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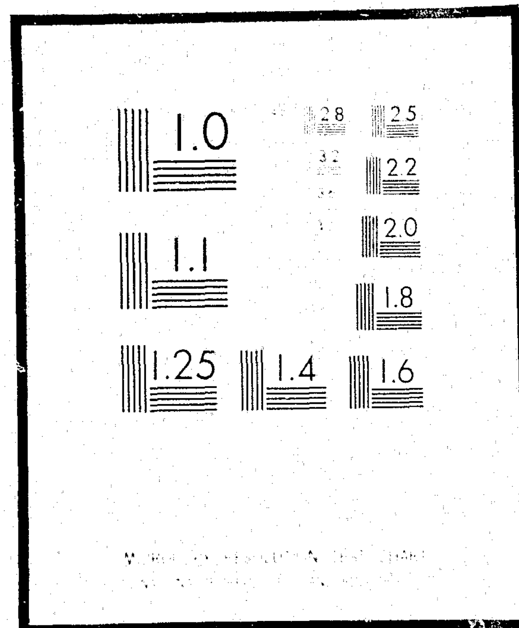

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EFFECTIVENESS OF GROUP PSYCHOTHERAPY WITH CHARACTER DISORDERED PRISONERS

CHARLES C. JEW

LUKE I. C. KIM

A. L. MATTOCKS

RESEARCH DIVISION • DEPARTMENT OF CORRECTIONS • STATE OF CALIFORNIA •

OCTOBER 1975

STATE OF CALIFORNIA

EDMUND G. BROWN, JR.

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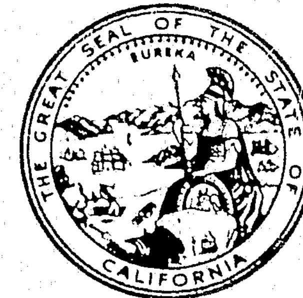

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Charles C. Jew

Luke I. C. Kim

A. L. Mattocks

Research Unit
California Department of Corrections
Sacramento, California

October 1975

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TABLE OF CONTENTS

	Page
LIST OF TABLES	ii
INTRODUCTION	1
RESEARCH ON THE EFFECTIVENESS OF TREATMENT IN PRISONS	2
THE GROUP PSYCHOTHERAPY PROGRAM AT CMF	5
The California Medical Facility	5
Selection for Group Psychotherapy	6
The Psychiatric Council	7
The Psychiatric Evaluation	8
Plan of the Study	8
Data System and Samples of Patients	9
Comparison Group	10
Characteristics of the Treatment Population	10
Criteria of Evaluation	13
RESULTS OF THE EVALUATION	15
Impact and Duration of Impact of Treatment	15
No Problem or Difficulty	15
Return to Prison	17
Failures: Major Problems and Return to Prison	17
FACTORS ASSOCIATED WITH RETURN TO PRISON	18
Offense Type and Return to Prison	18
Age, Prior Prison Record and Recidivism	19
DISCUSSION AND CONCLUSIONS	22
Differential Impact	22
Long and Short Term Impact	22
Overall Parole Performance	23
General Conclusions	23
APPENDICES	25
BIBLIOGRAPHY	27

LIST OF TABLES

		Page
TABLE I.	Characteristics of Treatment and Comparison Groups....................................	11
TABLE II.	Comparison of Mean MMPI Scores of Treatment and Comparison Groups..........................	12
TABLE III.	Parole Outcome of Treated and Comparison Groups at 6, 12, 24 Mos..........................	16
TABLE IV.	Recidivism by Commitment Offense at Two Years.....	18
TABLE V.	Age, Prior Prison Record and Return to Prison.....	19
TABLE VI.	Age and Prior Record Subgroups by Offense.........	20

INTRODUCTION

A basic philosophy guiding the California correctional system and it operations has been that the causes of crime are multi-faceted. It rejects the simple notion that criminal activity is basically caused by environmental or social factors (such as poverty or ghetto life) or that crime is committed principally because of emotional or personality problems of the offender. Most likely it is the interaction between the individual factors and the environmental factors that is important in the understanding of criminal activity. In a California Department of Corrections survey done in 1968 (Kim and Clanon, 1971), it was estimated that about twenty percent of the felons committed to the prison system would benefit from some kind of professional psychological counseling or psychiatric treatment because their offense and behavior were heavily influenced by emotional or psychological factors. The remaining eighty percent of the incoming prison population would benefit primarily from programs other than psychological or psychiatric treatment, e.g., vocational training, education, or employment in correctional industries.

Among individuals whose criminal behavior is heavily determined by emotional or psychological factors are psychotics. However, a great proportion are considered as suffering from character or personality disorders with emotional overlays. These are usually recommended for participation in a group psychotherapy treatment program before the Adult Authority will seriously consider their release to society. Reports on their treatment progress, along with psychiatric recommendations, are mandatory documents submitted to the Adult Authority for release consideration. It is this latter kind of population to which the present study addresses itself.

This study represents an in-house examination of the effectiveness of this group psychotherapy program at the California Medical Facility (CMF). The focus of the study is on the subsequent parole performance of 736 severely character disordered patients who were terminated from the program between 1965 and 1968. These men were compared in parole performance with a comparison group selected through a rigorous process of matching on relevant parole-risk variables such as Base Expectancy score, offense, and prior arrest record.

RESEARCH ON THE EFFECTIVENESS OF TREATMENT IN PRISONS

Bailey (1961) surveyed 100 evaluative reports on treatment programs within prison settings. After an intensive analysis of the reports, he concluded that "evidence supporting the efficacy of correctional treatment is slight, inconsistent, and of questionable reliability" (Bailey, 1961, p. 168). This review was followed by empirical studies which tended not only to report that correctional treatment had little or no positive impact but that in some cases the treatment efforts were detrimental to the population receiving the treatment. For example, Cohen (1962) reported that the group receiving treatment showed even worse maladjustment behaviors than the control group that had not received treatment. Evidence that psychiatric treatment worsens the patient's condition was also reported by Shorer (1968) when he noted that the number of psychoneurotic symptoms presented by treated patients were significantly higher than those who did not experience such treatment. Additional evidence of a deteriorating effect was found in a study by the Bureau of Social Research (1966) which showed that recidivism rates of treated inmates were considerably higher than those of a control group that had not received such treatment. Negative results were also reported by Wirt and Jacobsen (1969) in their study conducted in the Minnesota Department of Corrections.

