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Combining Abuse and Neglect Investigations With Intensive Family Preservation Services: An Innovative Approach to Protecting Children

Elaine Walton
Brigham Young University

Objective: Evaluate an experimental model for enhancing child protective service (CPS) investigations by teaming CPS investigators with family preservation services (FPS) caseworkers.

Method: Using a posttest-only experimental design, high priority cases referred to a state child welfare agency for abuse or neglect were randomly assigned to an experimental or control group. During the interval between referral and case determination, families in the experimental group were served by a pair of caseworkers—CPS and FPS—who investigated the allegation and prepared a joint recommendation. Results: When compared 7 months later, families in the experimental group (a) had their children home for a greater percentage of time, (b) used a broader array of services, and (c) were more satisfied. Both CPS and FPS caseworkers felt that (a) better decisions were made, (b) families were strengthened, and (c) job satisfaction was greater. Conclusions: The model was effective and should be implemented on a broader scale.

Children are being abused and neglected in ever increasing numbers, and commensurate problems are evident with complex demands on child welfare agencies (Barth, Courtney, Berrick, & Albert, 1994; Berrick, Needell, Barth, & Jonson-Reid, 1998; Kemp, 1998). Accordingly, the number of children placed in foster care continues to increase (Committee on Ways and Means, U.S. House of Representatives, 1991; Tatara, 1992). In addressing incidents of domestic violence, child welfare agencies are mandated to make the child’s safety and well-being the first priority. However, removing children and placing them in out-of-home care is replete with problems because of a lack of permanence—with accompanying negative sequelae for children (Fanshel & Shinn, 1978; Maluccio, Fein, & Olmstead, 1986) as well as increased cost of child welfare services with the use of expensive substitute

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care resources. As a result, many child welfare agencies across the country have focused on family preservation services (FPS) as a way of strengthening at-risk families and, in many cases, rendering out-of-home placement unnecessary.

FPS programs are varied, but most (a) provide for intensive intervention (i.e., small caseloads making it possible for large blocks of time to be invested in the family and the availability of the caseworker 24 hours a day, 7 days a week); (b) deal with the family as a unit; (c) provide services primarily in the home; (d) provide services based on need rather than categories; and (e) provide intensive services on a short-term basis (Walton, 1991). FPS programs build on a series of premises within an empowerment and strength-based perspective and emphasize training in a variety of life management skills in combination with the networking of resources—both hard and soft, formal and informal. Workers using the FPS approach advocate for client families in accessing resources while at the same time helping them discover their own strengths in an effort to become independent.

Many evaluations of FPS have shown impressive success in keeping families together and in avoiding out-of-home placement (Auclair & Schwartz, 1986; Carroccio, 1982; Dennis-Small & Washburn, 1986; Fraser, Pecora, & Haapala, 1991; Jones, 1985; Henggeler, Melton, & Smith, 1992; Kinney, Haapala, & Booth, 1991; Magura, 1981; Nelson & Landsman, 1992; Szykula & Fleischman, 1985; Walton, 1998; Walton, Fraser, Lewis, Pecora, & Walton, 1993; Wharf, 1988; Wood, Barton, & Schroeder, 1988). However, several authors (Frankel, 1988; Jones, 1985; Magura, 1981; Pecora, 1991), in reviewing the literature on family-based program evaluation, noted that many studies were compromised by limited measures of child or family functioning, by inadequate analyses, by small samples, and by poor research designs—citing in particular the absence of experimental designs. More recently, findings from program evaluations have been mixed and indicate that claims of success may be overrated (Gelles, 1993; Rossi, 1992; Schuerman, Rzepnicki, & Littell, 1994; Wells, 1994; Wells & Biegel, 1992).

Currently, the use of FPS is fraught with controversy. Warsh, Pine, and Maluccio (1995) hold that, at least in part, the controversy is traceable to a confounding of mission (philosophy) and method (approach). They advocate a broad definition of family preservation and support a “spirit of experimentation and change as we learn what families need from the service-delivery system in order to remain connected” (p. 625). In that spirit of experimentation, the current demonstration project departed from the normal use of FPS by implementing it in combination with child protective services (CPS) investigations at the time of initial referral.
Most FPS programs provide intensive services for periods of time ranging from 30 to 90 days and are provided after the completion of the initial CPS investigation. However, an agency in Lucas County, Ohio, implemented an experimental model for enhancing child protective and investigative decisions by providing FPS at the time of initial referral in combination with the investigation (Walton, 1994, 1997). Using a posttest-only experimental design, 134 families were randomly selected from daily referrals and randomly assigned to an experimental \( (n = 69) \) or control \( (n = 65) \) group. In the period between referral and case determination (approximately 30 days), families in the control group received the routine services that accompany investigation whereas those in the experimental group also received 2 weeks of intensive FPS involvement.

