# THE EFFICACY OF AN INTERPERSONAL/ COGNITIVE-BEHAVIORAL GROUP PSYCHOTHERAPY PROGRAM WITH MALE INMATES

By

ROBERT D. MORGAN

Bachelor of Science
University of Nebraska at Kearney
Kearney, Nebraska
1991

Master of Science
Fort Hays State University
Hays, Kansas
1993

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
December, 1999

THE EFFICACY OF AN INTERPERSONAL/

COGNITIVE-BEHAVIORAL GROUP

PSYCHOTHERAPY PROGRAM

WITH MALE INMATES

Thesis Approved:

Carrie J. Butterowd

Thesis Adviser

Katye M. Perry

Donald L. Yates

John D. Romaine

Dale R. Fuqua

Wayne K. Powell

Dean of the Graduate College

ACKNOWLEDGMENTS

Special thanks go to Dr. Carrie Winterowd, the director of this research. Carrie, I owe you many thanks not only for helping me complete the best dissertation possible, but for your mentoring my professional development throughout my doctoral education. You have not only taught me how to conduct better research and to better articulate my writings, but have also shaped my development as a psychologist. Thank you for your time and commitment to my growth and development.

I owe a sincere appreciation to Dr. Fuqua for your gentle direction, statistical expertise, and overall dedication to this project, especially during those times when I doubted myself and the utility of this endeavor. I also wish to extend my sincere appreciation to Dr. John Romans, Dr. Kayte Perry, and Dr. Donald Yates who served as members of my committee. Thank you for your commitment in helping me make this a better dissertation.

I also wish to thank the Kansas Department of Corrections for allowing me the opportunity to conduct my research in their correctional system. Many thanks also go to Scott Wilson, LMLP, Angie Weber, LMLP, and Alysin Edwards, LMLP, LMFT, for their assistance and commitment to facilitating the group psychotherapy program. Lastly, I owe an indebted gratitude to the inmates who volunteered to participate in this program, for without your assistance this study would not have been possible.

I also wish to acknowledge the unyielding support of my parents. You have provided me with the tools and self-confidence to complete my educational endeavors. Thank you for your confidence, encouragement, and never-ending support of my academic pursuits (even when none of us knew where they may lead).

Lastly, a heartfelt thank you to my family, Stacy, Taylor, and Ryan. My sincere appreciation to Taylor and Ryan, not only for your patience and understanding when I could not play with you as often as we both would have liked, but also for your enthusiasm and excitement on those occasions when we could play. You consistently offered a very enjoyable and much needed alternative to my work. My most heartfelt thank you goes to my wife, Stacy. While no one else truly understands the depth of the sacrifices that you made to allow me to pursue my educational pursuits, I do, and I thank you. You have contributed to my development in many ways, from the mundane tasks of editing many boring papers, to the larger task of keeping me grounded and focused on those things that are truly important. Most of all, I thank you for your support and love during all those times when I truly needed it. I love you.

TABLE OF CONTENTS

LIST OF TABLES

Table Page

# CHAPTER ONE

## INTRODUCTION

With a continuing increase in this nation's prison population, rehabilitation programs need to maximize the services that are provided by professionals in corrections. Psychotherapy is one approach to rehabilitation implemented in penitentiaries and maintains a goal of modifying inmates' attitudes and behaviors for the constructive resolution of conflicts (Mathias & Sindberg, 1985). It is not uncommon for inmates to enter prison with antisocial behavior, defensiveness, lack of empathy, narcissism, unrealistic expectations and world views, and chronic anger. Group psychotherapy offers an optimal treatment milieu to addresses these presenting problems. Furthermore, group psychotherapy is an economical treatment option which allows therapists to provide psychological services to a greater number of inmates compared to individual psychotherapy services (Wilson, 1990). As a result, group psychotherapy became a correctional treatment of choice beginning in the early 1960's (Corsini, 1964; Yong, 1971). In addition to the economic advantages, group therapy in correctional settings offers treatment advantages that individual therapy can not offer (Yong, 1971). Group psychotherapy provides clients with an opportunity to experience therapeutic factors (e.g., group cohesiveness, universality, altruism, the development of socializing techniques) that are difficult to create in individual counseling (Yalom, 1995). These therapeutic factors appear especially relevant for inmates who may have never previously experienced any of these factors. Yalom (1995) also proposes that group psychotherapy offers clients the opportunity to actively focus on interpersonal relationships in the here-and-now. In the group therapy setting, patients will begin to exhibit their interpersonal

pathologies, which allows the group to process this information and provide constructive feedback to the individual (Yalom, 1995). Similarly, Yong (1971) proposes that the primary benefit of group treatment is that inmates learn to develop functional peer relationships. In addition, the group support may aid inmates in coping with the problems encountered in a penitentiary (Mathias & Sindberg, 1986).

Group psychotherapy has been shown to be a viable treatment option (e.g., Orlinsky & Howard, 1986; Smith, Glass, & Miller, 1980). Two common group therapy approaches available to consumers are process-oriented group psychotherapy and cognitive-behavioral group psychotherapy. Yalom (1970) developed an interpersonal process-oriented approach to group psychotherapy. Interpersonal process-oriented group psychotherapy identifies dysfunctional patterns of interaction and focuses on the emergence of these interactional patterns as they occur between group members in the here-and-now (Ballinger & Yalom, 1995). Cognitive-behavioral group therapy offers an alternative approach to group psychotherapy as cognitive-behavioral theory can be applied to the group setting (Ellis, 1992). Beck's (1976) well known approach to cognitive therapy focuses on the need to identify, evaluate, and modify thinking errors for the alleviation of problematic behavior(s). This is accomplished through techniques of cognitive restructuring and problem-solving, and may be applied to the group setting.

A study by Deffenbacher, McNamara, Stark, and Sabadell (1990) compared a process-oriented group counseling approach to a cognitive-behavioral group counseling approach for anger reduction in college students. The results of this study indicated that both forms of counseling were equally effective in general anger reduction with college students. This study provides encouraging results for the use of process-oriented and

cognitive-behavioral group therapy as separate treatment approaches for anger reduction; however, with growing evidence that no treatment modality is superior to other treatment modalities (Garfield & Bergin, 1986; Luborsky, Singer, & Luborsky, 1975), it may be beneficial to begin evaluating eclectic treatment approaches.

As with other clinical populations, the effectiveness of group psychotherapy in corrections has been evaluated. Investigators have evaluated the effectiveness of group psychotherapy programs with inmates using a variety of outcome measures including: disciplinary reports (Goldenberg & Cowden, 1977; Homant, 1976; Levinson, Ingram, & Azcarate, 1968; Stallone, 1993; Wolk, 1963), institutional work performance (Homant, 1976, 1977), personality measures (e.g., MMPI, CPI) (Persons, 1966), recidivism measures (Homant, 1986; Jew, Clanon, & Mattocks, 1972; Jew, Kim, & Mattocks, 1975; Persons, 1967), attitudes toward rehabilitation programs (Nedd & Shihadeh, 1974), self-actualization (Chance, 1981), anger and aggression (Fink, 1981), empathy (Andrews, Wormith, Daigle-Zinn, Kennedy, & Nelson, 1980), and locus of control (Serok & Levi, 1993; Stasiw, 1977). These studies found that group psychotherapy can result in positive changes in inmates attitudes, feelings, and behaviors.

As previously indicated, inmates enter prison with numerous presenting problems including conduct problems, defensiveness and guardedness, empathy, and the presence of criminal thinking errors. Inmates receive disciplinary or conduct reports when they commit infractions against the rules of their institution. Good institutional behavior is not necessarily reflected by lower rates of recidivism (Homant, 1977); however, it may be argued that adjusting to the "demands and expectations in the institutional environment", may help offenders to meet the demands and expectations of society (Garrett, 1985). Not

surprisingly, inmates have frequently been referred to as manipulators who may attempt to present themselves in a favorable light while participating in rehabilitation programs (e.g., Stasiw, 1977; Yochelson & Samenow, 1976), while maintaining a negative attitude towards rehabilitation programs (Rappaport, 1982). Inmates also differ from noncriminals in empathy. Hogan (1969) found that criminals had significantly less empathy than a control group of military officers. Furthermore, Deardorff, Finch, Kendall, Lira, and Indrisano (1975) found that nonprisoners and first offenders had significantly higher empathy scores than did repeat offenders. Finally, inmates have learned cognitive patterns of thinking about the world that differ from nonoffenders, and these "criminal thinking errors" perpetuate the continuation of illegal behavior (Yochelson & Samenow, 1976). These presenting problems encompass but a few of the issues that inmates bring to the therapy arena; however, improvements in these presenting problems may facilitate a process of change that is required for inmates to become productive members of society. Group psychotherapy offers one treatment approach towards this end.

Group therapy has been shown to be an effective treatment modality for helping inmates adjust to the prison environment. Several studies (e.g., Leak, 1980; Stallone, 1993; and Wolk, 1963) demonstrated that inmates who participate in group therapy had significantly fewer disciplinary reports than inmates who did not participate in a group therapy program. In addition, group therapy improved inmates' institutional adjustment as measured by a combination of behavioral conduct and work ratings (Homant, 1976). Group therapy has also improved inmates' attitudes toward other rehabilitation programs

such as vocational training (Nedd & Shihadeh, 1974), and toward the criminal justice system (Andrews et al., 1980).

In addition to institutional adjustment, group therapy has been effective in modifying enduring characterological traits in inmates. Inmates who participated in a gestalt group therapy program assumed more responsibility for their own behavior compared to a control group (Serok & Levi, 1993). In another study, inmates who participated in a highly structured group experienced improvements in empathy and interpersonal functioning (Leak, 1980).

Group therapy treatment programs have provided mixed results with regard to post-release functioning. Some studies found no appreciative effects of group therapy on recidivism (Homant, 1986) while other studies found that group therapy resulted in improved parole outcomes (i.e., reduced recidivism) at one-year follow-up (Jew et al., 1972; Jew et al., 1975). Participation in group psychotherapy may result in positive changes, however, recidivism rates may not be reduced (Martin, 1989). It is possible that recidivism may not be an accurate outcome measure for rehabilitation programs, including group psychotherapy services (Reppucci & Clingempeel, 1978).

Not all studies evaluating group therapy services with offender populations have resulted in positive outcomes. For example, some studies attempted to extend the group treatment literature by assessing group therapy with deviant subsections of inmate populations (Goldenberg & Cowden, 1977), and assessing long-term recidivism outcomes (Homant, 1986) without success. With these mixed results, the effectiveness of group psychotherapy with offender populations remains somewhat questionable.

Nevertheless, there does appear to be enough evidence to conclude that group psychotherapy is an appropriate treatment option with correctional populations.

Over the past ten years researchers have evaluated the effectiveness of a variety of group therapy programs with offenders. Life skills training groups (Marshall, Turner, & Barbaree, 1989; and Reker & Meissner, 1977), assertiveness training groups (Marshall, Keltner, and Marshall, 1981), time-limited group therapy (Mathias & Sindberg, 1985), psychodidactic support groups (Sultan, Long, Kiefer, 1986), music therapy groups (Thaut, 1989), anger management groups (Fink, 1981), and problem-solving skills groups (Klarreich,1981), have been identified as effective treatment programs with correctional populations. Thus, the research questions appear to have changed slightly from "is group psychotherapy effective with correctional populations?", to "what types of group psychotherapy are effective in corrections and with what type of correctional populations?".

Nevertheless, relatively few studies have evaluated the effectiveness of differing theoretical approaches to group work with offenders. The theoretical approaches to group therapy in correctional settings that have been studied to date include cognitive-behavioral (Fink, 1981), reality therapy (Williams, 1976), gestalt therapy (Serok & Levi, 1993), psychodrama (Schramski, Feldman, Harvey and Holiman, 1984), transactional analysis (Stasiw, 1977), transactional analysis and behavior modification (Jessness, 1975), and comparisons between psychodrama, rational behavior therapy, and transactional analysis (Chance, 1981).

While there is limited research regarding different theoretical approaches to group therapy in corrections, research does suggest that structured treatment programs produce

superior results when compared to unstructured programs with inmates (Homant, 1986; Leak, 1980; Martin, 1989). A meta-analysis by Andrews, Zinger, Hodge, Bonta, Gendreau, and Cullen (1990) found that cognitive-behavioral treatment programs generally result in more positive outcomes than less structured treatment programs with inmate populations.

Some researchers argue that pure theoretical approaches to group work with inmates may limit the effectiveness and breadth of their work with inmates. Gendreau (1996) has identified characteristics of effective rehabilitation programs which include: the implementation of intensive services, the incorporation of cognitive-behavioral theory, and sensitive and constructive interactions between therapists and offenders. These considerations are consistent with Scott's (1976) proposal that an eclectic treatment approach can produce the most favorable results with inmate populations and that the therapist should refrain from implementing any one theoretical approach. To date, no study has attempted to assess the efficacy of combining two purist approaches into one treatment program. It is possible that a combination of interpersonal process-oriented and cognitive-behavioral approaches could serve to benefit inmates in learning how they relate to others and how to interact with others more effectively, as well as learn specific skills related to problem-solving and cognitive restructuring. Further research on group psychotherapy approaches with inmate populations is warranted to better determine what is most efficacious with criminal populations.

## PURPOSE OF THE STUDY

The purpose of this study was to assess the efficacy of a group psychotherapy treatment approach that integrates an interpersonal process-oriented treatment approach

with a cognitive-behavioral treatment approach with male inmates. Treatment effectiveness was assessed by comparing the treatment group with a no treatment control group.

As mentioned previously, inmates enter prison with numerous presenting problems including antisocial behavior, conduct problems, defensiveness, lack of empathy, narcissism, cognitive distortions, and chronic anger. This study evaluated the effectiveness of the group psychotherapy treatment approach on alleviating some of these presenting problems including institutional adjustment (conduct problems), defensiveness/guardedness, empathy, and criminal thinking errors.

For this study, an interpersonal process-oriented group psychotherapy approach and a cognitive-behavioral treatment approach were integrated into one intervention for male inmates. The cognitive-behavioral approach was chosen based on the necessity of including cognitive-behavioral strategies into correctional rehabilitation programs (Gendreau, 1996), given the unrealistic and often narcissistic world views of inmates. The interpersonal process-oriented group psychotherapy approach was chosen for its potential to increase the interpersonal awareness that inmates typically lack.

## SIGNIFICANCE OF THE STUDY

Previous studies have shown that group psychotherapy is a viable treatment option with inmates placed in correctional settings (e.g., Jew et al., 1972; Jew et al., 1975; Persons, 1966; Serok & Levi, 1993; Wolk, 1963); however, some studies have shown less conclusive or satisfying results (e.g., Chance, 1981, Goldenberg & Cowden, 1977). It was hoped that this study would be an addition to the current literature by exploring the

effectiveness of one integrative approach to group psychotherapy with adult male inmates.

As this was a brief 12-week group treatment program with inmates, Hilkey, Wilhelm, and Horne (1982) indicate that it would be unrealistic to expect a significant personality change in persons with such extreme maladaptive characterological traits as with an inmate population; however, if this treatment program proved effective in reducing some inmate behaviors (e.g., defensiveness/guardedness) it would present a significant contribution to the field of correctional rehabilitation, as less defensive inmates may be more receptive of other more comprehensive rehabilitation programs. In addition, if inmates were able to reduce their criminal thinking errors and increase their empathy, they may also function more effectively both in and out of the penitentiary setting. It seems reasonable to suggest that a more empathic person with fewer criminal thinking errors would be less likely to exploit others and less likely to engage in further criminal behavior.

## RESEARCH QUESTIONS

The following research questions were addressed in this study:

1. Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of defensiveness?
2. Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of empathy?

3. Does inmate participation in an interpersonal process-oriented/cognitive behavioral group relate to the number of disciplinary reports received?
4. Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of criminal thinking errors?
5. How satisfied are the inmates with this group treatment program as measured by a treatment satisfaction questionnaire?

RESEARCH HYPOTHESES

The following hypotheses were tested in this study:

1. Inmates participating in the treatment group would have significantly decreased defensiveness scores when compared to the inmates in the control group.
2. Inmates participating in the treatment group would have significantly increased empathy scores when compared to the inmates in the control group.
3. Inmates participating in the treatment group would be more likely to receive significantly fewer disciplinary reports when compared to the inmates in the control group.
4. Inmates participating in the treatment group would have significantly lower levels of criminal thinking errors when compared to the inmates in the control group.

5. Inmates receiving the group treatment program would be satisfied with the services they received (as measured by the Client Satisfaction Questionnaire).

## ASSUMPTIONS

Assumptions for this study included the following:

1. Inmates participating in this study are representative of inmate populations.
2. Inmate participants responded to the assessment instruments with similar motivations.
3. Therapists facilitated the group therapy treatment program with similar motivations.
4. Institutional adjustment is reflected by the number of disciplinary reports inmates receive. Improvement in institutional adjustment will be defined as fewer disciplinary reports overtime compared to baseline (pre) behaviors of disciplinary problems.
5. The assessment instruments chosen for this study were valid and reliable measures of the identified variables.
6. Changes in inmates scores on pre and post outcome measures reflect changes occurring as a result of the proposed treatment approach, rather than due to environmental or participant factors.
7. The type of inmate crime was unrelated to treatment success (i.e., heterogeneous crime group did not effect outcome differences).
8. The type of clinical interviews conducted by the group facilitators were unrelated to treatment success.

9. Administering only the identified MMPI-2 validity scales did not significantly alter the content validity or the usefulness of the scales in measuring guardedness/defensiveness as previous studies have also implemented the use of these scales to measure test taking attitudes (e.g., defensiveness) without administering the clinical scales (e.g., Frueh, 1992/1993; Gaies, 1993/1994; Spana, 1992/1993).
10. Treatment success would be unrelated to the inmates' phase of rehabilitation.
11. Those inmates on a waiting list did not differ from those who were actively recruited to participate.

DEFINITION OF TERMS

Group Psychotherapy: Group psychotherapy is "the use of group interaction to facilitate self-understanding as well as individual behavior change" (George & Dustin, 1988). While Corey (1990) differentiates between group counseling and group psychotherapy, throughout this dissertation the terms group psychotherapy, group therapy, and group counseling are used interchangeably unless otherwise noted.

Interpersonal process-oriented approach to group psychotherapy: A process-oriented approach to group psychotherapy refers to a psychotherapy group which maintains a focus on the interactional patterns of individual group members in the here-and-now (Ballinger & Yalom, 1995). Yalom (1995) further posits that the process focus (examining the here-and-now behavior as it occurs in the group) is the one feature that is truly unique to experiential groups.

Cognitive-Behavioral Approach to Group Psychotherapy: This treatment program included two cognitive-behavioral components. Inmates were instructed in

problem-solving skills as described by D'Zurilla and Goldfried (1971), as well as identifying and modifying criminal thinking errors as identified by Yochelson and Samenow (1976) and implementing the cognitive restructuring intervention as described by Beck (1995). Furthermore, structured cognitive-behavioral exercises (e.g., automatic thought records) were implemented to aid inmate attainment of these skills.

Inmate: For purposes of this study, an inmate referred to any man who was 18 years of age or older, who was sentenced to a state correctional institution as the result of a felony conviction and had a remaining prison sentence of nine months or more.

Institutional Adjustment: Institutional adjustment was defined as an inmates' ability to comply with institutional rules and regulations. Institutional adjustment was measured by the number of disciplinary reports that inmates received.

Defensiveness/Guardedness: For purposes of this study, defensiveness and guardedness were defined as inmate attempts to portray themselves in the most favorable light while denying minor flaws or disturbances. Defensiveness/guardedness was measured by the MMPI-2 traditional validity scales and the positive malingering (Mp) scale.

Empathy: Empathy is a construct that refers to one's ability to perceive the mood and feelings of another person and/or to understand the feelings, sufferings, or situation of another person (Wolman, 1989). For purposes of this study, empathy was measured by the Hogan Empathy Scale (Hogan, 1969).

# CHAPTER TWO

## LITERATURE REVIEW

With the continued increase in the United States prison population, investigators continue to disagree on the most effective correctional philosophy. Proponents of punishment have contended that rehabilitation with offenders is generally ineffective (Martinson, 1974) while proponents of rehabilitation have presented evidence that suggests that correctional rehabilitation programs are effective (Gendreau, 1996; Gendreau & Ross, 1987; Palmer, 1975). Rehabilitation in penitentiaries occurs in the guise of education programs, vocational training programs, recreational programs, substance abuse programs, and psychological programs. Psychological programs include both individual and group therapy, although group therapy appears to have become a treatment of choice (Corsini, 1964; Wilson, 1990; and Yong, 1971).

The initial goal of group therapy outcome studies with inmate populations was to evaluate the effectiveness of this treatment approach (Homant 1976, 1986; Jew et al., 1972, 1975; Persons, 1966, 1967; and Wolk, 1963). These preliminary studies indicated that group therapy is an effective treatment modality with incarcerated prisoners. Theoretical orientations to group therapy with prisoners shown to result in treatment gains are: reality therapy (Williams, 1976), transactional analysis (Jessness, 1975; and Stasiw, 1977), cognitive-behavioral (Fink, 1981), psychodrama (Schramski et al., 1984; and Stallone, 1993), and Gestalt therapy (Serok & Levi, 1993). Specific focus groups have also proven effective with inmate populations including: Life skills training (Marshall, et al., 1989; and Reker & Meissner, 1977), group therapy eliciting citizen volunteers as leaders (Andrews, et al., 1980), structural differences (Leak, 1980), and

pretherapy training (Hilkey et al., 1982). In addition, evaluations have assessed the effectiveness of group therapy with inmates with specific presenting problems such as inmates placed in segregation units (Goldenberg & Cowden, 1977; Levinson et al., 1968) and inmates with insomnia (Toler, 1978). These studies generally conclude that group therapy with inmate populations can be effective; however, further research is warranted to assess for the most effective theoretical models as well as identify inmates that may benefit from placement in a group treatment program.

## Rehabilitation

### What is Rehabilitation?

Rehabilitation is "a process that includes a variety of treatments" (Boudouris, 1984, pg. 46). This "process" of rehabilitation indicates that each treatment is integral to the overall rehabilitation of the offender, and that no one treatment in and of itself, is sufficient for the rehabilitation of the offender. The goal of rehabilitation is that this process will help inmates return to society and to become productive members of society (Rapport, 1982). The treatments referred to by Boudouris typically include educational, vocational, recreational, substance abuse, and psychological programs. Each of these treatments is described briefly.

Educational programs have been implemented in penitentiary settings to provide inmates an opportunity to obtain an education that may have been missed in the free world. It is assumed that by addressing the educational deficits of offenders (Glaser, 1969), the offender is then better able to adjust to society upon release from the penitentiary. Furthermore, it is assumed that by remediating educational deficits, offenders released from prison may be able to obtain better jobs than if they were not

provided educational opportunities. This may have a reciprocal effect of assisting inmates to avoid criminal behavior and maintain their freedom.

Vocational rehabilitation has been implemented in several prison systems with the objective of "returning the offender to society as a more useful and productive member" (Lawrence, 1974 pg. 253-254) as s/he is able to engage in productive work activity. Vocational training teaches inmates specialized skills (e.g., auto mechanics, plumbing) that may be applied to the attainment of jobs in the free world upon their release. By developing a specialized vocational skill, inmates may be less inclined to pursue criminal activities as a means of income.

Recreational programs (e.g., art classes, weight lifting, basketball, crochet) in penitentiaries serve a twofold purpose. First, they attempt to provide inmates with a productive method of occupying their time while incarcerated. It does not seem unreasonable to suggest that if inmates are involved in functional recreational activities then they will spend less time in disruptive behavior. Second, the development of recreational activities will aid inmates in their adjustment to the free world by aiding them in changing their lifestyles and possibly their circumstances (McIntosh, 1986). With this in mind, recreational programs should not be viewed as a privilege for inmates, rather as a necessity for rehabilitation to occur (Walker, 1974).

With the increase in drug related crimes, substance abuse programs remain an important treatment component in the rehabilitation process. According to the Justice Department's Bureau of Justice Statistics, drug-related offenses of all federal inmates grew from 25 percent in 1980 to 60 percent in 1993 (Associated Press, 1995). The aim of substance abuse programs is to provide inmates with an opportunity to develop insight

into their abusing patterns and to assist inmates in developing a relapse prevention plan. Gorski (1995) states that substance abuse and criminal personality is a reciprocal relationship and they go hand-in-hand. In other words, Gorski views criminal personality and substance abuse as reciprocal influences. It should also be noted that, contrary to Gorski's theory, it is possible that some offenders engage in criminal activity as a result of the influence of drugs and alcohol. Nevertheless, in both cases, crimes are being committed and drugs and alcohol are intricately involved, therefore, as Gorski (1995) asserts, their is continued need to treat the substance abuse during the rehabilitation process.

Psychological programs implement the use of psychotherapy to aid in the process of rehabilitation (e.g., helping inmates return to society as more productive members). The goal of psychotherapy in penitentiaries is to modify inmates' attitudes and behaviors "so that their internal and external conflicts are resolved in constructive rather than antisocial ways" (Mathias & Sindberg, 1985 pg. 265). As in the free world, psychotherapy in penitentiaries is conducted individually or in groups. While correctional mental health professionals who provide group therapy appear to spend approximately equal amounts of time in the provision of individual and group psychotherapy services (Morgan, Winterowd, & Ferrell, 1997), the goal of these two services appears to vary. The use of individual psychotherapy is primarily geared towards the treatment of psychopathology rather than for purposes of reducing recidivism. Group psychotherapy, on the other hand, has experienced a rapid growth since the 1950's in its use as a rehabilitative tool (Arnold & Stiles, 1972; McCorkle, 1953; and McCorkle & Elias, 1960).

Punishment versus Rehabilitation

This country has seen a dramatic increase in crime since 1980. During this time, the United States prison population has grown by approximately 290 percent. The state and federal prison population was 302,960 in 1980 (American Correctional Association, 1981). By June of 1993, this population had grown to 878,532 (American Correctional Association, 1994). The operating budget required for these state and federal facilities to maintain this current population is 20,400,651,668 dollars (American Correctional Association, 1994). Obviously, American tax payers have reason to be concerned. As these figures continue to rise, the correctional debate of punishment versus rehabilitation continues to gain national attention. This debate dates back hundreds of years.

In 1974, Robert Martinson refueled this debate with his renown work which concluded that "nothing works" when referring to the use of rehabilitation in penitentiary settings. Martinson and his colleagues reviewed every study published in the English language relating to rehabilitation in corrections from 1945 through 1967. This comprehensive review of the literature evaluated studies from all facets of rehabilitation including educational and vocational training, individual and group counseling, medical treatment, and other rehabilitation efforts both within a penitentiary setting and in society. Based on a review of the literature, Martinson concluded that "with few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect..." (pg. 25). Thus, the phrase "nothing works" evolved.

Martinson's "nothing works" conclusion was a major setback to those pursuing rehabilitation as a treatment option. In fact, Martinson's paper was to corrections what Eysenck's "bombshell" (Eysenck, 1952) was to psychotherapists. Just as Eysenck's

paper questioned the utility of psychotherapy, Martinson's review questioned the utility of rehabilitation in corrections. Immediately following publication of his findings, the correctional field was beset by doubt and disheartened attitudes; however, rather than destroy the rehabilitation movement, this "nothing works" doctrine fueled the fire for a more thorough evaluation of the rehabilitation literature, and also initiated a marked surge in the publication of rehabilitation outcome studies. Just as Eysenck's work motivated psychotherapists of all fields to empirically prove the validity of their work, Martinson's work redefined the next twenty years of correctional research.