The group counseling program at the California Men's Colony, another California Department of Corrections institution, was subjected to an intensive evaluation by Kassebaum, Ward and Wilner (1971). Their findings on the effectiveness of group counseling as related to parole outcome can be summarized as:

> "there were no differences in parole outcome by treatment status measured at 6, 12, 24 and 36 months after release...no treatment or control differences on the number of misdemeanor or felony arrests recorded in the parole records, no differences in the total number of weeks spent in jail, and no differences in serious dispositions received within three years after release" (Kassebaum, Ward and Wilner, 1971, p. 233, 242).

In a review which focused on the overall effectiveness of California correctional programs, Robison and Smith (1971) examined data on the following five approaches to correctional rehabilitation and found that all had fallen short in producing discernible differential impact upon recidivism: (1) imprisonment vs. probation, (2) varying length of stay in prison, (3) varying the intensity of parole or probation supervision, (4) outright discharge from prison vs. parole and (5) special treatment programs in prisons.

Recently, Martinson and his colleagues have reported on a survey of reports on correctional treatment published between 1945 and 1967 (Lipton, Martinson and Wilks, 1975). Martinson and his colleagues maintain that with few and isolated exceptions, the rehabilitative efforts they surveyed have had no appreciable effect on recidivism.

The message from all of these observers appears to be that the treatment programs in corrections have been a complete and abysmal failure and that rehabilitation is a myth and that attempts at it are at best a complete waste of time and effort. Indeed, a highly prevalent view is that prisons and prison programs are likely to be more effective as "breeding grounds" for careerists in crime than as rehabilitative influences (Gottfredson, et al 1973).

Yet, not all studies of correctional treatment have found evidence of negative results or no impact. Indeed, many studies have pointed to favorable treatment outcomes as a result of psychotherapy even in a prison setting. Cabeen and Coleman (1961), for example, reported highly significant positive results on patients adjudged to be mentally disordered sex offenders who participated in a special group psychotherapy treatment program at California's Atascadero State Hospital. Mueller and Harrison (1964) also reported positive results from group counseling with patients who participated with one leader for more than a year. Jessness (1965) reported positive but diminishing results upon delinquents as the parole exposure increased. Shore and Massimo (1966) studied delinquent boys exposed to vocational and psychiatric treatment and found considerable differences in test ratings and behavioral changes in a positive direction among experimentals in contrast to the controls. Persons (1966), using behavioral ratings and parole follow-up as criterion measures, also reported highly positive results from group and individual psychotherapy on institutionalized boys. Jew, Clanon and Mattocks (1972) found a moderately positive but time-limited impact on patients treated by group psychotherapy within the California Department of Corrections.

Carney (1969) using data from the Massachusetts correctional system, reported that the recidivism rate for the sample receiving group psychotherapy was significantly lower than the expected rate in a four-year follow-up period. Carney emphasized that positive effects of treatment are obtainable if the impact of treatment programs on particular types of offenders is assessed, rather than on offenders in general. This conceptualization stresses the idea of differential impact in treatment and is in agreement with the research focus of the Community Treatment Project in California (Palmer, 1974), in which the emphasis is on discovering what kinds of treatment programs, in what kinds of settings, are most effective with what kinds of juvenile delinquents.

The latter group of studies documents, clearly the existence of positive effects with group psychotherapy in some programs in prison settings. This contrasts markedly with essentially negative results described in the studies of Ward, Kassebaum and Wilner (1971), Bailey (1961), Cohen (1962), and Schorer et al (1968). Overall, it would appear from these conflicting reports that the whole issue of the effectiveness of treatment is still inconclusive. At best, it may be concluded that some treatment programs are effective, some are ineffective, while still others may have a negative or detrimental effect.

THE GROUP PSYCHOTHERAPY PROGRAM AT CMF

The California Medical Facility

It will be well at this point to place the function of the California Medical Facility in its proper context as a treatment facility for the Department of Corrections.

In 1950, a law (now embodied in Section 6102 of the California Penal Code) was enacted establishing the California Medical Facility with functions to include: "receiving, segregation, confinement, treatment and care, of male felons under the custody of the Department of Corrections, who are either: (1) mentally ill, (2) mentally defective, (3) epileptic, (4) addicted to the use of narcotics, (5) otherwise physically or mentally abnormal, including, but not confined to psychotic and sex offenders, or (6) suffering from any chronic disease or conditions."

The California Medical Facility, which opened in 1955, utilizes medical-psychiatric programming to provide treatment to the mentally ill and difficult-to-treat character disordered personalities in the California correctional system. Indeed, very few correctional institutions within California or elsewhere in the United States can match the number of these cases in its treatment programs. The present facility, with 1450 beds in the hospital, 472 beds in the Reception Center, and a staff of 667, was constructed at a cost of almost twenty million dollars.

The group psychotherapy program at the California Medical Facility has at least these two basic goals: 1) to provide treatment to enable the patient to return to a satisfactory level of emotional, social and psychological adjustment within the institutional setting, and 2) to effect change in the patient that will assist him in avoiding criminal behavior or returning to prison after release.

The group therapy approach used at CMF leans toward concepts and approaches developed by Slavson (1950). These included reorienting or changing the patient's personal adjustment patterns, reducing anxiety levels and psychiatric symptoms, as well as assisting the patient toward a more constructive use of his assets. Group psychotherapy sessions at CMF are usually not highly directive and permit the patients to set their own pace and direction. At the same time, the therapist feels free to point out inappropriate behavior, question feelings, or offer interpretations at appropriate times. However, the therapist keeps his participation to a minimum in order to allow as much interaction as possible. The focus of the discussions is on feelings, especially anxiety-provoking feelings.

