Journal of Criminal Law and Criminology

Volume 55
Issue 1 *March*

Article 10

Spring 1964

Accessibility to Group Psychotheraphy of Incarcerated Adolescent Offenders

Irving Jacks

ACCESSIBILITY TO GROUP PSYCHOTHERAPY OF INCARCERATED ADOLESCENT OFFENDERS*

IRVING JACKS†

Early in 1959, a project was undertaken at the New York City Department of Correction, having for its overall purpose an evaluation of the place of group psychotherapy in the treatment of incarcerated delinquent adolescents (aged 16 to 21). The setting for the study was the New York City Correctional Institution for Men, located on Rikers Island. The present report deals with one phase of the project, namely the development of a technique for the early identification of accessible group members.[1]

As group therapy has become integrated into the treatment programs of correctional institutions,[2] the conviction has grown among therapists that there are differences among patients regarding their ability to participate in the group therapy process. The question of group therapy accessibility has been raised by a number of authors.[3]

That there remains a serious lag in research findings of utility to the clinician—especially the one working in the correctional setting—in his early identification of treatable cases has been acknowledged in a number of places.[4] In the field of corrections, moreover, there appears to be an underlying feeling on the part of some writers that the delinquent population presents accessibility problems of a character significantly different from those seen in the more conventional psychiatric facility. Some authors have related the differences to deficiencies in motivation,[5] others to the greater

* Based on a study conducted in partial fulfillment of the requirements for the Ph.D. degree at New York University. The present report is a revision of a paper presented by the writer at the annual convention of the American Psychological Association in September, 1960. A condensed version has appeared in the *American Journal of Orthopsychiatry*, 1963. Acknowledgements for encouragement, assistance, and critical review of this work are due to the following: Professors H. H. Giles, M. Schwebel, and M. Bamburger, members of my doctoral committee; Doctors P. Benedict, A. Bugansky, S. Shiff, M. Wisotsky, L. Birner, F. Steiner, I. Rosenblatt, G. Panger, and R. Korn, members of the mental health staff of the New York City Department of Correction at the time the present study was made.

† Assistant Professor of Psychology, Department of Psychiatry, Temple University School of Medicine.

[1] The reader's attention is called, at the outset, to the distinction between treatment accessibility, as used here, and treatment outcome. The latter has been quite extensively studied in a number of "pre and post" evaluations of improvement. A presumption here is that accessibility—while undoubtedly related to outcome—can, nevertheless be distinguished from it; it is, in other words, possible for an individual to have high treatment accessibility, in the sense of ability to participate in the treatment process, and still not show improvement. We would hold that outcome is a quite complex variable, influenced by a variety of environmental events well outside the treatment situation as such, whereas accessibility is more directly a function of the resources which the patient himself brings into therapy.

[2] McCorkle reported on a survey conducted in 1950 by the Committee on Group Psychotherapy in Correctional Institutions and Agencies: "It was found that 35 percent of the institutions are currently using some form of group therapy and another five percent are planning to start this kind of program soon." McCorkle, *The Present Status of Group Therapy in United States Correctional Institutions*, 3 INTERNAT. J. GROUP PSYCHOTHER. 79 (1953). It is a safe guess that, by now, a majority of American correctional institutions have instituted group therapy programs of one form or another.