Other theorists and researchers in the field of corrections have vehemently argued against Martinson's conclusions and have shown that rehabilitation can and does occur within the confines of a penitentiary (e.g., Adams, 1977; Boudouris, 1984; Gendreau, 1996; Gendreau & Ross, 1979, 1987; Palmer, 1975). Ted Palmer (1975) launched the first in-depth attack on Martinson's conclusions by providing a critical review of Martinson's paper as he reassessed several of the studies that were used. He concluded that Martinson was biased with regard to his statement of "few and isolated exceptions", as several of the studies that demonstrated treatment effects were discredited due to a criterion of "inconsistency". Essentially, this means that studies resulting in treatment differences for some offenders, but not an overall effect on recidivism were considered treatment failures, and Martinson jumped to the conclusion that the study showed no evidence for rehabilitation.

Boudouris (1984) questioned Martinson's methodology as Martinson used recidivism as his only dependent measure. Boudouris argued that such a measure is not a valid reflection of the efficacy of rehabilitation. He pointed out that recidivism was a

process mediated by a number of variables (e.g., experience in the criminal justice system), therefore, recidivism, as a dependent measure, may not be a true reflection of the effectiveness of a rehabilitative program. In addition, all rehabilitative attempts were judged by Martinson as either a success or a failure and this did not allow for individual program evaluations. Simply stated, recidivism as a treatment measure presents numerous methodological problems (Reppucci and Clingempeel, 1978).

Following the publication of Martinson's work, Gendreau and Ross (1979) conducted a literature review of their own. This review consisted of studies published between 1973 and 1978 and led to the conclusion that "there are several types of intervention programs that have proven successful with offender populations" (p. 463) (e.g., family and community intervention programs, contingency management programs, counseling, diversion programs). Gendreau and Ross (1987) substantiated this conclusion with a follow-up literature review in the 1980's, and they concluded that rehabilitation does occur with offenders and that "it is downright ridiculous to say 'Nothing works' " (p. 395).

One of the strongest empirical rejections of the "nothing works" doctrine was produced by Andrews et al. (1990) in a meta-analysis of 80 studies assessing the effectiveness of correctional treatment. These authors concluded that treatment is effective when provided under appropriate conditions (e.g., delivery of service to higher risk cases, targeting of criminogenic need). One of the primary conditions indicated by this study is the inclusion of a cognitive-behavioral element (Andrew's et al., 1990). Overall, they concluded that "Appropriate correctional service appears to work better than criminal sanctions not involving rehabilitative service." (pg. 384). This clearly

supports the need for continued efforts at establishing and implementing rehabilitative programs.

The rebuttal of Martinson's original work was quick and to the point. The doctrine that "nothing works" was no longer accepted. Even Martinson retracted on his initial conclusions after a reevaluation of his original position. In a subsequent paper, Martinson acknowledges that treatment programs are beneficial and that some have "appreciable" effects on recidivism (Martinson, 1979). Gendreau (1996) was further able to postulate the characteristics of those programs that have shown to be effective in the rehabilitation process. These characteristics include the implementation of intensive services, incorporation of behavioral theory including cognitive theory, and therapists interact with offenders in sensitive and constructive ways. Thus, the question facing scientists in the field of corrections changed from "does rehabilitation work?" to "what works most effectively?", and "what works with which type of offenders and under what conditions?" The remainder of this review will focus on the use of group psychotherapy as a rehabilitational program, and the efficacy of such procedures in penitentiary settings.

## Group Psychotherapy

Group psychotherapy is "the use of group interaction to facilitate self-understanding as well as individual behavior change" (George & Dustin, 1988). This group interaction is best facilitated in groups of five to ten members (Yalom, 1995) with a treatment focus of alleviating symptoms or psychological problems (Corey & Corey, 1987). Several studies and reviews of the group therapy literature validate the use of group psychotherapy as a viable treatment option with clients (e.g., Dies, 1993; Orlinsky & Howard, 1986; Smith et al., 1980; Yalom, 1995). There have been a plethora of group

treatment approaches available to the consumer. Vinogradov and Yalom (1994) identify acute inpatient groups, aftercare groups, medication groups, behavioral groups, medical disorder groups, life events groups, and specialized support groups as just a few of the examples of the various group practices available today.

Group Psychotherapy in Penitentiaries

Group psychotherapy in a penitentiary presents problems not encountered in the free world (Coyne & Fabricatore, 1979). Attitudes towards rehabilitation programs such as group therapy tends to be "universally negative" (Rappaport, 1982); therefore, support is minimal. In addition, the social structure of a prison creates barriers to therapy (Mathias & Sindberg, 1985). The prison environment does not lend itself to trust and self-disclosure (Halleck, 1960) as feelings of suspicion and paranoia are common among both inmates and staff (Mathias & Sindberg, 1985). Inmates typically view therapists as "cops" and may perceive group therapy as a "snitch session". This lack of trust which is so fundamental to the therapeutic alliance may never be fully overcome (Mathias & Sindberg, 1985). Inmates may also receive negative consequences from peers for attending group therapy or for engaging in the therapeutic process. Typically, group members will be viewed with suspicion by other inmates in the prison.

In addition to the barriers presented by the social structure of the penitentiary, client-therapist differences present difficulties to the therapeutic alliance. These differences include social class, ethnic identity, and cultural variance (Mathias & Sindberg, 1985). Cultural differences are not germane to the criminal population as group therapists in other professional settings encounter cultural diversity (e.g., international students in university counseling centers); however, these differences along with the pre-

existing distrust and suspicion fostered by the prison environment create a therapeutic barrier that is most difficult to overcome when facilitating group therapy in correctional settings. In spite of these barriers, group therapy remains an effective treatment option.

Of final note with regard to the provision of group psychotherapy services in penitentiary settings is that group membership, by default, is generally homogenous. That is, group members are of the same gender. While many group treatment approaches recommend unisex groups for transference purposes (Dore, 1994), it has become increasingly accepted that same sex groups can be therapeutically beneficial for various presenting problems including: bulimia nervosa in women (e.g., Romano, Quinn, & Halmi, 1994), mentally ill homeless women (e.g., Dail & Koshes, 1992), male alcoholics (e.g., Van Wormer, 1989), and women alcoholics (e.g., Nichols, 1985). While same sex groups may limit transference issues as suggested by Dore (1994), the facilitation of same sex groups (rather by default or design) allows for a more intense focus on issues that are gender specific (e.g., Romano et al., 1994; Van Wormer, 1989).

Approaches to Group Psychotherapy in Corrections

Group psychotherapy became a correctional treatment of choice beginning in the early 1960's due to obvious economic reasons (Corsini, 1964; Yong, 1971). With the continuing increase in the national prison population, group therapy will remain the most economical treatment option (Wilson, 1990). In addition, group therapy offers treatment advantages that individual therapy can not offer. The group support may aid inmates in coping with the problems encountered in a penitentiary (Mathias & Sindberg, 1986). Yong (1971) proposes that the group is able to offer a setting that is conducive to inmate

growth that can not be matched in individual therapy, and that the primary benefit of group treatment is that inmates learn to develop functional peer relationships.

A review of the literature indicates that approaches to group therapy with inmates tend to be eclectic (i.e., integrate a variety of theoretical orientations) in nature and appear dependent upon the therapist's orientation rather than scientific evidence for any particular treatment modality. Scott (1976) concludes that an eclectic approach produces the most favorable results and that the therapist should refrain from implementing any one theoretical approach. In addition to a variety of theoretical approaches, the goals of the group may vary according to the facilitator and the penitentiary security level (i.e., maximum, medium, minimum). From the author's professional experience, group therapy in maximum security settings tends to be geared towards institutional adjustment, while post-release adjustment tends to be the focus in minimum security settings. This seems reasonable as there is minimal benefit in focusing on post-release issues with maximum security inmates serving lengthy sentences (e.g., ten years or more). At the same time, one would not want to focus a group of minimum security inmates with short sentences (e.g., less than one year) towards adjusting to life in a penitentiary setting.

Efficacy of Group Therapy with Inmates in Prisons

The research on the efficacy of group psychotherapy with offender populations has focused on it's use in the rehabilitational process for inmates by assessing a variety of outcome measures (e.g., institutional adjustment, parole outcome), evaluations of specific theoretical orientations, and evaluations of topical or theme groups. While opinions of the appropriateness of group psychotherapy programs in corrections remains somewhat mixed, their appears to be substantial evidence to suggest that it remains a viable

treatment option. Preliminary studies focused on the efficacy of group psychotherapy with offender populations in general.

Wolk (1963) conducted one of the first group therapy outcome studies with incarcerated males. While this study is dated and the scientific methodology is poor by current standards, it was one of the first attempts at using the scientific method to evaluate group psychotherapy effectiveness with incarcerated adults. In an attempt to evaluate the institutional adjustment of group members as compared to nongroup members, Wolk assessed differences in the number of disciplinary reports received in one year by the treated versus nontreated groups. What he found was that treated group members averaged 0.86 disciplinary reports for the year, while nontreated group members averaged 2.29 disciplinary reports for the same year. This resulted in a statistically significant difference. The design of this study is not scientifically sound; however, it was one of the first published studies to empirically show that group psychotherapy can be an effective treatment modality with an inmate population (i.e., reduce the number of inmate disciplinary reports).

Following the Wolk study, Persons (1966) conducted a similar study to evaluate the effectiveness of psychotherapy with delinquent boys. Persons implemented a more rigorous treatment regimen as he required the boys to attend group and individual therapy simultaneously, with the primary emphasis being group therapy. By comparing pre and post therapy measures on the Minnesota Multiphasic Personality Inventory, Taylor Manifest Anxiety Scale, and Delinquency Scale scores, he concluded that the use of psychotherapy resulted in behavioral and psychological changes. One year later, Persons conducted a follow-up study to evaluate the community adjustment of the boys receiving

psychotherapy (Persons, 1967). Using a variety of post-release measures (e.g., recidivism, length of employment, etc.,) he again concluded that psychotherapy was an effective rehabilitative modality as it "helped most of the boys reverse their antisocial behavior and become more productive individuals" (pg. 141). As discussed previously, recidivism is a poor measure of the effectiveness of individual rehabilitation programs and admittedly, it is a big leap to conclude that antisocial behavior is reversed after only one year of post-release success. Nevertheless, these results suggest that intensive psychotherapy, with emphasis on group psychotherapy, is a viable option for the treatment of incarcerated offenders.

Group therapy has been shown to promote favorable inmate attitudes toward other rehabilitative programs (Nedd & Shihadeh, 1974). Nedd and Shihadeh (1974) assessed 175 adult male inmates' attitudes toward educational and vocational programs and found that group therapy assisted inmates in developing favorable attitudes toward vocational training. This finding indicates a potentially significant contribution of group therapy in corrections. No one treatment modality has proven sufficient in reducing recidivism (Martinson, 1974). If group therapy can increase an inmate's attitude toward other rehabilitation programs, hopefully an empirically based combination of treatment programs may eventually prove effective for reducing recidivism rates.

Two comprehensive evaluations of the effectiveness of group psychotherapy were facilitated by Jew (1972, 1975) and colleagues who concluded that group psychotherapy could improve parole outcomes. In the first study, 257 inmates were assigned to treatment groups and were compared to a matched control group of 257 inmates (Jew et al., 1972). With parole outcomes (return or not return to prison) as the dependent

measure, these authors found that there were significant differences between the treatment group and the control group at a one year follow-up, with group therapy resulting in more favorable parole outcomes. These results were not maintained at two and four year follow-ups indicating the need for post-release treatment programs.

A second study assessed the effectiveness of group psychotherapy with character disordered inmates (Jew et al., 1975). The treatment group for this study consisted of 736 inmates while a matched control group also consisted of 736 inmates. The majority of inmates were considered to be characterologically disturbed (i.e., personality disorders) with no presence of psychotic features. With a two year parole status of "no problem", "minor problem", "major problem", and "return to prison" as the outcome measure, the overall results of this study indicate that group psychotherapy with inmates resulted in "fewer parolees with major problems, fewer persons returned to prison, and considerably more parolees who were able to remain free of arrest or difficulty on parole" (pg. 15) (i.e., decreased recidivism).

In an effort to further evaluate the effectiveness of group therapy, Homant (1976) conducted studies similar to Persons (1966, 1967) with incarcerated adult males. Homant (1976) measured the success of group psychotherapy by comparing inmates who received group therapy to a control group on work performance ratings and conduct reports. As in the Wolk study, Homant's research design became a limitation of the study. His control group was not a true waiting list or no treatment group as they were free to seek counseling via regular institutional channels. While this study implemented a less than satisfactory research design, its conclusions are worth noting. As in the previous studies,

Homant found that inmates participating in group psychotherapy had significantly improved institutional behavior as measured by work ratings and conduct reports.

Ten years later, Homant conducted a follow-up to evaluate the long-term benefits of the group psychotherapy experience (Homant, 1986). Using parole status as his criterion, he evaluated the success of 92 of the original 104 inmates and found that group psychotherapy did not improve post release adjustment as compared to the control group; however, as previously indicated, the use of recidivism (including parole status) as a dependent measure is a poor measure of the effectiveness of Homant's group psychotherapy. Too many extraneous variables affect the success of an inmate's release status, and it is difficult to determine the cause of post-release failure. Thus, while Homant's evaluation of the long-term effectiveness of a group psychotherapy program reflects a critical step for outcome studies, it failed to accurately measure potential gains. Similar studies that more accurately reflect psychological changes are needed.

Not all studies evaluating group psychotherapy effectiveness with offenders have resulted in noticeable differences. In his doctoral dissertation comparing different modes of group psychotherapy, Chance (1981) found that group psychotherapy did not increase the self-actualization of inmates as measured by the Personal Orientation Inventory or result in behavioral changes as measured by a behavior description checklist. Similarly, group psychotherapy with inmates confined in isolation units resulted in no significant differences on institutional behavior as compared to a no treatment control group (Goldenberg & Cowden, 1977). In addition, Slaikeu (1973) reviewed 23 group treatment outcome studies with juvenile and adult offenders between the years 1945-1970 and determined that the studies were insufficient to conclude that group treatment is effective;

however, this was not a scientific review (e.g., meta-analysis) and the previous citations (e.g., Homant, 1976; Jew et al., 1972; Jew et al., 1975; Nedd & Shihadeh, 1974; Persons, 1966, 1967; Wolk, 1963) have shown what is generally accepted among corrections professionals (i.e., that group psychotherapy can be an effective treatment option). Following these general efficacy studies, the focus of inquiry changed from "is group psychotherapy effective?" to "what type and with whom is group psychotherapy most effective?". In fact, the two studies presented here that demonstrated no treatment effects were not evaluating the effectiveness of group psychotherapy with offenders, rather they were comparing different treatment approaches (Chance, 1981), and assessing group psychotherapy with a deviant subsection of the inmate population (Goldenberg & Cowden, 1977).

Following these preliminary efficacy studies, the questions began to change to what type of group psychotherapy intervention is most efficacious with offender populations; however, there remains a paucity of studies that have been conducted to evaluate the effectiveness of different theoretical orientations with offenders. The Chance (1981) study compared group psychotherapy approaches implementing psychodrama, rational behavior therapy (modeled after the Ellis and Maultsby theoretical approach), and transactional analysis, with two control groups. As stated previously, the treatment groups resulted in no significant differences on measures of self-actualization or behavioral measures. Williams (1976) subjectively assessed a group therapy approach implementing reality therapy, modeled after the reality therapy of Glaser. This study was a quasi-experimental design and did not include a control group nor did it entail statistical analysis. Thus, all conclusions based on this subjective assessment can be considered

tentative conclusions at best. Williams (1976) concluded that reality therapy was an effective treatment approach as indicated by inmate self-reports.

A more rigorous scientific study compared a transactional analysis institutional treatment program with a behavior modification institutional treatment program for incarcerated delinquents (Jessness, 1975). While this study evaluated entire institutional treatment programs rather than group therapy treatment programs, theoretical implications are relevant. Both treatment approaches resulted in improvements as compared to nontreatment control groups on psychological (e.g., Jesness Inventory and behavioral (e.g., Jesness Behavior Checklist) measures. Treatment differences were noted as the transactional analysis program resulted in improvement on psychological measures while the behavior modification program resulted in improved behavioral measures. These results suggest that both treatment approaches were effective with regard to their specialty areas and that selection of appropriate dependent measures is critical for effective evaluation of treatment effectiveness.

Stasiw (1977) produced further empirical evidence for the efficacy of group therapy implementing transactional analysis. While this study also has many confounding variables and is a poor example of the scientific method; it is a tentative conclusion that short-term transactional analysis training resulted in inmates taking more control for and of their lives following treatment as measured by Rotter's Internal-External Locus of Control Scale.

Other theoretical approaches have also been assessed. Fink (1981) implemented a cognitive-behavioral group therapy program for the treatment of anger and aggression with adult male inmates. Without the use of comparison groups, and relying on mean

comparisons of dependent measures and subjective ratings, Fink concluded that cognitive-behavioral group therapy aided inmates in institutional adjustment. Schramski et al. (1984) compared a psychodrama group treatment approach with three other group treatment approaches (anger therapy, values clarification and decision making) and a no treatment control group with adult male inmates. They concluded that all treatment approaches were significantly better (on at least some of the subscales from The Correctional Institutions Environment Scale and the Hopkins Symptom Checklist-Revised) than no treatment at all. With regard to the treatment groups, the authors concluded that the psychodrama group was superior to the other group methods in reducing distressing symptomatology and improving inmate attitudes.

Serok and Levi (1993) evaluated the effectiveness of a gestalt group treatment approach with "hard-core" adult male inmates. This study assessed changes in inmates' willingness to accept responsibility for their own behavior (as measured by Rotter's Locus of Control Inventory). When compared to a control group, the gestalt group therapy approach resulted in lower external locus of control scores (i.e., inmates assumed more responsibility for their own behavior). The use of psychodrama group therapy within a structured behavioral modification program has also been evaluated (Stallone, 1993). Using the frequency of disciplinary reports as a measure of unacceptable behavior, Stallone found that inmates in the behavior modification with psychodrama group treatment program significantly reduced their unacceptable behaviors when compared to inmates in the treatment program not receiving the psychodrama group therapy and the no treatment control group. This study suggests that psychodrama group therapy may aid inmates in reducing unacceptable behaviors.

In addition to the assessment of theoretical orientations, the last twenty years has seen a slight increase in the study of particular focus or theme groups with offenders. Life skills training has shown to be an effective treatment modality (Marshall et al. 1989; Reker & Meissner, 1977). The Reker and Meissner (1977) study compared two groups implementing life skills training with a placebo group and a control group. While no differences were found on personality measures, treatment effects were found for measures of institutional adjustment. The Marshall et al. (1989) study compared a life skills training group with a treatment dropout group and a no treatment control group, and also found positive results. The authors of this study concluded that life skills training effectively changed features of inmates' behaviors which are considered to be linked with recidivism (e.g., social behavior, attitudinal measures, and criminal dispositions). Such a powerful conclusion may seem a little premature; however, the effectiveness of a life skills training program is demonstrated.

Leak (1980) compared the effectiveness of a highly structured treatment approach with a nondirective treatment approach with 80 adult male inmates. He found that compared to the nondirective treatment group, the highly structured treatment program resulted in significant improvements in empathy (as measured by the California Personality Inventory and the Bipolar Psychological Inventory), interpersonal functioning (as measured by the California Personality Inventory), and the number of serious rule violations. Thus, structured treatment programs appear to produce superior results when compared to unstructured programs.

Focused group therapy can reduce social fear and increase assertiveness (Marshall et al., 1981). This study by Marshall et al. compared assertiveness training, anxiety

reduction, and no treatment on social response scales and a social fear scale. The authors found that assertiveness training increased assertion scores as measured by the assertion scales, but did not decrease social fear. Conversely, the anxiety reduction treatment reduced social fear but had no effect on assertion scores. Implications for the use of specific treatment modalities for specific goals are once again verified.

As stated previously, group therapy in a penitentiary is different from group therapy in the free world. The majority of inmates are unfamiliar with the therapeutic process and as previously indicated, they enter this endeavor with suspiciousness and anxiety. As resistance is a common phenomena in penitentiary settings, short-term group therapy is unlikely to facilitate significant character changes in incarcerated prisoners (Hilkey et al., 1982). Pre-therapy training may reduce suspicion and anxiety, thereby reducing inmate resistance. This may greatly increase the effectiveness of early therapy sessions as it could reduce the amount of time necessary to developing the therapeutic alliance. Hilkey et al. evaluated the effects of a pretherapy training program on inmates' participation in group therapy with 90 adult male inmates who were assigned to one of two experimental conditions (received pretherapy training or did not receive pretherapy training). All participants then received group therapy. Results of this study indicate that pretherapy training with a short-term (eight weeks) group therapy treatment program more effectively facilitated the treatment process. The authors of this study concluded that short-term group therapy, when accompanied by pretherapy training, may promote quicker progress in therapy. Thus, with treatment knowledge, resistant clients may become less resistant and better able to work within a treatment program.

One of the current questions proponents of rehabilitation are attempting to address is what types of inmates benefit from group therapy. Group psychotherapy has been used as a treatment approach with various presenting problems and prison populations. In contrast to the Goldenberg and Cowden (1977) study, Levinson et al. (1968) found that inmates frequently placed in solitary confinement were able to reduce their number of disciplinary reports as well as their number of placements in segregation as a result of participating in a group therapy program. Toler (1978) implemented a group treatment approach in the treatment of insomnia with incarcerated males. This study compared three treatment groups of inmates experiencing sleeping disturbances (relaxation training, relaxation training and stimulus-control instructions, and a delayed treatment control group). Initial treatment effects were noted for the relaxation training and stimulus-control group on the number of nightly awakenings as measured by pre and post treatment data. The treatment effects were not maintained at an eight week follow-up. This result highlights the need for controlled follow-up measures to determine the long-term implications of group therapy approaches with incarcerated adults.

More research is needed on comparisons of theoretical treatment approaches or on particular treatment goals (e.g., anger management) with inmate populations. As indicated previously, Scott (1976) proposes that eclectic approaches are the most effective when conducting therapy with criminal offenders; however, researchers must continue to assess different approaches to be better able to determine what techniques and theories are most applicable with the criminal population. In addition to conducting more studies comparing theoretical orientations, it is crucial that researchers better implement the scientific method in our quest for information. The poor designs noted above simply

are no longer acceptable. Without the use of appropriate methodology, researchers add fuel to the fire for proponents of punishment as opposed to rehabilitation. With the scientific knowledge present today, there simply is no excuse to conduct poorly designed research studies. Thus, while group therapy has shown to be effective with criminal offenders, much research remains to be done.

Two group psychotherapy treatment approaches that have not been adequately studied with offender populations are interpersonal process-oriented and cognitive-behavioral group psychotherapy approaches. Deffenbacher et al. (1990) compared a process-oriented group counseling approach to a cognitive-behavioral group counseling approach for anger reduction in college students. They found that both forms of group counseling were equally effective in general anger reduction, and concluded that the two theoretically different treatment modalities led to generally equivalent outcomes. While this study was completed with college students rather than inmates, the focus on anger reduction appears relevant for an offender population. Therefore, this study provides encouraging results for the use of process-oriented and cognitive-behavioral group therapy as separate treatment approaches for anger reduction; however, with growing evidence that no one treatment modality is superior to other treatment modalities (Garfield & Bergin, 1986; Luborsky et al., 1975) it may be beneficial to begin evaluating eclectic treatment approaches.

Process-Oriented Group Psychotherapy

Interpersonal process-oriented group psychotherapy identifies dysfunctional patterns of interaction and focuses on the emergence of these interactional patterns as they occur between group members in the present (here-and-now); (Ballinger & Yalom,

1995). This process-oriented approach to group psychotherapy, which is based on Sullivan's (1938) interpersonal theory of psychiatry, became a group treatment of choice following the publication of Yalom's classic group psychotherapy text in 1970. In describing this treatment approach, Yalom (1995) has indicated eleven therapeutic factors, and maintenance of a "here-and-now" focus as key components of his therapeutic approach.

The eleven therapeutic factors identified by Yalom (1995) are as follows: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. Each of these therapeutic factors are discussed briefly here (for more detail of these therapeutic factors with specific references to the inmate client population, see the treatment manual in Appendix B).

(1) Instillation of Hope: Hope is crucial to the therapy process. Inmates and therapists need to maintain hope that change is possible. Hope is required to not only keep clients in therapy, but "faith in a treatment mode can in itself be therapeutically effective" (pg. 4).

(2) Universality: Inmates may enter therapy with the preconceived idea that they are alone with their problems and that others do not share similar difficulties. While this is true to some extent, the disconfirmation of an inmate's uniqueness may be a powerful sense of relief. That is, inmates learn that they are universally similar.

(3) Imparting Information: This therapeutic factor includes both didactic instruction (e.g., psychoeducational information) and direct advise (by the therapist as well as group members).

(4) Altruism: In group therapy, clients receive through giving and group members may become very helpful to one another.

(5) The Corrective Recapitulation of the Primary Family Group: Group therapy results in group dynamics that closely resemble familial dynamics. Many aspects of families are re-experienced in the therapy group, for example, dealing with authority/parental figures, rivalries (such as sibling rivalries), strong emotions, deep intimacy, and anger and competitive feelings. Of therapeutic importance is not that early family experiences or conflicts are merely relived, rather that they are relived correctly.

(6) Development of Socializing Techniques: Group therapy provides an instant laboratory for the observation and development of social skills. The development of socializing skills in a interpersonal process-oriented group is a secondary gain as social skills training is not a focus of these groups; however, inmates may learn from feedback from others about their social behaviors.

(7) Imitative Behavior: Everyone at one time or another has imitated behaviors of others. Group therapy is no different as inmates will model their own behaviors from other group members and facilitator(s).

(8) Interpersonal Learning: Interpersonal learning includes processes that are similar to individual therapy such as insight, working through transference,

and a corrective emotional experience. Insight is the discovery of something of importance about oneself. In addition, it is assumed that the group will rekindle previous emotional experiences, and that clients may undergo a "corrective emotional experience". Growth may develop through self disclosure of emotionally laden material, and group feedback allows for reality testing. One of the primary benefits from interactive groups is that they facilitate the interpersonal relationships among group members, and these relationships represent a microcosm of the clients larger society. With the passage of time, group members will display their interpersonal pathologies. They will behave like their true selves during group interactions. Prior to turning the social microcosm to a therapeutic advantage, therapists must first identify group members recurrent maladaptive patterns. Consensual validation must be obtained to truly aid in the identification of maladaptive interpersonal styles.

(9) Group Cohesiveness: Group cohesiveness in its most basic form refers to the attractiveness of a group for its members. Defined more behaviorally, group cohesiveness refers to members feelings of warmth and comfort in the group, feelings of belonging, valuing the group, and feelings of being valued, unconditionally accepted and supported by the other group members.

(10) Catharsis: Catharsis is a process of an emotional experience, and generally refers to expressing and discharging previously repressed emotions.

(11) Existential Factors: The existential factors consists of recognizing that life is not always fair, pain and death are inevitable, one is ultimately alone in life,

and one is facing issues of life and death, as well as assuming ultimate responsibility for one's life.

Only a couple of studies have explored Yalom's therapeutic factors with offender clients. Long and Cope (1980) assessed these therapeutic factors with an adult offender population using a 60 item Q-sort method. This study concluded that the therapeutic factors were viewed by these group members in generally the same fashion as in previous studies assessing the therapeutic factors (e.g., Yalom, Tinklenberg, & Gilula, 1968 as cited in Yalom, 1995). More specifically, this study found that catharsis, cohesiveness, and interpersonal learning "output" were the most highly valued therapeutic factors among adult offenders which reflects previous findings in the Yalom et al. (1968, 1995) study. The Long and Cope (1980) study was expanded by MacDevitt and Sanislow III (1987). These authors assessed Yalom's curative factors among offender populations of different security levels. Using a modified Q-sort questionnaire, they found that factors identified by group members varied with changes in environmental restrictiveness (e.g., maximum security). For example, interpersonal learning is increasingly valued by inmates as the restrictiveness of the environment increases; however, some general trends of those factors consistently perceived as more important by inmates are present. The factors of catharsis, interpersonal learning, existential awareness, and instillation of hope are generally perceived as important for inmate populations. Overall, the therapeutic factors first identified by Yalom (1970) appear to apply to offender populations.