Group psychotherapy sessions are conducted by staff members trained in various disciplines, such as psychiatry, psychology, social work and sociology. Community ward living and mini-marathon groups are also utilized in the therapy program.

Selection for Group Psychotherapy. A patient selected for the group psychotherapy program is generally considered different from the "run of the mill" inmate within the Department of Corrections. At any one time only a small fraction of the Department's felon population is in the program. Indeed the MMPI profiles of inmates selected for treatment are markedly and significantly different from those of the regular inmates.

For the most part, inmates are initially screened for group psychotherapy by psychological staff at both the Northern and Southern Reception Centers on the basis of need and motivation for treatment. However, approximately 30 percent of the candidates are received from institutions in the Department of Corrections other than the Reception Centers. A small number of patients are received from the institutions of the Youth Authority and the Department of Health. On an annual basis approximately 250 (18 percent) of the 1,400 inmates received by the California Medical Facility are assigned to the group psychotherapy program.

Upon transfer to the California Medical Facility for therapy, an inmate goes through a second screening process. This usually takes place in a "pre-initial" interview conducted by a staff member of one of the treatment units. During this "pre-initial" interview, the inmate is evaluated for suitability for therapy, and a statement is written giving the interviewer's assessment of the inmate.

The candidate then appears before a screening committee which is composed of a Program Administrator (i.e., of a treatment unit), a Correctional Counselor II, a Program Lieutenant, a Clinical Psychologist and a Psychiatrist. Again, this committee's function is to separate the suitable from the unsuitable therapy candidates. Those found unsuitable are transferred to another institution or assigned to another program at CMF.

Once accepted, a patient in the group psychotherapy program is assigned to either one of the two treatment units, La March or Pinel. The unit is then responsible for assigning the prospective patient to a therapist for treatment. Each unit occupies three housing wings on a single floor within the institution. The unit staff includes a Program Administrator, Psychiatrist, Psychologist, Correctional Counselor and a Program Lieutenant, who is a representative of the custodial staff. The entire staff of each treatment unit, including custodial personnel, is responsible for close observation of all patients in the unit and works together in dealing with the individual's treatment problems. This approach provides a means through which the treatment and custodial staff are kept continuously apprised of the progress of each patient.

Prospective patients are generally assigned to particular groups on the initiative of the therapists leading them. Therapists have considerable flexibility in choosing patients for their groups from a predetermined waiting list of patients. Therapists select their patients on the basis of whom they think would most likely respond favorably or whom they think they could best work with. One method a therapist might have used in the choice of candidates for his group, at the time the subjects in this study were in treatment at CMF, was to attend the unit orientation and select among the newly arrived candidates on the basis of his impressions. Other approaches were to review the potential patients' records thoroughly or interview them privately. Some therapists may even have selected randomly from the names of candidates appearing on the waiting list. While a therapist may choose to specify his criteria beforehand and choose only those candidates who appear best to fit them, it is unusual for a group to be homogeneous. More often, the members are selected to provide enough similarity to give support to each other, yet enough difference to expose each member to a wide variety of problems, issues, and means of dealing with them. Thus, a group would ordinarily consist of patients differing widely in offense, diagnosis, age, I.Q., education, and other social and personal characteristics.

The unit orientation meetings were held each week to introduce new patients to the administrative operations, rules, expectations, and schedule of activities of the institution. It was also a means by which unit staff could become acquainted with the patients and their problems, and it served to reduce the anxiety level of newly assigned candidates needing reassurance about what they would be doing in the future. The orientations were generally conducted by the unit Program Administrator, Program Lieutenant, Correctional Counselor II, or Psychologist, or a combination of these staff members.

Therapy groups usually vary in size at CMF from eight to fourteen patients. Therapy sessions are held twice weekly to provide a minimum of eight hours of treatment per month, although many therapists exceed this minimum. While attendance is not viewed by all therapists as compulsory, failure to attend group for other therapists could be grounds for program review or dismissal from the group. In general, each therapist can decide whether attendance is to made compulsory or not.

The average patient who becomes involved in group psychotherapy remains in a group for approximately eighteen months to two years. This means that a therapist can establish long term treatment goals ranging from major reconstruction of the personality to providing ego support and developing minimal controls.

The Psychiatric Council. The psychiatric council of each unit is the central decision making body concerned with administrative planning, policy determination, and assessment of the progress of each patient

in the unit. This committee consists of the Program Administrator, who acts as chairman; a Psychiatrist; a Psychologist; a Correctional Counselor; and a Program Lieutenant. The council assists in the screening process and convenes weekly for this purpose, as well as to review and appraise the program directions of inmates in the unit. The committee meets with the patients furnishing them an opportunity to encounter the persons most involved in the administrative decisions which affect their daily lives and determine when and if they will be transferred from the institution. The council also represents a link between the inmate and the Adult Authority, since it evaluates the patient immediately prior to, and after, each appearance before the Adult Authority. One advantage of the psychiatric council is that the final evaluation of the progress of a patient becomes a joint assessment, based on the pooled evaluations of several people. Frustrations do arise when the other members of the council and the therapist do not agree on the progress of the patient.

The Psychiatric Evaluation. Formal evaluation of the patient's progress continues throughout the course of his therapy program. The formal evaluations include those before and after the Adult Authority hearing. The appraisals of the unit screening committees, and the six-month reviews. For the latter reviews, the therapists submit progress reports to the psychiatric councils on individual patients at the end of six months of therapy, noting problems, improvements, and prognosis. Supplementing that report, the psychiatric council assesses the patient's overall status through discussions and reviewing reports about him from custody, work, vocational, educational, and recreational programs. The patient's treatment plans are reformulated when necessary. The evaluation of utmost concern to the patient is the psychiatric evaluation submitted to the Adult Authority for release consideration. A complete psychiatric report is prepared by the therapist on a yearly basis documenting the patient's performance in the treatment program, including an estimate of the patient's ability to perform in the outside community. The use of the psychiatric evaluation by the Adult Authority is a source of leverage for the therapist and a source of motivation for the patient in the psychotherapeutic situation. While in actuality, most therapists do not use the psychiatric report as an inducement to those resistive to therapy and change, it certainly is not uncommon that the inmate perceives it with a great deal of anxiety. The psychotherapy program has the support of the prison administration and the Adult Authority, so that the recommendation of the therapist plays a role in determining the time of the inmate's release. While a favorable recommendation from the therapist does not necessarily guarantee favorable release consideration from the Adult Authority, a negative recommendation may be a prime reason for denying a parole date.

