Audio tape induction of juvenile delinquents into a group living milieu

Philip J. Blende

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AUDIO TAPE INDUCTION OF JUVENILE DELINQUENTS
INTO A GROUP LIVING MILIEU

A Thesis
Presented to the
Faculty of
California State College
San Bernardino

In Partial Fulfillment
of the Requirements for the Degree
Master of Arts
in
Psychology

by
Philip J. Blende
May 1976
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Approved by:

[Signatures]
Chairperson
[Date]

[Signatures]
[Date]
ABSTRACT

This research study focused on the need within a detention facility for an effective role-induction instrument to introduce juvenile delinquents into their group living milieu. It was hypothesized that subjects exposed to an induction tape would exhibit more positive behaviors as rated by counselors than those delinquents not exposed to the experimental treatment. Forty male subjects in one living group at a juvenile hall were randomly assigned to either an experimental or control group. Prior to being released into the group living milieu, the experimental subjects listened to an audio taped explanation of the rationale of the group's program and of its rules and regulations. The control subjects listened to a neutral taped talk on dental hygiene. Each subject was rated daily on selected behavior by Group Counselors using a Behavior Rating Scale. After a 14-day period, the data were gathered and a statistical analysis was completed. The research hypothesis was not supported. A discussion of suggested rationale as to the lack of significant findings and the needs of future research was presented.
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INTRODUCTION

Among the more serious problems facing detention facilities housing juvenile delinquents are those dealing with the proper and humane control of children being detained. The problem stems from the fact that a juvenile hall is a "detention" as opposed to a "treatment" facility. Children are placed at the hall awaiting a jurisdictional hearing. In addition, they are there because they present a threat to themselves or to the property and person of another. There is also an underlying fear that they may flee the jurisdiction of the court prior to their hearing.

While they are being detained, the group living milieu, according to the California Welfare and Institutions Code, is to be structured as near like a "home" environment as possible. Consequently, juvenile halls want to present programming which will make the most impact upon youth they detain in the shortest period of time. Although not considered treatment in the strict therapeutic sense, it is, nonetheless, due to the programming that takes place within the group setting. The effectiveness of the program, along with how it could be improved, are issues that will be under investigation in this research study.
**Review of Related Literature**

The relevant literature addressing the research issues to be investigated was primarily concerned with group induction methods. Client/therapist expectancies form the foundations of these studies. Goldstein (1962) found that expectancies of both the client and therapist were the most influential features in the effective process of psychotherapy. It should be noted that client and therapist expectancies did not always correspond.

The different expectancies cause many problems. Consequently, a clear working agreement should be made between the therapist and the client in an attempt to arrive at a solution (Standish, Gurri, Semrad, & Day, 1952). In their investigation, the researchers worked with psychotics undergoing group psychotherapy. The results indicated "that an effective working agreement would include 4 elements: (1) the purpose of the group, (2) the method through which this purpose is realized, (3) the role of the members, (4) the role of the therapist" (p. 283). However, no research data was reported comparing patients having had an explanation with a group that had no explanation of group psychotherapy.

According to Overall and Aaronson (1963), the cause of the many dropouts in therapy was seen as a function of the treatment expectancies of the lower socioeconomic class of patients. The fulfillment of these expectancies determined whether they would or would not return for treatment.
In this study of 40 patients of lower socioeconomic class, the authors found that the clients' expectations were a more accurate determiner of return to therapy than were the therapist's expectations. In concordance with their findings, it was recommended that "one way of reducing cognitive inaccuracy is to attempt, during the initial phases of treatment, to re-educate the patient as to both his own and the therapist's role in treatment" (p. 429).

In an earlier study, Heine and Trosman (1960) found that faulty expectations were also a contributing factor to continuation or termination of therapy. The authors hypothesized that patients and therapists in the early stages of a therapeutic relationship entertained expectations which were noncomplementary and disruptive. By using questionnaires, they interviewed patients regarding how they viewed the treatment that they would receive. The discrepancy between doctor/patient expectancies was again seen as the causal factor in early dropouts from therapy. They concluded that therapists should not only be aware of different model expectancies, but work to overcome them. However, no specific recommendations were given as to how to accomplish this feat.

The effects of varied clarity of group goals revealed the necessity for an individual to have a clear idea of his ultimate goal and his role as part of the group in his effort to obtain the desired end result (Raven & Rietsema,
1957). Individuals with unclarified goal and role ideas tended to experience hostile feelings and anxiety. Conversely, individuals were more productive and less hostile when their goals were clear and the paths well defined.

Other research findings indicated that patient-doctor compatibilities and mutual perceptions were related to outcome. Sapolsky (1965) found the degree of compatibility to be positively correlated with outcome of treatment. According to Parloff (1956), the therapists who were able to establish better social relationships also established better therapeutic relationships. In addition, the therapists who perceived a patient as approximating their "Ideal Patient" concept created a better relationship with those patients.

Stoler (1963) found client likeability and success in psychotherapy to be related. The therapist who "likes" his client results in having a client who is more successful in therapy. This very subjective measure by a therapist and how it influences positive outcome includes many variables such as in-therapy behavior, acceptance of therapist's goals by the client, etc.

Initial in-therapy behavior as a determinant of success and/or failure in client-centered therapy has also been examined by Kirtner and Cartwright (1958). Their findings indicated that the first therapy interviews of 42 clients clients who were seen by client-centered therapists were
very important in determining which clients would succeed and which would fail.

These findings represented some of the background studies which resulted in supporting the rationale for the structuring of clients entering psychotherapy. Therapist expectancies regarding criteria for a "good" client, along with the "process" of therapy in which the clients engaged, should be clearly defined. If the path to be traveled during this process is not clearly understood by the client, the outcome, according to the research, may be affected adversely. Consequently, many dropouts will be experienced, resulting in dissatisfied clients and time wasted by the therapist. If the clients know what is expected, then they can work towards these common goals in a faster, more knowledgeable fashion. As a result, there would be less frustration on the part of the therapist and client and better outcomes could then be predicted together with the lessening of the dropout rate. The next step was to apply these research findings to hypotheses relating to methods of preparing clients for psychotherapy.

**Role-Induction Studies**

The use of written instructions was found to be beneficial in helping group members know what was expected of them as well as what they could expect from psychotherapy (Martin & Shewmacher, 1962). No empirical data were given in this article which dealt primarily with the subjective
views of the authors as they interpreted the results of having group members receive written instructions during the third session of their group meetings and talking about them during the fourth session. While no immediate effects were noticeable, the authors were able to discern certain changes in members as they referred to those instructions. This was the first attempt reported in the literature to give findings relevant to the structuring of clients for therapy.