When compared 6 months after case determination, there was no significant difference between the groups in terms of out-of-home placements. However, cases that were opened for families in the experimental group were more frequently opened with the children remaining at home \( (\chi^2 = 3.38; p = .066) \), and these cases were opened for shorter periods of time \( (t = 3.38; p = .003) \). Caregivers from the experimental group were more likely to use the array of services available, viewed the agency as more responsive and supportive, appeared more willing to express their needs and problems, utilized education services and general support services more often, and generally found the services helpful. Moreover, both groups of caseworkers supported the model. They believed that better decisions were made, and they experienced greater job satisfaction. Because of the success of the Ohio experiment, a similar model was implemented in Utah and is reported herein.

In 1996, the Western Region of the Utah State Division of Child and Family Services (hereafter referred to as the agency) implemented an experimental model for delivering child welfare services in which CPS investigators were teamed with FPS workers in responding to initial referrals of abuse and neglect. Although the use of family preservation services in this study was built on a theory base and on accumulated knowledge gathered from previous FPS program evaluations, it differed in scope. First, it is acknowledged that 4 weeks is probably too brief for significant change from long-standing family dysfunction. However, it was posited that a 4-week intensive intervention provided at the very time when a family is in crisis, and therefore presumably most needy, might make a difference in terms of the family’s general functioning as well as its cooperation with the agency. Second, the brief intervention would focus on surrounding the family with a network of resources designed to outlive the caseworkers’ involvement. Third, it was reasoned that such timely intervention might affect the way in which the agency makes
decisions about how best to help the family. With the intensive involvement of the CPS investigator, it was felt that fewer families would need continued supervision by the agency, and CPS workers would feel more confident in the appropriateness of their decisions. The study was designed not only to strengthen families in crisis so as to reduce the need for out-of-home placements but also as a means for enhancing the agency’s decision-making process—thus broadening the scope of possibilities in individualizing the plan for each family.

METHOD

The purpose of the study was to examine whether providing CPS investigations simultaneously with FPS involvement from the time of referral would produce measurable differences between families who received the combined services and those who did not.

Clients

Families who participated in the study had been referred to the agency for abuse or neglect and had been designated as high priority cases. One third of the families consisted of birth parents living together. The remaining families had been disrupted by divorce or separation, remarriage, or were mothers who had never married. The annual income of the families varied from $15,000 and below (30.2%) to $30,000 and above (31.3%). On average, the family had three children, lived in a rented home (48.4%), and had changed residences twice in the previous 5 years. The typical primary caregiver was a woman (80.0%) 35 years of age who had graduated from high school (50.0%) and was the natural mother of the child (72.0%). The combined number of children from the experimental and control groups was 307. Of this number, most were White (90.1%), male (54.6%), with an average age of 8 years. Hispanics accounted for 7.0% of the total. At the time of referral, physical abuse was alleged most often (74.5% of the cases—multiple allegations were recorded), emotional maltreatment for 10.8%, and physical neglect for 7.4%. Sexual abuse was alleged for 6.4% of the cases.

Research Design

The study employed a posttest-only experimental design. During a 15-month period, 331 high priority cases of alleged child abuse or neglect were referred to the agency. From this pool, cases were selected at random to
receive either the experimental CPS-FPS treatment or the customary CPS investigative services. By the end of the experimental period, the experimental and control groups numbered 97 and 111 cases, respectively. (It was originally intended that the numbers included in the two groups be equal, but as the study progressed, occasionally a CPS-FPS team was unavailable to accept a new referral and the case was dropped from consideration for the experimental or comparison groups.) Seven months after the initial referral, the two groups were compared on a number of variables. Comparison data were collected from caretakers, caseworkers, and agency records.

Although it was an agency decision (following the agreed-upon randomization protocol) whether a family received the experimental or control treatment, participation in the follow-up interviews was voluntary. When contacted 7 months after the initial referral, each family was asked to permit an interviewer to come to their home to determine their reactions to the services received since the referral and to obtain demographic information about the family. Prior to being interviewed, the caregiver signed an informed consent form. Following completion of the interview the respondent was paid $20.00.