Plan for The Study. The design of the present study has two parts. Part one deals with the evaluation of the total treatment program in terms of its impact upon treated patients contrasted with a comparison group matched on relevant variables such as Base Expectancy score, offense, and prior prison record. The effort in the first part is to analyze overall treatment effects and the duration of such effects.

The second part focuses on the issue of the impact of treatment upon different subgroups defined by (1) commitment offense, (2) prior prison experience, and (3) age at release.

<u>Data System and Samples of Patients</u>. The data presented in this study relate to the performance of the group therapy program during the period 1965 through 1968. A substantial portion of the data presented was collected in an information system which accumulates social and demographic information about each individual entering the treatment program. Information about his prior offense history and his performance during incarceration was also collected in this system.

From January 1965 to December 1968, 1237 treated male felons were terminated from the group therapy program at CMF. Of these, 12 died in prison, 66 were Mental Hygiene or Youth Authority cases, 82 were directly discharged, 50 were paroled out-of-state, and 196 were not yet paroled at the time of the study. All of these latter types of cases were not included in the study. Of the 819 remaining, 95 cases were so recently paroled that no parole follow-up data were available; these were also eliminated.

The resulting sample of 736 represented all cases terminated during the study period who were exposed to parole supervision long enough to be included in a follow-up evaluation. Subsequent studies will deal with the results for direct discharges and out-of-state parole, Youth Authority, and Mental Hygiene cases. In the present study the sample of 736 cases was followed up on parole for a two year period.

There were no special criteria used to select the participants in this study except that they were patients who terminated from the group therapy program during the years specified. Thus, the patients included those who had successfully completed as well as those who did not complete the program. The reasons for non-completion include voluntary transfer to another institution, disciplinary problems, lack of improvement in therapy, or being due for discharge or parole.

Since the population studied consisted of all patients terminated from therapy groups during 1965 through 1968, almost all of the permanent, full time, active therapists who held groups at CMF during that period have clients in the sample. These 736 cases were patients of a total of 63 therapists. Variations in the number of cases terminated by individual therapists may be a function of the number of patients in their caseloads, whether they conducted groups on a full or part-time basis, or the length of time they actually served as therapists during the defined period. The highest number of patients in the sample terminated by one therapist was 59, representing seven percent of the total study population. Several therapists had terminated only one patient.

<u>Comparison Group</u>. Ideally, to evaluate the influence of group psychotherapy on parole performance, there should be a control group that is comparable at the beginning of the study to an experimental group in factors which are related to the criterion of parole performance. Theoretically, this ideal would best be achieved through a procedure of random assignment to experimental and control groups, with treatment for the control group being intentionally withheld. However, even in the early stages of design, the difficulties of developing a study based on randomized assignment became evident. Two of the more obvious problems are 1) the appropriateness of the Department of Corrections withholding treatment from a group of individuals deemed in need of treatment by clinical staff and 2) the possible differences in time ultimately served between the experimental and control groups under such a research design. The latter problem arises from the possibility that just the fact that an inmate participated in therapy might lead the Adult Authority to a release decision that would result in his serving more or less time than would have been the case if he had not been in therapy. If time served is causally related to parole outcome, then the advantages of randomization are counterbalanced. (As it turned out it was not possible to match the subjects in the comparison group finally selected with the therapy subjects in time served, anyway.) As a result of these concerns the strategy of selecting a comparison group by matching non-treated with treated individuals on relevant parole risk variables was adopted for the study. This approach avoids the ethical issue of withholding treatment to those deemed in need. A total of 736 parolees (See Table I) on parole in California during 1965 - 1968, were selected for the comparison group. The selection involved a matching process which began by locating among 25,000 parolees those individuals whose B.E. scores matched those of the treated group. Then the experimental and comparison cases were further matched on offense and prior record. The procedure was to match in order on three major variables: (1) B.E. score, (2) offense, and (3) prior prison record. In addition, care was taken to avoid selecting individuals for the comparison group who were at CMF or other institutions which might have involved them in psychiatric treatment programs. In the present study the B.E. score was used as the main controlling variable. In utilizing the B.E. score, the objective was to obtain a comparison group for which essentially the same pattern of parole outcomes would have been predicted as the for treatment group, in the absence of any effective treatment intervention. (See Appendix A for a description of the process of computing a B.E. score.)

<u>Characteristics of the Treatment Population</u>. The study population consists of patients who participated in, and terminated from, the group psychotherapy program at CMF during 1965 through 1968. The principal feature of this group from the standpoint of this evaluation was that they were primarily diagnostically classified (86 percent of the total group) as having character or personality disorders. These were not psychotic individuals but persons with significant emotional problems who tended to manifest their symptoms through deviant behavior.

In terms of offense, approximately 55 percent of the cases had committed offenses against persons, such as homicide (5 percent), robbery (23 percent) assault (7 percent) and sex (19 percent). (See Table I) A previous staff report (Jew, 1968) asserted that chronic check writers and forgers are not generally considered good candidates for treatment because of the low degree of guilt they are regarded as having about their offenses in contrast to, for example, the Penal Code Section 288 cases (child molesters), whose offenses are considered to have an etiology in psychosexual conflict.