"Warm-up" procedures in analytic therapy groups were significantly shortened by the introduction of certain group-centered procedures in the first few sessions. The techniques also were found to be effective in speeding up the development of cohesiveness in the group (Munzer, 1964). This study was more experimentally sophisticated than previous quasi-anecdotal reports employing two experimental and two control groups, matched on several variables. However, not all relevant variables, such as presenting problems and therapy sophistication, were controlled. The therapists used in all four groups were the author and a colleague with similar training. In the first five sessions of the experimental groups, they employed five experimental procedures which were designed to heighten awareness of the other group members by various devices. During these first five sessions, the control groups received the customary nondirective group-analytic approach.

The results of Munzer's study indicated that these interventions did improve the cohesiveness of the experimental
groups over the control groups. For short-term psychotherapy, implications of these interventions would be productive, but may in a long-term therapy setting have little relevance. For low-functioning clients, intensive feelings of belonging to a group may have therapeutic effects which would help them continue with therapy.

The first study of any depth in the systematic preparation of patients for psychotherapy was conducted in 1964, using a Role Induction Interview (Rudolph Hoehn-Saric et al., 1964). Forty psychoneurotic patients selected from the outpatient department of a psychiatric clinic were interviewed by one of two senior psychiatrists. They were rated for "attractiveness" to therapy and were then assigned to either an experimental or control group. The experimental clients were given the Role Induction Interview, while the control clients were merely assigned to a group and dismissed. The four therapists were then each assigned a group of 10 clients which consisted of three attractive experimental and controls, and two unattractive experimental and controls.

The Role Induction Interview consisted of a general exposition of psychotherapy; a description and explanation of the expected behavior of a patient and of the therapist; a preparation for certain typical phenomena in the course of therapy (e.g., resistance); and the induction of a realistic expectation for improvement within four months of treatment.
The hypotheses to be tested were the following: (1) better therapy behavior in the third therapy session; (2) decreased resistance to therapy as measured by better attendance; (3) greater readiness to establish and maintain a therapeutic relationship as judged by the therapist; (4) more favorable outcome after four months of treatment.

The results supported the hypotheses in favor of the experimental groups. The experimental group exhibited better therapy behavior than the control group on five of seven measures. These differences reached the .05 level of significance for three of the five measures. The experimental group not only scored better on the Therapy Behavior Scale in the third session, but they also had a better attendance rate. In addition, the therapists rated the experimental group more favorably with respect to establishing and maintaining therapeutic relationships. Furthermore, the experimental group showed a more favorable outcome on five of eight outcome measures. Three of those five favored the experimental group at a significant level—the therapist's rating of improvement, patient's rating of mean target symptom improvement and social ineffectiveness ratings.

It was concluded that the Role Induction Interview had a favorable effect on certain aspects of patients' therapy behavior and improvement. Left unanswered were questions pertaining to the portion of the interview that caused the improvement in outcome—the role induction or the expectation
of the improvement by the fourth month. Another question of importance dealt with the effectiveness of the person giving the interview—the patient's therapists or someone not associated with the client.

Lennard and Bernstein (1967) investigated the role that learning has in psychotherapy in relationship to the schizophrenic patient, the psychoneurotic patient, and the therapist. They also pointed out that the responsibility for delivering role-induction information is clearly on the shoulders of the therapist, stating:

Teaching a person how to be a patient and what to expect from a therapist is an important part of what transpires during psychotherapy. The burden of reducing the lack of complementarity in expectations between them naturally falls upon the psychotherapist. Knowing the rules of the therapeutic "game" (and by implication, the game of life), a therapist must know how to induct his patient into the unique treatment role. If he fails to do this adequately, the person who applies to him for treatment never assumes the role of a patient and a treatment relationship does not materialize [p. 2].

In an earlier study, Lennard and Bernstein (1960) reported an analysis of the first 50 sessions of psychotherapy for eight neurotic cases considered "typical of office practice." During the first three sessions, 20% of all therapist communications were classifiable as primary role system communications. Over the course of treatment, there was a consistent downward trend in the percentage of such communication. By the fourth month, it was less than 8%. The authors also reported analyses of tape recordings of the first four sessions of three therapists with five
schizophrenic patients. Only 5% of the therapists' verbal output with schizophrenic patients referred to the primary role system, while .003%, an insignificant proportion of the patient propositions, referred to it.

The authors concluded that, "Something about the experience of interacting with schizophrenics seems to lower the frequency of therapists' role references and even to bring it to zero within one or two treatment sessions" (p. 4). Thus, it would seem from these findings that the need to focus on role learning with schizophrenic patients is of more importance than with neurotic patients due to lack of reference to this topic by the therapist with schizophrenic patients.

While having presented a good basic theory to the importance of role-induction learning in psychotherapy, Lennard and Bernstein (1960) did not indicate how they arrived at their conclusions. Two other points were also left unanswered. The first dealt with whether their findings were derived from tape recordings and the second pertained to who were used as judges. A logical explanation as to why role induction must take place was presented, but it is not clear what they meant by the terms "patient role" and "therapist role." There are several meanings and expectations of these roles as they are seen in terms of the different schools of therapy (i.e., analytical, client-centered, Jungian, etc.), along with the model they
represent—medical model, learning theory model, etc.

The above studies pertained virtually exclusively to individuals undergoing one-to-one therapy, with little attention to group therapy. Will an explanatory session preparing prospective patients increase the efficacy of group therapy? This was the question focused on by researchers at Stanford University (Yalem et al., 1967). They reported that approximately one-third of all patients beginning group therapy in a university outpatient clinic dropped out unimproved during the first twelve meetings. According to presented information "Psychotherapy . . . is a rational, teachable process, the efficacy of which is enhanced rather than impaired by explication" (p. 416).

Given the above rationale, three hypotheses were studied: (1) patients in the experimental groups were expected to have greater faith in group therapy than patients in the control groups; (2) patients in the experimental groups were expected to have greater attraction (cohesiveness) to their groups than in control groups; (3) patients in the experimental groups were expected to engage in more here-and-now discussion of interpersonal relations within the group than patients in the control group.

A sample of 60 patients was divided into two groups, experimental and control, by random assignment, after which they were assigned to groups of ten members each. The groups were to be led by six pairs of cotherapists who were blind
to the nature of the treatment. The therapists, first-year residents matched for competence, were randomly assigned to the experimental or the control groups.

The patients were then asked to come to the clinic for a discussion regarding their request for group therapy. The experimental patients were given a 25-minute group preparatory lecture. The major goals of this lecture were to test the above hypotheses. The control patients were also seen by the same interviewer for the same amount of time, but were given neutral information. In addition, all were asked to attend at least twelve successive meetings.

