters of the situation to produce spontaneity.

Conclusion

Oral examinations are not purely psychometric procedures, nor are they intended to be. Acknowledging, addressing, and even expanding on the advantages of generic oral testing situations can make them an effective tool. (Or, more accurately, because they incorporate different types of sociometric procedures for various goals, they can be tools.)

Recognizing this potential will not be easy. In reality, the general guidelines for sociometric procedures and the suggestions adapted from them, specifically aimed at oral examinations, are virtually inapplicable in an absolute sense. Given the circumstances in which many oral tests are used (e.g., 10-minute presentations at professional meetings), the recommendations are impractical and unrealistic. As ideals, however, they represent excellent goals. The closer we can come to implementing them, the more productive and comfortable the oral examination process will be for all concerned.

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BRIEF REPORT

Note on Some Forms of Resistance to Psychodrama

ZERKA T. MORENO

A number of us who work in institutional settings, regardless of philosophy of therapy, encounter resistance from staff members, most frequently nurses, who are disturbed by the fact that patients often seem disequilibrated after having been in a psychodrama. The psychodrama therapist may be met with questions such as: "What have you done to my patient?" or "Why are the patients so often upset when they come out of their psychodrama sessions?"

It strikes me as incumbent upon us to educate other staff members about the effects psychodrama may have upon patients, which are noticeable afterwards. The anxiety that their state arouses is not merely malicious; the nonparticipating staff member may not be aware of the implications of treatment. The patient may still be in what I have come to describe as the "recovery room." The simplest way to clarify their state is to let the anxious staff member know that psychodrama is deep surgery of an emotional nature. They are familiar with the recovery room after surgical procedures to patients. Tender, loving, and highly individualized care is given there. Is the mind less sacrosanct than the body? Merely because emotional states are not as evident as physical ones make them no less valid. The best way to handle the recovery period is by gentle, loving attention. Above all, the upheaval should not be handled by tranquilizing or administering other drug approaches; it must be allowed to be worked through and integrated. Also, the patient should not be scolded for what may appear to be even outrageous behavior to an objective observer, but rather he should be gently guided into a more stable mood. A delicate approach is called for. Soft words may take away wrath.

Another form of resistance may be met in the psychodrama session itself, this time on the part of the protagonist. Most often, it involves the patient's resistance to taking the role of the other with whom the protagonist is in conflict. This may appear to be a sociometric rejection. Actually, it is more than that and, from the point of view of psychodynamics, it is a good diagnostic clue. It means that the pain caused by the other has not yet healed. The protagonist needs more work in order to be purged of

that particular hurt. Humans cannot give up what they do not own. The indication is, therefore, for the protagonist to work more on the conflict. The self has to be intact before it can yield itself to others in role reversal.

The absent other will have to be portrayed by an auxiliary ego, even if the portrayal is based on little or no information. Role reversal for specific needs, such as for correction of perception and portrayal, may be possible by the protagonist for brief moments. Sometimes the auxiliary ego is not sufficiently aware of the amount of pain that person being portrayed has placed on the protagonist or in what manner it was inflicted. Once the protagonist has made this clear, in role reversal, the action can continue with the protagonist, back in role, working through whatever material is brought to light.

The protagonist requires validation in every respect. Validation comes before resolution.

Let me illustrate this by an experience of my own while in training. I was going to work on a scene with my mother when I was 3 years old. Although I had shown my mother as a tough lady to deal with even for an adult, the auxiliary ego was much too gentle in her interaction with me. I fell out of my role and began to laugh at the very point where, in life itself, I had begun to cry. When the director asked me what was happening, I replied: "If my mother had been like this, I would not now have to do this scene." I then role reversed and corrected and resumed my own role.

It is true that I did not reject taking my mother's role; the auxiliary ego perceived it as pejorative and, because she liked me, wanted to be kind to me. That was not only a bad start, it was not really kindness because it took the wind out of my sails. I certainly would have rejected taking my mother's role in the form in which it was being enacted. There again, the validation of my perception and experience had to be completed before I could deal with the hurt in an integrative manner.

The psychodrama must never be less intense than life itself. We need to enlarge the experience if catharsis is to take place; therefore, wholehearted validation must be our first concern.

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RESEARCH REPORT

Role-Playing Interviews and Self-Regulated Isolation for Nursing Home Residents

ALTON BARBOUR

Psychodramatists may be interested in both the research methods and the results of a recent study done by Joanna Rowe Kaakinen. The research focused on nursing home residents' perceptions of the communication rules that governed their behavior. Many elderly are segregated from the rest of society when they are admitted to nursing homes. In addition, in American society, the aged are relegated to vague roles. Elderly people have been found to have a significant decline in the number of their daily interactions. Research has shown that there is a paucity of spoken communication among residents in nursing homes. Because nursing homes are social systems that evolve norms to regulate the behavior of the residents, Dr. Kaakinen was interested in discovering the rules that governed talking behavior and how the residents learn them. Particularly, she was interested in isolation, which might lead to cognitive, social, and emotional impairment.