Table I
Characteristics of
Treatment and Comparison Groups

OFFENSE	Treatment (N-736)	Comparison (N-736)
Homicide	.05	.05
Robbery	.23	.23
Assault	.07	.07
Sex	.19	.19
Burglary	.19	.19
Theft	.08	.08
Forgery	.08	.08
Drugs (all)	.07	.07
All Others	.04	.04
	1.00	1.00
NARCOTIC HISTORY		
None	.70	.79
Opiate	.16	.11
Marijuana	.11	.08
Dangerous Drugs	.03	.02
	1.00	1.00
PRIOR RECORD		
None	.19	.14
1 or 2 Jail/Juvenile	.31	.32
3+ Jail/Juvenile	.20	.19
1 Prison	.18	.22
2+ Prison	.12	.13
	1.00	1.00
RACE		
White	.83	.65
Mexican	.06	.13
Black	.10	.21
Other	.01	.01
	1.00	1.00
Age at Release (Median)	28	32
B.E. 61A (Average)	44.3	43.4
Grade Level (Average)	8.5	7.6
Time Served (Avg. Mos.)	49.9	37.9

The subjects in the treatment group tended to be relatively free of a known heavy involvement with drugs and narcotics (70 percent). Ethnically, there was an over-representation of whites, (83 percent), and an under-representation of blacks (10 percent). On the average the treatment group had a slightly higher I.Q. and educational level. Their median age was 28 and mean B.E. score was 44. Seventy percent of the treatment group were first termers, as opposed to 65 percent of the comparison subjects. To provide an idea of the pattern of offenses in the treatment group, it should be pointed out that the percentage of the sample committed for forgery and theft did not equal the percentage committed for sex offenses (mostly lewd and lascivious conduct, Section 288 of the Penal Code). Also the percentage of robbers was greater than the percentage of burglars.

Table II

Comparison of Mean MMPI Scores of
Treatment and Comparison Groups

SCALE	Treatment (N-330)	Comparison (N-175)	t-test
L	51	51	.14
F	64	57	6.6 **
K	51	55	4.3 **
Hs	53	35	13.5 **
D	69	62	5.6 **
Hy	62	57	4.6 **
Pd	74	60	8.6 **
Mf	62	54	7.0 **
Pa	64	57	6.2 **
Pt	58	32	17.5 **
Sc	63	32	18.2 **
Ma	61	53	7.1 **

** Significant at .01 level

When the psychological characteristics of the treatment group were examined, distinct differences could be seen between it and the comparison group. The MMPI profiles of those selected for therapy revealed the presence of a considerable number of disturbing symtoms. (See Table II). The treatment subjects tended to exhibit a personality pattern close to that of the classical "sociopath", with major elevations significantly higher than the comparison subjects on the Depression, Psychopathic Deviate, Paranoia, and Manic Scales. The high elevation on these scales indicated an overlay of serious psychopathology characterized by extreme antisocial attitudes, impulsiveness, a tendency to act out their emotions on others and a tendency to project negagive intent and causation rather than recognizing one's own role in the progress of events. In most of the treatment cases, the extent of their psychopathology appeared to produce a subjective awareness that

something was wrong. That is, they were experiencing considerable discomfort and had some recognition that the "problems" were somehow related to them, (higher F, D, and Pt) in contrast to those in the comparison group who experienced little anxiety about their own behavior (low Pt), exhibited few or no psychotic symptoms (low Sc), and showed little tendency to somatacize (low Hs). On the other hand, the treatment group tended to admit to more bizarre symptoms (higher Sc), to exhibit a greater amount of anxiety and apprehension about themselves, and to act more impulsively under pressure than the comparison group (high Ma). Overall, therefore, the treatment group showed a significantly greater degree of psychopathology with accompanying subjective discomfort than did the comparison group.

These MMPI profile patterns provide substantial evidence to the effect that the men selected for the treatment program in 1965 - 1968, have a greater than average amount of psychiatric difficulty. While it is impossible to determine with certainty because of the numerous factors which enter into parole adjustment, it would seem that the presence of the more extensive psychiatric symptomatology would create greater problems for these men in attempting to maintain themselves on parole. Therefore, it would appear that rehabilitation for this group must deal not only with their antisocial activity (as in the case with their counterparts in the control group) but also with their psychiatric symptomatology and predispositions. It is analogous in some ways to starting a race from behind "go".

<u>Criteria of Evaluation</u>. All offenders in this study were under parole supervision in California. The manner and intensity of parole supervision varies according to the nature of the parolee's offense and background as well as recommendations from the institution and decisions by the Adult Authority. Some parole patients from the study sample were placed in a special intensive caseload program (work unit), while others were placed in the conventional parole program. Some carried a stipulation for continued psychiatric treatment in the parole outpatient clinic program and some did not.

The basic criterion for evaluation in the present study is parole performance. Parole performance is recorded by the CDC Research Unit for intervals of 6, 12, and 24 months after release. These time units enable the assessment of the degree as well as the duration of treatment effects.

An offender's involvement with the criminal justice system on parole can vary from being arrest-free to conviction of and return to prison for a new and serious crime. With the standard definitions of parole performance developed by the CDC Research Unit as the basis, the following classification of parole outcome was used in the present study: 1) no problem, 2) minor problem, 3) major problem, and 4) return to prison. This classification scheme is similar to that used by Kassebaum, Ward, and Wilner (1971) in their study of group counseling. (See Appendix B for an outline of the classification scheme). The

category of minor problems includes technical arrest (parole agent hold), arrest and release, trial and release, conviction with fine or misdemeanor probation, or a sentence to jail of less than 90 days. The major problems category includes a felony arrest with admitted guilt but with a release, a felony arrest with admitted guilt where the Adult Authority did not revoke parole at the District Attorney's request, the status of a parolee-at-large for six or more months or a parole violator awaiting trial or sentence, a death in the course of committing a crime, and a jail sentence of 90 days or more.

Returns to prison are of two types. The first is the return to finish term (TFT) in response to a technical violation. This applied to the parolee who has violated specified conditions of parole and who may be returned even though he has not been involved or charged with criminal conduct. The second is the return with new term (WNT) which means that the offender was involved in renewed criminal activity and convicted of a new felony and resentenced to prison.