The results, using the Hill Interaction Matrix, Post-group questionnaires, Cohesiveness questionnaire, faith in group therapy questionnaire, and attendance and dropout records, demonstrated that the preparatory session increased the development of interpersonal interaction, that is, the discussion of intermember relationships in the group. According to the evidence, the patient's faith in group therapy was strengthened by the preparatory session. However, there was no effect of the experimental procedure on the patient's attraction to their particular groups. Thus, a preparatory interview clarifying group process and role expectations could enhance the efficacy of interactional group therapy by hastening the appearance of effective levels of group communication.

The Yalom et al., study was generally well controlled. It provided much information for the rationale in the use of
a pretherapy interview and preparatory sessions in group therapy. This helped cut through the ritualized tasks during the initial meetings that could be taken care of during the preparatory session. Yalom also is careful to point out that "A systematic preparation for group therapy by no means implies a structuring of the group experience. We do not espouse didactic or directive group therapy, but on the contrary, suggest a technique which will enhance the formation of a freely interacting autonomous group" (p. 426). "We would suggest that anxiety stemming from unclarity of the group task, process, and role expectations in the early meetings of the therapy group may, in fact, be a deterrent to effective therapy" (p. 426). Here Yalom makes reference to the crux of the situation at hand. If clients are to make effective progress, then they must be free from excessive anxiety. This can be accomplished through the use of a preparatory session to reduce anxiety caused by the unclarity of a new situation.

The differences between the ground rules of psychotherapy and those of medical-surgical treatment were noted as the possible explanation of the difficulty in the patient's understanding of therapy and role expectations (Orne & Wender, 1968). The characteristics of psychotherapy are generally seen as (1) the patient participates actively and verbally; (2) the psychiatrist's task is to help the patient understand himself; (3) the course of therapy is stormy; (4) causality is complex and unconscious.
The underlying assumptions of normal medical and surgical treatment, as seen by the patient, include (1) the patient is relatively passive; (2) the doctor's task is to make the patient well; (3) medical treatment is sometimes quickly effective and sometimes prolonged, but the patient's personal feelings have little to do with the results; (4) causality is often simple and generally physical. Thus, we see divergent views of these two models as to their basic assumptions about them by the patient. Yet, clients may utilize these faulty medical treatment assumptions when seeing a psychiatrist whom they view as another doctor.

"Anticipatory socialization" is the term given by researchers to the proper preparatory statements in regard to psychotherapy. Any type of statement which prepares an individual for a role or a task in which he will be engaged falls into this category. This applies to other roles such as father, husband, employee, employer, etc. A socialized individual has developed appropriate role expectations for each of these.

In other instances, socialization is carried out in preparation for future roles. A boy may learn how a man behaves by observing his father, or he may be taught in graduate school how a therapist behaves. These are examples of "anticipatory socialization" because they anticipate specific social interactions before they occur.

Orne and Wender (1968) state that "the typical middle-class patient has had a good deal of anticipatory socialization
before entering psychiatric treatment. . . . Upper middle-
class patients generally have had considerably more antici-
patory socialization than members of less privileged classes" (p. 92). The authors describe the effects of inadequate
socialization upon the patients who come to a psychiatric
clinic for treatment. The patient, relying on the only
appropriate model in his experience, acts as if the psy-
chiatrist were another medical doctor. The psychiatrist
may feel that he has gotten another "untreatable patient."
Thus, both parties become dissatisfied. This may go on for
some time before the patient and the therapist terminate the
relationship, having not solved any of the patient's pre-
senting problems.

The answer to attenuating such poor outcomes is that of
explicit socialization—the patient is told what he needs to
know. This can be achieved during a preliminary socializa-
tion interview that is conducted by either the therapist or
another trained individual. The main purpose of this inter-
view was (1) to provide some rational basis for the patient
to accept psychotherapy as a means for helping him deal with
his problem, recognizing that talking is not seen by most
patients as a "medical modality"; (2) to clarify the role of
patient and therapist in the course of treatment; and (3) to
provide a general outline of the course of therapy and its
characteristics, with particular emphasis on the clarifica-
tion of negative transference.
This was accomplished by (1) establishing rapport through history taking; (2) an explanation of psychotherapy in order that some rationale for therapy was presented to the patient whether he understood it or not, including some statement of goals and an approximation of length of time involved; (3) the role of the participant, that is the patient taking an active role, with the therapist helping, but not advising, the decisions always being made by the patient and not the therapist; (4) anticipating the patient's resistances, that is, talking about negative transference reactions and resistance at the very onset of therapy would help the patient become aware of these events before they occur.

By referring to several other studies, Orne and Wender stated that this kind of anticipatory socialization interview would provide better outcome results because clients would remain in therapy in lieu of dropping out. In other medical situations, the client is manipulated or given prescriptions, but in psychotherapy such procedures are avoided, and a client who fails to realize this is at a grave disadvantage. By making the necessary information available to him, therapists remove this disadvantage and give the unsophisticated patient an opportunity equal to that of most middle-class patients.

The Orne and Wender study, a theoretical and conceptual paper based on the findings of others, did not deal directly with any research data. The rationale is quite evident;
however, several questions were left unanswered. If the patient is not to consider psychiatry in the strict medical model set, is he to see it in the general view of being a medical role at all? How can we be sure that the upper middle-class patients really view the psychotherapeutic processes correctly?

An explanation of the process of psychotherapy, combined with the suggestion that the patient should improve in a few months, has been shown to produce better results in therapy (Hoehn-Saric et al., 1964). In another study, Sloane et al., (1970) tried to determine whether it was the explanation or the suggestion which was more powerful in aiding improvement. Thirty-six patients were randomly assigned to four groups after receiving different indoctrinations given by a research psychiatrist. The first group was assigned to a psychotherapist without further explanation. The second group was told that they should feel and function better after four months of psychotherapy; the third group had the process of psychotherapy explained to them by means of Orne's anticipatory socialization interview. As for the fourth group, they had the process of psychotherapy explained to them and, in addition, were told firmly they should expect to feel and function better in four months of psychotherapy.

The therapists, nine senior residents, knew that research was taking place, but they didn't know and were
unable to guess the procedure or aims. They completed questionnaires pertaining to how much they liked the patient as well as how much they could help him after the first interview. Independent assessment, before and after four months of treatment, was made by another psychiatrist. The findings, as determined by the research psychiatrist's ratings, attendance records, patient ratings, and the resident's rating of patient attractiveness, indicated that inclusion of the expectation of improvement in four months with the anticipatory socialization interview was not significantly greater than the group who had the anticipatory socialization interview only. The suggestion that they would feel better after four months had no effect on the outcome. Moreover, patients who received this suggestion were found by the therapists to be less likeable than those who did not.