[3] Frank, Gliedman, Imber, Nash & Stone, *Why Patients Leave Psychotherapy*, 77 ARCH. NEUROL. & PSYCHIAT. 283 (1957); Katz, Lorr & Rubinstein, *Remainer Patient Attributes and Their Relation to Subsequent Improvement in Psychotherapy*, 22 J. CONSULT. PSYCHOL. 411 (1958); Lorr, Katz & Rubinstein, *The Prediction of Length of Stay in Psychotherapy*, 22 J. CONSULT. PSYCHOL. 321 (1958); McLean, Monroe, Yolles, Hill & Storrow, *Acceptability for Psychotherapy in Institutionalized Narcotic Addicts*, 24 ARCH. NEUROL. & PSYCHIAT. 356 (1955); Monroe & Hill, *The Hill-Monroe Inventory for Predicting Acceptability for Psychotherapy in the Institutionalized Narcotic Addict*, 14 J. CLIN. PSYCHOL. 31 (1958); Nash, Frank, Gliedman, Imber & Stone, *Some Factors Related to Patients Remaining in Group Psychotherapy*, 7 INTERNAT. J. GROUP PSYCHOTHER. 264 (1957); POWDERMAKER, FLORENCE & FRANK, GROUP PSYCHOTHERAPY (1953); SLAVSON, AN INTRODUCTION TO GROUP THERAPY (1956); Slavson, *Group Psychotherapy in Delinquency Prevention*, 24 J. EDUCAT. SOCIOL. 45 (1950); Slavson, *Current Trends in Group Psychotherapy*, 1 INTERNAT. J. GROUP PSYCHOTHER. 7 (1951); Slavson, *Criteria for Selection and Rejection of Patients for Various Types of Group Psychotherapy*, 5 INTERNAT. J. GROUP PSYCHOTHER. 3 (1955).

[4] Gersten, *An Experimental Evaluation of Group Therapy With Juvenile Delinquents*, 1 INTERNAT. J. GROUP PSYCHOTHER. 311 (1951); Halleck, *A Role of the Psychiatrist in Residential Treatment of Delinquents*, 4 J. SOCIAL THER. 189 (1958); Jenkins, *Problems of Treating Delinquents*, 22 Fed. Prob. 27 (Dec. 1958); Schulman, *Delinquents*, in THE FIELDS OF GROUP PSYCHOTHERAPY (Slavson ed. 1956).

[5] Aarons, *Some Problems of Delinquency and Their Treatment by a Social Agency*, 40 SOC. CASEWORK 254

profundity of disturbance.[6] Perhaps the most explicit statement is that of Cressey, who cautions: "At the outset, a distinction must be made between the use of group sessions for treating psychiatric patients and the use of group sessions for reforming prisoners."[7]

Thus, when the New York City Department of Correction undertook its pilot program in group psychotherapy, it was felt that a useful contribution to practice could be made by giving attention to the matter of accessibility, an area in which the need for research was well-recognized.[8] The problem was seen as having the following elements: a) identification of the factors involved in inmate accessibility to group therapy; b) incorporation of these factors into an objective index of accessibility; c) validation of such an index against therapists' ratings of their patients' accessibility; and d) comparison of the predictive power of the obtained index with measures in current clinical use. It is the results of this study which are being reported here.

PROCEDURES

A. *Selection of Subjects*

During the first week following his admission to the institution, each adolescent was evaluated for inclusion in the study, on the basis of the following criteria of eligibility:

1) IQ of 80 or over.—This was determined with the Revised Beta examination, a nonverbal group test of intelligence routinely administered to all incoming inmates.

2) English-speaking.—This was gauged in rough fashion during an interview with each inmate conducted by the writer. Since group therapy essentially involves verbal exchange, the ability to communicate in English was considered basic to participation.

3) Nonpsychotic.—This was determined on the basis of: a) a short screening interview with a staff psychiatrist; b) a projective figure-drawing test—the House-Tree-Person—which is administered routinely to all incoming inmates. It was deemed desirable to exclude the psychotic inmates, to enable the therapy to focus on those elements of personality disturbance most directly related to delinquency in the largest number of offenders.

4) Nonhandicapped physically for participation in group therapy.—Essentially, this resulted in eliminating inmates with serious hearing or speech defects, or any others which might interfere with continued attendance and participation in the sessions.

Each boy found eligible for inclusion was assigned in rotation to one of six therapy groups. Thus, given therapy groups A, B, C, D, E, and F, the first eligible subject was assigned to group A, the second to group B, the third to group C, and so on, until each group was built up to a full strength of ten members. While the original plan thus called for a total of 60 subjects, the nature of the sentences served by a number of the inmates resulted in their early release. Their places were filled by new arrivals who met the criteria. This procedure increased the size of the total sample to 68.