Outcome Measures

The effects of the experimental intervention on the families and caseworkers were examined using five sources of information: (a) follow-up interviews of the caretakers, (b) interviews of the caseworkers, (c) interviews of administrators and supervisors, (d) agency databases, and (e) a survey of caseworker demographics.

Approximately 7 months after the initial referral, as many as possible of the caretakers from both groups were interviewed in person. The interviewers asked the caretakers to complete the Index of Parental Attitudes (W. W. Hudson, 1982). The interviewers also asked about the general demographics of the family and about the caretaker’s satisfaction with the services received from the agency. Their responses were noted on a specially prepared form referred to as the follow-up survey.

The Index of Parental Attitudes is one of the 18 scales in The Clinical Measurement Package, designed by W. W. Hudson (1982). It is a 25-item, pencil-and-paper, self-report questionnaire with summed scores designed to measure the magnitude of a unidimensional problem. The scale is limited in the sense that it is possible for the client to lie without being detected. Nevertheless, reliability data have been summarized from a number of studies using these scales, and the reported alpha coefficient for the scale was higher than .90 (W. W. Hudson, 1982). The Clinical Measurement Package scales also reasonably discriminate between criterion groups.
The follow-up survey is an instrument designed by the principal investigator. It is a pencil-and-paper questionnaire completed by the interviewer on behalf of the family and is based on a questionnaire used in the Family Reunification Project (Walton, 1991), the Family-Based Intensive Treatment Project (Fraser et al., 1991), and the Lucas County Study (Walton, 1994, 1997). The instrument has not been normed.

The follow-up interviews were conducted by graduate students from the School of Social Work at Brigham Young University. The students received at least 4 hours of formal training prior to their conducting any interviews and weekly in-service instruction thereafter. The training included (a) a full briefing regarding the experimental intervention, (b) the methodology for data collection and analysis, (c) a discussion of the agency’s general policies and procedures as they affected the project, (d) the agency’s and the university’s policies regarding the protection of human participants, (e) interviewing techniques and the use of culturally sensitive language—including the recognition of acceptable but variant responses to survey questions, and (f) practice in conducting interviews.

Immediately after the close of the experimental period, the principal investigator met with the caseworkers who participated in the experiment. During this meeting the caseworkers completed a questionnaire respecting their reactions to the project and were interviewed as a group in an open discussion that was audiotape recorded and later transcribed.

The principal investigator also met with the agency’s supervisors and administrators in an open discussion of their reactions to the experimental project. The discussion was tape recorded and later transcribed. Each of the caseworkers associated with the experimental group completed a demographic survey developed by the principal investigator.

Case history, service, and referral history information were obtained from the agency’s databases for each person in the experimental group and each in the control group. The specific reports used were (a) child abuse/neglect (CAN) report, (b) CAN registry name search, (c) CAN investigation display, (d) client name search, (e) client status and eligibility history, (f) client direct services, (g) purchase services, (h) review/update case action completion dates, (i) child-in-custody custody history, (j) child-in-custody placement history, and (k) client payment history by service date.

Interventions

During the period between referral and case determination (usually 30 days), families in the control group received the services customarily provided by the investigative unit of the agency, whereas those in the
experimental group received both investigative and family preservation services. The latter services were provided by a pair of caseworkers—a CPS investigator teamed with an FPS caseworker.

Although the two workers in each experimental team usually visited the family together, they had unique roles. The CPS investigator determined whether the allegation of abuse or neglect could be substantiated, assessed ongoing risk of harm to the children, and protected the children as warranted. Simultaneously, the FPS worker engaged the family in problem-solving counseling, skills training, and in developing a network of formal and informal supportive resources. Because of the greater involvement of the FPS worker, the CPS worker was generally able to manage a small number of regular CPS cases in addition to the experimental cases, but care was taken to ensure that these cases were not included in the control group.

At the end of the investigative period, the team pooled their knowledge in making a case determination. In the few cases where joint decision making was difficult, the respective supervisors joined the caseworkers in deciding the disposition of the case.

The flexibility of the model permitted the workers and supervisors with the experimental group to adjust the level of involvement with the families to match the level of need. The total number of hours of service provided each family in the experimental group ranged from 1 to 62, with a mean of 14 hours (compared with 0.2 to 19 hours, with a mean of 5.6, for the control group).