Sloane attributed the lessened effect of the anticipatory interview on his subjects as due to the level of sophistication of the population he utilized. In the discussion of his findings, he gives the following advice, "It would seem advisable in future studies to take a direct measure of the patient's attitude toward therapy before the socialization interview, after it, and again at the end of treatment, to measure how much change actually took place" (p. 25).

The problem of whether the therapist or another trained individual should give the anticipatory socialization interview and how this would effect outcome became another matter
for research. In the Sloane study, there may have been some conflict between what had been told the patients in the preparatory session and what therapeutic techniques were used by the individual therapist. This could have resulted in a hindrance of the treatment process. Sloane concluded, "... our findings indicated clearly that an explanation of psychotherapy was of greater value than mere exhortation to improve" (p. 26).

Psychotherapy and the lower-class patient have traditionally been a poor match. Thus, the preparing of lower-class patients for group psychotherapy by the development of a role-induction film was the subject of a most recent study (Strupp & Bloxom, 1973). The film, "Turning Point", was developed to be shown in an attempt to change the attitudes of clients who had minimal motivation to seek and accept mental health services. The film was designed to appeal to a wide audience, particularly to members of the lower-income group who were seen as the prime target audience, for dramatic impact, and for a realistic presentation of the nature and extent of the benefits from group psychotherapy.

One hundred twenty-two patients were selected to undergo a twelve-week group therapy program. The subjects were introduced to therapy by three different induction modes: (1) The film group viewed "Turning Point" and were informed that they were to see a motion picture; no further
instructions were given. (2) The interview group received a role-induction interview patterned after the anticipatory socialization interview developed by Orne. Interviews were conducted by a psychiatrist who met with designated groups at their first scheduled meeting. Patients were also encouraged to ask questions about group psychotherapy and relevant concerns. (3) The neutral group viewed a neutral (control) film dealing with early marriage. It occupied a comparable amount of time, but contained no information relevant to the induction process. Instructions paralleled those of the role-induction film.

Four therapists saw three groups of 10 members each for the 12-week period. Therapeutic techniques were defined as broadly eclectic. Each session lasted 1-1 1/2 hours within the agency that had indicated interest in having their clients involved in a therapy setting. Unbiased evaluations were made several times throughout the 12-week period.

The results of this study indicated favorable outcomes for patients who were in the two role-induction groups as opposed to those in the neutral group. As Strupp puts it, "Participation in either of the role-induction procedures was clearly more beneficial than the neutral procedure. The interview seemed to be superior in conveying a detailed knowledge of the process of group therapy, whereas the film was superior over a wider range of measures" (p. 381).

The implications of this study were that it may be very profitable to view role-induction in terms of learning. By
teaching clients the processes and purposes of therapy, we may find that we are giving them more realistic expectations towards psychotherapy in general. We can, in most cases, direct them to become involved in these processes in less time and with more profitable outcomes than any we have experienced in the past.

These studies then conclude the work with role-induction in the forms of written instruction, interview methods, and film techniques. The methods used focused on the purpose and process of therapy with attention to learning as the most important aspect of overcoming negative client expectancies. There have been additional studies which focus on client preparation in the processes of psychotherapy.

**Process-Induction Studies**

The main focus of process-induction studies is not so much on the purpose and rationale of psychotherapy, but more towards the "how" it happens—the process. It is here, researchers theorize, that most of the work of therapy takes place, and, if clients understand how therapy works in terms of the process, then more successful outcomes could be anticipated.

Vicarious therapy pretraining (VTP) was one of the variables studied in working with institutionalized juvenile delinquents and mental patients (Truax et al., 1966). Different samples listened to "good" patient therapy behavior on taped therapy interviews. This was to provide a
vicarious experience of therapy, prior to the patient's introduction into actual group psychotherapy. It demonstrated the ways in which patients go about exploring their feelings and beliefs, and it gave the subjects some notion of the kinds of topics explored in group sessions. Resident therapists within each institution were used in the subsequent psychotherapy sessions. Qsorts were used to measure outcome variables.

The results indicated that the mental patients moved towards the positive direction, while juvenile delinquents moved in the negative or away from society's theoretical concept of ideal adjustment. This may have been due to the confounding of the two samples upon the results. The hypothesis regarding the use of VTP was partly supported by the data collected. However, there were too many uncontrolled variables to yield unequivocal information.

Truax again attempted to measure the effects of vicarious therapy pretraining (Truax, Wargo, & Voksdorf, 1970). Two other variables, therapeutic conditions (warmth, empathy, and genuineness) and alternate sessions, were also mixed with VTP and non-VTP conditions. The results demonstrated that the effects of VTP as related to outcome was not supported by the findings.

Thus, it appears that vicarious therapy pretraining may be effective with mental patients, but not with juvenile delinquents. As Truax reflects, "It may well be that
patients must be more socially responsible in order to benefit . . . " (p. 242). It may well be that juvenile delinquents do not ordinarily handle their problems in a verbal manner because of a lack of training and education, whereas mental patients may be more verbally oriented, thus yielding the differences noted in the above studies.

Focusing ability is defined as an ability which may be taught to clients in order to effect positive outcomes in psychotherapy (Gendlin et al., 1968). In this study the word focusing names the positive mode of behaving in therapy interviews. He presents his theoretical point of view with an emphasis towards teaching high school seniors the focusing process after which he deals with the implications of these procedures. "Since we have repeatedly found that high levels of experimental scales applied to therapy protocols predict success, we could predict success from our new measure (Manual and PFQ) of focusing ability--if we can first directly establish this presumed equation between focusing ability in the laboratory and experience level during therapy interviews" (p. 230).

Thus, there is no longer a need to let a case go on for years just to end in failure. The therapist will have some ability to measure what is taking place in therapy and need not wait to predict successful outcomes. He will be able to take an evaluative look at the patient's progress and determine if other measures need to be taken. Repeated
administrations and developing further methods may eventuate in a successful teaching procedure, both for psychotherapy purposes, and generally, as preventive psychology. At this point in time, however, Gendlin's work still remains in a theoretical perspective.

Internalization versus externalization is also seen as a process by which a client approaches his problems in therapy. Internalization is valued by therapists, and clients who do so are seen as "successful" in therapy. The subject of another process study (Pierce, Schauble, & Farkas, 1970) was whether this type of behavior could be taught to prospective clients. A secondary purpose of the study was to develop a means of predicting internalization behavior in clients.