RESULTS OF THE EVALUATION

Impact and Duration of Impact of Treatment. The test, of course, of the rehabilitative effect of the treatment program is whether the patients get into further difficulty after release from prison. Table III provides a global view of the parole outcome of the treated and comparison groups in terms of the number of persons who failed on their parole and returned to prison, those who remained free of difficulty in society, as well as those who were involved in some minor or major difficulty not sufficiently serious to warrant a return to prison.

Overall, Table III shows that in terms of parole performance at 24 months the treated group had 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. A detailed analysis of these findings will be presented in this section of the report.

No Problem or Difficulty. One important element expressing the impact of treatment of the parolee is his ability to remain free of criminal involvement or difficulty subsequent to release. This is a stringent test and is one of the fundamental goals of treatment. The ability of a treatment program to influence or reduce the level of arrests or criminal involvement bears on both the rehabilitation of the inmate and the protection of society. Overall, the data tend to show that the treated parolees exhibited a greater capacity to remain free of criminal involvement than their comparison counterparts. At six months, 497 (68 percent) remain free of problems in the treated group while 464 (63 percent) of the comparison group were similarly classified. While the difference at six months was not statistically significant, (X^2 = 3.28 df = 1), the ability of treated parolees to remain free of criminal involvement was expressed in a statistically significant difference as parole exposure was increased. Indeed, at the end of one year 51 percent of the treated parolees remained free of difficulty in contrast to only 44 percent in the comparison group. By the end of two years, 36 percent of those treated were able to remain free of difficulty in contrast to only 30 percent in the comparison group. Significant chi-squares were obtained on both the one year (X^2 = 7.1 df = 1) and two year (X^2 = 5.9 df - 1) parole outcome data.

Table III

PAROLE OUTCOME OF TREATED AND COMPARISON GROUPS AT 6, 12, 24 MOS.

PAROLE STATUS	6 MONTHS		12 MONTHS		24 MONTHS	
	Trt.*	Com.*	Trt.	Com.	Trt.	Com.
No Problems	497	464	372	321	268	224
(Percent)	67.5	63.0	50.6	43.6	36.4	30.4
Minor Problems	117	140	145	172	158	157
(Percent)	15.9	19.0	19.7	23.4	21.5	21.3
Major Problems	78	52	96	93	92	111
(Percent)	10.6	7.1	13.0	12.6	12.5	15.1
Return to Prison	44	80	123	150	218	244
(Percent)	6.0	10.9	16.7	20.4	29.6	33.2

*N = 736 for both Treated and Comparison Group

SIGNIFICANCE TESTS

FOLLOW UP PERIOD	TYPE OF OUTCOME [1]	TRT.	COM.	X^2
(1) At 6 mos.	Ret. Prison	6	11	11.4**
	Not Return	94	89	
(2) At 12 mos.	Ret. Prison	17	20	N.S.
	Not Return	83	80	
(3) At 24 mos.	Ret. Prison	30	33	N.S.
	Not Return	70	67	
(4) At 6 mos.	Success	83	82	N.S.
	Failure	17	18	
(5) At 12 mos.	Success	70	67	N.S.
	Failure	30	33	
(6) At 24 mos.	Success	58	52	5.5*
	Failure	42	48	
(7) At 6 mos.	No Problem	68	63	N.S.
	Problem	32	37	
(8) At 12 mos.	No Problem	51	44	7.1**
	Problem	49	56	
(9) At 24 mos.	No Problem	36	30	5.9**
	Problem	64	70	

(1.) Outcome definitions are contained in the text.
* at .05 level of Confidence
** at .01 level of Confidence

Return to Prison. Another important index of the impact of treatment is the rate of return to prison. In terms of this index, a significant treatment impact can be observed at six months after release, 80 men in the comparison group were returned to prison to finish term or commitment, while only 44 of the treated group had similar dispositions. The percentage of return was 6 for the treated group compared to 11 for the non-treated comparison group. The chi-square test of the difference between the two groups was significant at the .01 level of confidence (X^2 = 11.4 df = 1), indicating the existence of positive impact upon the treated group reflected immediately after release in the criterion of return to prison. However, as the length of parole exposure increased to one and two years the differences between the two groups failed to be statistically significant. This is a function in large measure of a large number of patients returning to prison after six months of parole exposure. The number of returnees increased from 44 at six months to 123 at the end of twelve months. This represents almost a two hundred percent increase over the initial six month period. Thus, while there appears to be strong indications that positive treatment effects endure through the initial months after release, many of the treated parolees have faltered in their attempts to survive on parole by the end of the first year. Nonetheless, the treated group at all parole exposure periods consistently maintained a more favorable parole outcome picture than the non-treated comparison group.

Failures: Major Problems and Return to Prison. In the present study, both Major Problem cases and men returned to prison are considered "failures". In Table III, an important phenomenon is shown in the rate of "failure" among the treated and non-treated viewed from the standpoint of time. In the initial six months, there were no discernible differences in the rate of "failure". However, as the length of parole exposure increased, differences in the rate of failure began to emerge. Indeed, the data show that by the end of two years, 48 percent of the comparison group became classified as "failures" while only 42 percent among the treated group were similarly classified. This difference of six percent is statistically significant at the .05 level of confidence (X^2 = 5.5 df = 1).

FACTORS ASSOCIATED WITH RETURN TO PRISON

The major purpose of the present study is not only to explore the overall effectiveness of the treatment program, but also to pinpoint some of the conditions and personal characteristics which may be related to the effectiveness of treatment. The second major set of findings in this study are observed relationships between the level of recidivism in the treated population and background and personal characteristics. These include offense type, age, and prior prison record.

Offense Type and Return to Prison. Offense type was chosen for examination in this study because numerous studies have shown that different types of offenders vary considerably in parole outcome after treatment. For example, Carney found specifically that psychotherapy was particularly ineffective with assaultive offenders.