B. *The Therapy*

Each therapy group was considered constituted and ready to begin its sessions when it had reached a strength of five members. Each member was seen prior to the first group session, in a private interview with his prospective therapist; at this time the therapist made an estimate of the patient's accessibility (see "Therapists' Pretherapy Rating of Accessibility," below), notified the patient of his assignment to group therapy, and briefly oriented the patient regarding its nature.

The groups continued to be augmented, according to the rotation described, until they reached their full strength of ten members. No drop-outs, regardless of motivation, were permitted, and each member was required to attend all sessions (the only exceptions were special emergencies, such as serious illness requiring hospitalization or serious assaultive behavior requiring segregation).

All six therapy groups met at the same time, according to a schedule set up so as not to deprive the group members of other institutional activities in which the remainder of the population participated (school, shops, recreation, clinics, commissary,

(1959); Chwast, Harari & Delany, *Experimental Techniques in Group Psychotherapy With Delinquents*, 52 J. CRIM. L., C. & P.S. 156 (1961); Dean, *Treatment of the Reluctant Client*, 13 AM. PSYCHOL. 627 (1958); KORN & MCCORKLE, CRIMINOLOGY AND PENOLOGY (1959).

[6] AICHORN, WAYWARD YOUTH (1935); DAVIDOFF & NOETZEL, THE CHILD GUIDANCE APPROACH TO JUVENILE DELINQUENCY (1951); HEALY & BRONNER, NEW LIGHT ON DELINQUENCY AND ITS TREATMENT (1936).

[7] Cressey, *Contradictory Theories in Correctional Group Therapy Programs*, 18 Fed. Prob. 20 (June 1954).

[8] Kotkov, in a survey of research, writes: "only a trickle of experimental research has been applied to such gross problems as selection." Kotkov, *Research*, in THE FIELDS OF GROUP PSYCHOTHERAPY 319 (Slavson ed. 1956).

etc.). The schedule called for sessions to be held on Mondays and Wednesdays, 11 a.m. to 12 noon, and on Fridays from 12:30 to 2 p.m., making a weekly total of three and one-half hours of therapy for each group.

C. *The Therapists*

The six group therapists were all clinical psychologists who met Civil Service requirements of experience and graduate study prior to appointment and had a minimum of two years subsequent experience at the New York City Correctional Institution for Men. All either had their Ph.D. or were matriculated in doctoral programs. The experience of each, at Rikers Island, had included both group and individual psychotherapy with adolescent inmates, under the supervision of a senior psychologist and an institutional psychiatrist. Thus, they were deemed well-qualified to function as group therapists.

D. *Measures of Accessibility Used*

1. Psychiatrist's rating.—In addition to ruling out psychosis during his screening interview, the psychiatrist was asked to estimate the inmate's accessibility to group psychotherapy. No instructions as to how to arrive at his determinations were supplied, only that at no time during the interview was he to let the inmate know that he might be assigned to group therapy. Following the interview, the psychiatrist rated the inmate's accessibility to group therapy on a five-point intensity scale, "one" representing minimal accessibility, "five" maximal.

2. Therapist's pretherapy rating of accessibility.—Following his pretherapy interview with each member of his group, the therapist was asked to rate the inmate's accessibility to group therapy, on the same five-point scale used by the psychiatrist.

3. Psychologist's pretherapy rating.—Each inmate assigned to a therapy group was referred to a psychologist—other than the one to whose group he had been assigned—for projective personality testing. The test battery included the Rorschach technique, five selected cards of the Thematic Apperception Test (1, 3BM, 12M, 13MF, 18GF), and the House-Tree-Person, a standard figure-drawing technique administered routinely to all new admissions as part of their admission screening. As part of his interpretation of the test findings, the psychologist was asked to estimate the subject's accessibility to group therapy on the same five-point scale used by the psychiatrist.