Fifteen students who sought help at a university counseling center were the subjects for the study. Two experienced counselors worked with all clients. At the first session, the clients were asked to take four tests. During the second session, they were allowed to talk about their problems in any way they saw fit. During the second 20 minutes of the second session, the therapist stopped the client and explained what internalization and externalization was about. He then proceeded to reinforce internalization and to call to the client's attention any noninternalization behavior. For the final 20 minutes the client and therapist returned to their usual therapeutic choices of behavior.
The results indicated that clients who were initially high in internalizing behavior remained high. Those who were low increased in the desired behavior, but still remained below clients who were initially at higher levels. Thus, it would appear from this study that the teaching of internalization behavior in therapy would benefit clients in the therapeutic processes and also generalize to their outside behaviors. This also meant that therapists would take a more directive and concrete role in teaching clients to be aware of what they were doing with their problems.

The results of this study are not without some reservations because of insufficient variable control. The subjects and experimenters were both aware of the process being investigated and the results therefore could fall under the self-fulfilling prophecy heading. The sample of behavior was judged from only one meeting and no outcome results were given. While the results were heartening, there was some hesitation to accept them without further and better controlled experiments.

Psychotherapy for low-prognosis clients was the subject of a rather involved study (Warren & Rice, 1972). The therapy behavior of clients has been shown to be correlated with the amount of change which has occurred by the end of therapy. Also, the systematic preparation of clients has been shown as an effective technique in altering attendance and outcome, but no one had focused on extratherapy.
intervention with low-prognosis clients in connection with time-limited, client-centered psychotherapy.

The 55 subjects were put into one of three groups. The experimental group received both the stabilizing and structuring parts of the treatment. The semicontrol group received only the stabilizing sections of the treatment and the control group received no outside-of-therapy assistance. The structuring interview was a carefully constructed teaching approach designed to train the client to participate productively in the therapeutic process. The stabilizing interview was designed to encourage the client to discuss any problems he was having with the therapy or the therapist. These interviews were conducted outside of the therapeutic interviews by other individuals trained in these procedures.

The stabilizing and structuring interviews came before the second, third, fifth, and eighth interviews. The rating of the preliminary, first, second, and eleventh interviews were made on all groups by graduate students trained in the instruments used.

Results obtained showed that clients in the experimental and semicontrol groups who were stabilized showed less attrition. While the experimental group completed the first 20 interviews, the semicontrol group did not. Favorable outcome as rated by client questionnaires and therapist ratings was clearly supported, while Q-sorts gave only limited support.

The evidence presented by this study seems to reflect the fact that the client, when given the opportunity to
learn the process of therapy in which he is engaged, benefit from such instruction. Consequently, he will remain in therapy a longer period of time than those clients who remain naive to the process. There appears to be no particular advantage for a client remaining in therapy a longer period of time if they are not processing the information in a "therapeutic manner."

The results also indicated that clients who were taught this way to handle their problems were able to relate to their experience in a significantly more productive way. Even if they are "taught" therapy behaviors, it results in more productive and positive outcomes than clients who do not have the benefit of such training. Further investigation is needed to determine if the therapist should instruct as well as facilitate the client in therapy or if this should be done outside the therapy setting by someone else.

The Warren and Rice study was one of the most experimentally sound in the review of pertinent literature. However, one might ask the result of the additional factor of attention on the experimental and semicontrol groups as opposed to the control group which received no additional extratherapeutic attention. This factor alone may account for some of the positive responses and less attrition. The clients may have perceived the time as being reinforcement to return to the sessions. If the control group had received additional time of a neutral nature, the results may have reflected some further significance.
These studies have looked at role-induction instructions, interviews, and films, as well as "process" induction methods of better preparing clients for their participation in psychotherapy. It is evident in most cases that the client's probability of successful outcome will be increased if he is properly prepared for the task which he is to experience. It also seems that less time is wasted during the first sessions of therapy by properly inducting clients prior to their actually being involved in a therapy situation.

With the results of the cited studies in mind, it seems desirable to explore whether a role-induction instrument could be developed which would prove effective in working with juvenile delinquents in a detention facility so that their stay would be more beneficial in breaking down the barriers of expectations, and to produce better overall behaviors from the start of their detention and maintaining high levels of those behaviors throughout their group living milieu experience. The purpose of this study was to develop such an instrument and to assess its value in the institutional setting.

**Research Hypothesis**

It was hypothesized that:

An individual with prior knowledge of the conditions, and of the rationale of the program of his group living
milieu, will perform at a significantly higher level of desired behavior than an individual who has no prior knowledge of the conditions or of the rationale for the program of the group living milieu.
METHOD

Subjects and Raters

A total of 40 male subjects, randomly assigned to one of two groups, ranged from 15 to 17 years of age. They were assigned to one living group at Juvenile Hall and received the same treatment milieu throughout their stay at the Hall.

The raters were Juvenile Hall Group Counselors who were currently employed, trained, and made familiar with the Behavior Rating Sheet. They were uninformed as to the purpose of this study. Each counselor was randomly assigned subjects for individual counseling sessions. Their counseling styles were broadly eclectic. Their experience as counselors varied from a few months to several years.

Development of a Role-Induction Audio Tape

The anticipatory socialization interview (Orne & Wender, 1968) served three major purposes: (1) to establish a rational basis for the patient to accept psychotherapy as a means of helping him deal with his problems, recognizing that talking is not seen by most patients as a treatment modality; (2) to clarify the role of patient and therapist in the course of treatment; and (3) to provide a general outline of the course of therapy and its vicissitudes,
with particular emphasis on the clarification of the patient's negative and hostile feelings.

To investigate the goals thus established, an audio tape was produced which gave the subjects the following information: (1) the facts about his stay at Juvenile Hall, that is, anticipated length of stay, court procedures, group living procedures, the behavior modification program, etc.; (2) the subject's and the counselor's roles in the particular living group's behavior modification program; (3) some of the possible obstacles and problems that the subject may face during his detention; and (4) the rationale as to why the group behavior modification program was established.

A second tape was produced which was a talk concerning good dental hygiene habits while at Juvenile Hall. No explanation as to the processes or programs of the group living milieu were presented.

Design

Each subject was introduced into the living group milieu after listening to one of the following audio tapes:

1. Tape A explained the Honor Room Program and the reasons why it was in effect. In addition, it explained how the subject could use the Honor Room Program to improve his behavior (see Appendix A).

2. Tape B explained the importance of good dental hygiene habits while at Juvenile Hall. No specific information pertaining to the Honor Room Program was given. This
was a neutral (control) tape to equalize the interest and attention given to the other subjects (see Appendix B).