Table IV

Recidivism By Commitment Offense
At Two Years

Commitment Offense	Treatment		Comparison		
	N	Ret.	N	Ret.	X^2
Homicide	40	3	40	9	4.5*
Robbery	167	54	167	52	.1
Assault	53	13	53	8	1.5
Burglary	141	45	142	50	.2
Theft	59	24	59	25	.3
Forgery	55	22	55	25	.1
Sex	141	26	141	47	8.2**
Drugs	52	21	51	17	.2
Other	28	10	28	11	.8
Total	736	218	736	244	

* Chi-square significant at .05 level
** Chi-square significant at .01 level

Table IV shows that the several types of offenders in the treated group differed considerably in parole outcome. It indicated that treatment is particularly effective with homicide and sex offenders (X^2 = 4.5 df = 1 and 8.2 df = 1 respectively) but ineffective, or even detrimental, with assaultive and drug offenders. In addition, treatment appears to have little or no effect on theft, burglary, and robbery offenders. The poor performance of the assaultive cases in this study supports Carney's finding of the ineffectiveness of psychotherapy with this type of offender.

Age, Prior Prison Record, and Recidivism. Traditionally, two factors which have a significant relationship with the rate of return to prison are age and prior prison experience. Glaser and O'Leary (1966), for example, found consistently higher rates of recidivism among younger offenders and among those with long prison records. By combining these two factors, Carney (1969) defined several subgroups and investigated their response to psychotherapy. He found a wide range of differences among these subgroups in terms of recidivism associated with psychotherapy. Psychotherapy was found to be highly effective with patients who had shorter records (5 or fewer arrests) or patients with longer records but older (34 or above). Those least likely to benefit consisted of inmates who had longer records (6 or more arrests) and were younger (33 or under).

For purposes of the present study, four subgroups consisting of inmates who had (1) longer records and were younger in age, (2) longer records and were older, (3) shorter records and were younger, and (4) shorter records and were older were set up to determine possible differences in their outcome subsequent to treatment. The specific definition of each subgroup is presented in Table V.

Table V

Age, Prior Prison Record and Return to Prison

Group	Age & Prior Record	Trt	Com.	X^2
I	Older (33+)/Short Record [1]	12	26	6.9**
II	Older (33+)/Long Record [2]	32	47	4.0*
III	Younger (-33)/Short Record	27	34	5.1*
IV	Younger (-33)/Long Record	45	28	8.6**

1 Short Record = 2 juvenile or 1 prison
2 Long Record = 3 juvenile or 2 prisons
* Significant at .05 level
** Significant at .01 level

The recidivism rate in the two year follow-up for older treated patients with shorter records (Group I) was 12 percent. This rate was significantly lower than that of their non-therapy counterparts, 28 percent. Among older patients with longer records (Group II), the recidivism rate of 32 percent was also significantly lower than the 47 percent found in the comparison group. Similarly, those younger with shorter records (Group III) had a significantly lower recidivism rate (27 percent) than their non-treated counterparts.(34 percent). However the most revealing finding in this set of data was that among the younger subjects with long records (Group IV) there was a significant negative response to treatment; 45 percent of the treated subjects were returned to prison

in contrast to 28 percent of the comparison subjects. Thus, the greatest benefit from treatment was received by the older subjects with short records, followed by the older with long records. The poorest results were shown by the younger with long records. This ranking of the groups in terms of benefit from therapy shows that by itself, the factor of prior prison record tends to have a stronger relationship than age with the potential for recidivism. However, when both young age and long prison records are combined in a subject, the propensity to recidivate and resist traditional forms of treatment is substantially increased.

Table VI

Age and Prior Record Subgroups By Offense

(Two Year Return Rate in Percents)

Offense	Group I Older/short Record		Group II Older/long Record		Group III Young/short Record		Group IV Young/long Record	
	Trt.	Com.	Trt.	Com.	Trt.	Com.	Trt.	Com.
Homicide	00	16	00	40	10	27	17	00
Robbery	56	32	48	48	22	28	47	21
Assault	9	8	66	33	22	15	33	13
Burglary	00	27	22	41	29	39	43	23
Theft	00	36	38	00	41	56	54	33
Forgery	30	27	20	54	33	55	63	43
Sex	6	27	25	57	19	29	35	39
Drugs	00	27	29	100	48	39	50	25
Other	00	29	00	67	39	30	50	50

When the offense factor is used to classify the above subgroups further, another profile of the likelihood of benefiting from treatment emerges. For example, treatment has an essentially negative impact upon young persons with long records regardless of their offense. There is almost complete uniformity in the various offense categories among these offenders in resistance to treatment. At the same time, robbery and assaultive offenders tend to be equally resistant to treatment efforts regardless of their age and prior record. On the other hand, homicide, burglary, and sex offenders, (minus those in the young and long record groups) tend to show high promise for positive outcomes in treatment. (See Table VI).

DISCUSSIONS AND CONCLUSIONS

What do these findings suggest about the nature of the group psychotherapy program at CMF and its effectiveness? For one thing the results are not necessarily what one might expect on the basis of the current literature on the effectiveness of treatment, which has generally argued that psychotherapeutic treatment if inefficacious within a prison setting. Neither, however, do these findings indicate that psychotherapy is a magic cure-all process which transforms or rehabilitates any and all offenders who become involved in it. What seems to emerge from the study is the conclusion that therapy can be effectively applied within a prison setting to many types of offenders but not all with positive results as related to parole performance.

Differential Impact. A major finding of the study is that positive impact from psychotherapy is possible for certain offenders, while for others the impact is likely to be negligible or detrimental. This finding is not uncommon, different individuals seem to respond to treatment differently. Some may benefit from it, some may not, and some may even be affected negatively. This finding of differential impact has previously been reported by Gottfredson (1967), Grant and Grant (1959), Carney (1969), and Adams (1962). Specificcally the findings from the present study are that older homicide and sex offenders with few prior prison terms can be expected to benefit positively. On the other hand, younger assaultive, drug and robbery offenders with long prison records can be expected to benefit very little from treatment or even to show negative effects.