4. Therapist's criterion rating of accessibility.—Following the twelfth session of group therapy, the therapists were again asked to rate the inmates' accessibility, as observed during this early phase of treatment. To assist the therapists in making this rating, attention was called to the following as particularly relevant: willingness to participate; awareness of emotional problems; level of felt anxiety; likelihood of participating actively in group; ability to profit from treatment. This second therapist rating served as the criterion to be predicted by the pretherapy accessibility measures.

5. Scale of accessibility.—As part of the routine admission testing, each boy completed the Accessibility Scale. Since construction of this scale was a focal aspect of the entire study, the steps followed will now be described in detail.

E. *Developing the Accessibility Scale*

1. An initial pool of 189 items was derived from a survey of the literature of group therapy and informal interviews with experienced group therapists. The items were formulated in such fashion as to include both positive and negative statements regarding a variety of attitudes and self-descriptions judged to be related to group therapy accessibility. An effort was made to couch them in language appropriate to the inmate population to which they were to be administered.

2. Each of the 189 items was then typed on a "three by five" index card, one item per card. The set of cards was given to each of six judges, in turn, with instructions to rate each item on a five-point scale of relevance to the area of group therapy accessibility. The six ratings obtained for each item were summed, so that each item was now characterized by a single numerical value. These values were then placed in rank order.

3. The rank-values were inspected to determine whether any rank-value would so divide the set as to yield an obvious cut-off point. This proved to be the case; by using all items having a rank of 76 or less, a scale containing a total of 83 items could be derived. These items, then, constituted the Accessibility Scale proper (Table I).

4. The 83 items selected were again typed on "three by five" index cards, this time with the words: "I agree____" and "I do not agree____" under each item. Two such sets were made up, one set with an "x" alongside the "agree" response.

TABLE I

ACCESSIBILITY SCALE

1. It is easier to "do a bit" in prison if you keep in touch with your family.
2. If I find something valuable lying in the street, my conscience would bother me if I didn't return it to its owner.
3. Whenever I go on a trip, I like to bring souvenirs home to my family.
4. Any man who commits a crime proves that he needs psychiatric treatment.
5. The advantage of psychiatric treatment is that it teaches a man how to go straight.
6. Every person alive has something wrong with him mentally, which could be helped by psychiatric treatment.
7. Most people feel a lot worse inside themselves than they ever show on the outside to other people.
8. I guess I am a pretty nervous person.
9. I missed some pretty good jobs because I felt too "shook up" to go for an interview.
10. I worry too much about small things.
11. I'm the kind of a person who likes to stick to a problem until I've figured it out, even if it takes all night.
12. If any one stands around watching me work, even doing the easiest things makes me go to pieces.
13. It never hurts to talk over one's troubles with the psychologist.
14. For a long time now, I've been trying to figure out what makes me get into trouble and wind up in these places.
15. I think it would do me good to talk over my problems with a psychologist.
16. Many times I have wanted to see the psychologist, but got cold feet at the last minute.
17. When I receive visits from my family in here, I feel ashamed to have them see me like this.
18. Although I know it's wrong to break the law, something in me makes me do it.
19. I'm glad I got caught, otherwise I might have gotten into a lot more serious trouble.
20. When I get out of here, I'm sure I'll be able to go straight.
21. When I make up my mind to do something, I usually get it done.
22. Talking before an audience is something I could never do without getting "all shook up."
23. If my home life had been better, I probably would not have gotten into trouble.
24. The hardest thing for me to do is to admit that I'm wrong in an argument.
25. I'm glad that I was picked to get psychological treatment.
26. Even though I doubt that there's anything seriously wrong with me, I guess I could be helped by receiving psychiatric treatment.