Two units from the agency were designated by the director to participate in the study—one CPS unit, the other FPS. Six CPS and six FPS caseworkers were teamed to provide the experimental services. Eight were female, four male. The mean age was 30 years. Each held at least a bachelor’s degree in social work or related field, and all had at least 2 years experience in child welfare.

Caseworkers with the experimental group received training prior to the study, at its outset, and throughout the study. Prior to the study, the CPS and FPS caseworkers completed the Comprehensive Competency-Based Inservice Training of the Child Welfare Core Curriculum developed by the Institute for Human Services of Columbus, Ohio. In addition, the FPS workers received the family preservation training of the Homebuilders Program prepared by the Behavioral Sciences Institute of Federal Way, Washington.

At the outset of the study, all team members participated in an intensive 1-day training session, and throughout the course of the project the caseworkers received both informal and formal in-service instruction. Informal instruction was provided frequently in conjunction with weekly staff meetings, whereas formal instruction was provided on a quarterly basis by
administrative staff of the agency and by the principal investigator. Topics for
the formal instruction included (a) description of the study and reporting
responsibilities, (b) criteria for decision making, (c) CPS investigative pro-
cedures, (d) identification and use of formal and informal support mechanisms
for the families and accessing resources, and (e) specialized training on crisis
intervention and the combining of CPS and FPS. The sessions provided
team-building opportunities as workers practiced new skills using each other
as simulated families. In all, 16 caseworkers provided the comparison ser-
dices. These workers each had received the core child welfare training
(described above) required of all in the unit.

RESULTS

To evaluate the effectiveness of the CPS-FPS team approach, the experi-
mental and control groups were compared on measures of family function-
ing, the results of the case determination, and on their interactions with the
agency. The caregivers were interviewed to assess the effects of the experi-
mental services. Caseworkers were interviewed for their reactions to the
model and for comments as to its possible adoption. Of the 208 families in
the original sample (97 experimental and 111 control), attrition (through mov-
ing, inability to locate, and refusal to participate) reduced the sample inter-
viewed to 65 experimental families (67.0%) and 60 control families (54.0%).

Findings—Families Who Participated in the Study

In-home status of children. At the end of the follow-up observation period,
there was no significant difference between the groups as to the number of
children found in their homes ($p = .338$). However, in those cases where chil-
dren were removed, the children in the experimental group were more likely
to return to and remain in their homes for longer periods ($p = .008$) (see
Table 1).

Investigation findings and disposition. There was no significant differ-
ence between the groups in terms of investigation findings—“unfounded”
versus “substantiated” ($p = .866$).

Services provided. In general, families in the experimental group more
often used the available services than did those in the control group. For
example, 44.4% of the families in the experimental group used informal
support compared with 29.3% for the control group, and 41.3% of the experimental families used family support versus 27.6% for the control. When the number of services received per group was summed (and a weighting applied to the disparate ns for the two groups), the experimental group used 14.3% more services, but the difference was not significant ($p = .10$).

**Parental attitudes.** Based on the Hudson Index of Parental Attitudes (W. W. Hudson, 1982), it was determined that more parents in the experimental group had clinically significant problems as measured by their own perception of their parent/child relationships and their attitudes about being a parent (14% vs. 7% in the control group). The reason for this difference is unclear, but it should be noted that more parents from the experimental group agreed to be interviewed.

One-third of failed interviews were due to the parents’ refusal to cooperate. Of those, 75% were from the control group and 25% from the experimental group—clearly a difference but not statistically significant ($p = .081$).

Parents from the experimental group, regardless of their problems, were more cooperative with interviewers; hence, their difficulties were more likely to become a part of the findings. In any case, the observation that more parents were struggling with significant parenting problems may, in fact, make the other findings more meaningful (i.e., the success of the families in the experimental group came despite a greater number of problems). It might also be speculated that the intensive FPS intervention for the experimental group contributed to their willingness to be interviewed.