In addition to the implementation of the 11 therapeutic factors, Yalom specifies the necessity of focusing the group attention in the "here-and-now". This is the process-orientation of this treatment approach. Working in the "here-and-now" consists of

assisting the group to work on group relationships and issues in the present and then helping the group to reflect upon and process this information. Stated more succinctly by Yalom (1995), "the effective use of the here-and-now requires two steps: the group lives in the here-and-now, and it also doubles back on itself; it performs a self-reflective loop and examines the here-and-now behavior that has just occurred" (p. 130).

Yalom (1995) discusses other group therapy factors (e.g., culture building and norm shaping, stages of group therapy) that effect or warrant consideration prior to facilitating a process-oriented treatment group. While these factors are significant in Yalom's theoretical model, they do not appear as central to his approach as the therapeutic factors and the "here-and-now" focus. Thus, additional information related to the other group dynamics that contribute or result in the group will not be provided here. The reader is referred to the treatment manual in appendix B for further information related to these issues.

While interpersonal process-oriented group psychotherapy may be beneficial for offender populations, it is not sufficient for the reduction of recidivism (e.g., Andrews et al., 1990). As previously indicated, Gendreau (1996) posits that cognitive-behavioral theory must be incorporated into any treatment program to be of benefit for inmates in the rehabilitation process. This would appear to hold true for group psychotherapy programs as well.

Cognitive-Behavioral Group Psychotherapy

Cognitive approaches in individual therapy have included a personal construct approach (Kelly, 1955), rational emotive therapy (Ellis, 1962), cognitive therapy (Beck 1970, 1976), problem-solving approaches (D'Zurilla & Goldfried, 1971), coping skills

training (Goldfried, 1971), and cognitive-behavioral approaches (Lazrus, 1971; Meichenbaum, 1977). The theory of cognitive-behavioral therapy can be applied to groups and may be inherent in groups as they will inevitably discuss the group members thoughts as well as their feelings and behavior (Ellis, 1992).

Some of the goals of cognitive-behavioral group therapy include altering cognitive and behavioral patterns (Kraft, 1996), and developing cognitive coping skills to improve clients functioning (Rose & LeCroy, 1991). In addition, cognitive-behavioral group therapy allows members the opportunity to focus on the lives of others which may result in a lessened attention on their own negative thoughts (Courchaine & Dowd, 1994).

In his cognitive model, Beck (1976) postulates that thoughts, feelings and behaviors are interrelated. A person's thoughts and perceptions influence subsequent feelings/emotions and behaviors. Cognitive therapy focuses on the need to identify, evaluate, and modify negative automatic thoughts for the alleviation of problematic behavior(s). This is accomplished through techniques of cognitive restructuring (i.e., clients identify negative automatic thoughts and types of cognitive distortions, view these negative thoughts as hypothesis to be tested, explore the evidence for and against the negative thought, and develop alternative more realistic thoughts) and problem-solving.

Two cognitive-behavioral treatment approaches will be implemented in this dissertation: Beck's cognitive restructuring approach based on the criminal thinking errors identified by Yochelson and Samenow (1976), and a five stage problem-solving strategy developed by D'Zurilla and Goldfried (1971).

Yochelson and Samenow (1976) presented a cognitive-behavioral theoretical approach to working with inmate populations that identifies criminal thinking errors as an

antecedent to criminal behavior and these errors in thinking are differentiated from Beck's thinking errors as they are germane to the criminal population. A criminal is a person with a pattern of thoughts and actions that lead to unlawful behavior (Yochelson & Samenow, 1976). This approach focuses on the criminals thinking errors. The authors have identified 16 criminal thinking patterns and 16 automatic thinking errors characteristic of criminals.

While criminal thinking patterns and automatic thinking errors are identified separately, both refer to cognitive processes that are thinking errors. These cognitive processes are errors from a "perspective of responsibility" (Yochelson & Samenow, 1976). The authors define responsibility not in legal accountability or crimelessness, rather as a way of life that is in need of a change in ways of thinking (Hitchcock, 1994/1995). Furthermore, the criminal will not consider these thought patterns or automatic thoughts as "errors", as they are ingrained in the individual and constitute the criminals sense of self (Yochelson & Samenow, 1976).

Yochelson and Samenow (1977) have proposed treatment considerations based on their cognitive-behavioral model of criminality. First and foremost, they propose that to effect change in criminals, one must be familiar and direct treatment efforts at changing the thinking errors identified in their work, as it is these thinking errors that lead to criminal behavior. Secondly, they discourage treatment efforts aimed at altering a few individual thinking patterns in favor of an overall alteration; however, the alteration of all of the thinking errors identified by the authors is a comprehensive treatment program requiring several years of treatment. Others have modified the Yochelson and Samenow

(1977) treatment approach into a brief model to evaluate the effectiveness of this theoretical approach.

Hitchcock (1994/1995) evaluated the effectiveness of this model in a group therapy context with a deviant subsample (i.e., psychopath) of an inmate population. For purposes of this study, Hitchcock (1994/1995) focused his treatment efforts on modifying the 16 criminal thinking patterns proposed by Yochelson and Samenow (1976). Using a treatment group versus a nontreatment group design with two groups of inmates (40 psychopath and 40 nonpsychopath inmates), he found that two of the 16 thinking errors (fragmentation and suggestibility) decreased after participation in this study (Hitchcock, 1994/1995). Several limitations were noted by Hitchcock (1994/1995) including poor facilitator treatment adherence, small group sizes, and a gradual presentation of the thinking errors rather than presenting the group members with all 16 thinking errors at once. Finally, he indicated that a longitudinal study may more accurately reflect the efficacy of this treatment approach. As indicated in chapter one, several of the limitations identified by the Hitchcock (1994/1995) study have been noted and this study attempts to avoid similar mistakes (e.g., select a small subsample of thinking errors).

Based on the professional experience of this author, eight of the criminal's 16 automatic thinking errors identified by Yochelson and Samenow (1976) appear to be appropriate for short-term treatment considerations. These eight automatic errors of thinking are: "I can't, the victim stance, failure to put oneself in another's position, failure to consider injury to others, ownership, refusal to be dependent, pretentiousness, and failure to make an effort or endure adversity" (Yochelson & Samenow, 1976). These

eight thinking errors are briefly described below (for more information of these thinking errors, see the treatment manual in Appendix B):

1. "I Can't" is a thought used by criminals to avoid acting responsibly
2. "The Victim Stance" refers to the thought that the criminal is not to blame for his behavior.
3. "Failure to Put Oneself in Another's Position" is a thinking error whereby the criminal is unable to think about what others are thinking, feeling, or expecting.
4. "Failure to Consider Injury to Others" refers to a criminals inability to identify the injury or damage they cause others (injury here does not simply refer to physical injury or loss of property).
5. "Ownership" is the thought that if the criminal wants something, it is his to have.
6. "Refusal to be Dependent" is an error in thinking characterized by a fear of dependence. Criminals maintain a belief that they are completely independent without a need for others.
7. "Pretentiousness" is the criminal's thoughts of himself as superior to others.
8. "Failure to Make an Effort or Endure Adversity" is a pattern of criminal thinking where the criminal is unwilling to put forth the effort into tasks that they deem unworthy and an unwillingness to endure pain/adversity.

Problem-solving is a "cognitive-affective-behavioral process through which an individual (or group) attempts to identify, discover, or invent effective means of coping with problems encountered in every day living" (D'Zurilla, 1988; pg. 86). This process

allows the client to develop the skill of "working through a set of steps for analyzing a problem, discovering new approaches, evaluating those approaches, and developing strategies for implementing those approaches in the real world" (Rose, 1986; pg. 440). Problem-solving may be used in the treatment of numerous psychological problems (Dixon & Glover, 1984) and has shown to be effective with a variety of presenting problems (Cormier & Cormier, 1991).

The problem-solving strategy proposed by D'Zurilla and Goldfried (1971) includes five stages to effective problem-solving. The five stages consist of the following: general orientation, problem definition and formulation, generation of alternatives, decision making, and verification. These stages are briefly presented here; however, the treatment manual included in appendix B provides more detail on this problem-solving approach.

(1) General orientation refers to a goal of developing a positive attitude toward problems.

(2) Problem definition and formulation refers to identifying and defining the presenting problem.

(3) Generation of alternatives is the goal of generating as many alternative solutions to the problem as possible.

(4) Decision making refers to the evaluation of the solutions to determine the best solution(s) for the presenting problem.

(5) Verification is the final stage and involves the implementation and evaluation of the chosen solutions.

Summary

With the continued increase in the United States prison population, investigators continue to disagree on the most effective correctional philosophy. Proponents of punishment have contended that rehabilitation with offenders is generally ineffective (Martinson, 1974) while proponents of rehabilitation have presented evidence that suggests that correctional rehabilitation programs are effective (Gendreau, 1996; Gendreau & Ross, 1987; Palmer, 1975). Rehabilitation in penitentiaries occurs in the guise of education programs, vocational training programs, recreational programs, substance abuse programs, and psychological programs. Psychological programs include both individual and group therapy, although group therapy appears to have become a treatment of choice (Corsini, 1964; Wilson, 1990; and Yong, 1971).

The initial goal of group therapy outcome studies with inmate populations was to evaluate the effectiveness of this treatment approach (Homant 1976, 1986; Jew et al., 1972, 1975; Persons, 1966, 1967; and Wolk, 1963). These preliminary studies indicated that group therapy is an effective treatment modality with incarcerated prisoners. Theoretical orientations to group therapy with prisoners shown to result in treatment gains are: reality therapy (Williams, 1976), transactional analysis (Jessness, 1975; and Stasiw, 1977), cognitive-behavioral (Fink, 1981), psychodrama (Schramski et al., 1984; and Stallone, 1993), and Gestalt therapy (Serok & Levi, 1993). Specific focus groups have also proven effective with inmate populations including: Life skills training (Marshall et al., 1989; and Reker & Meissner, 1977), group therapy eliciting citizen volunteers as leaders (Andrews et al., 1980), structural differences (Leak, 1980), and pretherapy training (Hilkey et al., 1982). In addition, evaluations have assessed the

effectiveness of group therapy with inmates with specific presenting problems such as inmates placed in segregation units (Goldenberg & Cowden, 1977; Levinson et al., 1968) and inmates with insomnia (Toler, 1978). These studies generally conclude that group therapy with inmate populations can be effective; however, further research is warranted to assess for the most effective theoretical models as well as identify inmates that may benefit from placement in a group treatment program.

As indicated in this review of the correctional group psychotherapy literature, the focus of the studies completed to date has changed over the years from evaluating the general effectiveness of this treatment approach (e.g., Homant, 1976, 1977; Jew et al., 1972; Jew et al., 1975; Persons, 1966, 1967; Wolk, 1963), different theoretical orientations (Fink, 1981; Jessness, 1975; Schramski et al., 1984; Serok & Levi, 1993; Stasiw, 1977; Stallone, 1993; and Williams, 1976), and finally specific focus groups (e.g., Andrews et al., 1980; Hilkey et al., 1982; Leak, 1980; Marshall, et al., 1989; and Reker & Meissner, 1977). Essentially, no study has evaluated the efficacy of an eclectic treatment approach to group psychotherapy with inmate clients; this in spite of the proposition of Scott (1976) that eclectic approaches are the most effective when conducting therapy with criminal offenders.

Additionally, as indicated in Chapter 1, inmates present themselves to prison with several presenting problems including: conduct problems, defensiveness and guardedness, empathy, and the presence of criminal thinking errors. Previous studies have frequently used many of these issues as outcome variables to assess the effectiveness of group psychotherapy with inmates, and the need to focus on these presenting concerns has not diminished.

Institutional adjustment remains a concern of for correctional administrators, staff, and inmates alike (Hassine, 1996). Good institutional behavior is not necessarily reflected by lower rates of recidivism (Homant, 1977); however, it may be argued that adjusting to the "demands and expectations in the institutional environment", may help offenders to meet the demands and expectations of society (Garrett, 1985). Therefore, it should be of no surprise that previous studies have used behavioral indices such as disciplinary reports (Adams et al., 1994; Homant, 1976, 1977; Leak, 1980; and Stallone, 1993) and program/work attendance (Leeman, Gibbs, & Fuller, 1993) as measures of institutional adjustment. It has generally been accepted in the corrections literature that these behavioral measures of the frequency and severity of disciplinary reports as well as inmate attendance to work or scheduled programs is an indication of how inmates are coping with and comply with the expectations of their facility.

As previously indicated, resistance (i.e., defensiveness and guardedness) presents a concern for any rehabilitation program with offender populations. It is of no surprise that inmates have frequently been referred to as manipulators who may attempt to present themselves in a favorable light while participating in rehabilitation programs (e.g., Stasiw, 1977; Yochelson & Samenow, 1976), while maintaining a negative attitude towards rehabilitation programs (Rappaport, 1982). In the absence of a true measure of client guardedness and defensiveness, several studies have assessed the ability of the Minnesota Multiphasic Personality Inventory (MMPI) (Hathaway & McKinley, 1951) and the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) to discriminate between accurate and inaccurate test-taking behavior (e.g., Exner, McDowell, Pabst, Stackman, & Kirk, 1963; Ganellen,

1994; Gendreau, Irvine, & Knight, 1973; Grow, McVaugh, & Eno, 1980; Kelly & Greene, 1989). The MMPI has been the most frequently used test in professional settings (Lubin, Larsen, Matarazzo, & Seever, 1985) and has become one of the most recognized and respected objective personality instruments available.

The MMPI was one of the first personality tests to assess test-taking attitudes of the client (Greene, 1991). The MMPI-2 has maintained the four traditional validity indicators from the MMPI. These traditional validity indicators offer the opportunity to assess not only test-taking attitudes, but also allow the evaluator to make "inferences about extratest behaviors" (Graham, 1990, pg. 22) based on their test taking approach; for example, defensiveness, malingering, and random responding. In addition, the positive malingering scale (Mp) was developed by Cofer, Chance, and Judson (1949) to identify individuals who underreported psychopathology (i.e., defensiveness).

A number of studies have assessed the various MMPI validity indicators and meta- analysis (Baer, Wetter, & Berry, 1992) have shown favorable results of the detection of underreporting of symptoms (i.e., defensiveness or socially desirable responding) from the L and K scales, the Mp scale, and the L + K index. In their meta-analysis of underreporting of psychopathology on the MMPI, Baer and her associates (1992) found that "clinicians may be best advised to consider the L and K scales when making judgments about underreporting of psychopathology" (pg. 523) and that the Mp scale resulted in "promising effect sizes" to also measure underreporting of psychopathology (pg. 509). The author of this dissertation is interested in guarded and defensive behaviors and these scales appear to measure such behaviors (e.g., Baer et al., 1992; Berry, Baer, and Harris, 1991).

Inmates also differ from noncriminals in empathy. Hogan (1969) found that criminals had significantly less empathy than a control group of military officers. Furthermore, Deardorff et al. (1975) found that nonprisoners and first offenders had significantly higher empathy scores than did repeat offenders. Additionally, significantly higher empathy scores were found for inmates volunteering to work with disadvantaged people as compared to inmates not volunteering to work with disadvantaged people (Gendreau, Burke, & Grant, 1980). Thus, treatment programs that demonstrate effectiveness at increasing inmates' level of empathy may be of particular benefit from a societal perspective, as it appears likely that a more empathic person is less likely to violate the rights of others.

Finally, inmates have learned cognitive patterns of thinking about the world that differ from nonoffenders, and these "criminal thinking errors" perpetuate the continuation of illegal behavior (Yochelson & Samenow, 1976). Based on clinical experience, these authors have delineated 16 automatic thinking errors that characterize the thinking process of criminals. These automatic thinking errors refers to the mental processes that criminals use to maintain his/her antisocial lifestyle. Therefore, changes in inmates automatic thoughts may result in decreased antisocial tendencies.

These presenting problems encompass but a few of the issues that inmates bring to the therapy arena; however, improvements in these presenting problems may facilitate a process of change that is required for inmates to become productive members of society.

# CHAPTER THREE

# METHODOLOGY

## PARTICIPANTS

Participants in this study consisted of 46 incarcerated male inmates from three associated correctional facilities; however, due to circumstances unrelated to this study (e.g., early release, facility transfer), 36 inmates completed participation in this study. The inclusion criteria for this study was that all participants were adult male inmates with a remaining sentence of at least nine months (270 days) duration, and who voluntarily gave his permission to participate. For purposes of this study, an adult inmate was defined as any inmate with a chronological age of 18 years or greater. Of the 36 participants who completed this study, 20 were in the treatment condition, and 16 were in the no treatment (control) condition.

All participants of this study were male inmates with a mean age of 32.2 years (Sd=8.1). The participants were predominantly Caucasian (n=15) and African-American (n=13). While other ethnic groups were represented in this sample including: Hispanic (n=4), American-Indian (n=2), multicultural (n=1), and other (n=1), for purposes of data analyses, these participants were collapsed into one category referred to as "other". The majority of the participants were unmarried (n=19), while seven were married, five were widowed, three were divorced, and two were partnered. For purposes of data analyses, participants were collapsed into one of two groups (i.e., married, not married). Most of the participants completed high school or a General Education Diploma (GED) (n=19) with a mean of 11.8 years of education (Sd=1.3). The participants in this study were incarcerated for a variety of offenses including: drug/alcohol related offenses (n=10),

robbery/theft (n=10), aggravated battery/aggravated assault (n=5), murder/manslaughter (n=4), violent sex crime (n=2), nonviolent sex crime (n=1), and other (n=3), with 20 of the participants being convicted of more than one offense. For purposes of data analyses, participants were collapsed into one of two groups for primary charge (i.e., violent offense, nonviolent offense). The inmates were sentenced to a median of 44.5 years with a range of 17 to 150 years. Of the 36 participants in this study, 25 maintained minimum security classification, nine were classified as medium security, one was classified as maximum security, and one identified his security level as "other". For purposes of data collection, the 25 participants classified as minimum security remained in one group, while the remaining participants were collapsed into a other classification level.

## INDEPENDENT VARIABLES

### Group Condition

The independent variable in this study was the type of group condition to which inmates were assigned: either a 12-week group treatment program or a 12-week no treatment control group. The group treatment program consisted of an interpersonal process-oriented approach integrated with structured cognitive-behavioral strategies. This group implemented Yalom's (1995) well publicized theory of group psychotherapy in addition to structured cognitive-behavioral strategies and homework exercises. In particular, the group facilitator attempted to implement and utilize the 11 therapeutic factors described by Yalom. These factors are: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors (Yalom, 1995). These therapeutic factors

and their importance in this study are described in greater detail in the treatment manual that was provided to each of the group facilitators (see Appendix B). In addition to the implementation of these 11 therapeutic factors, this group focused on working in the "here-and-now". This is the process orientation of this treatment approach as working in the "here-and-now" consists of assisting the group to work on group relationships and issues in the present and then helping the group to reflect upon and process this information. Stated more succinctly by Yalom (1995), "the effective use of the here-and-now requires two steps: the group lives in the here-and-now, and it also doubles back on itself; it performs a self-reflective loop and examines the here-and-now behavior that has just occurred" (pg. 130). As with the therapeutic factors, a more detailed explanation of this tenant can be found in the treatment manual (see Appendix B).

This group treatment approach also implemented specific cognitive-behavioral techniques. More specifically, this group incorporated structured exercises and discussions for the development of two cognitive-behavioral skills. First, the group focused on identifying and modifying criminal thinking errors by implementing cognitive restructuring exercises and secondly, shifting to the development of problem-solving skills.

For purposes of this study, the group focused on criminological thinking errors as identified by Yochelson and Samenow (1976). Of the 16 criminal thinking errors identified by these authors (Yochelson & Samenow, 1976), eight were selected for focus in this study. These eight thinking errors are as follows (Yochelson & Samenow, 1976):

1. I Can't
2. The Victim Stance

3. Failure to Put Oneself in Another's Position
4. Failure to Consider Injury to Others
5. Ownership
6. Refusal to be Dependent.
7. Pretentiousness
8. Failure to Make an Effort or Endure Adversity

Although Yochelson and Samenow (1977) discourage therapists from focusing treatment efforts aimed at altering a few individual thinking patterns in favor of an overall alteration, due to the brief nature of this study, only these eight thinking errors were a treatment focus. It should be noted that the selection of these eight thinking errors was not based on empirical findings. They, were selected based on the author's intuition of those thinking errors that would be most easily understood by the inmate participants as well as those thinking errors that appeared to be most amenable to remediation in a short-term group therapy format. In addition, as suggested by Hitchcock (1994/1995), only eight criminal thinking errors were selected based on an intuitive estimate of what could be reasonably covered in this short-term treatment program. Following the introduction and processing of these criminal thinking errors, the group focused on the cognitive restructuring approach described by Beck (1995). Cognitive restructuring included identifying, evaluating, and modifying inmates automatic thoughts. The Dysfunctional Thought Record (Beck, 1995) was used to help inmates identify and evaluate their thought processes and thinking errors. This treatment approach (including the eight criminal thinking errors) is described in greater detail in the therapist training manual (see appendix B).

The group then focused on developing problem-solving skills. For purposes of this study, the problem-solving strategy described by D'Zurilla and Goldfried (1971) was implemented. This strategy incorporates five steps to functional problem-solving (D'Zurilla & Goldfried, 1971):

(1) General Orientation

(2) Problem Definition and Formulation

(3) Generation of Alternatives

(4) Decision Making

(5) Verification

The treatment manual included in appendix B provides more detail on this approach to problem-solving. This group met for two hours per week for 12 weeks with pretesting one week before the start of the group, and posttesting one week after the conclusion of the group.

The second group condition was a 12 week no-treatment waiting list control group. The participants in this group did not receive any group counseling treatment over the same 12-week period. The participants in this condition completed the pre and post assessments as a group one week before and one week after the 12-week no treatment waiting period (i.e., in the same manner as the participants in the treatment condition). In addition, while this study was being completed at the three facilities at different time periods, the participants in the control group participated in the study during the same time period as the treatment group members from their respective facility. Following the completion of this study, the inmates in the control group were offered a comparable group treatment program by a therapist at their facility.

Group Facilitators

One of the original goals of this study was to generalize the results across correctional settings. It was first proposed to complete this study in the Kansas Department of Corrections (KDOC) and the federal correctional system; however, after an initial institutional review for federal approval, permission was not deemed possible, and this study was then limited to three KDOC correctional facilities. While this study was conducted in three different correctional facilities, due to participant attrition, there was not a sufficient sample size to evaluate therapist/correctional setting outcome differences. As previously reported, the three participating correctional facilities were in the Kansas correctional system and are described briefly here.

The El Dorado Correctional Facility-Central (EDCF-C) in El Dorado, Kansas was the first facility to participate in this study. This facility is a state operated medium/maximum security correctional facility that houses approximately 950 medium, maximum, and super-maximum security inmates. The El Dorado Correctional Facility-East Unit (EDCF-E) in Toronto, Kansas also participated in this study. This is a minimum security correctional facility that houses approximately 200 minimum security inmates. Finally, the Winfield Correctional Facility (WCF) in Winfield, Kansas is a minimum security correctional facility that also served as a site for this study. The Winfield Correctional Facility houses approximately 350 minimum security inmates.

Three Mental Health Professionals facilitated the therapy groups at their facility of employment. The treatment and control groups at the EDCF-C were facilitated by a 28 year old male with a Masters of Science degree in clinical psychology. This therapist was licensed by the state of Kansas as a Licensed Masters Level Psychologist (LMLP) and

had five years of correctional psychology experience prior to serving as a group therapist for this study. The therapist at EDCF-E was a 26 year old female with a Masters of Science degree in clinical psychology from the same educational institution as the first group facilitator. This therapist is also licensed by the state of Kansas as a LMLP and had four years of correctional psychology experience prior to serving as a group facilitator for this study. Finally, the therapist at the WCF was a 37 year old female therapist with a Masters of Marriage and Family Therapy degree. This therapist was also licensed by the state of Kansas as a LMLP and is also a Licensed Marriage and Family Therapist (LMFT), and had four and one-half years of correctional psychology experience prior to serving as a group therapist for this study.

## MEASURES

This study attempted to assess five main dependent variables: institutional adjustment, guardedness and defensiveness, empathy, criminal thinking errors, and treatment satisfaction. The following measures were implemented in this study.

### Demographic Form

A standard demographic form was administered to all participants in both the treatment and control groups at the pretesting phase of data collection. This form asked for information regarding: age, gender, racial identity, marital status, years of education, charge(s) convicted of, length of sentence, and security level. See Appendix C for a copy of the demographic form.

### Institutional Adjustment

Institutional adjustment was measured by the number of disciplinary reports inmates received over a six month period (three months before the start of the group

condition, and the three months during the group condition) for inmates who participated in this study. These data were obtained from the inmates' central file and recorded on a disciplinary report record form (see Appendix D). The central files of all inmate volunteers (including those in the no treatment group) were reviewed by the group facilitators and the number of disciplinary reports received for the three months prior to and the three months during the treatment program were tallied. The three months prior to participation in the counseling program served as the pre-testing phase and the three months during the treatment program served as the post-testing phase for this measure. Although it was originally proposed to assess inmate program/work attendance, no data were available and thus could not be included in this study.

Guardedness and Defensiveness

As mentioned in Chapter 2, the MMPI-2 validity indicators (L, F, K, Mp) have been used to assess guarded and defensive behaviors in client's (Baer et al., 1992; Berry et al., 1991; Ray, 1992/1993). For purposes of this study, participants completed the MMPI-2 items from the L, F, K, and Mp scales.

The L scale consists of 15 items (Butcher et al., 1989) and is used to detect persons attempting to present themselves in the most favorable light (Meehl & Hathaway, 1946). Examples of items from the L scale include "Once in awhile I think of things too bad to talk about", "I do not always tell the truth", and "Once in a while I put off until tomorrow what I ought to do today". High scores on the L scale may be indicative of clients' attempting to create a favorable impression, defensiveness or denial, lack of insight, overevaluate their own self worth, rigid and inflexible in problem-solving, while low scores may be indicative of clients' attempts to respond in a frank and confident

manner with the ability to acknowledge minor faults and shortcomings (Graham, 1990). The L scale has a test-retest correlation of .77 after one week and a internal consistency estimate of .62 for a male normative sample (Butcher et al., 1989). According to Graham (1990) "Because of the continuity between the MMPI and the MMPI-2, the research base that supported the validity of the original MMPI also supports the validity of MMPI-2" (pg. 180).

The 60 items of the F scale (Butcher et al., 1989) were designed to detect unusual or atypical responses to the MMPI-2 (Greene, 1991). Examples of items from the F scale include: "Evil spirits possess me at times", "I believe I am being followed", "I believe in law enforcement", I am liked by most people who know me", and "Someone has been trying to influence my mind". High scores on the F scale may be indicative of extreme distress and psychopathology (Greene, 1991), faking bad/malingering, exaggerating symptoms in a plea for help, or responded randomly to the items (Graham, 1990). Low scores on the F scale may be indicative of social conformity, faking good, freedom from severe psychopathology, or a normal response set (Graham, 1990). A one week test-retest interval for the F scale resulted in a correlation coefficient of .78 for the male normative sample (Butcher et al., 1989). The F scale has an internal consistency estimate of .64 for the male normative sample (Butcher et al., 1989) indicating adequate reliability.