TABLE I—*Continued*

27. Whenever I feel tense or worried about something, my stomach gets upset.
28. I have diarrhea at least once a month.
29. If I had not had any brothers (or sisters), I would have gotten along better with my folks.
30. My brothers (or sisters) were treated better than me by my parents.
31. It's easier to discuss very personal problems if others with the same kind of problems are in the discussion also.
32. A man would be a fool to admit doing things that might get him into trouble.
33. I don't think that I would like the life that most people lead on the outside.
34. I wish I could be as normal as everybody else.
35. Sometimes my life seems so hopeless, I feel like crying inside.
36. Guys who get scared or cry make me feel disgusted with them.
37. Prisons nowadays do more to help the inmates than they used to.
38. When I was in school, I used to feel stupid and less capable than the other kids.
39. I can honestly say that I never hurt anyone on purpose.
40. I'd rather stay poor than get rich by cheating somebody else.
41. I've tried to help other people solve their problems by using psychology.
42. I've tried to psychoanalyze myself, and I believe I now understand myself better.
43. I read books on psychology whenever I can.
44. I'd be ashamed to have my buddies know that I was seeing a psychologist.
45. If I thought it would help me to stay out of trouble in the future, I'd be willing to finish up my time in here.
46. I'd rather talk to the psychologist privately about my problems, than discuss them in front of a group of other inmates.
47. I wish I understood why I do things that get me into trouble.
48. Most girls are true to their boyfriends, while the boys are in prison.
49. It's going to be hard to face the neighbors when I get out of here.
50. I wish I had more self-confidence.
51. Most of the time I feel depressed, down in the dumps.
52. If my parents had taken better care of me when I was younger, I probably would not be here now.
53. When a man makes up his mind to do something, he should first figure out if it will hurt anyone.
54. I enjoy sitting around with a group of guys and having a bull-session.

TABLE I—*Continued*

55. Whenever I get into a club or a crowd, I like to take charge of things.
56. It's easier for me to do a favor than to ask someone to do me a favor.
57. Most people have the same kind of problems as everyone else.
58. Whenever I start to worry about anything, I get an upset stomach.
59. It's easier for me to talk about personal matters in a group than to one person in private.
60. It's hard for me to act natural when I'm in a group.
61. I've been responsible for a lot of the trouble I've been in.
62. If I could get rid of the bad habits which I have acquired in my life, I would have a better life.
63. It's been a long time since I stopped and thought about my future life.
64. It takes me a long time to get going on a new task.
65. I try to get out of responsibilities because of a fear that I won't measure up.
66. I become tired more easily when I'm doing something that makes me anxious.
67. So much of my life consists of playing various parts, that the "real me" seems never to come out.
68. It's easier to promise to do things better than to actually do them better.
69. I criticize and resent the success of other people out of bitterness regarding my own lack of success.
70. Whenever I come into some new situation, I get panicky and worry about whether I will be able to do what's expected.
71. I frequently say things to people, especially important people, just to be agreeable, because of a fear of making them dislike me.
72. I prefer going on doing the same old things, because new things or new places frighten me.
73. I do my best work on jobs where someone else is likely to get the credit or blame for the outcome.
74. Whenever I get started on something that may do me some good, I seem to do something to spoil it.
75. I keep from getting too close to people, because I fear that getting close would result in their hurting me.
76. I feel more tense in some situations than in others.
77. I sometimes give reasons for my actions, which I know are not the real reasons.
78. Some of my ideas are so strange, that it would embarrass me to mention them to another person.
79. I'm afraid to admit even to myself some of the things I sometimes think about.
80. I feel disgusted everytime I "jerk off."
81. A man's friends usually understand him better than his family does.
82. How far a man goes in life depends pretty much on himself.
83. I enjoy discussions in which each person has a different idea or opinion on a subject.

the other set with an "x" along "do not agree." The 166 cards were shuffled and given to each of the six judges, in turn, this time with instructions to rate each item for accessibility, on the basis of a nine-step predetermined symmetrical distribution from least accessible to most accessible, viz.:

Least Accessible								*Most Accessible*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
8	12	20	26	34	26	20	12	8

Thus, each item received a total of twelve ratings, with a possible range from one to nine. The obtained ratings for each item were averaged, thereby yielding a weight for each item, based on whether the response to the item was in a positive ("I agree") or a negative ("I do not agree") direction.