The differential impact of group psychotherapy has important implications for correctional planning and improving the level of effectiveness of treatment program. The highly positive results for older homicide and sex offenders provide concrete evidence for the validity of the treatment approach for these offenders. When viewed in terms of the seriousness of the offenses of these offenders, this finding has special significance. On the other hand, the negative results such as found among the younger assaultive, drug, and robbery offenders suggest the need for alternative programs for them. Glaser (1968), prompted by negative findings from other programs, suggested that vocational training provided within a firm atmosphere, plus immediately reinforceable education and work programs, may have high potential for a positive impact. A specialized treatment program for this sort supplied to the younger drug, assaultive, or robbery offender might prove to be effective.

Long and Short Term Impact. Among persons who benefited from psychotherapy, there are long and short term impact differentials. For some patients the impact tends to be positive and lasting; for others the positive impact is only tenuous or temporary. The latter finding is most clearly illustrated by the significantly lower rate of return

observed among the treatment group at six months but not at the end of the first year. For the patients returning, treatment may have played a role in delaying but did not prevent the individual's eventual return to prison. The delayed return to prison suggests that some initial treatment effects may be experienced by the patients, but for some reason the gains were not sufficiently integrated for the individual to continue to avoid the commission of unacceptable behaviors with the passage of time.

This delay of return to prison repeats an earlier finding and introduces again the importance of the maintenance of treatment effects in the early stages of parole (Jew et al, 1972). Effective methods of stabilizing the effects of institutional therapy in the parole situation need to be developed. The Parole Outpatient Clinic could provide an important service at this early critical time. Unfortunately, at the time of the study, only 74, or 10 percent, of the treated parolees were involved in some form of an outpatient clinic service. The small size of this group in treatment on parole makes it difficult to arrive at any definite conclusions about the impact this extended service may potentially have upon the population of parolees with prior psychotherapy in prison. Research is sorely needed in this area.

Another approach to the maintenance of treatment effects would be to develop a program which extends the services of the patient's institution-therapist into the parole setting. This approach has the advantage of providing continuity of treatment in the interest of minimizing feelings of abandonment and isolation in the patient in this early and crucial stage of readjustment to society.

Overall Parole Performance. A third important finding is that the rate of return to prison alone does not reflect fully the effects of treatment. The effects of treatment tend to become more obvious in other ways with the passage of time. For example, more treated parolees remained "free of difficulty" with law enforcement agencies at two years of parole exposure. This was not obvious at the six month follow-up. Similarly, fewer treated parolees were involved in "major problems" with law enforcement agencies. Thus, when these factors were examined in conjunction with the rate of return to prison, the treated population did significantly better than the non-treated in overall parole performance. However, if the criterion is recidivism alone, the finding would still remain that the treatment program failed to achieve its goal of reducing recidivism on any long term basis.

General Conclusions. In summary the results of this study indicate that the psychotherapy program can be effective with certain offenders and not effective with others. The psychotherapy program as it was administered at the time this study is concerned with was not sufficiently varied in approach to provide appropriate effective alternatives to certain offenders within the treatment population. One of the thrusts of this study is the necessity of providing various treatment alternatives "tailored" to the requirements of defined groups of inmates, a differential approach to treatment. The adoption of a

differential treatment approach would seem to be worthwhile not only from an economic viewpoint (i.e., less cost to state and local governments) but also from the viewpoint of the protection of society.

The principal limitation of the present study is the lack of actual baseline recidivism data from a randomly assigned non-treated population. While it is true that both treated and comparison groups were matched on relevant parole risk variables such as B.E. score, offense and prior record, nevertheless important clinical differences existed and were well-documented, based on MMPI profile comparisons. At the same time, the comparison group also enjoyed some parole risk advantage in being, on the average, an older age group, as well as having fewer individuals with long prison records and individuals who served less time in CDC for similar offenses. Thus, it is a crucial issue whether the baseline recidivism rate from a randomly assigned group with no psychotherapeutic treatment might not be substantially different from what was observed for the current comparison group.

The most adequate approach to assessing the impact of group therapy would be in a study in which subjects were randomly assigned to a treatment and a control condition from a pool of eligible cases.

APPENDIX A

The Base Expectancy 61A Scale used in the present study was originally developed and validated in 1961 by Gottfredson and has since been adopted by the California Department of Corrections as an instrument for prediction of parole outcome and for use in the assessment of the impact of programs. The BE 61A score factors and the method of deriving the score are as follows:

	IF	
A.	Arrest-free period of five or more years...............	12 ____
B.	No history of any opiate use.........................	9 ____
C.	Few jail commitments (none, one or two)..............	8 ____
D.	Not checks or burglary (present commitment)...........	7 ____
E.	No family criminal record............................	6 ____
F.	No alcohol involvement...............................	6 ____
G.	Not first arrested for auto theft....................	5 ____
H.	Six months or more in any one job....................	5 ____
I.	No aliases...	5 ____
J.	Original commitment..................................	5 ____
K.	Favorable living arrangement.........................	4 ____
L.	Few prior arrests (none, one or two).................	4 ____
	TOTAL SCORE..................	____

APPENDIX B

PAROLE OUTCOME CLASSIFICATION

CATEGORY OF PAROLE OUTCOME	CDC CODES	
NO PROBLEMS	No disposition recorded	
MINOR PROBLEMS	NTCU return (narcotic treatment) Technical arrest (hold) Parolee at large (PAL) Arrest and release Trial and release Conviction with misdemeanor probation, fine, or bail forfeited Jail less than 90 days	
MAJOR PROBLEMS	Parolee at large 6 months or more, Or, as technical violator (PVAL) Felony arrest with admitted guilt but released, 1) after restitution made, or 2) if AA did not revoke parole at District Attorney's request	Awaiting trial or sentence on felon charge Jail 90 or more days Felony probation and/or suspended prison sentence Died in course of committing a crime
RETURN TO PRISON	Return to prison to finish term (TFT), that is, technical violation	Return to prison with new term (WNT)

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