The K scale consists of 30 items (Butcher et al., 1989) with the purpose of identifying persons who underreport psychopathology (Greene, 1991). The K scale is related to defensiveness (Graham, 1990). Examples of items from the K scale include: "I think a great many people exaggerate their misfortunes in order to gain the sympathy and help of others", "What others think of me does not bother me", "It takes a lot of argument

to convince most people of the truth", and "Most people will use somewhat unfair means to gain profit or an advantage rather than to lose it". High scores on the K scale may be indicative of attempts to fake good, attempts to present the appearance of adequacy, in control and effectiveness (Graham, 1990) as well as defensive and lacking insight into their own behavior (Greene, 1991). Low scores on the K scale are commonly observed in people who are attempting to fake bad, critical of self and others, ineffective in dealing with daily problems, lack insight into their own behavior, are suspicious of others and maintain an outlook towards life that is generally cynical, skeptical and disbelieving (Graham, 1990). Test-retest correlations for the male normative sample following approximately one week intervals were .84 (Butcher et al., 1989). In addition, internal consistency correlations for the male normative sample were .74 (Butcher et al., 1989). Thus, the K scale has good reliability.

The Mp scale was developed by Cofer et al. (1949) to identify underreporting of psychopathology on the MMPI. These authors identified 34 items from the MMPI that they concluded represent flaws that most normal people were willing to acknowledge when responding honestly, but denied when faking good (Baer et al., 1992). Examples of items from the Mp scale include: "If given the chance I could do some things that would be of great benefit to the world", "I like to flirt", and "I am entirely self-confident". With the introduction of MMPI-2, the Mp scale lost seven of the 34 items, and no apparent research as been conducted to validate the use of this scale; however, Baer et al. (1992) indicated that this scale may remain a useful scale for detecting the underreporting of psychopathology. The analysis by Baer et al. (1992) indicated that a cutoff of 18 or more

was indicative of defensive individuals. For purposes of interpretation, the higher the Mp scale score, the more defensive the individual.

Total scores for the L, F, K, and Mp scales were calculated separately for each inmate participant using the standard MMPI-2 scoring procedures. That is, participants deviant responses to the L, F, K, and Mp scale questions were added together to obtain a total score. These total scores (or raw scores) were then used in the analysis of the results. The use of the L, F, and K scales to assess guardedness and defensiveness is typical of previous research (Frueh, 1992/1993; Gaies, 1993/1994; Spana, 1992/1993). The Mp scale was added based on the conclusion of Baer et al. (1992) that the Mp scale "might provide useful supplementary information" (p. 523) when making judgments about defensiveness.

Empathy

Empathy is the ability to perceive the mood and feelings of another person (Wolman, 1989). Hogan (1969) developed a 64 item self-report measure of empathy, in which he defined empathy as "the intellectual or imaginative apprehension of another's condition or state of mind" (pg. 307). Hogan and his colleagues initially developed a description of an empathic person using the California Q Sort and determined that empathy is a "recognizable and meaningful concept" (Chlopan, McCain, Carbonell, & Hagen, 1985 pg. 641). The validity of the 64 item scale was assessed by comparing it to the initial Q Sort. This comparison resulted in an average correlation of .62 (Hogan, 1969). Hogan (1969) further assessed the validity of this measure by examining its relationship to social acuity. Hogan's description of social acuity and empathy are related thus, the two concepts would be expected to be correlated (Chlopan et al., 1985). The

average correlation between empathy scale scores and social acuity is .58 (Hogan, 1969). The reliability of the empathy scale was assessed by Hogan (1969). Using a sample of 50 college undergraduates, Hogan (1969) found the test-retest correlation of the empathy scale to be .84 after a two month interval. Others have found the empathy scale's reliability to be less satisfactory (e.g., Cross & Sharpley, 1982). In spite of only moderate reliability and validity correlations, the Hogan Empathy Scale is only one of two empathy scales that has empirical support for adequate reliability and validity (Chlopan et al., 1985).

A 38 item shortened version of the Hogan Empathy Scale has been constructed and this scale has been found to correlate above .90 with the 64-item scale (Pecukonis, 1990; Sheer, 1989) This shortened version of the Hogan Empathy Scale was utilized in this study, and examples of items from this scale include: "A person needs to 'show off' a little now and then", "I like to talk before groups of people", and "I don't really care whether people like me or dislike me". As mentioned in Chapter 2, the Hogan Empathy Scale is capable of differentiating empathy ratings in an inmate population.

A total score was obtained by calculating inmate deviant responses to each of the 38 questions. The total number of deviant responses were than summed, and this total was subtracted from 38 (the number of items), and resulted in a Empathy score. As a double check of the data, non deviant responses were summed, and this score was compared to the previously calculated empathy score to ensure scoring accuracy. For purposes of interpretation, the higher the empathy score, the more empathic the inmate. The lower the empathy score, the less empathic the inmate.

Criminal Thinking Errors

A 16 item Criminal Thinking Errors Questionnaire (CTEQ) (see appendix E) was developed for this study to evaluate changes in inmates' criminal thinking errors following the group treatment program. This questionnaire is based on eight types of criminal thinking errors proposed by Yochelson and Samenow (1976). Participants are asked to rate the degree to which they agree or disagree with each item, using a seven point Likert scale (1 = totally disagree, 7 = totally agree). Two questions were developed to assess each of the eight criminal thinking errors. The two questions for each type of error were designed to be rated in the opposite direction. For example, if the thinking error of pretentiousness was present, one of the questions would be scored affirmatively (e.g., totally agree) and the other question would be scored in the opposite direction (e.g., totally disagree).

This questionnaire was assessed prior to use in this experiment by first administering the instrument to a panel of ten graduate student volunteers. The students were provided with a handout that briefly described the eight criminal thinking errors and were given the questionnaire and asked to identify which questions pertained to which thinking error. Those questions that had an 80 percent consensus among the student panel were maintained as questions accurately assessing the identified criminal thinking error. Those questions that did not meet the 80 percent criteria were discarded and new questions were developed and assessed following this same procedure until 16 questions were identified by the student panel as accurate questions of the criminal thinking errors.

Of the 16 questions on the questionnaire, nine were correctly identified by all ten (100%) graduate student volunteers. Two of the items were correctly identified by 90

percent while one item was correctly identified by 80 percent of the graduate student volunteers. These 12 items were maintained in the questionnaire. The remaining four items were correctly identified by 70 percent of the volunteers. As indicated previously, these four items were discarded, new items were developed, and reassessed. The graduate student volunteers correctly identified two of the new items at 100 percent accuracy, one of the new items at 90 percent accuracy and the fourth item at 80 percent accuracy. Thus, 16 questions, each with a minimum of 80 percent identification accuracy by a panel of ten graduate student volunteers, were maintained for this CTEQ.

To determine the psychometric properties of the CTEQ, it was then administered to 65 randomly selected inmate volunteers at the El Dorado Correctional Facility-Central. These inmate volunteers were administered the questionnaire at two intervals, the initial presentation and then at a 30 day follow-up. Items that were written in the opposite direction were reverse coded for purposes of data analysis. Correlation coefficients were computed for each of the eight thinking errors at the pre and posttesting phases, and ranged from a high of .57 and a low of .36 (see Table 1, Appendix A). Internal consistency was assessed by computing separate alpha coefficients for the pairs of items representing each of the eight thinking errors. That is, one alpha coefficient was computed for the two items for each of the eight thinking errors. The results of these analyses resulted in alpha coefficients that ranged from a low of 0.052 to a high of 0.456 (see Table 2, Appendix A). Obviously, these correlations and alpha coefficients are below acceptable standards to use the scale as originally designed. This questionnaire was then factor analyzed using a varimax rotation, and a principal components factor analysis using a promax rotation to further evaluate the potential use of this questionnaire

as an outcome variable in this study. Based on the results of a scree test and using eigenvalues of greater than 1.0 (Stevens, 1996), seven factors emerged; however, these seven factors were not consistent with the theoretical underpinnings of the implemented treatment program. As a result of this analysis, it was determined that this instrument does not have adequate psychometric properties and lacked theoretical structure on the factor analysis; therefore, this questionnaire did not warrant inclusion as an outcome (dependent) variable in this study.

Treatment Satisfaction

The Client Satisfaction Questionnaire (CSQ-8) is a measure of clients "general satisfaction" with therapeutic services (Larsen, Attkisson, Hargreaves, & Nguyen, 1979). This eight item self-report measure assess client satisfaction with mental health services (Gaston & Sabourin, 1992). An example of an item from this questionnaire is "To what extent has our program met your needs?" Participants rate their satisfaction with the service they received using a 4-point Likert scale (the scale anchors varied depending on the question). On this measure, higher scores indicate more satisfaction with the services received. Initial measures of the CSQ-8 by Larsen et al. (1979) resulted in an alpha coefficient of .93 indicating good internal consistency. Furthermore, Larsen (1977) found an alpha coefficient of .92, again indicating high internal consistency. In addition, only one factor has consistently been yielded during factor analysis of the CSQ-8 (Gaston & Sabourin, 1979). Overall, the CSQ-8 is a brief measure of client satisfaction that is "acceptably reliable and valid, tapping the consumer satisfaction aspect of treatment outcome" (Gaston & Sabourin, 1992 pg. 228).

Structured Interview

After completing the facilitation of the group treatment program, each therapist was asked to participate in a brief interview to inquire about their use of the group treatment approach. Each therapist was asked to verbally respond to the following six questions:

1. "What about the group therapy approach was most helpful?"
2. "What about the group therapy approach was most difficult?"
3. "What was most limiting about the group treatment program?"
4. "What did you like most about the group therapy approach?"
5. "What would you change in this group therapy approach?"
6. "What, if anything, might you use from this group therapy approach in your future work with inmates?"

PROCEDURE

Each of the group facilitators received individual training in the procedures of this study. The training of the group therapists included two phases: (1) each facilitator was trained in the data collection process for this study, and (2) they received training in the prescribed treatment approach.

Training for the data collection included instruction on the pre and post test design as well as the procedure to code disciplinary reports from the inmates' records. For this study, the assessment procedure began with a review (by the group facilitators) of the inmates' central file to collect the behavioral domain data (i.e., disciplinary reports), and included the pre and post data collection which was completed in the groups.

Following this first phase of training, the group facilitators were trained in the group psychotherapy treatment approach. As previously stated, the treatment approach implemented in this study is an interpersonal process-oriented approach implementing Yalom's (1995) group psychotherapy theory with the addition of structured cognitive-behavioral strategies.

Training of the group facilitators began by providing the group facilitators with the treatment manual (see Appendix B) and asking that he/she read the manual. Appointments for the next two weeks were then made with the group facilitator. These two appointments (training sessions) lasted for four hours each and consisted of training the facilitators in the use of the treatment approach as delineated in the treatment manual. The first of these two appointments focused on training the group facilitator in the use of Yalom's (1995) approach to group psychotherapy. The last appointment focused on the implementation of the cognitive-behavioral treatment component.

After completing the training phase, group facilitators began soliciting group participants for participation in this study. The participants for this study were selected from mental health waiting lists maintained at each facility and via normal institutional recruitment and communication methods (e.g., posted flier advertisements, staff referrals). Participants were asked to volunteer their participation in a study that evaluates a new rehabilitation treatment approach. Those inmates volunteering to participate in this study were then randomly assigned to one of two treatment conditions: a group therapy program with an emphasis on process-oriented and structured cognitive-behavioral interventions, or a no treatment control group. The exception to this random assignment was that inmates with a parole or release date within nine months of the start

of the group and who were required to participate in a group treatment program were assigned to the treatment condition. All participants who were randomly assigned to the no treatment control group were offered a comparable treatment program at the conclusion of this study.

After selection and random assignment to one of the group conditions, each participant met individually with the group facilitator, and were informed that an experiment evaluating a new approach to group counseling was being completed and they were offered an opportunity to participate in the study. They were informed that their participation in this study was completely voluntary and that if they choose not to participate, they would incur no negative consequence. All inmate volunteers were asked to sign a consent to participate form that briefly described this study, their expectations for participation (e.g., completing all measures at two different times, that their group therapist would review their institutional file to review their disciplinary record), and informed the inmate of his rights and privileges as a subject of this research (see appendix F).

Next, the group facilitator conducted an intake interview with those inmates assigned to the treatment condition as described in the treatment manual (see appendix B). In addition, the inmates were asked to sign a limits to confidentiality form, as well as all other forms required by the Kansas Department of Corrections. Finally, inmates received a brief verbal overview of the treatment approach to be implemented and any questions were answered by the group facilitators.

The pre-test data collection consisted of all group members completing the assessment instruments as a group and was completed one week before the start of the

first group session. Upon completion of the group, inmates again met as a group to complete the post-test assessment instruments. Following the completion of the group, the group facilitator reviewed the inmates' chart to collect the post-test behavioral data. Finally, inmates that completed the group treatment program were provided a certificate of completion that was placed in their central files.

Subjects in the waiting list control group condition followed the same procedure with the exception that after completing the pre-test assessment instruments, they did not participate in a treatment group. One week after the duration of the treatment condition had passed (12 weeks), these participants completed the post-test assessment instruments. As stated previously, at the conclusion of this study, these inmates were offered a comparable treatment program.

One week after the pre-test assessment was completed, the group facilitator began facilitating their groups in the manner prescribed by this investigator. At this time, all groups were closed so that no new members were admitted to the group once the treatment began. Following the completion of each group therapy session, each facilitator was called by this experimenter for the purpose of providing consultation services and to identify and attempt to solve any problems encountered. These consultations were also for the purpose of ensuring treatment adherence, for resolving potential problems/conflicts, and for providing therapist feedback as warranted. Finally, after completing the group treatment program, each therapist was interviewed about their perceptions of the group treatment program. As indicated previously, this interview included the following questions: (1) What about the group therapy approach was most helpful?, (2) What about the group therapy approach was most difficult?, (3) What was

most limiting about the group treatment program?, (4) What did you like most about the group therapy approach?, (5) What would you change in this group therapy approach?, and (6) What, if anything, might you use from this group therapy approach in your future group work with inmates?.

To ensure treatment adherence, each group facilitator audio taped one 30 minute segment of every fourth group counseling session (for a total of three taped segments). The therapists were asked to audiotape one segment from the interpersonal process-oriented section of a session, one segment from a cognitive-behavioral section of a session, and a third segment of their choice. For purposes of this study, only the first two tapes covering the prescribed treatment sections were rated. The tapes were rated by two doctoral level graduate students who have been trained and received supervised experience in the provision of group psychotherapy. The raters were trained in the principals of this group treatment program and then were asked to code each tape to determine whether the audiotaped segment represented the interpersonal processes or the cognitive-behavioral component of the treatment program. A coding sheet was developed by this experimenter (see Appendix G) for use by the raters. The purpose of this rating was to ensure that the group facilitators followed the prescribed treatment approach. On these ratings, the coders were able to accurately identify all six of the tapes (two from each therapist), thus, it was concluded that the group facilitators adhered to the treatment program delineate in this study. These tapes remained strictly confidential and each tape will be erased at the end of the study.

## DESIGN OF THE STUDY

The design for this study is a 2 X 2 split-plot factorial multivariate analysis of variance (MANOVA). The treatment condition (group treatment versus no treatment control group) served as the between-subjects factor, and test interval with two points of assessment (pre and post) as the within-subjects variable. As previously indicated, the dependent variables included one behavioral measure of institutional adjustment (i.e., disciplinary reports), the guardedness and defensive indexes, and empathy.

## ANALYSIS OF THE DATA

A 2 (treatment condition) X 2 (test interval) split-plot multivariate analysis of variance (MANOVA) procedure was performed for the four validity scales of the MMPI-2. This is a split-plot design as the independent variable of treatment condition is a between subjects variable, and the test interval is a within subjects variable. A similar 2 X 2 split-plot analysis of variance (ANOVA) procedure was implemented for the empathy scale. A Chi Square procedure was performed for the number of disciplinary reports received by inmates in the treatment and no treatment control groups. In addition, means and standard deviations were calculated on the client satisfaction measure to evaluate the inmates' satisfaction with the treatment program.

Due to a clerical error with the MMPI validity scales questionnaire used in this study, 15 of the 118 items were not completed by 15 of the participants. Of these 15 participants, 8 were in the treatment group and 7 were in the control group. These 15 items included: four F scale items, six K scale items, and seven Mp scale items. Note that the L scale was unaffected by this error. To account for this missing data, the mean

score for each of the 15 items, from the respective groups (i.e., treatment and control groups), were used to estimate the missing scores.

# CHAPTER FOUR

# RESULTS

## INTRODUCTION:

The purpose of this study was to evaluate the efficacy of a group psychotherapy treatment intervention that integrates interpersonal process-oriented and cognitive-behavioral theories with male inmates. Treatment effectiveness was assessed by comparing the treatment group with a no treatment control group on measures of defensiveness, empathy, and institutional adjustment at both pre and post testing periods. Inmate treatment satisfaction and facilitator satisfaction was assessed at the end of the group psychotherapy program.

## STATISTICAL ANALYSES:

### Procedural Question:

In light of the relatively small sample size, statistical analyses were conducted on demographic variables to assess the equivalence of the treatment group and the control group. Preliminary analyses were first conducted using independent t-tests for three continuous variables including age, years of education, and length of sentence in years. Table 3 (Appendix A) is a summary of these three analyses. As seen in the table, the t-test for age indicated that the participants in the control group were significantly older ($\underline{M}$ = 35.44, $\underline{Sd}$ = 6.95) than the participants in the treatment group ($\underline{M}$ = 29.65, $\underline{Sd}$ = 8.24), $T(1,34) = -2.24$, $p = .03$. As a result, the decision was made to control for the effects of age by using age as a covariate in subsequent analyses comparing the two groups (treatment versus control) on measures of defensiveness, empathy, and institutional adjustment.

A second set of procedural analyses were performed for demographic variables in categorical form including: race, security level, marital status, and primary charge. Using a Chi Square procedure, no statistically significant relationships between the treatment condition (treatment and control groups) and the demographic variables were found (see table 4, Appendix A). The results of these analyses indicate that the treatment group and the control group did not significantly differ on any of the demographic variables except age.

The following is a summary of the results for each research question and hypothesis

Research Questions:

Research Question One: Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of defensiveness? The null hypothesis for this question is that there will be no statistically significant differences between the treatment and control group participants on measures of defensiveness. The alternative hypothesis was that inmates participating in the treatment group would report significantly lower levels of defensiveness compared to the inmates in the control group.

The four MMPI-2 validity scales, L, F, K, and Mp (measuring defensiveness) were analyzed using a 2 (treatment group vs. control group) X 2 (pretest and posttest) split-plot multivariate analysis of covariance (MANCOVA) procedure with age as the covariate. The means and standard deviations for the treatment and control group on the four MMPI-2 validity scales are presented in Table 5 (Appendix A). Using the MANCOVA procedure, the interaction effect was not statistically significant for the

measures of defensiveness, exact $F(4,31) = 0.794$, $p = 0.54$. Similarly, the main effects for treatment condition (i.e., treatment group versus control group), exact $F(4,30) = 2.034$, $p = 0.12$, and time (pretest or posttest), exact $F(4,31) = 1.853$, $p = 0.14$ were not statistically significant for measures of defensiveness. Therefore, one fails to reject the null hypothesis as inmates in the treatment and control conditions did not differ significantly on measures of defensiveness.

Research Question Two: Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of empathy? The null hypothesis for this question is that there will be no statistically significant difference between the treatment and control group participants on levels of empathy. The alternative hypothesis was that inmates participating in the treatment group would have significantly higher levels of empathy compared to the inmates in the control group. Total empathy scores were analyzed using a 2 X 2 split-plot analysis of covariance (ANCOVA) procedure, with age as the covariate. The means and standard deviations for the treatment and control group on levels of empathy are presented in Table 6 (Appendix A). The 2 X 2 ANCOVA for the empathy scores resulted in no statistically significant interaction effect, exact $F(1,34) = 0.02$, $p = 0.88$, or significant main effects for treatment condition, exact $F(1,33) = 2.14$, $p = 0.15$, or time, exact $F(1,34) = 3.56$, $p = 0.07$. Thus, one fails to reject the null hypothesis as inmates in the group treatment and control conditions did not significantly differ on levels of empathy.

Research Question Three: Does inmate participation in an interpersonal process-oriented/cognitive behavioral group relate to the number of disciplinary reports received? A frequency count of disciplinary reports yielded the results reported in Table 7

(Appendix A). The null hypothesis for this question was that there would be no statistically significant relationship between the treatment condition and the number of disciplinary reports received. The alternative hypothesis was that inmates receiving the group treatment program would be more likely to receive no disciplinary reports over the last six months compared to the inmates in the no treatment control group. A Chi Square procedure was used to test for the independence of treatment group membership and the number of disciplinary reports received. This Chi Square procedure resulted in no statistically significant relationship between group membership and disciplinary reports at the pretest, $\chi^2$ (1df) = 0.60, $p > 0.80$ or the posttest, $\chi^2$ (1df) = 2.40, $p > 0.10$. Thus, one fails to reject the null hypothesis as inmates in the treatment and control conditions did not significantly differ on the number of disciplinary reports received over a six month period .

Research Question Four: Does inmate participation in an interpersonal process-oriented/cognitive behavioral group effect significant change in their level of criminal thinking errors? The null hypothesis for this question was that there would be no statistically significant difference between the treatment and control group participants on levels of criminal thinking errors. The alternative hypothesis was that inmates participating in the treatment group would have significantly lower levels of criminal thinking errors compared to the inmates in the control group. Due to the lack of adequate psychometric properties, for the proposed instrument (CTEQ), the data could not be analyzed for this study. Therefore, this research question remains unanswered.

Research Question Five: How satisfied were the inmates with this group treatment program? It was hypothesized that inmates receiving the group treatment program would be satisfied with the services they received (as measured by the CSQ). The inmates reported that on average they were "mostly satisfied" with the group treatment program they received, that the quality of service was "good", and that the group treatment program "generally" provided the kind of service they wanted. They also reported that the group treatment program met "most of my needs", that they were "mostly satisfied" with the amount of help they received, and that the group treatment program helped them deal with their problems more effectively. Finally, the group therapy participants reported that they would come back to this program if they were to seek help again, and that they would recommend this group therapy program to a friend who was in need of help. Descriptive statistics for the participants responses to the eight item satisfaction questionnaire are presented in Table 8 (Appendix A).

QUALITATIVE ANALYSES:

Each of the three therapists were asked the six questions described in chapter three to elicit their perceptions of using this group therapy treatment program with adult male inmates. Overall, the group facilitators responded favorably towards this group therapy approach. This was most strongly articulated by therapist three who stated "I really liked this approach, and I wish it was more universally used". The questions and summaries of the therapist responses to each question are listed here.

Question One: "What about the group therapy approach was most helpful?" Group therapists 2 and 3 stated that incorporating both the structure as well as the group

process into each session was most helpful. Group therapist 1 stated that he thought the problem-solving approach was most helpful as "they seemed more ready to use that".

Question Two: "What about the group therapy approach was most difficult?" Group therapist 1 and 2 stated that the most difficult aspect of this group was shifting from the group process (first part of group) to the more structured cognitive-behavioral portion of the group. As therapist 1 stated, "cutting off the group process and focusing on the homework, they wanted to go back and discuss the previous stuff". In fact, this issue of the transition between the two approaches (interpersonal process and cognitive-behavioral) was frequently discussed with all three therapists during the weekly consultations, and all three therapists reported some difficulty making this shift. With regard to this question, therapist 3 stated that "the thinking errors" were the most difficult part of the program to implement because the inmates were hesitant to admit having a "thinking error" and were resistant to identifying how the thinking errors applied to them.

Question Three: "What was most limiting about the group treatment program?" Group therapist 1 stated that the homework was most limiting because he "had a hard time getting them to do it". This was another theme during the weekly phone consultations. This was especially true for therapists 1 and 2 as their groups appeared more resistant to completing the homework assignments.

Group therapist 2 stated that the most limiting aspect of this therapy approach was the length of the program being only 12 sessions. She stated she would have preferred to have more time to work with her group. Therapist 3 had no response for this question. She stated she was unable to identify anything that she perceived as particularly limiting.

Question Four: "What did you like most about the group therapy approach?" Group therapists 1 and 2 reported that they liked the process of the group and both reported that the group members became responsible for the group. This was succinctly stated by therapist two who stated "The group did most of the work, I had to keep them focused, but they did the work...after the fourth or fifth session they started leading themselves". Group therapist 3 again pointed out the benefit of the structure of the treatment approach and stated "having something structured with these guys, I liked having a specific approach to dealing with inmates, and having specific content to go over".

Question Five: "What would you change in this group therapy approach?" With regard to what they would change about the treatment approach, group therapists 1 and 2 again focused on the difficulties shifting from the process orientation to the cognitive-behavioral orientation and suggested a change to ease this transition. For example, therapist 1 stated "I'm wondering if the exercises would be better at the beginning" of the group. Therapist 3 stated that she would consider changing the thinking errors that were selected from the work of Yochelson and Samenow (1976). She also stated that she would double the number of therapy sessions to increase the treatment length.

Question Six: "What, if anything, might you use from this group therapy approach in your future group work with inmates?" All three therapists reported they would use the interpersonal process orientation in their future group work with inmates. Group therapists 1 and 2 stated that this was their first introduction to Yalom's theoretical approach and that they would definitely use it again. As therapist 2 put it "the interpersonal bringing the group into the here-and-now and evaluating the

relationships...it's amazing to me how close the guys in the group got". In addition, therapists 1 and 3 stated that they would use all aspects of the treatment approach again, but also noted that limitations existed in the approach. For example, therapist 1 stated "well, I'd probably use all of it, although the cognitive stuff was less accepted, almost like they were defensive against that".

Overall, these interviews with the group therapists indicated that they were generally satisfied with this group therapy intervention and indicated they would use some or maybe even all aspects again in their group work with male inmates. Common themes in the therapists perceptions of the treatment approach were: (1) overall satisfaction with the approach, (2), benefit of the format for incorporating both the interpersonal process orientation and the cognitive-behavioral orientation into the group work, (3) difficulty shifting between the two orientations, (4) tendency for the inmates to be more resistant to the focus on the criminal thinking errors, (5) a need to increase the number of group sessions, (6) the effectiveness of the approach to facilitating the inmates taking responsibility (i.e., leading) the group work, (7) difficulty getting inmates to complete the homework assignments, and (8) a positive reaction to a structured plan for what they were going to do and try to accomplish in the group for any given session.

# CHAPTER FIVE

## DISCUSSION

This study evaluated the efficacy of a group psychotherapy treatment intervention with male inmates that integrated interpersonal process-oriented and cognitive-behavioral approaches. Treatment effectiveness was assessed by comparing the treatment group with a no treatment control group on measures of defensiveness, empathy, and institutional adjustment at both pre and post testing periods. Inmate treatment satisfaction was also assessed using a client satisfaction questionnaire. Interviews were conducted with the group therapists to explore their reactions to the group treatment program for male inmates.

The participants that received this group treatment approach did not experience improvement on the outcome measures over time and were no different at posttesting than those participants that did not receive the treatment intervention. More specifically, the participants receiving the group psychotherapy intervention did not experience a decrease in their defensiveness scores as measured by the L, F, K, and Mp scales of the MMPI-2, nor a decrease in their frequency of disciplinary reports, and they did not experience an increase in their level of empathy as measured by the Hogan Empathy Scale, as expected.

While this study did not result in significantly improved outcomes for those participants receiving the group treatment program compared to a no treatment control group, the inmates that participated in the treatment program reported that they were "mostly" satisfied with the service they received and indicated that the treatment they received was helpful to them. Furthermore, the group therapists reported being very

satisfied with the group psychotherapy program and found the treatment approach to be useful in their work with adult male inmates. Finally, the therapists reported that they believed the intervention was effective in facilitating participant responsibility for the group and for fostering a cohesive group atmosphere.