On their duty shift, each counselor rated every subject in the group on each of the behaviors indicated on the Behavior Rating Sheet. Rating points were 3 points = Excellent; 2 points = Good; 1 point = Acceptable, and 0 points = Needs Improvement (see Appendix C).

Procedure

Each subject listened to one of the audio tapes prior to being placed into the group living milieu. Subsequently, the conditions were the same in the treatment milieu for all the subjects. Each day the subject's total points from each shift were added up, after which the total points were charted on a Behavior Graph (see Appendix D). This gave a graphic representation of the subject's behavior in relation to expected ranges of behavior points—Excellent (72-86 points), Good (56-71 points), Acceptable (28-55 points), and Needs Improvement (0-27 points). The counselors reviewed the chart with the subjects on a weekly basis while the subjects were able to review the chart whenever they desired.

At the end of a two-week period (14 days), the data were collected on each subject. During this time, both raters and subjects were unaware of the design and the purpose of the study.

Research Instrument

A rating scale was developed for the present study.
Each subject was rated daily on each of the following behaviors: Participation, Peer Relations, Attitude, General Behavior, School, Grooming, Bunk, and Sportsmanship. Each of these categories received point scores ranging from 0 to 3 (a 3 being Excellent). At the end of the day, the total score recorded for each subject was placed on the Behavior Graph. This information was available to both the subject and his counselor.

Statistical Procedures

A completely randomized design (Kirk, 1968) was used and t-test was conducted to determine if there was a significant difference between the two induction methods at the .05 level of significance.
RESULTS

The means and variances of each Induction Tape Group was computed yielding the results indicated in Table 1.

Table 1
Means and Variances of Induction Tape Groups

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<td>Tape A</td>
<td>818.90</td>
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<td>Tape B</td>
<td>833.45</td>
<td>77.84</td>
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The mean of Tape A (Experimental) Group's Behavior Points was 818.90, while the mean of Tape B (Control) Group was 833.45. The variance for Tape A was 105.45, and 77.84 for Tape B.

A one-tailed $t$ test was computed to see if there was a significant difference between the means of these two independent groups. The result was -.495, which indicated that there was no significant difference between the two groups.
DISCUSSION

The research hypothesis was not supported. The data indicate that those individuals who were exposed to prior knowledge of the conditions and of the rationale of the program in the group living milieu did not perform at a significantly higher level of desired behavior than those individuals who had no prior knowledge of those factors. Why this was so is difficult to ascertain because extraneous variables in the group living milieu such as prior experiences at Juvenile Hall, information from other peers, and counselor differences of inducting wards into the group were uncontrollable.

Each subject was to hear the tape before he was placed into the group. This was usually done in his receiving room and without being observed. How the subject attended to the tape was not controlled to insure that the subject actually listened to the tape recording. If the stimulus was thought to be boring, uninteresting, or not relevant by the subject, its potential effect was minimized.

The familiarity of the individual with the group due to prior experiences was uncontrolled. In viewing this information, it was not found to be a significantly influencing factor. Recidivism among the group members was accounted for by the number of prior admissions to Juvenile Hall.
The average number of priors for the experimental and control groups were 4.90 and 4.25, respectively.

In looking at the normal induction method, the subject is talked to by a counselor before his placement into a group. It is the counselor's task to attempt to make sure that the subject is not a security risk, reducing the chance of running away when he is released to the group and living in a less secure setting. This would mean that the experimental group would have heard the "ground rules" twice prior to their release into the group, whereas the control group would have had the tape reinforce and would add another factor to why they should have scored significantly higher than the control group.

The Behavior Rating Scale employed in this study is an objective measure of the rating counselor's "subjective" view of an individual's behavior. Thus, the true level of objectivity of the measure is in question, as is its reliability.

The degree to which the reinforcement from viewing the Behavior Graphs alone affected positive behavior patterns in both groups needs to be assessed. This factor alone may have overshadowed the effects of any induction method and confounded the results. Also, the use of the Behavior Graphs by individual counselors and the importance that they placed on them, as well as how each subject interpreted his own graph, may have influenced the outcome of the study.
Future Research

This study addressed itself to a single question. The search for an answer to that question raised several other issues. The control of extraneous variables is clearly necessary in order to answer the majority of further research questions.

In order to sort out the influence of prior experiences upon the induction method, it would be necessary to investigate truly naive subjects with no experience in a detention facility and use the tape induction method on one group, while another group of naive subjects would receive no induction whatsoever into the group living milieu. The results would give a clearer picture of the effects of the induction method then is presented in the present study with a rather sophisticated group of delinquents.

The importance of positive reinforcement needs to be taken into consideration by separating the influence of the Behavior Graphs from that of the induction method. Would the subjects behave in a significantly more positive manner when given the opportunity to see their behavior in a graphic representation on a daily basis than those who had no opportunity to do so?

Counselor attitudes towards delinquents is another area of further research. How do counselors view their clients and their role in relation to the client? Do they view delinquents in a negative or positive set and how much do
these attitudes affect their "subjective" grading of the subject's "objective" behavior? The reliability of the Behavior Rating Sheet should also be tested to determine if it truly consistently reflects the counselor's evaluation of the child's behavior.

Another area to investigate would be the importance of short-term versus long-term learning effects of the induction method upon the delinquent population. Possibly, the tape-induction method in a more stringently controlled experiment, may have immediate rather than long-term effects in the wanted behaviors. The short-term learning may be important during the first days, but thereafter may be dissipated by the influence of the total group living milieu.

The comprehension by the subjects of the induction tape also needs to be evaluated. A postinduction instrument should be incorporated in the design of future studies.

The importance of this research is that those who attempt to find the answers will effect a clearer understanding of motivating positive behaviors in a population where "the negative is the norm."
During the next few minutes, I will be explaining what you may expect during your stay here at Juvenile Hall and also what is expected of you while you are here. It is important to pay close attention because this information will be affecting you all the time you're at Juvenile Hall.

First, let me tell you about how your time will be spent here and how long you may be staying. When the Police Officer brought you here, he filled out a petition requesting that you be made a ward of the court. That is, that you be placed on probation. Now it will be up to the Probation Department to investigate all the facts and circumstances of your case.

Within 72 hours (3 days, not counting Saturdays, Sundays, or holidays), you will have a Detention Hearing. At this hearing, it will be determined if you will go home to await your court appearance or if you will stay at Juvenile Hall until your court date. If you are released at that hearing you will be told when your court date will be and you will be released into the custody of your parents or guardian.