A sample of 72 nursing home residents from eight nursing homes participated in the study. The researcher did survey research, in particular, interviews, but with an interesting twist. Clinical psychodramatists are prone to see socio-psychodrama as an action methodology, or group therapy and role playing as a technique in support of that methodology. Dr. Kaakinen, however, used role playing as an essential way to gather data, as a research methodology. She role played a situation designed as a simulation in which the interviewer portrayed a new elderly resident who had just come to live in the nursing home. The subjects were placed in the role of expert, now that they had been living in the nursing home for some period of time. The interviewer explained, as a part of the protocol, that she was not familiar with the rules and regulations and did not want to make a mistake. The subject volunteered to help her adjust to living in the nursing home and to provide her with her perceptions of the rules. The elderly nursing home residents were asked to remain in their routine character, to play themselves, so the situation was not artificial or dislocating. The role of the interviewer as a new resident was one that the residents had all personally experienced in the past. The design al-

lowed for physical and psychological reality with a high degree of personalization of the role.

The role-playing interview technique was designed to replicate reality, to encourage the sharing of information, and to encourage an active response on the part of the residents. Residents were guaranteed anonymity and reassured that the information would not be shared with anyone in the home.

Dr. Kaakinen noted that residents repeatedly identified specific unstated rules that they used or perceived other residents to use to regulate their talking behavior with other residents of the nursing home. Twenty-one self-regulatory conventions were found to be used by residents. Reliability was tested by having three independent coders code 190 items out of 600 total items. A stratified random sample of each category or self-regulatory convention was selected for the reliability test. Krippendorff's canonical coefficient was used to calculate reliability. The reliability coefficient for total agreement was .88. Residents said that they perceived a power imbalance between residents and staff and that they talked less since entering the nursing home than they had before they were admitted. Generally, the self-regulatory norms were restrictive and increased isolation and loneliness.

Dr. Kaakinen can be contacted about her role-playing research method for data gathering and her results, which are reported very briefly here. Readers may write to Dr. Joanna Rowe Kaakinen at Rt. 3, Box 235C, Astoria, Oregon 97103.

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BOOK REVIEW

TITLE: *Critical Incidents in Group Therapy*
AUTHORS: Jeremiah Donigian and Richard Malnati
PUBLISHER: Brooks/Cole Publishing, Monterey, California
DATE: 1987

This is a book that the group therapy field has needed for many years. Every group therapist faces a number of critical incidents with any group and in any session. When faced with these choice points, the therapist is often left without sound theory, outcome studies, or strategies upon which to draw resources. This work partially fills this gap.

The book is divided into three parts. The first part provides a theoretical overview of a number of selected theories of group therapy. Included in this discussion are client-centered therapy, gestalt therapy, individual psychology, rational-emotive therapy, reality therapy, and transactional analysis. Each of these models is adequately developed for a sufficient review. What is missing here is a psychodramatic model and a systems model, both of which have major influence upon the practice of group therapy today.

Part two of the book presents theoretical practitioners' responses to specific critical incidents. This is the real meat of the book. What the authors do is to present material that might emerge in a group session and then discuss how each of the theoretical models presented earlier might respond to that incident. The topics include: opening the group sessions, the group attacks the therapist, mass group denial, a member chooses to leave, a deep disclosure near session termination, a member maintains distance. All of us as group therapists have faced each of these incidents, and it is good to have a range of potential responses based on theory consistency.

In part three, the authors examine a number of issues related to therapy practice. They present a sound chapter on congruence of theory with practice, a topic often neglected in this day of eclecticism. A chapter is spent examining the consistency of interventions made, using the models discussed in part one and offering a critique of these. The final chapter is devoted to consideration in developing the practitioner's unique style of group therapy, based on his/her own theory formulation.

This is an excellent handbook for group therapists in training as well as a resource for experienced therapists wishing to expand. The work lacks out-

come studies that confirm which interventions tend to produce the most consistent or beneficial results for the group and its individual members. Research of an empirical nature tends to be missing far too frequently in the group psychotherapy field. Despite this gap, this book fills a need long present in the group therapy literature.

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Information for Authors

The *Journal of Group Psychotherapy, Psychodrama and Sociometry* publishes manuscripts that deal with the application of group psychotherapy, psychodrama, sociometry, role playing, life skills training, and other action methods to the fields of psychotherapy, counseling, and education. Preference will be given to articles dealing with experimental research and empirical studies. The journal will continue to publish reviews of the literature, case reports, and action techniques. Theoretical articles will be published if they have practical application. Theme issues will be published from time to time.

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Aims: to establish standards for specialists in group psychotherapy, psychodrama, sociometry, and allied methods; to increase knowledge about them; and to aid and support the exploration of new areas of endeavor in research, practice, teaching, and training.

The pioneering membership organization in group psychotherapy, the American Society of Group Psychotherapy and Psychodrama, founded by J. L. Moreno, MD, in April 1942 has been the source and inspiration of the later developments in this field. It sponsored and made possible the organization of the International Association on Group Psychotherapy. It also made possible a number of international congresses of group psychotherapy. Membership includes subscription to *The Journal of Group Psychotherapy, Psychodrama & Sociometry,* founded in 1947 by J. L. Moreno as the first journal devoted to group psychotherapy in all its forms.

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