Several explanations for the lack of statistical significance on the outcome variables (e.g., defensiveness, empathy, and disciplinary reports) appear plausible. One possible explanation is that the group therapists did not receive enough training and/or did not fully comprehend or have enough experience to facilitate the designed treatment approach. It is also possible that due to the complexity of Yalom's interpersonal process-oriented approach as well as the number of structured cognitive-behavioral exercises, eight hours of training may not have been sufficient to allow the group therapists to master the intervention. Similarly, while the interrater codings revealed that the group therapists in this study implemented the treatment program, the three group facilitators may not have had the experience or group psychotherapy training necessary to achieve the depth necessary to most effectively facilitate this group psychotherapy approach.

It is also possible that the group treatment program may not have been of sufficient length to facilitate the desired changes in inmates' thoughts, feelings, and behaviors. The group therapists alluded to this possibility when two of the three therapists reported during the interview that the treatment duration was a limitation of the approach. While the tendency for brief therapy has been noted (e.g., Garfield, 1978; Koss & Butcher, 1986), it may be that the severity of the "criminal personality" is so pathological that short-term treatments are not sufficient to facilitate noticeable change in inmates.

This study may not have adequately measured the effectiveness of this group treatment approach. That is, the choice of these dependent variables may not have effectively measured the success of this group psychotherapy program. On average, the inmates in the treatment group and the control groups were not openly defensive or guarded, and did not present overly positive or negative test taking attitudes as measured by the L, F, K, or Mp scales of the MMPI-2, at the pre or post testing phases.

One of the proposed benefits of this brief group treatment approach was that inmates participating in this group psychotherapy program would be less resistant to correctional rehabilitation programs in general. Thus, a better measure of the expected treatment benefit may have been a measure (e.g., Attitudes toward Psychotherapy and Psychotherapist scale) that assesses the inmates readiness for more intense rehabilitation programs.

Although disciplinary reports have been used as a measure of inmate behavior change in previous studies (e.g., Andrews & Young, 1974; Goldenberg & Cowden, 1977; Leeman et al., 1993), it may be an inadequate measure of brief group psychotherapy effectiveness. The disciplinary reports in this study had only been collected over a six month period of time (i.e., three months for pretest and three months for posttest). The average number of inmate disciplinary reports during this time was less than one report. It is possible that, very little time had elapsed to obtain a truly good measure of the impact this group intervention my have had on inmates' institutional behavior. The incorporation of additional behavioral measures (e.g., work/program attendance records, work performance rankings, cellhouse officer rankings) may have been able to provide a

more accurate measure of the effectiveness of this treatment approach for facilitating behavioral change.

The Hogan Empathy Scale may have been inadequate in and of itself to measure changes in empathy over time. This scale assesses empathic dispositions that are based on moral character development (Pecukonis, 1990). Thus, while this study did assess empathy, it did not assess more direct effects of empathy that may have occurred between group members. One focus of this group was on the interpersonal relationships of the group members to each other and to the therapist, yet no evaluation was conducted on the quality of these interactions to assess for changes in empathic responding. The implementation of a group interaction based assessment instrument may have provided a more thorough evaluation of changes in inmate empathy. It should be noted that inmates in both group conditions had fairly high levels of empathy at the pretesting phase of this study. Therefore, changes in empathy scores might have been unrealistic.

It is also possible that the benefits of this intervention were not apparent in a short-term analysis, rather, the benefits could occur at a later date. In other words, it may be possible that a seed of change was planted, and while this intervention did not result in immediate change, change might be forthcoming and could occur at a later, unmeasured date.

Another possibility is that inmates may have already participated in similar treatment programs, which already led to personal growth and a lack of defensiveness/guardedness, disciplinary problems, or empathy at the pretesting phase of assessment. For example, inmates in this study may have received previous

psychotherapy therefore, limiting the amount of potential improvement inmates could make in their level of defensiveness, empathy, or conduct problems .

Still another possibility is that this type of group intervention was not effective with incarcerated adult males; however, it should be noted that other process-focused and content-focused group psychotherapy approaches have previously demonstrated effectiveness with inmate populations (e.g., Andrews et al., 1980; Homant, 1976; Leak, 1980; Nedd & Shihadeh, 1974; Serok & Levi, 1993; Stallone, 1993; Wolk, 1963). In addition, both the inmates and the group therapists reported positive benefits resulting from this intervention. While client perceptions of treatment effectiveness may be biased (Brock, Green, Reich, & Evans, 1996; Kotkin, Daviet, & Gurin, 1996) as they tend to report being quite satisfied with psychotherapy (e.g., Attkisson & Zwick, 1982), client perspectives have "a validity of its own" (Strupp, 1996; p. 1022). Therefore, client reports provide important and useful information about the success of psychotherapy (e.g., Gaston & Sabourin, 1992; Seligman, 1995; Strupp, 1996). Thus, while this study did not result in the desired outcomes for change on the variables of interest (i.e., defensiveness and guardedness, empathy, or institutional behavior), it appears premature to dismiss this interpersonal process-oriented and cognitive-behavioral treatment approach as ineffective with adult male inmates given the favorable views of the program by inmates and group therapists. By the same token, this study obviously does not validate the injudicious use of this treatment approach, and obviously more research is needed to further evaluate the utility of this group treatment intervention.

## IMPLICATIONS FOR PRACTICE

As previously indicated, the group therapists considered this group psychotherapy program to be effective in facilitating inmate responsibility for the work of the group and for fostering a cohesive group atmosphere. This offers practical implications for similar treatment models. According to Yochelson and Samenow (1976), inmates lack responsibility. They extended their definition of responsibility beyond legal accountability to an entire way of life. Therefore, a treatment program that fosters inmate responsibility may begin the process of change that is needed to help inmates begin living a more responsible way of life. Additionally, the therapists' perception that this group psychotherapy program fostered group cohesiveness is potentially significant. As previously defined in Chapter 2, group cohesiveness refers to members feelings of warmth and comfort in the group, feelings of belonging, valuing the group, and feelings of being valued, unconditionally accepted and supported by other group members. This appears particularly important for inmate populations as inmates are frequently reared in impoverished environments, and may experience few opportunities to join and function in groups. Yalom (1995) recognized the significance of group cohesiveness when he posited that as clients develop a sense of public esteem (in this case the groups evaluation of the inmate), increased self-esteem is sure to follow.

Also of interest is that the inmates in both the treatment and control group in this study were not defensive or guarded, were fairly compliant with institutional rules and regulations, and displayed appropriate levels of empathy. This indicates that it is important for clinicians working with male inmates to avoid assumptions that inmates are defensive and resistant, uncaring and insensitive, and/or consistently act out. As clinical

assumptions may be erroneous, inmate clients may benefit from the implementation of a preliminary needs assessment.

Clinicians may also benefit from conducting a needs assessment (e.g., pretest assessment) prior to providing any treatment intervention to discern the needs of the inmate groups with which they work. This appears especially important for therapists facilitating groups with inmates that are required to complete a group treatment program. According to Morgan, Winterowd, and Ferrell (1997), approximately 20 percent of adult male inmates participating in group psychotherapy programs are required to do so, and as previously indicated, may enter a treatment program with a variety of presenting problems. It is also likely that inmates required to attend group psychotherapy programs may do so without clearly established goals (other than the goal of satisfactorily completing the treatment requirement). A needs assessment may provide valuable information for therapeutic direction as well as allow the therapist to tailor a group program to the needs of the inmate.

## IMPLICATIONS FOR FUTURE RESEARCH

In addition to treatment implications, this study led to some implications for future research. First, the use of quantitative and qualitative dependent variables allows for a thorough evaluation of the efficacy of the treatment program from both the clients, and therapists perception. As the debate over the value of efficacy versus effectiveness evaluations continue (e.g., VandenBos, 1996), this design appears to offer a viable balance between the two. Additionally, the use of a treatment manual and independent raters to evaluate the adherence to the treatment program provides a research design that

allows for a more thorough evaluation of the intervention. Future studies assessing the efficacy of psychotherapy interventions may benefit by utilizing similar designs.

Future research is needed to further evaluate the efficacy of this group psychotherapy treatment approach. For example, this intervention did not result in inmate changes in empathic dispositions as measured by the Hogan Empathy Scale; however, further studies need to assess the effects of this intervention on the interpersonal interactions that occur between group members during sessions. This may facilitate further studies that identify means of transferring changes accrued during the group sessions to the inmates real world (i.e., transfer learning from the social microcosm of the group experience to the inmates larger social environment). In addition, future studies may find it beneficial to evaluate the effect this short-term treatment approach has on inmates' preparation for other rehabilitation programs. This brief group psychotherapy intervention was not developed to remedy widespread characterological traits, thus, future research needs to assess the utility of this intervention on effecting inmate readiness for further rehabilitative work.

Additionally, a more complete evaluation certainly needs to incorporate a psychometrically sound cognitive-behavioral measure of change. Cognitive-behavioral interventions are a prominent feature of this integrative treatment approach, thus, any future evaluations should assess the effects of this intervention on changing criminal thinking errors and evaluate inmates ability to solve problems using well-developed psychometrically sound measures.

Finally, if further research validates the use of this treatment approach, continued research needs to evaluate the most efficient manner of facilitating this group treatment

approach. For example, future studies need to assess whether it is better to begin the group sessions with the interpersonal process-oriented approach as done in this study, or whether it would be more effective to begin each group session with the structured cognitive-behavioral approach.

## LIMITATIONS OF THE STUDY

As with any research, there are limitations with this study. The first and possibly most significant limitation of this study is the lack of a clean experimental design. Due to the population under consideration and a lack of experimental control, the design of this study does not account for all possible confounding variables. In many cases, research decisions related to methodology (e.g., number of groups facilitated, sample size, collection of follow-up data) were based on practical limitations, rather than scientific specifications.

Limitations in power is another potentially significant limitation of this study. Power refers to the ability to detect significant differences that are present between treatment conditions (Keppel, 1991). Due to the nature of this study and time restrictions of the group facilitators, the subject size of the two treatment conditions (treatment, no treatment) were less than desirable. According to Keppel (1991), the desired subject size for each condition in a study of this type is 44 subjects per cell (power = .80 and effect size = .06); however, due to practical limitations, a subject size of 20 inmates for the treatment group, and 16 for the control group were utilized. Subsequently, this led to a decrease in the potential power of this study.

Randomization was another limitation of this study. Due to the nature of the treatment setting, a completely random sample could not be drawn. Subjects requiring

group therapy prior to release or parole hearings and who were at the top of their respected mental health waiting lists could not ethically be restricted from group participation for research purposes. Thus, while all attempts were made to provide as much randomization as possible, this study lacked a completely true experimental randomization of conditions (treatment versus no treatment).

Selection bias was also a potential limitation of this study and may present a threat to internal validity. Inmates volunteered or were required to participate in mental health services for varied reasons, thus the motivation of group participants might have varied.

The internal validity of this study may also have been compromised by participant attrition. As time passed between the pre and post data collection phases of this study, 10 inmates were transferred, released, or placed in more restricted environments. This loss of participants presented a threat to the internal validity of this study.

As already indicated, the research design of this study has some inherent limitations that pose further threats to the internal validity of this study. For example, the recruitment procedure was slightly different at the differing facilities. Two of the identified facilities maintained functional mental health treatment waiting lists and participants were asked to participate in this study based on their random selection from this waiting list; however, the other identified facility did not maintain a mental health treatment waiting list and participants were recruited via that institutions' normal mental health recruiting procedure (e.g., consulting with correctional staff). In addition, the group facilitators had slightly differing educational and were slightly different in age and

gender. Such limitations of the design pose further threats to the internal validity of this study.

The lack of follow-up data (e.g., three months after the termination of the group) is another limitation of this study. Due to inmate participant attrition (e.g., facility transfer, release from incarceration), follow-up data was not obtained as previously proposed. Thus, this study is limited by the absence of any post treatment follow-up data.

Finally, as indicated by Yochelson and Samenow (1976) and Hitchcock (1994/1995), the modification of all of the thinking errors of this model could consume a great deal of treatment effort and time. Thus, when faced with time restrictions, it may be beneficial to focus treatment efforts on a small subsample of thinking errors; however, this limited the scope and potential benefits of this treatment approach. Yochelson and Samenow (1976) would invariably identify the selection of only eight of the thinking errors as a limitation of this study.

In conclusion, this study of the efficacy of an interpersonal process-oriented and cognitive-behavioral group psychotherapy program with male inmates did not result in significant changes in inmates level of defensiveness or guardedness, empathy, or institutional adjustment; however, the inmates receiving the intervention were satisfied with the service they received and considered the intervention to be helpful. Similarly, the group facilitators who implemented the treatment program perceived the intervention to be helpful in their facilitation of group therapy as well as beneficial for the inmates receiving the treatment program. Future studies are warranted to further assess the efficacy of this group psychotherapy approach with adult male inmates. In particular, future studies could evaluate the impact this treatment program has on inmates

interpersonal interactions, criminal thinking errors and problem-solving skills, and inmate preparation for other intensive rehabilitation programs.

# REFERENCES

Adams, K., Bennett, K. J., Flanagan, T. J., Marquart, J. W., Cuvelier, S. J., Fritsch, E., Gerber, J., Longmire, D. R., & Burton, Jr., V. S. (1994). A large-scale multidimensional test of the effect of prison education programs on offenders' behavior. The Prison Journal, 74, 433-449.

Adams, S. (1977). Evaluating correctional treatments: Toward a new Perspective. Criminal Justice and Behavior, 4, 323-339.

American Correctional Association. (1981). Directory: Juvenile & adult correctional departments, institutions, agencies & paroling authorities. Laurel, MD: Author.

American Correctional Association. (1994). Directory: Juvenile & adult correctional departments, institutions, agencies & paroling authorities. Laurel, MD: Author.

Andrews, D. A., Wormith, J. S., Daigle-Zinn, W. J., Kennedy, D. J., and Nelson, S. (1980). Low and high functioning volunteers in group counseling with anxious and non-anxious prisoners: The effects of interpersonal skills on group process and attitude change. Canadian Journal of Criminology, 22, 443-456.

Andrews, D. A., Zinger, I., Hodge, R. D., Bonta J., Gendreau P., and Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. Criminology, 28, 369-404.

Andrews, D. A., & Young, J. G. (1974). Short-term structured group counselling and prison adjustment. Canadian Journal of Criminology and Corrections, 16, 5-13.

Arnold, W. R., & Stiles, B. (1972). A summary of increasing use of "group methods" in correctional institutions. International Journal of Group Psychotherapy, 22, 77-92.

Associated Press (1995, December 4). Prisoner increase sets national, state records. The Daily O'Collegian, 10.

Attkisson, C. C., & Zwick, R. (1982). The Client Satisfaction Questionnaire: Properties and correlations with service utilization and psychotherapy outcome. Evaluation and Program Planning, 5, 233-237.

Baer, R. A., Wetter, M. W., & Berry, D. T. R. (1992). Detection of underreporting of psychopathology on the MMPI: A meta-analysis. Clinical Psychology Review, 12, 509-525.

Ballinger, B., & Yalom, I. D. (1995). Group therapy in practice. In B. Bongar & L. E. Beutler (Eds.), Comprehensive textbook of psychotherapy: Theory and practice (pp. 189-204). New York: Oxford University Press.

Beck, A. (1970). The core problem in depression: The cognitive triad. In J. Masserman (Ed.), Depression: Theories and therapies. New York: Grune & Stratton.

Beck, A. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press.

Berry, D. T. R., Baer, R. A., & Harris, M. J. (1991). Detection of malingering on the MMPI: A meta-analysis. Clinical Psychology Review, 11, 585-598.

Boudouris, J. (1984). Recidivism as a process. Journal of Offender Counseling, Services, & Rehabilitation, 8, 41-51.

Brock, T. C., Green, M. C., Reich, D. A., & Evans, L. M. (1996). The consumer reports study of psychotherapy: Invalid is invalid. American Psychologist, 51, 1083.

Butcher, J. N., Dahlstrom, W. G., Graham, J. R., Tellegen, A. M., & Kaemmer, B. (1989). MMPI-2: Manual for Administration and Scoring. Minneapolis: University of Minnesota Press.

Chance, G. R. (1981). The effects of group psychotherapy on the self-actualization of male inmates in a federal penitentiary. (Doctoral Dissertation, University of Missouri-Kansas City, 1981). Dissertation Abstracts International, 42, 2499.

Chlopan, B. E., McCain, M. L., Carbonell, J. L., & Hagen, R. L. (1985). Empathy: Review of available measures. Journal of Personality and Social Psychology, 48, 635-653.

Cofer, C. N., Chance, J., & Judson, A. J. (1949). A study of malingering on the MMPI. Journal of Psychology, 27, 491-499.

Corey, G. (1990). Theory and practice of group counseling (3rd ed.). Pacific Grove, CA: Brooks/Cole.

Corey, M. S., & Corey, G. (1987). Groups: Process and practice (3rd ed.). Monterey, CA: Brooks/Cole

Cormier, W. H., & Cormier, L. S. (1991). Interviewing strategies for helpers: Fundamental skills and cognitive behavioral interventions. Pacific Grove, CA: Brooks/Cole.

Corsini, R. J. (1964). Group psychotherapy in correctional rehabilitation. British Journal of Criminology, 4, 272-274.

Courchaine, K. E., & Dowd, E. T. (1994). Group approaches. In F. M. Dattilio & A. Freeman, (Eds.), Cognitive-behavioral strategies in crisis intervention (pp. 237). New York: Guilford Press.

Coyne, J. C., & Fabricatore, J. M. (1979). Group psychotherapy in a corrections facility: A case study of individual and institutional change. Professional Psychology, 8-14.

Cross, D. G., & Sharpley, C. F. (1982). Measurement of empathy with the Hogan Empathy Scale. Psychological Reports, 50, 62.

Dail, P. W., & Koshes, R. J. (1992). Treatment issues and treatment configurations for mentally ill homeless women. Social Work in Health Care, 17, 27-44.

Deardorff, P. A., Finch Jr., A. J., Kendall, P. C., Lira, F., & Indrisano, V. (1975). Empathy and socialization in repeat offenders, first offenders, and normals. Journal of Counseling Psychology, 22, 453-455.

Deffenbacher, J. L., McNamara, K., Stark, R. S., & Sabadell, P. M. (1990). A comparison of cognitive-behavioral and process-oriented group counseling for general anger reduction. Journal of Counseling & Development, 69, 167-172.

Dies, R. R. (1993). Research on group psychotherapy: Overview and clinical applications. In A. A. Swiller (Ed.), Group therapy in clinical practice (pp 473-518). Washington, DC: American Psychiatric Press.

Dixon, D. N., & Glover, J. A. (1984). Counseling: A problem-solving approach. New York: John Wiley & Sons.

Dore, J. (1994). A model of time-limited group therapy for men: Its use with recovering addicts. Group, 18, 243-258.

D'Zurilla, T. J. (1988). Problem-solving therapies. In K. D. Dobson (Ed.), Handbook of cognitive-behavioral therapies (pp. 85-135). New York: Guilford Press.

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem-solving and behavior modification. Journal of Abnormal Psychology, 78, 107-126.

Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Lyle Stuart.

Ellis, A. (1992). Group rational-emotive and cognitive-behavioral therapy. International Journal of Group Psychotherapy, 42, 63-80.

Exner, J. E., McDowell, E., Pabst, J., Stackman, W., & Kirk, L. (1963). On the detection of willful falsifications in the MMPI. Journal of Consulting Psychology, 27, 91-94.

Eysenck, H. J. (1952). The effects of psychotherapy: An evaluation. Journal of Consulting Psychology, 16, 319-324.

Fink, E. R. (1981). A cognitive-behavioral group therapy program for problems of anger and aggression in adult male offenders. (Doctoral Dissertation, Rutgers University, 1981). Dissertation Abstracts International, 41, 3570.

Frueh, B. C. (1993). The susceptibility of the Rorschach Inkblot Test to malingering of combat-related posttraumatic stress disorder. (Doctoral Dissertation, University of South Florida, 1992). Dissertation Abstracts International, 54, 1665.

Gaies, L. A. (1994). Malingering of depression on the Personality Assessment Inventory (PAI). (Doctoral Dissertation, University of South Florida, 1993). Dissertation Abstracts International, 55, 209.

Ganellen, R. J. (1994). Attempting to conceal psychological disturbance: MMPI defensive response sets and the Rorschach. Journal of Personality Assessment, 63, 423-437.

Garfield, S. L. (1978). Research on client variables in psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (2nd ed., pp191-232). New York: Wiley.

Garfield, S. L., & Bergin, A. E. (1986). Handbook of psychotherapy and behavior change (3rd ed.). New York: John Wiley & Sons.

Garrett, C. J. (1985). Effects of residential treatment on adjudicated delinquents: A meta-analysis. Journal of Research in Crime and Delinquency, 22, 287-308.

Gaston, L., & Sabourin, S. (1992). Client satisfaction and social desirability in psychotherapy. Evaluation and Program Planning, 15, 227-231.

Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done. Criminal Justice and Behavior, 23, 144-161.

Gendreau, P., Burke, D., & Grant, B. A. (1980). A second evaluation of the Rideau Inmate Volunteer Program. Canadian Journal of Criminology, 22, 66-77.

Gendreau, P., Irvine, M., & Knight, S. (1973). Evaluating response set styles on the MMPI with prisoners: Faking good adjustment and maladjustment. Canadian Journal of Behavioral Sciences, 5, 183-194.

Gendreau, P., & Ross, R. R. (1979). Effective correctional treatment: Bibliotherapy for cynics. Crime and Delinquency, 25, 463-489.

Gendreau, P., & Ross, R. R. (1987). Revivification of rehabilitation: Evidence from the 1980s. Justice Quarterly, 4, 349-407.

George, R. L., & Dustin, D. (1988). Group Counseling Theory and Practice. New Jersey: Prentice Hall.

Glaser, D. (1969). The effectiveness of a prison and parole system (abridged ed.). Indianapolis, IN: Bobbs-Merrill.

Goldenberg, E., & Cowden, J. E. (1977). An evaluation of intensive group psychotherapy with male offenders in isolation units. Corrective & Social Psychiatry & Journal of Behavior Technology, Methods & Therapy, 23, 68-72.

Goldfried, M. R. (1971). Systematic desensitization as training in self-control. Journal of Consulting and Clinical Psychology, 37, 228-234.

Gorski, T. T. (1995, June). Recovery and relapse prevention in the criminal justice system. In T. T. Gorski (chair), Managing chemically dependent criminal offender: The get tough and be smart program that work. Workshop conducted at the meeting of the Mental Health in Corrections Consortium, Kansas City, KS.

Graham, J. R. (1990). MMPI-2: Assessing personality and psychopathology. New York: Oxford University Press.

Greene, R. L. (1991). The MMPI-2/MMPI: An interpretive manual. Needham Heights, MA: Allyn and Bacon.

Grow, R., McVaugh, W., & Eno, T. D. (1980). Faking and the MMPI. Journal of Clinical Psychology, 36, 910-917.

Halleck, S. L. (1960). The criminal's problem with psychiatry. Psychiatry, 23, 409-412.

Hassine, V. (1996). Life without parole: Living in prison today. Los Angeles: Roxbury.

Hathaway, S. R., & McKinley, J. C. (1951). MMPI manual. New York: Psychological Corporation.

Hilkey, J. H., Wilhelm, C. L., & Horne, A. M. (1982). Comparative effectiveness of videotape pretraining versus no pretraining on selected process and outcome variables in group therapy. Psychological Reports, 50, 1151-1159.

Hitchcock, G. L. (1995). The efficacy of cognitive group therapy with incarcerated psychopaths. (Doctoral Dissertation, California School of Professional Psychology-Fresno Campus, 1994). Dissertation Abstracts International, 56, 525.

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

Homant, R. J. (1976). Therapy effectiveness in a correctional institution. Offender Rehabilitation, 1, 101-113.

Homant, R. J. (1977). Motivation, need, and therapy effectiveness in a correctional institution. Offender Rehabilitation, 2, 53-64.

Homant, R. J. (1986). Ten years after: A follow-up of therapy effectiveness. Journal of Offender Counseling, Services & Rehabilitation, 10, 51-57.

Jessness, C. F. (1975). Comparative effectiveness of behavior modification and transactional analysis programs for delinquents. Journal of Consulting and Clinical Psychology, 43, 758-779.

Jew, C. C., Clanon, T. L., & Mattocks, A. L. (1972). The effectiveness of group psychotherapy in a correctional institution. American Journal of Psychiatry, 129, 602-605.

Jew, C. C., Kim, L. I. C., & Mattocks, A. L. (1975). Effectiveness of group psychotherapy with character disordered prisoners (Research Report No. 56). Sacramento: California Department of Corrections.

Kelly, D. B., & Greene, R. L. (1989). Detection of faking good on the MMPI in a psychiatric inpatient population. Psychological Reports, 65, 747-750.

Kelly, G. A. (1955). The psychology of personal constructs. New York: Norton.

Keppel, G. (1991). Design and analysis: A researcher's handbook (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

Klarreich, S. H. (1981). Group training in problem-solving skills and group counseling: A study comparing two treatment approaches with adolescent probationers. Corrective and Social Psychiatry and Journal of Behavior Technology, Methods, and Theory, 27, 1-13.

Koss, M. P., & Butcher, J. N. (1986). Research on brief psychotherapy. In S. L. Garfield & A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed., pp. 627-670). New York: Wiley.

Kotkin, M., Daviet, C., & Gurin, J. (1996). The consumer reports mental health survey. American Psychologist, 51, 1080-1081.

Kraft, I. A. (1996). History. In P. Kymissis & D. A. Halperin (Eds.), Group therapy with children and adolescents (pp. 3-20). Washington, D.C.: American Psychiatric Press.

Larsen, D. L. (1977). Enhancing client utilization of community mental health outpatient services. (Unpublished Doctoral Dissertation, University of Kansas).

Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. Evaluation and Program Planning, 2, 197-207.

Lawrence, R. W. (1974). Vocational rehabilitation of the offender. In A. Roberts (Ed.), Correctional Treatment of the Offender (pp. 253-271). Springfield, Illinois: Charles C. Thomas.

Lazrus, A. (1971). Behavior therapy and beyond. New York: McGraw-Hill.

Leak, G. K. (1980). Effects of highly structured versus nondirective group counseling approaches on personality and behavioral measures of adjustment in incarcerated felons. Journal of Counseling Psychology, 27, 520-523.

Leeman, L. W., Gibbs, J. C., & Fuller, D. (1993). Evaluation of a multi-component group treatment program for juvenile delinquents. Aggressive Behavior, 19, 281-292.

Levinson, R. B., Ingram, G. L., & Azcarate, E. (1968). "Aversive" group therapy: Sometimes good medicine tastes bad. Crime and Delinquency, 14, 336-339.

Long, L. D., & Cope, C. S. (1980). Curative factors in a male felony offender group. Small Group Behavior, 11, 389-398.

Lubin, B., Larsen, R. M., Matarazzo, J. D., & Seever, M. (1985). Psychological test usage patterns in five professional settings. American Psychologist, 40, 857-861.

Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapy. Archives of General Psychiatry, 32, 995-1008.

MacDevitt, J. W., & Sanislow III, C. (1987). Curative factors in offenders' groups. Small Group Behavior, 18, 72-81.

Marshall, P. G., Keltner, A. A., & Marshall, W. L. (1981). Anxiety reduction, assertive training, and enactment of consequences: A comparative treatment study in the modification of nonassertion and social fear. Behavior Modification, 5, 85-102.

Marshall, W. L., Turner, B. A., & Barbaree, H. E. (1989). An evaluation of life skills training for penitentiary inmates. Journal of Offender, Services & Rehabilitation, 14, 41-59.

Martin, J. V. (1989). Optimal timing for group therapy in the criminal justice system. Journal of Offender Counseling, Services & Rehabilitation, 14, 149-158.

Martinson, R. (1974). What works?-questions and answers about prison reform. The Public Interest, 22-54.

Martinson, R. (1979). New findings, new views: A note of caution regarding sentencing reform. Hofstra Law Review, 7, 243-258.

Mathias, R. E., & Sindberg, R. (1985). Psychotherapy in Correctional Settings. International Journal of Offender Therapy and Comparative Criminology, 29, 265-275.