If you are detained at your hearing, you will remain at Juvenile Hall until your court date. In either case, an Investigating Probation Officer will be assigned to your case and will be contacting you before your court hearing. That Probation Officer will be talking to the Police, the school, your parents and gathering all the facts concerning your case during the time you are waiting to go to court. The Probation Officer will be talking with YOU and finding out your side to the story also. All this information will go into his court report to the judge. The judge will have the last say as to finding you guilty or innocent of the charge and, if you are found guilty, what will happen to you afterwards. Your Probation Officer will be talking with you more about this later on. However, if you have any questions about this or any of the facts regarding your case, you should request to see your Probation Officer through your Group Counselor.

Second, during your stay at Juvenile Hall, you will be a member of one particular group and you should know what
is expected from you as a group member. The basic thing to remember is to stay within the rules and regulations of your unit and to get along with the other members of the group. The counselors of your group are responsible for the health, safety, and welfare of the entire group, so it is important that YOU cooperate in helping to make the best of each day. You'll find that if you follow the rules and regulations and cooperate with the counselors, your stay will not be difficult and the counselors will listen to you and will help you whenever it is possible.

During the week, Monday through Friday, school will be held (9:00 to 3:00). Butterfield School is probably unlike any school you have attended. The classes are set up to help you learn new and interesting ideas as well as improve basic skills such as math and reading. Please cooperate with the teachers you will be coming into contact with for they, too, care about helping you as much as they can. If there is a problem at school, you will be returned to the group and along with the counselors and the teachers, a decision will be reached as to how best to solve the problems.

Let's talk briefly about some of the do's and dont's while you are living within a group:

1. **Bathroom and Dorm.** The bathroom is for showering, grooming and taking care of your personal needs. The dorm is for sleeping and changing clothes. Both rooms are off limits for gathering to talk or horseplay. You are directed to be particularly quiet at bed time so that all group members may have a chance to relax and fall asleep.

2. **Tatoos.** Tatooing is considered a health hazard. Should you be seen marking yourself in this way or should you be found with a fresh tatoo you will be placed in a room until seen by a doctor or nurse, and, if necessary, you will be given a tetanus shot.

3. **Visiting.** Your parents may visit once after you are first admitted and then may visit you on Sundays between 2:00-4:00 p.m., or with special permission from your Probation Officer, on a time other than Sunday if your parents work. At the time of the visit, your parents may bring you cigarettes (if you are 16 years of age or older), magazines, hand lotion in a plastic container, and deodorant. Smoking by either you or your visitors is NOT permitted. Your pastor or minister may visit you during the week as may your teachers and your school counselors.
We hope that your parents will visit you and that you will use this time to talk with them and work out some of the problems. However, if your behavior or your visitors' behavior is such that it upsets or disrupts other visits, the counselor will have to request that the visit end.

4. Smoking. Smoking is a PRIVILEGE which may be revoked by a counselor if the smoking rules are violated:

1. You are to be 16 years of age or older and may smoke at the time and the place authorized by a counselor.
2. Sealed packages of cigarettes may be brought in to you by your parents or another adult. They must be given to the counselor who will put them away for safe keeping and will give them to you at the appropriate time.
3. You may not have cigarettes or matches on your person, your room, or anyplace other than designated by a counselor.
4. If you find illegal cigarettes or matches in the unit, please give them to the counselor on duty.

5. Line Up. When requested to "line up" by a counselor or a teacher, you are expected to do so quickly and quietly. When quiet you and every other group member will be able to hear the instructions and then will not get into trouble later because you did not hear what was said to you. Do not comb or brush your hair in line. No group member is permitted to leave the unit; ALL in the line are quiet and attentive.

6. General Rules. You are requested to knock on the office door and wait until the counselor says to enter. This rule of courtesy makes it possible for personal matters to be discussed privately and with less embarrassment to you and to others. You will be assigned a sleeping area and you are responsible to keep the bed made up and your locker and personal items neat and clean. If you are assigned a sleeping room for some reason, please keep it neat and clean also. This is your temporary living quarters and along with the counselors you are responsible to keep it clean. You will be assigned work details by a counselor each day and you are expected to complete them when directed to do so. Cooperate fully with whoever is in charge of the detail (i.e., counselor, painter, cook, gardener, etc.).

7. Quiet Time. Means just that, a time set aside in the day to be quiet. You may read, write letters, or just think; but please do be quiet and let others have a chance to do so in peace and quiet.
8. **Letters.** You may write letters to your family and relatives. The counselor will provide paper and a pencil upon request. You may receive mail from your family and friends while here. Please note that all incoming and outgoing mail will be read by a counselor. Letters may be held back if it is felt that they are not decent or that they could be harmful to you or any other person. These letters will either be forwarded to your P.O., or will be put in your file and given to you at the time of your release. In your letters the following are not acceptable: (1) swearing and/or indecent language; (2) discussion or comments about any other person detained here, or (3) plans to take part in activities not acceptable to your P.O.

9. **Illness.** In case of your own illness or injury, no matter how slight, please advise a counselor and you will be seen by a nurse or doctor as soon as is possible.

10. **Dining Room.** You are expected to eat quietly and with good manners. You may talk quietly with those at your table, but please do not talk with those at other tables as this gets too noisy and makes the meals unpleasant for everyone. Do not leave your seat unless requested to do so by a counselor, or unless you first ask and are given permission to do so. During coed seating, you are expected to act like a gentleman. No loud talking or laughing, and no physical contact with the girls is permitted. Everyone is requested to participate in the flag salute and prayer before meals.

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**Honor Room**

Each day on the 7-3 shift and the 3-11 shift, the counselors will be watching your behavior. At the end of the shift, they will give you points from 0 to 3 on several categories of behavior, for how you acted on that shift. The more points you have at the end of the week will determine if you have earned extra privileges, such as staying up later, extra snacks, attending coeds, etc.

The two boys with the most points at the end of the week will be Honor Boys and will earn the privilege of sleeping in the Honor Room, having their own radio, staying up late, coeds, etc.

The next four boys with the highest points will be on the "clean-up crew." They may stay up longer, have extra
snacks, go to coeds, etc. Whatever privileges are available in your group, you earn; they are not just given to you.

How you earn these points and privileges is by how you act in the group, actions towards the counselors and other staff, and how you act toward other group members all are taken into consideration.

Specifically, you will receive points on the following:

1. **P.E. Participation** - That you actively participate in the P.E. program and use your athletic ability to the utmost. That you strive to personally improve your abilities.

2. **P.E. Sportsmanship** - That you encourage teammates to play fairly and with maximum effort. That you respect the judgment of the referees and don't hassle over their calls.

3. **Peer Relations** - That you get along well with other group members and seek interaction with them in a positive manner.