**Consumer satisfaction.** Although both groups of caregivers described the family situation as improved over what it had been at the time of referral

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**TABLE 1: In-Home Status of Children**

<table>
<thead>
<tr>
<th>Group</th>
<th>Experimental</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of children in home at end of observation period</td>
<td>87.6 (n=97)</td>
<td>82.9 ($^a$) (n=111)</td>
</tr>
<tr>
<td>Mean days home following out-of-home placement</td>
<td>117.16 (n=19)</td>
<td>43.29 ($^b$) (n=17)</td>
</tr>
</tbody>
</table>

$^a df = 1, \chi^2 = .919, p = .338$

$^b df = 34, t = 2.832, p = .008$
(70.8% of the experimental and 68.9% of the control), caregivers from the experimental group were more satisfied with the workers and the services received \((p = .007)\). They were more likely also to view the services as helpful \((p = .010)\), more likely to evaluate their caseworkers as competent and organized \((p = .042)\), and scored the caseworkers higher on a composite rating scale \((p = .028)\) (see Table 2).

When asked what was most helpful about agency involvement, caregivers in the experimental group most often indicated “therapeutic intervention” (20%), “referrals to other services” (16.9%), and caseworkers’ willingness to “educate and explain” (16.9%). By contrast, caregivers in the control group more often responded with “nothing” (29.5%).

As to their opinions of the least helpful activity, the groups were about equal on “general dissatisfaction” (23.1% for the experimental vs. 24.6%), “ineffective follow-up” (21.5% experimental vs. 23%), and “nothing” (21.5% vs. 23%). Interestingly, 12.3% of those in the experimental group expressed regret over when the services ended (that is, they wished them prolonged), contrasted with 1.6% of the control group.

When invited to suggest improvements in the services, caregivers from the experimental group most often suggested “better follow-through” (23.4%), expressed “general dissatisfaction” (19.1%), or recommended “better communication within the agency” (17%). The other (control group) caregivers most often listed “general dissatisfaction” (31.6%), “better follow-through” (26.3%), and “better communication within the agency” (15.8%).

<table>
<thead>
<tr>
<th></th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Experimental (%)</td>
</tr>
<tr>
<td>Satisfied with worker and services</td>
<td>78.2</td>
</tr>
<tr>
<td></td>
<td>((n = 55))</td>
</tr>
<tr>
<td>Counseling helpful</td>
<td>78.8</td>
</tr>
<tr>
<td></td>
<td>((n = 52))</td>
</tr>
<tr>
<td>Worker competent and organized</td>
<td>87.5</td>
</tr>
<tr>
<td></td>
<td>((n = 64))</td>
</tr>
<tr>
<td>Worker evaluation high</td>
<td>80.0</td>
</tr>
<tr>
<td></td>
<td>((n = 65))</td>
</tr>
</tbody>
</table>

a. \(df = 1, \chi^2 = 7.324, p = .007\).

b. \(df = 1, \chi^2 = 6.675, p = .010\).

c. \(df = 1, \chi^2 = 4.140, p = .042\).

d. \(df = 1, \chi^2 = 4.833, p = .028\).
Additional referrals. A search was made of case history records and agency databases to determine the number of additional referrals during the 6 months following the investigation. There was no difference between the two groups: 11.3% of the experimental families and 11.7% of the control families had additional referrals.

Major crises during follow-up period. In responding to the interviewers, twice as many caregivers from the experimental group reported no major crises during the follow-up period (16.7% compared with 8.0% in the control group). For the remaining 83.3% in the experimental group and 92.0% in the control group, the crises reported most frequently were emotional or behavioral problems of children, followed by removal of a child from the home and involvement in the legal system. Other significant events were marriage and remarriage, custody battles, domestic violence, fighting allegations of child abuse, employment that precluded involvement with children, and the follow-up interview itself.

Findings—Caseworker Opinions

Twelve caseworkers participated in the project. They completed a questionnaire individually and were interviewed as a group. Because of the small number, no attempt was made to quantify their responses.

Opinions regarding the experimental project. Regarding the experimental project, caseworkers generally liked (a) working as a team, (b) working longer with the families, (c) being able to put services in place more quickly, and (d) the therapeutic aspect of CPS involvement. They did not like (a) having insufficient time to accomplish therapeutic goals with some families, (b) not feeling needed when families did not want intensive involvement, and (c) working with families whom they considered inappropriate candidates for FPS.

Opinions regarding the CPS-FPS team approach. Caseworkers appreciated the team involvement. Mentioned frequently were (a) liking complementary roles, (b) better decision making, (c) more effective interventions, (d) feeling safer, (e) learning from each other, and (f) enhanced morale.