Mathias, R. E., & Sindberg, R. M. (1986). Time limited group therapy in minimum security. Journal of Offender Counseling, Services & Rehabilitation, 11, 7-17.

McCorkle, L. W. (1953). The present status of group therapy in United States Correctional institutions. International Journal of Group Psychotherapy, 3, 79-87.

McCorkle, L. W., & Elias, A., (1960). Group therapy in correctional institutions. Federal Probation, 24, 57-63.

McIntosh, M. (1986). The attitudes of minority inmates towards recreation programs as a rehabilitative tool. Journal of Offender Counseling, Services & Rehabilitation, 10, 79-86.

Meehl, P. E., & Hathaway, S. R. (1946). The K factor as a suppressor variable in the MMPI. Journal of Applied Psychology, 30, 525-564.

Meichenbaum, D. (1977). Cognitive-behavior modification: An integrative approach. New York: Plenum Press.

Morgan, R. D., Winterowd, C. L., & Ferrell, S. W. (1997, August). A national survey of group psychotherapy services in correctional facilities. Poster session presented at the annual meeting of the American Psychological Association, Chicago, Illinois.

Nedd, A. N. B., & Shihadeh, E. S. (1974). The impact of group therapy on penitentiary vocational and academic education programs. The Journal of Psychology, 88, 215-221.

Nichols, M. (1985). Theoretical concerns in the clinical treatment of substance-abusing women: A feminist analysis. Alcoholism Treatment Quarterly, 2, 79-91.

Orlinsky, D. E., & Howard, K. I. (1986). Process and outcome in psychotherapy. In S. L. Garfield and A. E. Bergin (Eds.), Handbook of psychotherapy and behavior change (3rd ed.) (pp 311-381). New York: John Wiley & Sons.

Palmer, T. (1975). Martinson revisited. Journal of Research in Crime and Delinquency, 12, 133-152.

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

Persons, R. W. (1966). Psychological and behavioral change in delinquents following psychotherapy. Journal of Clinical Psychology, 22, 337-340.

Persons, R. W. (1967). Relationship between psychotherapy with institutionalized boys and subsequent community adjustment. Journal of Consulting Psychology, 31, 137-141.

Rappaport, R. G. (1982). Group therapy in prison. In M. Seligman (Ed.), Group Psychotherapy and counseling with special populations (pp. 215-227). Baltimore: University Park Press.

Ray, K. D. (1993). The impact of resistance on effectiveness of substance abuse services provided to Illinois department of corrections work release center referrals (client resistance). (Doctoral Dissertation, Southern Illinois University at Carbondale, 1992). Dissertation Abstracts International, 53, 2997.

Reker, G. T., & Meissner, J. A. (1977). Life skills in a Canadian federal penitentiary: An experimental evaluation. Canadian Journal of Criminology, 19, 292-302.

Reppucci, N. D., & Clingempeel, W. G. (1978). Methodological issues in research with correctional populations. Journal of Consulting and Clinical Psychology, 46, 727-746.

Romano, S. J., Quinn, L., & Halmi, K. (1994). Cognitive-behavioral group psychotherapy for bulimia nervosa: Clinical considerations and group format. Eating Disorders, 2, 31-41.

Rose, S. D. (1986). Group methods. In F. H. Kanfer and A. P. Goldstein (Eds.), Helping people change (3rd ed.) (pp. 437-469). New York: Pergamon Press.

Rose, S. D., & LeCroy, C. W. (1991). Group methods. In F. H. Kanfer and A. P. Goldstein (Eds.), Helping people change (3rd ed.) (pp. 437-469). New York: Pergamon Press.: Pergamon Press.

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

Scott, E. M. (1976). Group therapy with convicts on work release in Oregon. International Journal of Offender Therapy and Comparative Criminology, 20, 225-235.

Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. American Psychologist, 50, 965-974.

Serok, S., & Levi, N. (1993). Application of gestalt therapy with long-term prison inmates in Israel. The Gestalt Journal, 16, 105-127.

Sheer, B. (1989). The relationship among socialization, empathy, autonomy and unethical student behaviors in baccalaureate nursing students. Unpublished doctoral dissertation, Widener University.

Slaikeu, K. A. (1973). Evaluation studies on group treatment of juvenile and adult offenders in correctional institutions: A review of the literature. Journal of Research in Crime and Delinquency, 87-100.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). The benefits of psychotherapy. Baltimore: Johns Hopkins University Press.

Spana, R. E. (1993). The effect of instructions to malinger schizophrenia on performance on the Rorschach Inkblot Test. (Doctoral Dissertation, University of South Florida, 1992). Dissertation Abstracts International, 54, 1113.

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

Stasiw, J. R. (1977). The effects of intensive, short term transactional analysis training and group therapy on affective states and locus of control with adult male offenders. (Doctoral Dissertation, University of Georgia, 1977). Dissertation Abstracts International, 38, 4592.

Stevens, J. (1996). Applied multivariate statistics for the social sciences (3rd ed.). New Jersey: Lawrence Erlbaum Associates.

Strupp, H. H. (1996). The tripartite model and the Consumer Reports study. American Psychologist, 51, 1017-1024.

Sullivan, H. S. (1938). Psychiatry: Introduction to the study of interpersonal relations. Psychiatry, 1, 121-134.

Sultan, F. E., Long, G. T., & Kiefer, S. A. (1986). The application of psychodidactic support groups to facilitate female offenders' adjustment to prison. Psychotherapy, 23, 469-471.

Thaut, M. H. (1989). The influence of music therapy interventions on self-rated changes in relaxation, affect, and thought in psychiatric prisoner-patients. Journal of Music Therapy, 26, 155-166.

Toler, H. C. (1978). The treatment of insomnia with relaxation and stimulus-control instructions among incarcerated males. Criminal Justice and Behavior, 5, 117-130.

VandenBos, G. R. (Ed.). (1996). Outcome assessment of psychotherapy [Special issue]. American Psychologist, 51,(10).

Van Wormer, K. (1989). The male-specific group in alcoholism treatment. Small group behavior, 20, 228-242.

Vinogradov, S., & Yalom, I. D. (1994). Group therapy. In R. E. Hales, S. C. Yudofsky, A. Talbott (Eds.), The American psychiatric press textbook of psychiatry (2nd ed.) (pp. 1143-1175). Washington, D.C.: American Psychiatric Press.

Walker, D. (1974). In the interest of public safety. Parks and recreation, 19.

Williams, E. W. (1976). Reality therapy in a correctional institution. Corrective & Social Psychiatry & Journal of Behavior Technology, Methods & Therapy, 22, 1-5.

Wilson, G. L. (1990). Psychotherapy with depressed incarcerated felons: A comparative evaluation of treatments. Psychological Reports, 67, 1027-1041.

Wolk, R. L. (1963). The relationship of group psychotherapy to institutional adjustment. Group Psychotherapy, 16, 141-145.

Wolman, B. B. (1989). Dictionary of behavioral science (2nd ed.). San Diego: Academic Press.

Yalom, I. D. (1970). The theory and practice of group psychotherapy. New York: Basic Books.

Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

Yochelson, S., & Samenow, S. E. (1977). The criminal personality volume II: The change process. New York: Jason Aronson.

Yochelson, S., & Samenow, S. E. (1976). The criminal personality volume I: A profile for change. New York: Jason Aronson.

Yong, J. N. (1971). Advantages of group therapy in relation to individual therapy for juvenile delinquents. Corrective Psychiatry and Journal of Social Therapy, 19, 34-39.

# APPENDICES

# APPENDIX A

# TABLES

Table 1

Correlation Coefficients for the Eight Items of the Criminal Thinking Errors Questionnaire at the Pretesting and Posttesting

| Thinking Error | Correlation Coefficient |
|---|---|
| Pretentiousness | 0. 53 |
| Failure to Consider Injury to Others | 0.37 |
| Failure to Make an Effort | 0.36 |
| Victim Stance | 0.57 |
| Failure to Put Oneself in Another's Shoes | 0.50 |
| Refusal to be Dependent | 0.57 |
| Ownership | 0.41 |
| I Can't | 0.55 |

Table 2

Internal Consistency Reliability Estimates for the Eight Items of the Criminal Thinking Errors Questionnaire

| Thinking Error | Alpha Coefficient |
|---|---|
| Pretentiousness | 0.052 |
| Failure to Consider Injury to Others | 0.171 |
| Failure to Make an Effort | 0.297 |
| Victim Stance | 0.456 |
| Failure to Put Oneself in Another's Shoes | 0.264 |
| Refusal to be Dependent | 0.251 |
| Ownership | 0.419 |
| I Can't | 0.331 |

Table 3

Means, Standard Deviations, and T-tests for Continuous Demographic Variables

| | Group | | | | | |
|---|---|---|---|---|---|---|
| | Treatment | | Control | | | |
| Variable | M | SD | M | SD | t-value | p |
| Age | 29.65 | 8.24 | 35.44 | 6.95 | -2.24 | 0.03* |
| Education | 11.71 | 1.24 | 11.88 | 1.40 | -0.37 | 0.71 |
| Sentence | 45.31 | 25.19 | 57.00 | 36.19 | -0.93 | 0.36 |

* $p < .05$.

Table 4

Chi Square Analyses for Categorical Demographic Variables

| Variable | $\chi^2$ | p |
|---|---|---|
| Race | 1.82 | 0.40 |
| Security Level | 1.89 | 0.17 |
| Marital Status | 2.40 | 0.12 |
| Primary Charge | 0.95 | 0.33 |

Table 5

Means and Standard Deviations for MMPI-2 Validity Scores for Inmates in the Treatment and Control Groups

| | Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Treatment | | | | Control | | | |
| MMPI-2 Validity Scales | Pre | | Post | | Pre | | Post | |
| | M | SD | M | SD | M | SD | M | SD |
| L scale | 4.95 | 3.09 | 5.15 | 3.35 | 5.06 | 2.11 | 4.94 | 2.05 |
| F scale | 6.57 | 3.26 | 5.83 | 3.22 | 5.03 | 4.32 | 3.80 | 2.72 |
| K scale | 16.20 | 5.09 | 16.64 | 5.25 | 15.40 | 4.31 | 14.45 | 4.73 |
| Mp scale | 11.48 | 3.09 | 10.96 | 3.40 | 11.34 | 2.94 | 11.25 | 3.68 |

Table 6

Means and Standard Deviations for Inmate Empathy Scores for the Treatment and Control Groups

| | Group | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Treatment | | | | Control | | | |
| Empathy Measure | Pre | | Post | | Pre | | Post | |
| | M | SD | M | SD | M | SD | M | SD |
| Empathy Scale | 22.3 | 3.36 | 23.2 | 4.41 | 20.19 | 4.92 | 21.25 | 3.94 |

Note. Range = 0-38

Table 7

Frequencies of the Presence or Absence of Disciplinary Reports for Inmates in the Treatment and Control Groups

| | Group | | | |
|---|---|---|---|---|
| | Treatment Group | Control Group | Treatment Group | Control Group |
| Disciplinary Reports | Pre | Pre | Post | Post |
| None | 14 | 13 | 13 | 14 |
| More Than One | 6 | 3 | 7 | 2 |

Table 8

Means and Standard Deviations for Inmate Responses on the Client Satisfaction Questionnaire

| Question | Mean | Standard Deviation |
|---|---|---|
| 1) How would you rate the quality of service you have received? (4=Excellent; 3=Good; 2=Fair; 1=Poor) | 3.20 | 0.70 |
| 2) Did you get the kind of service you wanted? (1=No, definitely not; 2=No, not really; 3=Yes, generally; 4=Yes, definitely) | 3.25 | 0.64 |
| 3) To what extent has our program met your needs? (4=Almost all of my needs have been met; 3=Most of my needs have been met; 2=Only a few of my needs have been met; 1=None of my needs have been met) | 2.95 | 0.83 |
| 4) If a friend were in need of similar help, would you recommend our program to him or her? (1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 1=Yes, definitely) | 3.50 | 0.51 |

Table 8

Means and Standard Deviations for Inmate Responses on the Client Satisfaction Questionnaire (continued)

| Question | Mean | Standard Deviation |
|---|---|---|
| 5) How satisfied are you with the amount of help you have received? (1=Quite dissatisfied; 2=Indifferent or mildly dissatisfied; 3=Mostly satisfied; 4=Very satisfied) | 3.35 | 0.67 |
| 6) Have the services you received helped you to deal more effectively with your problems? (4=Yes, they helped a great deal; 3=Yes, they helped somewhat; 2=No, they really didn't help; 1=No, they seemed to make things worse) | 3.50 | 0.61 |
| 7) In an overall, general sense, how satisfied are you with the service you have received? (4=very satisfied; 3=Mostly satisfied; 2=Indifferent or mildly dissatisfied; 1=Quite dissatisfied) | 3.35 | 0.59 |
| 8) If you were to seek help again, would you come back to our program? (1=No, definitely not; 2=No, I don't think so; 3=Yes, I think so; 4=Yes, definitely | 3.40 | 0.60 |

# APPENDIX B

# TREATMENT MANUAL

# A Treatment Manual

# for an Interpersonal/Cognitive-Behavioral

# Group Psychotherapy Approach with Inmates

by

**Robert Morgan, M.S.**

**Oklahoma State University**

# GROUP PSYCHOTHERAPY TREATMENT MANUAL

This treatment manual is intended to provide you with a guide for conducting a interpersonal (process-oriented) cognitive-behavioral approach to group psychotherapy with inmates in your facility. This manual is intended to function as a guide to this particular group treatment approach. It includes specific structured exercises and homework assignments for objectives for each session

The group treatment approach presented in this manual is based on the interpersonal, process-oriented approach to group psychotherapy as presented by Irvin Yalom (1995) in his classic text on group psychotherapy and on Beck's (1976) cognitive-behavioral approach (cognitive restructuring and problem-solving strategies). This cognitive-behavioral approach will include the criminal thinking errors proposed by Yochelson and Samenow (1976).

This treatment manual is presented in a fashion that is analogous to the treatment approach. As the interpersonal process-oriented approach is the basis for this treatment, it will be described in detail in Part I of this manual. The cognitive-behavioral treatment strategies supplement the interpersonal process-oriented approach and will be described as such in Part II of this treatment manual. This manual is intended to be written in a clear and reader friendly format; thus, scientific references will be implemented only as specifically warranted. Please note that the interpersonal process-oriented approach as described in this manual refers to the approach described by Yalom. I will not cite him for each statement or explanation, but you should be aware that this is his intellectual work (unless otherwise cited), not mine.

## PART I

### Interpersonal Process-Oriented Approach

As stated previously, this classic approach to group psychotherapy was initially developed by Yalom in 1970. My attempt here is to describe Yalom's theory briefly, yet in sufficient detail to allow you to implement this approach. The interpersonal process-oriented approach to group therapy as described here refers to an exploration of group members' interpersonal relationships with each other as well as their relationship to you (the facilitator). This exploration occurs within the group and remains the focus of the group; therefore, the process of this approach is centered in the "here and now" (i.e., the present) and focuses on interpersonal relationships.

In describing this treatment approach, Yalom has indicated several key components which you must be aware of and attempt to implement to adequately facilitate this interpersonal process-oriented approach to group therapy. These components include: the eleven therapeutic factors of group work, culture building and norm shaping, and maintenance of a "here-and-now" focus. In addition, stages of group therapy and group dynamics will be discussed briefly. These components are described briefly here, and will be presented in greater detail in the first two of the four training sessions.

Therapeutic Factors:

Yalom has empirically identified eleven therapeutic factors based on the "intricate interplay of human experience" (pg. 1) that opens the pathway to therapeutic change. These eleven factors are: (1) Instillation of Hope, (2) Universality, (3) Imparting Information, (4) Altruism, (5) The Corrective Recapitulation of the Primary Family

Group, (6) Development of Socializing Techniques, (7) Imitative Behavior, (8) Interpersonal Learning, (9) Group Cohesiveness, (10) Catharsis, and (11) Existential Factors. The following is a description and therapeutic explanation of each of the eleven therapeutic factors.

Instillation of Hope: Hope is crucial to the therapy process. Inmates (and therapists) need to achieve and maintain hope that change is possible. Hope is required to not only keep clients in therapy, but "faith in a treatment mode can in itself be therapeutically effective" (pg. 4). As the group facilitator, you must be able to communicate how this group approach will help inmates. In addition, you should attempt to capitalize on inmates' hope in the efficacy of this treatment approach whenever possible (e.g., early group sessions, reinforce positive expectations, educate when faced with negative preconceptions, and direct attention to improvements displayed during the course of the group).

Universality: Inmates may enter therapy with the preconceived idea that they are alone with their problems and that others do not share similar difficulties. While this is true to some extent, the disconfirmation of an inmates' uniqueness may be a powerful sense of relief. That is, inmates learn that they are universally similar. It is assumed that as inmates begin to share and learn of each others similarities, they will become more trusting and open with each other. Your role is to aid in the development of group universality by pointing out group similarities. When inmates present with problems or goals that are similar, it is important that you indicate the universal nature of their issues. This may be most easily achieved during the first group session. As inmates begin to

discuss their lives, you will help the group identify commonalties in their life histories, presenting problems, and treatment goals.

Imparting Information: This therapeutic factor includes both didactic instruction (e.g., psycho-education) and direct advise (by the therapist as well as group members). In general, clients in interpersonal process-oriented groups do not highly value didactic instruction or advice giving, and Yalom discourages such practices; however, you will be implementing both didactic instruction as well as providing direct advise to the inmates (as this is a primary element of the cognitive-behavioral supplement to this treatment approach). Group members will also give advice to one another, especially in early stages of the group. While group members typically do not find the advice of other group members as highly beneficial, advice giving serves a purpose. The process, rather than the content is important as it implies and conveys mutual interest and caring. This is an important facet of group therapy and inmates may benefit from acknowledging that they are interested in and care about one another.

Altruism: In group therapy, patients receive through giving. Inmates may particularly benefit from this factor as it may be one of the few times that he gives rather than takes. Inmates may believe that they are a burden to others and the experience that they can be helpful or of importance to others may be refreshing and may boost self-esteem. Inmates in group therapy may be helpful to one another via providing support, reassurances, suggestions, insight, and sharing of problems. Not infrequently, inmates in group therapy will accept observations from other inmates long before they accept your observations. You may be perceived as a cop or, at the least, a paid professional who is not from the real world, who cannot really understand them. Other inmates are real and

understand their plight, thus, are more credible sources of information. Typically, inmates question the utility of group therapy asking questions such as "How can the blind lead the blind?" This resistance may be best explored through the therapeutic factor of altruism. In effect, an inmate who says other inmates are in the same position as themselves and can not possibly be of help to him, is in effect saying "these inmates are like myself, and I have nothing of value to offer them." You can assist these inmates in exploring their negative self-evaluation by helping them identify ways that they can be of assistance to the group. Others may vicariously benefit from this process exploration. In addition, it may prove beneficial to reflect the support you notice in group sessions.

The Corrective Recapitulation of the Primary Family Group: Group therapy results in group dynamics that closely resemble familial dynamics. Many aspects of families are re-experienced in the therapy group: authority/parental figures, peer siblings, strong emotions, deep intimacy, and hostile and competitive feelings. Responses to other inmates in the group will be similar to reactions to family members. Of therapeutic importance, however, is not that early family experiences or conflicts are merely relived, rather that they are relived correctly. Your task is to find common ties between past and current feelings, thoughts, and behaviors, and to explore and challenge rigid interpersonal behaviors. You should assist inmates in identifying behaviors that are heavily influenced by early family experiences, and encourage them to experiment with new interpersonal behaviors in the group. The group should be a safe haven for them to try on new behaviors. Thus, when inmates can work out problems with you and the other members, they are actually working through unfinished business from previous relationships.

Development of Socializing Techniques: Group therapy provides an instant laboratory for the observation and development of social skills. The development of socializing skills in a interpersonal process-oriented group is a secondary gain as social skills training is not a focus of these groups; however, inmates may learn from feedback from others about their social behaviors. This may provide inmates with a unique and previously inexperienced opportunity of receiving direct feedback regarding interpersonal skills. It appears intuitively plausible that this feedback could only help inmates in their interpersonal relationships. Yalom emphasizes the potential benefits of this therapeutic factor when he states "senior members...are attuned to process; they have learned how to be helpfully responsive to others; they have acquired methods of conflict resolution; they are less likely to be judgmental and more capable of experiencing and expressing accurate empathy". Granted, an inmate population is not Yalom's typical clientele; however, it does not seem unreasonable to suggest that similar benefits may be encountered by inmates working in interpersonal process-oriented groups. Your task here is to aid inmates in developing more functional social skills via modeling and/or feedback.

Imitative Behavior: We have all at one time or another imitated behaviors of others. Group therapy is no different as inmates will model their own behavior on the aspects of other group members or you the facilitator. Inmates in this group will likely "try on" bits and pieces of other people in group and then keep those behaviors that "fit" and discard qualities that are ill fitting. Yalom articulates this point very succinctly when he writes about this process of trying on and discarding other's qualities or characteristics as beneficial because finding out who we are not is important for finding out who we are.

Interpersonal Learning: Interpersonal learning is by far the most abstract and difficult to explain of all of Yalom's therapeutic factors. Interpersonal learning includes processes that are similar to individual therapy such as insight, working through transference, and the corrective emotional experience. To understand interpersonal learning as identified by Yalom, you must first be familiar with his view of the importance of interpersonal relationships, the corrective emotional experience, and the group as a social microcosm.

Interpersonal relationships are important because we develop a sense of who we are based on the perceptions and reflections of others. The inmate code for example is a way of living life for some inmates that they can be proud of when facing their peers. They will develop a sense of self as an upstanding inmate based on the responses of others in the inmate population when adhering to the inmate code. With regard to interpersonal relationships, individuals have a tendency to distort perceptions of others (Yalom refers to these distorted perceptions as "parataxic distortions"). These distortions occur in response to facilitators as well as group members. For example, a chronically angry and resentful inmate may perceive others as harsh and rejecting. If this projection can be identified and discussed in group, than he may be in a unique position to obtain consensual validation (i.e., obtain feedback from the group with regard to his self-evaluation).

It is assumed that the group will rekindle previous emotional experiences, but that the inmate will be allowed to experience a "corrective emotional experience". That is, inmate growth may develop through self disclosure of emotionally laden material and group feedback allows for reality testing. Five components appear of utmost importance

with regard to the "corrective emotional experience": (1) inmates will take risks of expressing strong emotional reactions; (2) the group must support the inmates' risk; (3) group process is examined; (4) inappropriate feelings and behaviors or avoided interpersonal behaviors are recognized; and (5) more honest and deeper interactions are facilitated. Again it should be noted that the emotional expression is not sufficient to promote change and that a cognitive component is essential for change to occur. You will need to assist the group by framing and/or making sense of the emotions exhibited in the group.

One of the primary benefits from interactive groups is that they facilitate a social microcosm of the group members. That is, with the passage of time, group members will display their pathologies. They will be themselves during group interactions. You do not need to ask about their pathologies, because they will display it for you and everyone else to see. One of your most significant tasks will be to identify and subject to therapy those maladaptive interpersonal behaviors of group members and help them learn new ways of relating. Prior to turning the social microcosm to a therapeutic advantage, you must first identify group members' recurrent maladaptive patterns. Inmate group members will elicit feelings from other group members, and you need to consider these feelings as data. If these are not the feelings that the inmate desires to elicit then a problem has been identified. Note that one response of another group member is insufficient data and you must seek confirmatory data. Consensual validation (feedback about one's self-evaluation) from the group must be obtained to truly aid in the identification of maladaptive interpersonal styles in each group member. With regard to group therapy in prisons, one complaint frequently voiced by inmates is that the group and it's interactions

is not representative of the real world. That the group is artificial and contrived. It should be pointed out that while the group members meet only once a week, they are in a position to explore with great depth the life experiences and interpersonal functioning's of one another. To develop the kind of trust and honesty necessary to work together can not possibly be considered artificial. There is nothing artificial about an inmate expressing anger with you or another inmate.

Lastly, the therapeutic factor of interpersonal learning must include a discussion of insight. Insight is the discovery of something of importance about oneself, and may occur on at least four different levels.

1. Inmates may develop an objective impression of their interpersonal style. They may learn how others view them.
2. Inmates may develop an understanding of their interactional patterns.
3. Inmates may develop an understanding of the motivations behind their interactional patterns. They may learn why they interact the way they do. For example, inmates may learn that they behave in certain ways to avoid perceived catastrophes (e.g., if I express my anger I will end up in a fight; if I cry I will be perceived by others as weak).
4. Inmates may develop an understanding of how they became the way they are.

Group Cohesiveness: Group cohesiveness in it's most basic form refers to the attractiveness of a group for it's members. Defined more behaviorally, group cohesiveness refers to members feelings of warmth and comfort in the group, feelings of belonging, valuing the group, and feelings of being valued, unconditionally accepted and supported by the other group members. Group cohesiveness appears to be a necessary

component of group therapy, and an inmate group, as well as any other group, should be able to develop this therapeutic factor. Group cohesiveness is not a stagnant process, rather, the cohesiveness of any group fluctuates with the circumstances of the group; however, some level of group cohesiveness must be maintained or members are likely to leave the group.

Inmates frequently come from poverished backgrounds and unfortunately many inmates experience few opportunities to join and function in a group. Although group cohesiveness may be slow to develop with this population, once inmates develop a sense of public esteem, the groups evaluation of the inmate, increased self-esteem is sure to follow. Public esteem is critical to the efficacy of group therapy. The more significance an inmate places on the group in his life, the more that inmate will subscribe to the group norms and values, and the more inclined he will be to hear and accept group judgments.

Lastly, it is critical to the process of group therapy that you do not misinterpret group cohesiveness as comfort. Cohesive groups should be better able to develop and express anger and conflict. Hostility must be acknowledged and expressed to avoid covert hostility which would significantly hinder the effectiveness of the group. Hostility in group therapy must be processed and it is imperative that the conflicting group members establish a means of working together. Inmates may have a tendency to avoid open expression of anger and hostility; however, as the group facilitator you need to help the group identify and explore conflict via the open expression of anger. Be aware and prepare for the initial expression of anger to be directed at you. If the group members can not trust you with their anger, how can they trust the other inmates? This issue will be discussed in greater detail under the heading of "stages of group therapy", but suffice it to

say for now, that you should observe inmate challenges or confrontations at some point in the early group development. You may be confronted about your lack of direction, your lack of care and concern, that you are only in the job for the money, that you are a cop, or that you are part of the system. If you do not deal with this open expression of anger (e.g., allow members to share their disappointment, anger, etc.) you will inadvertently establish a group norm discouraging the open expression of intense feelings.

Catharsis: Catharsis is the process of emotional experience and generally refers to expressing and discharging previously repressed emotions. It is generally accepted by most theorists and clinicians that catharsis is not sufficient to promote psychological change. As the facilitator, one of your tasks is to help the inmate get beyond the ventilation of feelings and attempt to add meaning or significance to the cathartic experience. You must facilitate the dual process of expressing feelings and then reflecting back on the process (this process is known as the self-reflective loop and is discussed in greater detail below). For example, you might ask a group member what it was like to share those feelings in the group just now. Catharsis is critical to group therapy, without which the group would be a sterile intellectual discussion of ideas and thoughts, yet it is insufficient to promote change and must be supplemented by other therapeutic factors. In addition, this therapeutic factor allows inmates (possibly for the first time in their lives) to learn and be able to say what is bothering them. With regard to catharsis with inmates, please note that expression of affect is a relative experience. What one perceives as intense may not be the same as what others perceive as intense. Thus, if a relatively constricted inmate expresses an affective response, consider the experience from that inmates experiential world.