5. The total Accessibility score obtained by each of the 68 subjects used in the study was computed by summing the weights for each item. The Accessibility score for each subject generally came out to a three-figure value plus a fraction. To simplify the statistical analysis, each Accessibility score was divided by ten and rounded to the nearest whole number. The uncorrected scores ranged from 269.8 to 417.5; by correction, this became 27 to 42, with a mean corrected score of 33.47, and a standard deviation of 3.67.

F. *Analysis of Findings*

Since the goals of the study involved construction of a scale to predict treatment accessibility, and comparison of predictions from the scale with other predictors, the treatment of the basic data was designed to evaluate our success in achieving these goals. Four Pearson correlation coefficients were calculated between each of the pretherapy accessibility predictions, respectively (psychiatrist's ratings of accessibility, therapists' ratings of accessibility, psychologist's ratings, and Accessibility Scale scores), and the accessibility ratings by the therapist following the twelfth group therapy session.[9] To test whether the obtained coefficients of correlation were significant, reference was made to a table giving "Coefficients of Correlation and *T* Ratios Significant at the 5 percent Level and at the 1 percent Level for Varying Degrees of Freedom"[10],

[9] The following formula was used to calculate the coefficient of correlation (GUILFORD, FUNDAMENTAL STATISTICS IN PSYCHOLOGY AND EDUCATION 159 (1950)).

$$r_{xy} = \frac{N(EXY) - (EX)(EY)}{\sqrt{[NEX^2 - (EX)^2][NEY^2 - (EY)^2]}}$$

[10] *Id.* at 609.

using 70 degrees of freedom. Tests of the significance of differences were calculated between the correlation with the criterion obtained with the Accessibility Scale scores, on the one hand, and, respectively, the correlations with the criterion, of each of the other predictors, using Z′ transformation[11] and computing t ratios of the difference between *"Z's"* and the standard errors of d_z.

Results

Table II summarizes the findings with regard to the correlation coefficients computed for each of the four accessibility predictors against the twelfth-session criterion rating of accessibility.

a) The Accessibility Scale scores, the therapists' ratings, and the psychologists' ratings all predicted the criterion score with better than chance expectancy, whereas the psychiatric ratings failed to correlate significantly.[12] Most important, with respect to this study, is the finding that the Accessibility Scale scores correlate with the accessibility criterion more highly than do the other predictors, and that the probability of obtaining so high a correlation on the basis of chance is less than one in 100.

b) Table II also compares the correlation coefficients obtained using Accessibility Scale scores, on the one hand, with coefficients based on the other three predictors. The differences in favor of the Accessibility Scale, using the "Z′-transformation" method, are all significant at better than the five per cent level of confidence, indicating that the Accessibility Scale scores predicted therapists' ratings of accessibility following the twelfth group session more accurately than did the other predictors studied.

TABLE II

Correlations, and Differences Between Correlations, of Pretherapy Accessibility Ratings With Therapist Rating of Accessibility Following the Twelfth Session of Group Psychotherapy

Predictor	r	Z	d_z	S.E. d_z	d_z/S.E. d_z
Psychiatric Interview	.156	.16	.49	.17	2.88†
Psychological Testing	.319†	.33	.32	.17	1.88*
Therapist's Interview	.352†	.37	.28	.17	1.65*
Accessibility Scale Score	.570†	.65	—	—	—

* Indicates correlation coefficient or difference between coefficients significant at 5% level of confidence.

† Correlation coefficient or differences between coefficients significant at 1% level of confidence.