Recommendations. For continued use, caseworkers recommended the experimental model (a) be used more selectively, (b) provide more flexibility by allowing more time for some cases, (c) have more follow-up services available, (d) provide more cash assistance for families’ immediate needs, (e) allow team members to choose their partners, and (f) provide many more teams. A few of their comments follow.
I cannot say enough good about the project and its positive effects on my job satisfaction. I have been working in child protection for several years now and have spent much of that time debating whether or not to go out and find a new job. The field of child protection is a very stressful, crisis-oriented field, which leads to a quick burnout rate. As a result, child protective service agencies find themselves in a constant state of flux needing to hire and train new workers. Yet the decisions and responsibilities that rest on the shoulders of these workers demand highly trained and experienced workers. I feel the administration would do well to spend more time ensuring the job satisfaction of their frontline workers. (CPS caseworker)

The factors that have contributed to my increased job satisfaction while working on the project are many. My case load is lower, thus enabling me to spend more time with the clients I do have. I am better able to help them follow through with the services they need to access. I have also found that I am even more focused on the family strengths model. I am able to carry that attitude over to my non-project cases, thus empowering the families of our community. In this way I feel I am truly “saving the family for the children” rather than “saving the children from the family.” (CPS caseworker)

Another CPS caseworker expressed the sentiment, “I couldn’t go back to doing CPS the other way!”

**DISCUSSION AND APPLICATIONS TO SOCIAL WORK PRACTICE**

The implications from the findings for practice and policy include recommendations for continued use of the model, with some modifications. However, there were limitations to the study, and further research is needed.

There were four obvious limitations to the experimental design: (a) The principal investigator was unable to isolate the caseworkers in the experimental group from those in the control group; (b) the director favored the experimental treatment and his bias was well known; (c) the general attitude of the agency was to strengthen families; and (d) adherence to the randomization protocol obliged provision of the experimental services to some families that were unlikely to benefit from the special attention while denying such to others who might. Acknowledged as limitations to the design, each of the above likely blurred the distinctions between the services provided the two groups, reducing the chances of obtaining statistically significant differences between the groups.

Notwithstanding the limitations, the findings support a broader implementation of intensive family-based services in combination with CPS investigations. The model provides a family-strengthening focus as well as a format for more effective decision making in CPS investigations. CPS
investigators and FPS workers, as well as the families served, were positive in their attitudes regarding the experimental model. This collaborative approach may require a broader training for all frontline caseworkers, investigative as well as FPS workers. Members of both groups would likely profit from the opportunity to study and, where appropriate, adopt the orientation and techniques of the other. If, for practical reasons, representatives of both orientations cannot, as a team, be dispatched on every referral, perhaps a “hybrid worker” could be developed. Over time, it seems likely that investigators who tire of “always being the bad guy” would find greater satisfaction in their work.

Although the findings support continued use of the model, modifications may be in order. Modifications (based primarily on reports from caseworkers) might include (a) more careful screening of the families to receive intensive services, (b) greater flexibility in the services to be provided, and (c) a variety of possibilities in the structure and function of the CPS-FPS teams.

In addressing the screening issue, it should be noted that the rigors of a formal program evaluation (e.g., systematically assigning alternating incoming referrals to the experimental group) precluded the kind of flexibility that is consistent with competent practice in providing intensive family-based services. Although specific correlates for successful intervention with FPS programs have not yet been adequately identified, it seems clear that caseworkers’ personal involvement and experience give them credibility in determining which families would most likely benefit from the intensive services. It might be appropriate for policies and guidelines to be loosely structured in order to empower caseworkers and their supervisors to make those screening decisions. If this were done, however, caseworkers would likely need more information about the families than is normally provided at intake. Targeting the right families for intensive services is an ongoing challenge and an area particularly appropriate for further research (Denby, 1995).

Furthermore, regarding screening, many families will likely be able to remain together successfully without intensive intervention. Also, some families with serious problems will not be able to remain together regardless of the intensity of the intervention. Policy guidelines for screening should address procedures for targeting those families who will be able to remain together only if they receive intensive treatment (Denby, 1995).

In this study, the flexibility of the experimental program was limited, in part, by the 30-day time frame for CPS investigations. The intervention was designed to aid in the decision-making process and, by agency policy, a decision was expected within 30 days. Ordinarily, FPS programs are brief and time limited; however, the outcome of the intensive services may likely improve for some families if those services were extended beyond 30 days.
For efficient allocation of resources, lengthening the period of service for some families might be offset by shortening or eliminating altogether the intensive intervention for families who may not be appropriate candidates or who may be more resourceful and able to be strengthened without intensive intervention. For those families who require more than a 30-day intervention there should be a continuity of services with the same caseworkers involved from the time the case is opened until it is closed, or until satisfactory permanency plans are in place.