4. **Staff Relations** - That you demonstrate respect for those in authority and follow the counselor's directives in a positive fashion.

5. **Personal Hygiene** - That you regularly demonstrate good hygiene habits (i.e., wash before meals, brush teeth regularly, keep hair neatly combed, and that you shower daily.

6. **Bunk** - That you keep your bunk made neatly and keep the area around it clean. Bunks are judged by tightness, neatness, and originality.

7. **School** - That you participate actively in the school program, that you complete all assignments and that you are not disruptive in the class, and that you respect the teachers' directives.

8. **Attitude** - That you have a generally positive attitude while in the group.

9. **General Behavior** - That is, how you act overall, as a clown or as an attentive listener, you make the decision.

Remember, on each shift you will be judged on these different categories. Each day your total score will be announced, and be put on a Behavior Graph for you to look at. Take time to see how you're doing daily by looking at the Behavior Graph that the counselor's will keep for you.
You may look at yours and only yours, at anytime. It will tell you how you're doing compared to what is expected from you.

If you see you have a problem, talk it over with a counselor who will let you know how to improve in any of the behavior categories. The counselors want to assist you in improving in any way they can be of help. Feel free to talk to them about anything that is troubling you.

Remember, how you do and what you do while you're here at Juvenile Hall is your responsibility. You can make the difference between "dead time" or really learning more about yourself, so that you'll grow towards that person you want to be. Take the time to learn today! Thank you!
APPENDIX B

FULL TEXT FOR TAPE B

It is important during your stay at Juvenile Hall that you maintain a regular program of good dental hygiene. This tape will explain why and how you can start today. It will explain why Perio is the worst tooth-killer of all.

There's bad news and good news about periodontal disease, the disorder of gums, tissues, and bones around teeth that's sometimes called pyorrhea.

The bad news is that some 75,000,000 adult Americans have periodontal disease and millions have lost all their teeth because of it. By age 15, four out of five youngsters have the earliest form called gingivitis, and by age 65 nearly everyone has lost some teeth to perio.

The good news is that, though it destroys more teeth in adults than decay does, perio can be controlled if diagnosed and treated in time, and it can even be prevented.

Periodontal disease actually is a collection of diseases that may begin in a number of ways. The commonest cause is an accumulation under the gumline of plaque, a sticky, transparent film produced by bacteria reacting on saliva and fermentable food particles. If plaque is not removed by brushing or other means, it can become a hard, mineralized substance called tartar or calculus. Tartar's jagged, stony edges make gums vulnerable to the entry of bacteria, which produce the enzymes and poisons that bring on gingivitis, an inflammation of the gums. Periodontal disease may show up first with mild bleeding that causes "pink toothbrush." If untreated, the inflammation can become chronic and progressive; the gums becoming swollen and sore and bleeding quite easily as the disease worsens. Untreated gingivitis can lead to the advanced stage called pyorrhea in which gums recede from the teeth and the pockets that develop between teeth roots and gums harbor food, bacteria and infection. The periodontal ligament that holds the teeth in place and sometimes even the jawbone are damaged, and teeth must come out.

Other factors may contribute to perio, possibly including faulty bridgework that cuts the gums, poor tooth
alignment, hormonal imbalance, a tooth-grinding habit, and such diseases as diabetes.

What Can You Do For Yourself?

Preventing periodontal disease is a lifelong job and it begins at home, with a toothbrush and dental floss. Give children a small toothbrush at around age 2 and show them how to use it, even though you'll do most of the brushing for them at first. Schedule the initial visit to the dentist before all the first teeth have appeared, by age 2, and regularly afterward. Children of 6 or so can begin using dental floss. Serve balanced meals, keep sweets to a minimum and encourage snacks of such foods as raw carrots and celery sticks. Cooperate with the dentist in trying to save baby teeth as long as possible and have crooked teeth straightened early.

No matter what your age, if you have neglected your mouth, chances are you already have a touch of gum trouble. Luckily, damage can probably be offset and progression of the disease controlled with the practice of good preventive dentistry.

Brush and floss at least once each day, preferably before bedtime, and do a good enough job to remove plaque thoroughly. Have your dentist show you the brushing technique best suited for your own mouth, and get him to recommend a brush to fit your needs. Most dentists prescribe one with a flat brushing surface, a straight handle, and soft, rounded bristles to minimize gum injury. Ask about "disclosing" liquid or wafers, which show up hard-to-see plaque deposits in color so you can take a second crack at them. And since even the most diligent brushing misses spots between the teeth and along the gumline, master the technique of using dental floss.

Other devices have varying degrees of effectiveness, but use them only on the recommendation of your dentist. Electric brushes can be as useful as nonelectric ones for cleaning teeth and gums, and they can be a boon to handicapped people. Water jets, or "oral irrigating devices," do an okay job of flushing out loose debris from around orthodontic braces, but consider them an aid to brushing and flossing, not a substitute. If you use one, look for the seal of the American Dental Association's Council on Dental Materials and Devices, and avoid using excess water pressure that may damage tissue or drive food particles deeper into the gums. Rubber tips on toothbrushes, toothpicks and various devices for cleaning between the teeth
are of limited value. These devices can remove large food particles but have little effect on plaque. Used without the dentist's supervision, they may cause more harm than good to gum tissue.

What Can Your Dentist Do?

Regular checkups are important, and with the frequency depending on your dental health. Periodic full-mouth X-rays are necessary to diagnose disease.

Control calls for eliminating local irritation to the gums, including thorough scaling of tartar from the teeth below the gum line, removing impacted food and correcting bad dental restorations.

If disease is far advanced, the dentist has to eliminate pockets of infects that have formed around the roots of the teeth. Sometimes surgery must be done to reshape the gums to make them easier to clean, or a flap of gum may be temporarily pulled aside while infection and tartar are removed and the bone is reshaped. As a last resort, teeth beyond saving must come out, to be replaced by dentures or bridgework.

The simplest periodontal surgery is called curettage and involves removal of plaque, calculus and inflamed soft tissue around the tooth. The fees for the total treatment can cost several hundred dollars or even more for reshaping bone.

Caring for your teeth and gums may sound like a chore. Brushing, flossing and dental visits do take time and effort. Research may give you an easier time of it someday, perhaps with a mouthwash that breaks up plaque. But for now nothing will replace the cleaning routine that helps your teeth last a lifetime. Thank you!
# APPENDIX C

## BEHAVIOR RATING SHEET

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## APPENDIX D

### BEHAVIOR GRAPH

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REFERENCES


Raven, B. H., & Reitsema, J. The effects of varied clarity of group goal and group path upon the individual and his relation to his group. Human Relations, 1957, 10, 29-45.