Discussion

As was observed in the introduction, a number of writers have pointed to a need for research leading to the more effective selection of patients accessible to treatment—particularly patients accessible to group psychotherapy in correctional institutions. The present study, in the opinion of the writer, raises a hope for employing the intuitive insights of clinical workers in developing objective procedures for the early identification of accessible patients. Particularly in mass settings such as correctional institutions, where both diagnostic and treatment facilities tend chronically to be in short supply, is there a place for rapid, self-administered techniques, such as the type of scale developed for this study.

The writer would add the caution that the methodology utilized in this study represents only a preliminary step toward the objective selection of accessible patients. While the present phase did what it set out to do, namely demonstrate the feasibility of such an approach, it cannot be assumed that the scale which emerged as the tool for making this demonstration is ready for everyday clinical use. The mere fact that the items were selected for their appropriateness to a quite specialized population suggests that their applicability

[11] "Z's" corresponding to obtained "r's" were obtained by reference to an appropriate table. *Id.* at 616.

[12] The poor showing of the psychiatrist's prediction of accessibility is somewhat difficult to explain. Certain speculations may be relevant, however, and are here presented for the reader's consideration:

a) Possibly the psychiatrist, being asked to predict accessibility as judged by clinical psychologists, brought to the task a somewhat different therapeutic frame of reference, based on a difference in background and training from that of the psychologist-therapists.

b) In the present study, one psychiatrist made all the accessibility ratings. It would be unfair, consequently, to interpret the findings as necessarily representative of general psychiatric ability to predict accessibility.

c) It may be that psychiatric judgment of treatment accessibility is a special instance of psychiatric diagnosis and, as such, subject to the same elements of unreliability elsewhere reported for such diagnosis. See Ash, *The Reliability of Psychiatric Diagnosis*, 44 J. Abn. & Soc. Psychol. 272 (1949).

d) The present findings are consistent with the experience of McLean et al., *supra* note 3, who had patients interviewed by a board of three psychiatrists prior to beginning a "trial in therapy." There was so little agreement among the psychiatrists in predicting accessibility that the procedure was discontinued.

to other subjects in other settings may be questioned. It is quite possible that some other selection of items might have higher validity than the present set, even for the present purpose. In any event, it is reasonable to assume that among the items selected by the judges, some correlate more highly with the criterion measure than do others. It remains, then, for further research to carry out an item-analysis on the present scale, for the purpose of eliminating those items which fail to contribute to the overall predictive power of the scale. This should, on the one hand, increase the total validity of the scale, and on the other hand, would enhance its ultimate practical utility by reducing still further the time required for administration.

For the time being, then, the scale must be viewed as a research tool only; its empirical validity is tentative, although high according to the data thus far collected. The findings, even in this raw state, bear implications for the body of knowledge concerned with accessibility to group psychotherapy. Inspection of the items in the scale permits some preliminary inferences regarding factors judged by clinicians as having relevance to accessibility. These are, in order of frequency: awareness of emotional problems; sensitivity to group opinion; feelings of guilt and personal responsibility; acceptance of need for treatment; identification with the family.

SUMMARY

This paper reported preliminary results in the development of a rapid, self-administering technique for the prediction of accessibility to group psychotherapy, among incarcerated adolescent delinquents. Accessibility was rated by therapists following the twelfth therapy session. On the basis of judges' ratings of items for meaningfulness to group therapy accessibility, a scale of 83 items was derived, which were then assigned weights by averaging judges' ratings of each item from least to most accessible. Sixty-eight boys, aged 16 to 21, committed to the New York City Correctional Institution for Men, were assigned to group therapy. Prior to beginning therapy, each boy was given accessibility ratings based, respectively, on a psychiatric interview, a psychological test battery, and an interview with his prospective therapist. In addition, he completed the Accessibility Scale. Following the twelfth group therapy session, each boy was again given an accessibility rating by his therapist; this served as the criterion measure. Findings were as follows: a) correlation of Accessibility Scale scores with criterion accessibility ratings was significant at better than the one per cent level of confidence; b) correlation of Accessibility Scale scores with the criterion measure was significantly greater than correlations of each of the other predictors with the criterion.