Existential Factors: The existential factors refers to the search for purpose and meaning in life, and consists of five points:

(1) "Recognizing that life is at times unfair and unjust"

(2) "Recognizing that ultimately there is no escape from some of life's pain or from death"

(3) "Recognizing that no matter how close I get to other people, I must still face life alone"

(4) "Facing the basic issues of my life and death, and thus living my life more honestly and being less caught up in trivialities"

(5) "Learning that I must take ultimate responsibility for the way I live my life no matter how much guidance and support I get from others" (p. 88).

In a general sense these five existential factors emphasize awareness of death, freedom, isolation, the purpose of life and the struggle with existence. This therapeutic factor is not grounded in techniques or strategies, rather, it is an attitude or a way of viewing the world. Your task is to aid the inmate in exploring his role in the world and his way of living life, rather his life exist in prison or in the free world.

Integrating the Therapeutic Factors

As you read about the eleven therapeutic factors, you probably developed a sense of those therapeutic factors that carry more weight with regard to the change process. Yalom would not disagree with you. For example, instillation of hope in and of itself does not facilitate change; however, it helps keep members in the group to allow other therapeutic factors to facilitate change. In addition, the therapeutic factors should not be considered individually but collectively. Each factor contributes and is critical to the

process of change. If you think of the change process in a circular fashion with change at the top of the loop and each factor leading in a circular fashion to change, you can see that if any one factor is removed, the loop is broken. Thus, each factor is not necessarily a condition of change, rather a mechanism in the process of change. One of your goals for your group should be to facilitate the process of change by integrating the therapeutic factors as described above.

Culture Building and Norm Shaping:

One of your tasks as the group facilitator is to develop a group that works as a "therapeutic social system" (pg. 109). That is, you are not the agent of change, the group is. It should be the group members who facilitate change for one another via the therapeutic factors, thus it is your task to establish a group culture that maximizes the effective therapeutic interactions. Granted, Yalom developed this theory for outpatient populations and not inmate populations; however, it seems reasonable that inmates can obtain some level of a therapeutic environment as described by Yalom. Your task is similar to the outpatient therapist's task in that you must maximize the strengths of the group to facilitate an interactional group.

In building a therapeutic culture, group norms will evolve. Some of the norms of the group will be explicit (e.g., identified group rules as described below), while most will be implicit. You influence the type of norms that evolve. In fact, you cannot help but influence the development of group norms. You need to be conscious of your influence on group norms and attempt to establish norms that facilitate interactional group therapy. In developing group norms you will assume two basic roles: technical expert and model-setting participant.

As the technical expert, you do not need to rely on group exercises or gimmicks to develop therapeutic norms. Rather, you can rely on your knowledge and experience to actively facilitate the group norms. You already possess the necessary techniques for the development of the desired norms. You simply need to be conscious of how you effect group norms and plan your strategy appropriately. Yalom gives the following examples which I believe adequately describe your task here:

> "the leader must attempt to create an interactional network in which the members freely interact rather than directing all their comments to or through the therapist. To this end, therapists may implicitly instruct members in their pregroup interviews or in the first group sessions: they may, repeatedly during the meetings, ask for all members' reactions to another member or toward a group issue; they may wonder why conversation is invariably directed toward the therapist; they may refuse to answer questions or may even close their eyes when addressed; they may ask the group to engage in exercises that teach patients to interact-for example, asking each member of the group, in turn, to give his or her impressions of every other member; or therapists may , in a much less obtrusive manner, shape behavior by rewarding members who address one another-therapists may nod or smile at them, address them warmly, or shift their posture into a more receptive position" (pg. 113).

As the model setting participant, you shape group norms by example. You should attempt to model four basic functions: (1) honest and open communication, (2) appropriate restraint, (3) do not overly self-disclose too early in the group (i.e., avoid promiscuous self-disclosure), and (4) transparency (i.e., do not hide behind your role as group facilitator). To function as a model you must "join" the group. You will be expected to share with the group. You will not need to share identifying information (a process that can prove dangerous with this population); however, you should be willing to share your own interpersonal difficulties with the group. For example, if you find yourself in constant conflict with a particular inmate, you can model trust and openness by exposing this conflict to the process of the group. You will model honest, open communication and transparency, but to do this you must be comfortable with yourself and allow yourself to come out from behind your role as facilitator. In effect, you become a group member who is subjected to interpersonal difficulties just like every one else in the world. Finally, you should positively reinforce similar inmate behavior. Do not punish those who are less trusting and share only minimally. You should reinforce them for what they have shared. You can process their difficulty in opening up more to the group, you can engage in risk assessment of opening up, and you can encourage inmates to share more, but do not act in a punitive manner to the amount or your perceived tardiness of their sharing. To do so will inadvertently reinforce negative feelings of sharing. Inmates will learn that sharing only leads to greater expectations of what one must share and everyone will be afraid to be more open with the group.

Here-And-Now Focus

As stated previously, the here-and-now refers to the focus on the interpersonal relationships within the group and occurs in the present. The focus on the here-and-now is of paramount importance in Yalom's theory and is a concept that you will need to be familiar and comfortable with to facilitate an interpersonal process-oriented group. For this reason, I contribute more detail to this concept than any other concepts in this theory. To implement a here-and-now focus you need to know that this process occurs at two levels: first is an experiential level and second is an "illumination of process" level.

In the experiential level, group members will experience feelings in the here-and-now. Some of these feelings will be strong and will be in reaction to other group members, the therapist, and the group at large. The focus of this portion of the group will be on these feelings. Identifying and sharing these feelings with the group will be one of your primary goals for each of the individual members. The events in meetings must take precedence over any other events (e.g., conflict with officers, problems with cellmates). That is not to say that other events in the inmate's life are not to be discussed; however, the group focus must remain on intergroup behaviors. The here-and-now focus will remain incomplete without the second level, the illumination of process. That is, you must facilitate "process commentary" (i.e., explaining what you observed/heard happening in the group) on the events that occur in the here-and-now. Experiencing is insufficient to facilitate change. The experiencing must by accompanied by interpersonal learning which occurs through process commentary. Thus you have two tasks, facilitate a here-and-now focus and then lead the group in an exploration of the here-and-now

behaviors. In effect, the group will perform a "self-reflective loop". The group will live in the here-and-now, and then reflect back on the behavior that occurred.

For purposes of this group, process will refer to the interpersonal relationships between group members. Process is not the same as content. Content refers to the explicit meaning of statements, whereas process refers to underlying meanings. To understand the process you need to consider the reason, from an interpersonal perspective, that inmates make statements when they do, how they do, and to whom they do. In other words, why is a inmate saying what he is saying, how he is saying it, and to whom he is saying it. This is the group process and it is this process commentary that separates experiential group therapy from other social interactions.

Some techniques may aid you in activating a here-and-now focus; however, you are strongly encouraged not to rely on these techniques in a prescriptive format, rather to understand the purpose and intent behind the techniques. In so doing, you will then by in a position to initiate your own techniques that are consistent with your own individual style. First, it may help you to think in the here-and-now. Your focus should be on attempting to bring each group session, each event, into the here-and-now. Ask yourself questions such as how can I get this discussion into the here-and-now? This should be done as early as the first group session. For instance, after group introductions and initial discussion, you may interrupt the group with a process commentary. Yalom provides the following narrated example "We've done a great deal here today so far. Each of you has shared...But I have a hunch that something else is going on, and that is that you're sizing one another up, each arriving at some impressions of the other, each wondering how you'll fit in with the others. I wonder now if we could spend some time discussing what

each of us has come up with thus far." As you can see from this example, you can directly influence a here-and-now focus. You will attempt to adjust the focus from the external, abstract, and impersonal, to the internal, specific, and personal. Encourage the use of first person rather than third person. Identify when group members are talking to you and encourage group communication. Other examples of moving the focus to a here-and-now focus will be presented in the training sessions.

Another strategy is to provide feedback on how to ask and give feedback to and from other group members. It may be necessary for inmates to occasionally check out their beliefs with the group. Help inmates avoid group questions such as "Do you like me?" in favor of more effective questions such as "What is it about me that you like most and least?" This type of activity promotes process commentary and includes the following sequence:

1. A description of behavior. Inmates learn to see themselves as others see them.
2. Here is the impact of your behavior on others. Inmates learn how their behavior makes others feel.
3. Here is the impact of your behavior on others' attitudes toward you. Inmates learn how others feel about them as a result of their behavior.
4. Here is the impact of your behavior on your attitude toward yourself. Inmates learn how their behavior influences their own attitude about themselves.

When initially inquiring about intergroup relations, you will receive resistance from the group. Inmates will say something to the effect that they like all of the group members the same. It may be important for you to accept these defenses initially, but stay with the task, continue to probe and explore, and do not hesitate to model

interpersonal communications. For example, after a long silence you may initiate "process commentary" by asking for the thoughts of the group members that were "unsaid". You can then model this behavior by sharing your own thoughts that occurred during the silence.

At times it may occur to you that things are going "unsaid" as the group is nearing the end. You may have the members imagine that the group has just ended and they are walking back to their cells. Ask them what disappointments they would have about that session. Also, do not hesitate to wonder about how group discussions relate to the group session (e.g., if they are discussing the frustration of inmates in the facility, wonder aloud if that is how they are feeling in the group). Your wondering may or may not be accurate, but either way, you facilitate a here-and-now focus.

Once you have established a here-and-now focus, you must then use this process therapeutically (i.e., process illumination). The illumination of process consists of four stages: (1) inmate recognition of their behavior, (2) inmate understanding of the effects of this behavior, (3) determine their satisfaction with their behavior, and (4) change in behavior. To facilitate these stages, you must first be able to recognize process. This is a skill that generally occurs with experience, and you may or may not have had opportunities to develop this skill. Some specific examples will be provided to aid you, as needed, in the recognition of process.

Establishing a process orientation within the group is as difficult (maybe more so) as establishing a here-and-now focus; however, another one of your tasks will be to facilitate an environment that accepts a process orientation. In so doing, you are encouraged to attempt to facilitate inmate learning via their own route. That is you may

have to hold onto some process commentary until you are able to find a method that allows the inmate to obtain their own insight. This will carry much more weight than any brilliant interpretation that you as a facilitator can offer. This is not an easy task, and as the time frame for this group is relatively short (especially by Yalom's standards) you are encouraged to weigh the time limits against the clinical utility of making an interpretation.

When you choose to illuminate on the group process, you are advised to consider how you can aid the inmate in hearing your process commentary. Some basic concepts are suggested here. First and most obvious, inmates may hear your interpretations more clearly if they are framed in a supportive manner. Second, avoid the temptation to label or classify (e.g., antisocial, narcissistic, uncaring). A statement first describing some positive aspect of their group behavior followed by an observation and interpretation of the ineffective or aversive group behavior may be more easily heard by the inmate. Third, be observant of "moments of truth". That is, there are times when in an instant of openness an inmate discloses some truth that will provide you with therapeutic leverage at a later point in the group. For example, an inmate may state that they would like to develop more intimate relationships with others. By remembering this statement you may be in a position to use his stated desire in making a process commentary to how his intergroup behavior effects his relationships with others in the group.

If any of this information is unclear, I will reiterate many of these points during the first two training sessions. In addition, videotapes produced by Yalom will accurately display the use and impact of the here-and-now focus. Finally, please note that when this

manual refers to bringing the cognitive-behavioral components of this treatment approach into the here-and-now, it is the here-and-now as just described that is referred to.

Stages of Group Psychotherapy

Yalom identifies three stages of group therapy that all groups must obtain in order to become a functional therapeutic group. These stages include the initial stage; the conflict, dominance and rebellion stage; and the development of cohesiveness. These stages are not clearly defined as to when or how a particular group will progress through each stage, but as the facilitator you should be able to recognize and process with the group the stages as they occur.

The initial stage (also referred to by Yalom as the "in or out" stage) is characterized by four basic phases. First, there must be an orientation to the group. You can facilitate this phase by discussing the purpose of the group, expectations of group members, and structure of the group. Second, it is normal for group members to be hesitant about group participation and self-disclosure. Trust has not yet formed and the inmates will continue to seek approval from the group rather than openly discuss their life struggles. Thirdly, the group will experience a "search for meaning" phase. The inmates will attempt to make sense of the group, ask and explore how the group will help them, question how much they really want to share, and attempt to find a role within the group. Finally, there will be a dependency phase. Here the inmates will look for structure, typically from you. They will seek you out for direction, approval, acceptance, and you will see many of the group statements directed to you. You can exert great influence at this point and must remember that you are attempting to establish therapeutic norms as described previously.

The second stage of group therapy is the conflict, dominance and rebellion stage (which Yalom also refers to as the "top-bottom" stage). Here the group shifts focus from approval and acceptance to conflict, dominance, and power. A group hierarchy will likely emerge as inmates jostle for position within the group. In this stage, the inmates are becoming more real and you will begin to see who the group members really are. Controlling and dominant inmates will attempt to assume control in the group, while more passive inmates will allow the group to be directed by others. The inmates are allowed to be a little more real because in this stage they are becoming more comfortable with one another. The first sign that the second stage is occurring is the emergence of conflict. This conflict will typically not present itself in a hostile or aggressive fashion. Rather, subtle disagreements will become evident. This is the group's method of "testing the waters" for the acceptance of conflict. As stated previously, group conflict will invariably be directed to you first. If they cannot express conflict with you the facilitator, how can they trust to express conflict with one another?, and a group without conflict will be like a marriage without conflict--boring, distant, detached, and unreal. You must be prepared to accept conflict, no matter how great or small the challenge, because the group's challenge of you is essential to the life of the group. As such, you must not only permit but encourage confrontation (e.g., reinforce challenges) directed at you. Rest assured, the group will save you and eventually switch the focus of the challenges from you to one another.

Group cohesiveness is the third and final stage of group therapy identified by Yalom. He has also referred to this stage as a "close-far" stage. This stage is characterized by an increase in trust, self-disclosure, and group cohesion. The focus

typically shifts from a conflictual process to one of intimacy. This stage permits the emergence of the real person and secrets are commonly shared. The group develops the cohesion necessary for intimate work to occur. Group cohesion is a relative term. Inmates may develop a strong sense of cohesion that is not easily recognized by facilitators experienced with groups that have achieved more intimate levels. You should caution against harboring high expectations, yet allow yourself to develop a sense for and some expectations for intimacy to occur within the group. You should acknowledge with the group their movement towards intimacy and closeness, and reinforce behaviors that initiate this process.

Some Notes about Group Dynamics

You should already have a good sense about group dynamics, both from experience and from reading the previous sections of this manual. In this section, I want to clarify or describe some of the important group dynamics identified by Yalom that you should be aware of but that were not identified above. These dynamics include: group maintenance, group resistance, and problem patients.

Group maintenance will be one of your primary tasks once the group has begun. You must identify and deter any threats to group cohesiveness. Frequent tardiness, subgrouping, and scapegoating are examples of processes that can negatively impact group cohesiveness. You need to monitor the cohesiveness of the group and it may be necessary at times to delay work on an individual's problems for the betterment of the group. For example, if a new inmate enters the group and is unacknowledged while another group member immediately engages in a dialogue of his problems, you should consider stopping this member and processing with the group the new members presence

and the groups lack of acknowledgment to him. Again, you should attempt to confront this behavior in a nonpunitive manner. For example, you may ask the speaking inmate how he thinks the new inmate is feeling in the group at that point.

Group resistance is common in any group therapy, but this issue is even more salient when working with an inmate population. You may frequently observe group members becoming resistant (generally defined as pain avoidance) to you, to other group members, or to the group at large. When this occurs, your task is to help the inmate see through their resistance to be able to hear the message they are receiving. It is only then that they can accurately confirm or disconfirm a message. For example, it is likely at some point in your group that a group member will make an observation or interpretation to another group member who in turn becomes defensive and resistant to this message. You may encourage the inmate to listen to the message by acknowledging their ability to defend against or counter the message, but point out that in so doing, he is unable to accurately hear the message and is unable to discern which parts of the message are actually true for him.

Problem patients exist in all groups, and your inmate group will be no different. Common problem patient presentations include: the monopolist (talks a great deal in group), the silent patient (talks rarely), the boring patient (detailed stories that stay at a surface level), and most common for your group, the characterologically difficult client (personality problems/disorders). These group members will test your patients as well as your abilities to facilitate a therapeutic group; however, you may be helped by understanding that these are interpersonal problems. You will be unsuccessful in your attempts to confront or challenge this behavior, but you may find success in

interpretations of how the behavior affects their interpersonal relationships. Furthermore, you will be especially effective if you can aid the inmate in identifying how the effects of his behavior actually contradict what he desires in interpersonal relationships.

Summary of an Interpersonal Process-Oriented Approach to Group Therapy

This approach to group psychotherapy with inmates will incorporate Yalom's (1995) interpersonal process-oriented theory. The foundation of this treatment will consist of eleven therapeutic factors: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the primary family group, development of socializing techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors. These factors do not facilitate change independently, rather should be implemented collectively into the treatment process. One of your tasks is to facilitate a culture and develop norms that is conducive to interpersonal exploration. This interpersonal exploration should occur in the here-and-now, as group members will react with emotion to the other group members, the therapist, and the group as a whole; however, this is not sufficient for change. You must facilitate a self-reflective loop where group members share their feelings and then reflect back on this experience with the group. Lastly, you should be aware of the group stages your group members may progress through including: the initial stage (characterized by group orientation, hesitant participation, a "search for meaning", and dependency); the conflict, dominance and rebellion stage (characterized by a focus shift to issues of conflict, dominance, and power); and the group cohesiveness stage (characterized by increased trust, self-disclosure, and group cohesion).

By now you should have a sense of your task when facilitating an interpersonal process-oriented approach to group counseling. It is hoped that Part I of this manual has prepared you for facilitating a therapeutic environment that is rich in opportunity for interpersonal understanding and growth. The avenue to this end lies in the therapeutic factors and the here-and-now process as described previously. As you move into Part II of this manual, you are advised to maintain your present awareness of the interpersonal process-oriented approach. The supplement of the cognitive-behavioral treatment will be much less potent if you are unable to bring this component back into the here-and-now and subject it to a process orientation.

## PART II

### Cognitive-Behavioral Approach

The cognitive-behavioral component of this treatment approach is designed to complement the interpersonal learning that may occur with Yalom's approach by assisting inmates in the development of more effective problem-solving skills and facilitating a process of learning to identify, evaluate, and modify the criminal thinking errors that can effect feelings and behaviors. The premise for this component of the treatment approach is based on Bush and Bilodeau's (1993) statement that "how people think has a controlling effect on how they act" (p. 1-1). In other words, it is the way a person construes (thinks about) a situation that influences their feelings and behaviors (Beck, 1964, 1970). The foundation for this treatment component is the cognitive model described by Beck (1995). The cognitive model applies to an inmate population in that criminal thinking errors are common to disturbed feelings and behaviors. The realistic evaluation and modification of these thinking errors will result in improved mood and prosocial behavior. The treatment component presented here is based on two assumptions; (1) that inmates engage in criminal thinking errors (as identified by Yochelson and Samenow, 1976) that influence their feelings and actions, and (2) that inmates lack adequate problem-solving skills. As such, the cognitive-behavioral approach to this treatment approach will focus on these two cognitive deficits and will incorporate structured exercises and homework assignments to assist inmates in the attainment of these skills.

Criminal Thinking Errors and Cognitive Restructuring

In addition to lacking problem-solving skills, inmates think differently than most law abiding citizens. Cognitive therapy became a theoretical mainstay in the 1950's and continues to be a prominent therapeutic approach. Yochelson and Samenow (1976) have modified the more traditional cognitive therapy approaches of Beck (1976) and Ellis (1962). Yochelson and Samenow have identified 16 cognitive thinking errors, eight of which you will use in the second portion of this group treatment approach. Your task will be to teach the criminal thinking errors to the group members, help them identify the thinking errors that permeate their own thoughts, and begin to modify the thinking errors. The eight criminal thinking errors of focus in this group are listed below.

(1) I Can't: "I can't" is a thought that criminals use to avoid acting responsibly. Typical examples include "I can't work in that job", "I can't get along with that officer", "I can't do my homework assignments". Inmates are prone to "I can't" thoughts to avoid the unpleasantness of acting in responsible ways or avoiding the guilt of irresponsible actions.

(2) The Victim Stance: The victim stance occurs when inmates automatically believe that they are not to blame for their behavior. "That cop is always harassing me", "this system is against me", "the white man is keeping me down" are all examples of a victim stance. People are at times victims; however, the inmate has overly integrated this thought into their image so that they believe that they are a victim in all incidents that do not go their way.

(3) Failure to Put Oneself in Another's Position: Criminals are unable to put themselves in another person's shoes. The inmate is unable to think about what others

are thinking, feeling, or expecting. This error relates to thinking processes as the criminal's thoughts are void of an understanding of noncriminals' thoughts/perspectives on things. An example I encountered with an older male inmate was "why aren't you out their having babies, that's what life is all about." This inmate is unable to grasp the intellectual perspective of others and over generalizes his thinking processes to others.

(4) Failure to Consider Injury to Others: Criminals are unable to identify the "injury" they cause others. Injury here does not refer to physical injury or physical damage to property. Rather, injury refers to the anger, inconvenience, fear, or other emotional damage resulting from criminals' behavior. Inmates often do not view themselves as injuring others (they are generally good people in their own eyes). They may state beliefs like "I'm the one who's separated from his family", "they only lost some money" or "I'm paying restitution". These examples demonstrate that the inmate is unable to identify the injury they cause beyond the loss or immediate damage inflicted as a result of their behavior.

(5) Ownership: "Ownership" is the thought that if the criminal wants something it is his to have. An inmate once told me "if I want something that belongs to someone else I'm going to take it. If he's man enough to stop me then it's not mine to have. If he's not man enough to stop me, then he didn't deserve it in the first place". Obviously, noncriminals do not think along these lines. With regard to ownership, it is the acquisition of objects that is gratifying. The pleasure of ownership is worn out rather quickly and it is the acquisition of new objects that the criminal enjoys.

(6) Refusal to be Dependent: Criminals maintain a belief that they are completely independent without a need for others. They deny the interdependent needs

that we all have. They perceive any dependence as a weakness, thus, deny themselves the opportunity to depend on others for any possible needs. Inmates will frequently say "I don't need anybody" or "I don't need help from anyone, I'm my own man". Such beliefs essentially deny interpersonal needs that all humans have.

(7) Pretentiousness: Criminals think of themselves as superior individuals. They maintain beliefs that they can do or be anything if they really wanted to. These inmates' potential capacities will exceed their capabilities. We have all heard the young inmate without a high school diploma state "I'm going to go to college and be a lawyer", or "I can do anything I want if I really put my mind to it". Because of these beliefs, the criminal believes that others should acknowledge him and seek him out. He will often make statements about his mistreatment by prison personnel. This error in thinking appears to be related to narcissistic personality traits, although for purposes here, the pretentiousness again refers to thought processes.

(8) Failure to make an effort or endure adversity: Criminals do what they want to do. Criminals are unwilling to put forth effort into tasks that they themselves do not deem worthy, and when forced into such tasks they often quit prematurely or complete the task to less than satisfactory degrees. Statements such as "to hell with it" or "this is not worth my time" indicate the inmate's refusal to exert effort or energy into noncriminal tasks. In addition, criminals are unwilling to endure adversity. To borrow from an old cliché, "when the going gets tough, criminals get going". Criminals are notorious for refusing to endure pain and will go to great lengths to avoid enduring pain (physical or mental). Again, this must be thought of in relation to a criminals' thought

processes. That is, they maintain a belief system that minimizes effort and energy and adheres to the avoidance of adversity.

Following the introduction and processing of these criminal thinking errors, your group will focus on the cognitive restructuring approach described by Beck (1995). Cognitive restructuring here will include questioning automatic thoughts and the implementation of automatic thought records (referred to by Beck (1995) as dysfunctional thought records).

Questioning automatic thoughts includes a series of questions to evaluate the inmates' criminal thoughts. You should not challenge automatic thoughts; rather, you want to help inmates evaluate their thoughts (Beck, 1995).

1. "What is the evidence?" What is the evidence that supports the idea and what is the evidence against the idea?
2. "Is there an alternative explanation?" Are there other ways of looking at it?
3. "What is the worst that could happen? What is the best that could happen? What is the most realistic outcome?"
4. "What is the effect of my believing the automatic thought? What could be the effect of changing my belief"
5. "What should I do about it?"
6. "What would I tell a friend if he or she were in the same situation?"

Automatic thought records will help inmates respond more effectively to their automatic thoughts which can help alleviate problematic feelings and behaviors. This cognitive restructuring will implement the use of group exercises as well as homework

assignments to facilitate the process of changing inmates thoughts and beliefs. These exercises and homework assignments are described in greater detail below.

**Group Exercises**

Group exercise one (Session I): Review the handout one "Common Thinking Errors" and describe how these ways of thinking effect one's feelings and behavior.

Group exercise two (Session II): After reviewing the homework exercise one (identifying criminal thinking errors), discuss the thinking errors identified by the group members in terms of automatic thoughts. An automatic thought is a quick, instinctive thought that one has in response to situations/experiences. Your task is to relate how the inmates' automatic thoughts can lead to criminal behavior.

Group exercise three (Session III): Provide feedback to group members to facilitate more effective journalizing of their automatic thoughts. Facilitate a group discussion focusing on how the thoughts identified in their automatic thought logs lead to problematic behaviors (e.g., conflict with officers, familial discord).

Group exercise four (Session IV): Provide the handout (Handout Three: Questioning Automatic Thoughts) introducing a strategy for questioning automatic thoughts and discuss this strategy (include a rationale for questioning one's thoughts). Select some of the automatic thoughts from the inmates logs and begin questioning the thoughts.

Group exercise five (Session V): Provide feedback on the use of the dysfunctional thought record. Identify areas of difficulty with regard to questioning automatic thoughts. Select some examples from the inmates' thought records and work through the process of questioning thoughts.

Group exercise six (Session VI): Continue to provide feedback to facilitate more effective use of the dysfunctional thought record and the use of the questioning of automatic thoughts.

**Homework Exercises**

Homework exercise one: Assign the inmate the task of identifying at least one example of each of the eight criminal thinking errors from their own thoughts. That is, they should provide at least one written example that is characteristic of each of the thinking errors that they currently think or have thought in the recent past.

Homework exercise two: Assign group members the task of beginning a daily log of those automatic thoughts identified in the group. Provide the inmates with copies of the automatic thought log (Handout Two: Automatic Thought Log).

Homework exercise three: Assign the group members the task of continuing the automatic thought log (Handout two). Provide more copies of this log to the group members.

Homework exercise four: Provide (and explain) inmates with the dysfunctional thought record (Handout four) and assign them the task of replacing the automatic thought log with this dysfunctional thought record.

Homework exercise five: Continue with the dysfunctional thought record.

Problem-Solving Skills

One of the most basic skills lacking in most inmates is the skill to adequately solve problems (Yochelson & Samenow, 1976). The goal of this portion of the treatment component will be to teach inmates one strategy for more effective problem-solving. The treatment strategy implemented here was developed by D'Zurilla and Goldfried (1971)

and attempts to facilitate an effective method for resolving many of life's everyday difficulties. This component of the treatment program will consist of didactic presentation of the problem-solving strategy, in group practice and homework assignments implementing the strategy.

The problem-solving strategy proposed by D'Zurilla and Goldfried (1971) includes five stages to effective problem-solving. The five stages consist of: (1) general orientation, (2) problem definition and formulation, (3) generation of alternatives, (4) decision making, and (5) verification. These stages are briefly presented here, and more information will be provided during the last training session.

The goal of the general orientation stage is to develop a positive attitude towards problems. The acquisition of this goal requires an ability to: identify problems; maintain an attitude of acceptance towards problems as normal, changeable, and challenging; a belief in oneself as capable to deal problems; and the development of a habit of thinking how to solve a problem rather than simply reacting on one's first impulse.

The goal of the problem definition and formulation stage is to identify and define the presenting problem. The first step in this stage of is to define the problem. This is one of the keys to solving a problem, and inmates must learn to develop very specific definitions of their problems. In addition, to be successful in this stage of problem-solving, one must establish realistic goals for the problem. A goal refers to what the inmate would like to have happen as a result of solving the problem. Inmates must learn to be realistic or they will not be satisfied with the outcome.

The third stage of this approach is the generation of alternative solutions. The purpose of this stage is to generate as many alternative solutions to the problems as

possible. In other words, what can the inmate do or how can he handle the problem. To accomplish this stage the inmate needs to defer judgment of the solutions and develop as many solutions as possible (quantity breeds quality).

Decision making is the fourth stage of this problem-solving approach and the goal of this stage is to evaluate the best solution to use to solve the problem by judging and comparing all the alternatives. First, inmates must eliminate any solution that is obviously not feasible or risky. Next he must evaluate each idea by identifying the positive and negative consequences of each solution. Finally, the inmate must work towards a solution (e.g., what solution or combination of solutions should be used to solve the problem).

The final stage is solution implementation and verification. The goal of this stage is to test the chosen solution(s) and to verify whether these solutions solve the problem (i.e., fix the problem). To accomplish this goal, inmates must learn to specify the necessary details to implement the chosen solution(s). He needs to consider and anticipate difficulties that may arise during the implementation of the solution. The inmates need to evaluate the success of the solution, and finally, if the solution was unsuccessful, he needs to rework through the stages as identified above.

Your task will be to teach the inmates in your group these five stages to effective problem-solving. You will assist the inmates in developing problem-solving skills via didactic instruction and feedback. For this treatment component, you will have to be more directive in your therapy approach. Your task will be more structured and you will be expected to follow a prescribed regimen; however, you need to incorporate your own therapeutic style into this treatment component. Your goal here should be to build this

strategy into your therapeutic repertoire. To further aid in the inmate development of this strategy, group exercises and homework exercises will be implemented. Below is a description of the group and homework exercises.

**Group Exercises**

Group exercise seven (Session VII): Review handout five and describe the five stages of this problem solving strategy.

Group exercise eight (Session VIII): Ask for a volunteer to pick one of the problems or situations they identified in their homework assignment and work through the problem-solving strategy with the group.

Group exercise nine (Session IX): After reviewing the homework assignment, identify particular areas of difficulty and discuss these issues. If time permits, select one of the particularly difficult homework problems and rework the problem with the group members.

Group exercise ten (Session X): After reviewing the homework assignment, identify particular areas of weaknesses or difficulties and provide feedback for more effective use of this problem-solving strategy. If time permits, select a problem that was particularly difficult and work through the problem in the group.

Group exercise eleven (Session XI): Again, after reviewing the homework assignment identify particular areas of weaknesses or difficulties and provide feedback for more effective use of this problem-solving strategy. If time permits, select a problem that was particularly difficult and work through the problem in the group.

Group exercise twelve (Session XII): Review the work of the group with regard to implementing the problem-solving strategy in their daily lives.

**Homework Exercises**

Homework exercise six (Session VII): Assign the group members to be aware of problems or circumstances in the upcoming week in which using the problem-solving strategy could be useful. Provide handout six for the inmate to use in the completion of this assignment.

Homework exercise seven (Session VIII): Provide homework assignment seven (handout seven) to the group members and briefly explain this assignment.

Homework exercise eight (Session IX): Assign the group members the task of identifying and solving one minor problem they are currently experiencing or that they experience in the upcoming week. They should implement this problem-solving strategy and should document their work in each of the stages (i.e., they need to write out each of the five steps, not simply give a verbal report in the next group meeting).

Homework exercise nine (Session X): Assign the group members the task of identifying and solving one more intense problem they are currently experiencing or that they experience in the upcoming week. Again, they should document their work (i.e., write out the steps).

Homework exercise ten (Session XI): Assign the group members the task of identifying how this problem-solving approach will be useful to them. This task should also be in written form (e.g., a paper, a written list, etc.).

## PART III

### Treatment Plan

Intake Interview:

1. Establish rapport
2. Discuss limits of confidentiality (obtain signature on confidentiality form)
3. Provide an overview of this treatment program
    - focus on interpersonal relationships, criminal thinking errors, and establish effective problem solving skills
    - describe the purpose and procedure of the assessment phases
4. Obtain informed consent and have inmate sign consent form
5. Obtain background information via your normal clinical interview style

Session 1:

1. Administer pretest measures.

Session 2:

1. Discuss group confidentiality (including your limits to confidentiality)
2. Facilitate group introductions
3. Begin implementing the therapeutic factors (e.g., universality, instillation of hope)
4. Begin to facilitate a here-and-now focus
5. After 75 minutes into the session, direct the group to a focus on criminal thinking errors.

6. Provide a rational of the purpose and benefits of focusing on criminal thinking errors
7. Briefly explain and discuss cognitive distortions and automatic thoughts (e.g., thoughts lead to feelings and behavior)
8. Provide the handout (handout one) and describe the eight criminal thinking errors of focus in this study
9. Assign homework assignment one
10. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group. The goal with this task is to attempt to incorporate the structured cognitive-behavioral component into the here-and-now focus of the group and subject this information to the process commentary of the group

Session 3:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group to a focus on criminal thinking errors
3. Review homework assignment one
4. Facilitate group exercise two
5. Assign homework assignment two
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 4:

1. Facilitate the process-oriented group as discussed in this treatment manual

2. After 75 minutes into the session, direct the group to a focus on criminal thinking errors
3. Review homework assignment two
4. Facilitate group exercise three
5. Assign homework assignment three
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 5:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group to a focus on criminal thinking errors
3. Review homework assignment three
4. Facilitate group exercise four
5. Assign homework assignment four
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 6:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group to a focus on criminal thinking errors
3. Review homework assignment four
4. Facilitate group exercise five
5. Assign homework assignment five

6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group. Discuss termination issues

Session 7:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group to a focus on criminal thinking errors
3. Review homework assignment five
4. Facilitate group exercise six
5. Inform the group that the next session will begin the problem-solving focus
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group

Session 8:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Provide a rational of the purpose and benefits of this problem-solving approach
4. Provide the handout (handout five) and describe the five stages of this problem-solving strategy
5. Assign homework assignment six
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group. Again, the goal with this task is to attempt to incorporate the structured cognitive-behavioral component into the here-and-

now focus of the group and subject this information to the process commentary of the group

Session 9:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Review the five stages to effective problem-solving
4. Review homework assignment six
5. Facilitate in group exercise eight
6. Assign homework assignment seven
7. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 10:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Review homework assignment seven
4. Facilitate in group exercise nine
5. Assign homework assignment eight
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 11:

1. Facilitate the process-oriented group as discussed in this treatment manual

2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Review homework assignment eight
4. Facilitate in group exercise ten
5. Assign homework assignment nine
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 12:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Review homework assignment nine
4. Facilitate in group exercise eleven
5. Assign homework assignment ten
6. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.

Session 13:

1. Facilitate the process-oriented group as discussed in this treatment manual
2. After 75 minutes into the session, direct the group focus to a problem-solving orientation
3. Review homework assignment ten
4. Facilitate group exercise twelve

5. Direct the group back to a here-and-now process orientation for the last fifteen minutes of the group.
6. Discuss termination issues, review the work and progress of the group, and terminate the group

Session 14:

1. Administer post-test measures

**Handout One**
**Common Thinking Errors**

Listed below are eight common thinking errors.

(1) I Can't: "I can't" is a thought that is used to avoid acting responsibly. Typical examples include "I can't work in that job", "I can't get along with that person", "I can't do my homework assignments". People are prone to "I can't" thoughts to avoid the unpleasantness of acting in responsible ways or avoiding the guilt of irresponsible actions.

(2) The Victim Stance: The victim stance occurs when people automatically believe that they are not to blame for their behavior. "That supervisor is always harassing me", "this system is against me", "people don't want me to succeed" are all examples of a victim stance. People are at times victims; however, this is a thinking error when this thought is overly integrated into one's self image and a belief is maintained that one is a victim in all incidents that do not go their way.

(3) Failure to Put Oneself in Another's Position: Some people are unable to put themselves in another person's shoes. They are unable to think about what others are thinking, feeling, or expecting. This error relates to thinking processes as a person's thoughts may be void of an understanding of others thoughts/perspectives on things. For example, one might ask a volunteer why he/she is volunteering when they will not get paid. This person is unable to grasp the intellectual perspective of others and over generalizes his/her thinking processes to others.

(4) Failure to Consider Injury to Others: Some people are unable to identify injuries they cause others. Injury here does not refer to physical injury or physical damage to property. Rather, injury refers to the anger, inconvenience, fear, or other emotional damage that can result from some behavior. People often do not view themselves as injuring others (they are generally good people in their own eyes). They may state beliefs like "I'm the one who's separated from my family", "they only lost some money" or "I'm paying them back". These examples demonstrate that some people are unable to identify the injury they cause beyond the loss or immediate damage inflicted as a result of their behavior.

(5) Ownership: "Ownership" is the thought that if a person wants something, it is his/hers to have. For example, a person with this thinking error might say "if I want something that belongs to someone else I'm going to take it. If he's man enough to stop me then it's not mine to have. If he's not man enough to stop me, then he didn't deserve it in the first place". Most people do not think along these lines. With regard to ownership, it is the acquisition of objects that is gratifying. The pleasure of ownership is worn out rather quickly and it is the acquisition of new objects that people enjoy.

(6) Refusal to be Dependent: People may maintain a belief that they are completely independent without a need for others. They deny the interdependent needs that we all have. They perceive any dependence as a weakness, thus, deny themselves the opportunity to depend on others for any possible needs. These people will frequently say "I don't need anybody" or "I don't need help from anyone, I'm my own person". Such beliefs essentially deny interpersonal needs that all humans have.

(7) Pretentiousness: Some think of themselves as superior individuals. They maintain beliefs that they can do or be anything if they really wanted to. For example, young person without a high school diploma may state "I'm going to go to college and be a lawyer", or "I can do anything I want if I really put my mind to it". Because of these beliefs these people believe that others should acknowledge them and seek them out. They will often make statements about others mistreatment of them.

(8) Failure to make an effort or endure adversity: Some people do what they want to do. They are unwilling to put forth effort into tasks that they themselves do not deem worthy, and when forced into such tasks they often quit prematurely or complete the task to less than satisfactory degrees. Statements such as "to hell with it" or "this is not worth my time" indicate the refusal to exert effort or energy. In addition, these people are unwilling to endure adversity. To borrow from an old cliché, "when the going gets tough, some people get going". These people are notorious for refusing to endure pain and will go to great lengths to avoid pain (physical or mental). They maintain a belief system that minimizes effort and energy and adheres to the avoidance of adversity.

**Handout Two**
**Automatic Thought Log**

| Date/Time | Situation | Automatic Thought(s) | Feeling(s) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Handout Three**
**Questioning Automatic Thoughts**

Below are six questions you can use to evaluate the automatic thoughts you experience in your daily life. This procedure is an attempt to help you evaluate the accuracy of your thoughts.

1. What is the evidence for this thought? What is the evidence you have that supports your idea and what is the evidence against (does not support) your idea?

2. Is there an alternative explanation? Are there other ways of looking at the situation?

3. If my thought is true, what is the worst that could happen? If my thought is true, what is the best that could happen? What is the most realistic outcome?

4. What is the effect of my believing this automatic thought on my feelings and behavior? What could be the effect on my feelings and behavior of changing my belief

5. What should I do about this? What do I want to do about this?

6. What would I tell a friend if he or she were in the same situation?

**Handout Four**
**Automatic Thought Log**

| Date/Time | Situation | Automatic Thought(s) | Feeling(s) | Adaptive Response | Outcome |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Note. From Cognitive Therapy: Basics and Beyond (p. 126), by J. S. Beck, 1995, New York: Guilford Press.

**Handout Five**
**Five Stages of Problem-Solving**

Below are five stages for more effectively solving problems that we all encounter on a regular basis.

(1) General Orientation refers to a goal of developing a positive attitude toward problems. The acquisition of this goal requires an ability to identify problems, develop an attitude of acceptance towards problems as normal, changeable, and challenging, develop a belief in oneself as capable to deal problems, and the development of a habit of thinking how to solve a problems rather than simply reacting on one's first impulse.

(2) Problem Definition and formulation refers to identifying and defining the presenting problem. The first step in this stage is to define the problem. This is one of the keys to solving a problem, and you need to develop very specific definitions of your problems. In addition, to be successful in this stage of problem-solving, you must establish realistic goals for the problem. A goal here, refers to what you would like to have happen as a result of solving the problem.

(3) Generation of Alternatives is the goal of generating as many alternative solutions to the problem as possible. In other words, what can you do or how can you handle the problem. To accomplish this stage you should defer judgment of the solutions and develop as many solutions as possible (quantity breeds quality).

(4) Decision Making refers to the evaluation of the solutions to determine the best solution(s) for the presenting problem by judging and comparing all of the alternatives. First, eliminate any solution that is obviously not feasible or risky. Next, evaluate each idea by identifying the positive and negative consequences of each solution. Finally, work towards a solution (e.g., what solution or combination of solutions should be used to solve the problem).

(5) Verification is the final stage and involves the implementation and evaluation of the chosen solutions. The goal of this stage is to test the chosen solution(s) and to verify whether these solutions solve the problem (i.e., fix the problem). You need to specify the necessary details to implement the chosen solution(s), and consider and anticipate difficulties that may arise during the implementation of the solution. Evaluate the success of the solution, and if the solution was unsuccessful, rework through the stages as identified above.

**Handout Six**
**Homework Assignment Six**

In the upcoming week, be aware of problems or circumstances in which using the problem-solving strategy could be useful. Write down a brief description of five of these circumstances and if you used the problem-solving strategy indicate briefly how successful it was.

1._____

_____

_____

2._____

_____

_____

3._____

_____

_____

4._____

_____

_____

5._____

_____

_____

**Handout Seven**
**Assignment Seven**

The following are four problems. Work out solutions to three of the four problems using the problem-solving strategy covered in group. Use headings (i.e., Decision Making Stage) when working through the problems. I suggest you work on these problems alone so you can see where your strengths and weaknesses are with respect to this strategy. Keep in mind that problems can be challenging rather than threatening. The accompanying page may help you in solving the problems.

Problem One: A correctional officer is harassing you on a regular basis.

Problem Two: You are having problems getting along with your spouse, significant other, or family member.

Problem Three: You don't like the job you are working at.

Problem Four: Any other minor problem that you are currently encountering in your own life.

**Five Stages of Problem-Solving**

DEFINITION OF PROBLEM

Define the problem:

Set realistic goals:

GENERATE ALTERNATIVE SOLUTIONS (REMEMBER QUANTITY BREEDS QUALITY)

DECISION MAKING

Use accompanying handout

SOLUTION IMPLEMENTATION AND VERIFICATION

What?

When?

How?

Anticipate difficulties:

**Evaluate Each Solution**

| Solution | Will The Problem Be Solved | How Much Time and Effort Will be Needed to Solve the Problem | Overall effect on your personal and social well being |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

REFERENCES

Beck, A. (1964). Thinking and depression: II. Theory and therapy. Archives of General Psychiatry, 10, 561-571.

Beck, A. (1970). The core problem in depression: The cognitive triad. In J. Masserman (Ed.), Depression: Theories and therapies. New York: Grune & Stratton.

Beck, A. (1976). Cognitive therapy and the emotional disorders. New York: International Universities Press.

Beck, J. S. (1995). Cognitive therapy: Basics and beyond. New York: Guilford Press.

Bush, J. M., & Bilodeau. B. (1993). Options: A cognitive change program. Washington, D.C.: National Institute of Corrections.

D'Zurilla, T. J., & Goldfried, M. R. (1971). Problem-solving and behavior modification. Journal of Abnormal Psychology, 78, 107-126.

Ellis, A. (1962). Reason and emotion in psychotherapy. New York: Lyle Stuart.

Yalom, I. D. (1970). The theory and practice of group psychotherapy. New York: Basic Books.

Yalom, I. D. (1995). The theory and practice of group psychotherapy (4th ed.). New York: Basic Books.

Yochelson, S. & Samenow, S. E. (1976). The criminal personality volume I: A profile for change. New York: Jason Aronson.

# APPENDIX C

# DEMOGRAPHIC FORM

DEMOGRAPHIC SHEET

1) Age: _____

2) Gender: Male_____ Female_____

3) Racial/Ethnic Identity (Check only one):
_____ African-American/Black
_____ American Indian/Native American
_____ Asian/Asian American
_____ Caucasian/White
_____ Hispanic/Latino
_____ Other (please explain)_____

4). What is your marital status? (check one)
_____ single
_____ partnered/common law
_____ married
_____ separated
_____ divorced
_____ widowed

5) How many years of school have you completed? _____

6) What is/are the charge(s) you were convicted of? _____

_____

7) What is the length of your sentence? _____ years _____ months

8) Which of the following best describes your current classification level? (check one)
_____ Minimum
_____ Medium
_____ Maximum
_____ Other (explain) _____

# APPENDIX D

## DISCIPLINARY REPORT RECORD FORM

Subject #_____

Crime(s)_____
_____
_____

Sentence_____

Number of Disciplinary Report Prior to Group (3 months)_____

1.
2.
3.
4.
5.

Number of Disciplinary Reports Received During Group_____

1.
2.
3.
4.
5.

Number of Disciplinary Reports Following Group (3 months)_____

1.
2.
3.
4.
5.

Program Absenteeism Prior to Group (3 months)_____

Program Absenteeism During Group_____

Program Absenteeism Following Group (3 months)_____

# APPENDIX E

# CRIMINAL THINKING ERRORS QUESTIONNAIRE

Automatic Thought Questionnaire

Please read the statements below and rate how much you agree or disagree with each one.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Totally Disagree | Disagree Very Much | Disagree Slightly | Neutral | Agree Slightly | Agree Very Much | Totally Agree |

_____ 1. I do not view myself as better than most people.

_____ 2. My victim(s) were the only people injured by my crime.

_____ 3. I go to great lengths to avoid emotional pain.

_____ 4. Victims of my crime(s) suffered more than a loss of property.

_____ 5. I am frequently a victim of circumstance.

_____ 6. I can be anything I want to be.

_____ 7. I do not have trouble putting myself in someone else's shoes.

_____ 8. I often don't understand why others are upset.

_____ 9. Some required tasks are not worth doing, so I don't do them.

_____ 10. I do not need anybody.

_____ 11. I have a right to own anything I want.

_____ 12. I have gotten a fair shake in life.

_____ 13. I can't accept responsibility for my actions.

_____ 14. It is not a sign of weakness to be dependent on others for anything.

_____ 15. I can live a crime free life.

_____ 16. Some things are not mine to have.

# APPENDIX F

# INFORMED CONSENT FORMS

INFORMED CONSENT

The purpose of this project is to develop a new Group Therapy Treatment Program designed for incarcerated adult males.

I, _____, authorize Robert Morgan, M.S., of Oklahoma State University, and any research assistants designated by him, to gather information about me which is related to the topic stated above.

My participation in this study will involve completing three or four questionnaires at three different time periods. Also by participating in this study, I give my permission for the group therapist identified for this study to review my central file for my disciplinary record and program/work attendance record for the three months prior to the initiation of this study and for the three months following the completion of this study. I may be asked to participate in a group counseling program as a result of this study. If I am not offered the opportunity to participate in this treatment program during the course of this study, a comparable treatment program will be offered at the termination of this study.

I am aware that all of the information provided by me is strictly confidential, and I will not be identified in this study. For my protection, all information related to me will be coded with an identification number rather than by my name. If I choose not to participate, the researchers from Oklahoma State University will not be aware of this decision. Furthermore, I am aware that I may choose to end my participation in this study at any time without penalty. I also understand that if I feel any undue stress or anxiety as a result of participation in this study, I may consult any of the research assistants associated with this study, and I may ask questions related to this study.

I understand that if I participate in the group treatment program, my participation could at times result in feelings of uneasiness. Therapists and/or group members may ask me questions or make statements that might make me feel uncomfortable; however, I understand that I have the right to decide whether or not I wish to answer any questions asked of me in the group. I also understand and am aware that this group treatment program is aimed at helping me learn new skills. Finally, I am aware that the therapist will place appropriate documentation in my central file indicating that I have participated in a treatment program.

I also understand that to monitor this group counseling approach, the group facilitator will audio tape one 30 minute segment of every fourth session. This tape will be reviewed and rated by Robert Morgan, M.S., Carrie Winterowd, Ph.D., and research assistants at Oklahoma State University. All information will remain confidential and no group members will be identified during this process. These tapes will be reviewed for the purpose of providing consultation (e.g., suggestions) to the group facilitators. I understand that no person other than those already mentioned will have access to these

tapes and that all tapes will be erased immediately following their rating by the primary researchers and the research assistants.

I am aware that there is no connection between participation in this study and the treatment I will receive at this facility, and that my confidentiality and anonymity within this facility will be protected. If I choose not to participate in this study, no documentation indicating this decision will be placed in my central file.

American Psychological Association ethical standards for research with human subjects and the ethical guidelines of the Association for Specialists in Group Work will be followed in all stages of this study. I understand that if I have any questions about this study that are not satisfactorily answered, I may have the research assistants contact the primary researcher (Robert Morgan) or I may directly contact the following for assistance:

Robert Morgan, M.S.
Applied Behavioral Studies in Education
437 Willard Hall
Oklahoma State University
Stillwater, OK 74078
405-744-6036

Gay Clarkson
Department of Research
305 Whitehurst
Oklahoma State University
Stillwater, OK 74078
405-744-5700

Date: _____

Signed: _____

Witness: _____

INFORMED CONSENT

The purpose of this project is to evaluate a new questionnaire that was developed by the researchers identified in this consent form.

I, _____, authorize Robert Morgan, M.S., of Oklahoma State University, and any research assistants designated by him, to gather information about me which is related to the topic stated above.

My participation in this study will involve completing one questionnaire at two different time periods, and completing a demographic sheet. I am aware that all of the information provided by me is strictly confidential, and I will not be identified in this study. For my protection, all information related to me will be coded with an identification number rather than by my name. If I choose not to participate, the researchers from Oklahoma State University will not be aware of this decision. Furthermore, I am aware that I may choose to end my participation in this study at any time without penalty. I also understand that if I feel any undue stress or anxiety as a result of participation in this study, I may consult any of the research assistants associated with this study, and I may ask questions related to this study.

I am aware that there is no connection between participation in this study and the treatment I will receive at this facility, and that my confidentiality and anonymity within this facility will be protected. If I choose not to participate in this study, no documentation indicating this decision will be placed in my central file.

American Psychological Association ethical standards for research with human subjects will be followed in all stages of this study. I understand that if I have any questions about this study that are not satisfactorily answered, I may have the research assistants contact the primary researcher (Robert Morgan) or I may directly contact the following for assistance:

Robert Morgan, M.S.
Applied Behavioral Studies in Education
437 Willard Hall
Oklahoma State University
Stillwater, OK 74078
405-744-6036

Gay Clarkson
Department of Research
305 Whitehurst
Oklahoma State University
Stillwater, OK 74078
405-744-5700

Date: _____

Signed: _____

Witness: _____

# APPENDIX G

## RATER CODING SHEET

DISSERTATION TAPE CHECKLIST

Therapist: _____
Tape: _____
Reviewer: _____

Please use the following checklist to help you in determining the primary orientation of this tape segment.

**INTERPERSONAL-PROCESS ORIENTATION**

_____ Discuss group relationships (with one another and/or with therapist)

_____ Therapist encourages the group members to reflect on the process of the group

_____ Discuss/reinforce/or incorporate strategies aimed at Yalom's therapeutic factors (see therapeutic factors handout)

_____ Here and now focus (focusing on group content and relationships "in the moment")

_____ Group members learn how they relate to one another by reflecting on the process of the group

_____ Group members are encouraged to discuss their thoughts and feelings on events that happen in the group (self-reflective loop)

**COGNITIVE-BEHAVIORAL ORIENTATION**

_____ Discuss/focus on specific thinking errors (see Thinking Errors handout)

_____ Discuss homework exercises (assignments)

_____ Discuss/focus on problem-solving skills (see Problem-Solving handout)

_____ Discuss/focus on automatic thoughts record

_____ Teaching how to evaluate thoughts (e.g., looking at evidence for and against automatic thoughts)

_____ Developing alternative thoughts/beliefs (cognitive restructuring)

This tape is of (please Circle one):

1. Interpersonal-Process orientation
2. Cognitive-behavioral orientation

# APPENDIX H

# INSTITUTIONAL REVIEW OF HUMAN SUBJECTS

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

**Date:** 03-05-97 **IRB#:** ED-97-063

**Proposal Title:** THE EFFICACY OF A INTERPERSONAL/COGNITIVE-BEHAVIORAL GROUP PSYCHOTHERAPY APPROACH WITH INMATES

**Principal Investigator(s):** Carrie Winterowd, Dale Fuqua, Robert Morgan

**Reviewed and Processed as:** Full Board

**Approval Status Recommended by Reviewer(s):** Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE APPROVAL PERIOD.
APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

---

Comments, Modifications/Conditions for Approval or Disapproval are as follows:

Signature: _____ Date: March 19, 1997

Chair of Institutional Review Board

cc: Robert Morgan

# KANSAS DEPARTMENT OF CORRECTIONS

*A Safer Kansas through Effective Correctional Services*

BILL GRAVES, GOVERNOR | CHARLES E. SIMMONS, SECRETARY

LANDON STATE OFFICE BUILDING — 900 SW JACKSON
TOPEKA, KANSAS — 66612-1284
913-296-3317


April 30, 1997

Robert Morgan, M.S.
602 S. Willis
Stillwater, OK 74074

Dear Mr. Morgan:

This is to inform you that your research proposal, "The efficacy of a Interpersonal/Cognitive Behavioral Group Psychotherapy Approach with Inmates," has been approved by Secretary of Corrections Charles Simmons. Please contact Warden Michael Nelson at El Dorado Correctional Facility to make arrangements to begin the project.

Enclosed is a blank "Access Request and Non-disclosure Agreement" form. Please complete the "requestor" portions of the form, sign and date, and return to this office.

The Department is interested in the results of your study. As stated in IMPP 06-101, each researcher is required to submit to the Department of Corrections a copy of the final report on the project. Please review this IMPP for details on this requirement and for the procedure for obtaining permission to submit any research results for publication. Good luck with the project.

Sincerely,

Patricia Biggs
Director, Research and Staff Development Unit

PB:KWS:kws
Enclosure

cc Deputy Secretary Risley
Deputy Secretary Vohs
Deputy Secretary Werholtz
Warden Mike Nelson, EDCF
Robert Reitz, Director, Mental Health Services, PHS

# VITA

Robert D. Morgan

Candidate for the Degree of

Doctor of Philosophy

Dissertation: THE EFFICACY OF AN INTERPERSONAL/COGNITIVE-BEHAVIORAL GROUP PSYCHOTHERAPY PROGRAM WITH MALE INMATES

Major Field: Applied Behavioral Studies

Biographical:

Personal Data: Born in St. Joseph, Missouri, On October 12, 1967, the son of Richard and Betty Morgan.

Education: Graduated from Grand Island Senior High School, Grand Island, Nebraska, in May 1986; received Bachelor of Science degree in Psychology from the University of Nebraska at Kearney, Kearney, Nebraska in August 1991. Completed the requirements for the Master of Science degree with a major in clinical psychology at Fort Hays State University, Hays, Kansas in August 1993. Completed the requirements for the Doctor of Philosophy degree with a major in Applied Behavior Studies at Oklahoma State University (August, 1999).

Experience: Completed a summer internship in clinical psychology at the United States Penitentiary at Leavenworth in 1992. Employed as a Mental Health Professional by Prison Health Services to work in the Kansas Department of Corrections correctional facilities (1993 to 1995).

Professional Memberships: American Psychological Association, student affiliate.