The structure and function of the CPS-FPS teams were specifically defined and maintained throughout the experiment. This was a requirement of the controlled study. However, in the future, those teams may function more effectively if given more flexibility. For example, in some cases, equal involvement of the two workers was needed; but with others, the CPS investigator was required only for a short period of time or for less intensive involvement.

Flexibility is a prominent theme in the implications of the study. In fact, it appears that additional flexibility would complement the nature of certain FPS workers to go above and beyond the call of duty in some cases. Although it is difficult to specify an adequate job description or set of criteria for this particular brand of social worker, clearly required is a set of personal values that drives the worker to be intensely and intimately involved in the lives of struggling families. Of particular note, it was learned that many of the case-workers (approximately 80%) used their personal funds to purchase items of critical need for families in emergency situations (e.g., diapers, food, or warm clothing) when agency resources were not available immediately. Although they were later reimbursed, that reimbursement was not assured at the time they made the decision to use their personal funds.

Several follow-up studies are indicated by the findings. Four examples are provided. First, families in both groups should be followed for at least another year to determine the lasting effects of the intervention. For example, it would be meaningful to know whether the group receiving the intensive services differed from the control group with respect to additional referrals for abuse or neglect.

Second, another study is needed using a different method of targeting families for intensive services. In the current study, only moderate- and high-risk cases were included in the sampling pool. The rationale for that decision was that the families with children at greatest risk are most likely to require services and are also likely to benefit most from intensive family preservation services. However, immediate risk may not be the best criterion for determining which families should have the services provided and which families will benefit most from the services. For example, sexual abuse cases in which the
perpetrator does not have immediate access to the victim are generally classified as low priority. However, these families may be excellent candidates for intensive services. Although the variables may be difficult to measure, it would be beneficial to implement a study in which caseworkers and supervisors were empowered with a greater variety of decision-making options and a wider range of service possibilities.

Third, additional kinds of family-strengthening interventions should be explored. FPS programs are designed to be as comprehensive and flexible as required for a given situation; however, the range of service options may still be somewhat limited. For example, the repertoire of service options might be expanded to include the relatively new concept of family group conferences (J. Hudson, Morris, Maxwell, & Galaway, 1996; Marsh & Crow, 1998) involving the extended family in the decision-making and treatment processes.

Fourth, the cost-effectiveness of the intensive services should be explored. It is difficult to compare the cost of one service delivery model with another. Nevertheless, if children are more likely to remain in their homes, resolution would be faster and out-of-home placements reduced—producing cost savings to the agency. The real, long-term cost savings would be realized as families are strengthened, increasingly fewer services are needed, and the pattern is transmitted to future generations.

Based on the findings it was concluded that (a) the experimental services seem to have positively affected the families involved; (b) insights on family functioning provided by the FPS workers aided in effecting viable case determination plans; (c) both the CPS and FPS workers in the teams were supportive of the enhanced model; and (d) families who received the intensive services were more satisfied with the involvement of the caseworkers and the agency in their lives. Given the supportive involvement of caseworkers, it should not be surprising that families were satisfied with the experimental services. However, given the history of child welfare services, it is reassuring to know that dissatisfaction with CPS involvement does not have to be the norm.

During the 1970s and 1980s, the popularity of family preservation services reached overkill, and FPS was touted as the panacea for many of the needs in child welfare. Not surprisingly, but most regretfully, mishaps occurred and some children receiving family preservation services were harmed. As overzealous caseworkers scrambled to defend a plethora of programs somehow subsumed under the FPS rubric, and without thoughtful consideration of how FPS might reasonably be included in a continuum of child welfare services, support for FPS programs waned and in some instances vanished. The question at issue ought not to be whether FPS
programs are effective, but rather, which services are most helpful for which families at what point on the service continuum?

As demonstrated in this study, when reasonable and thoughtful effort is expended to invest in families, then the children, the families, the caseworkers, and the public all benefit. By providing concentrated and comprehensive services from the moment of referral, many families can be helped to work out their problems in minimally intrusive ways that strengthen family functioning, provide for an enhanced network of supportive resources, and reduce the likelihood of out-of-home placement, without endangering the lives of children.

REFERENCES


An Evaluation of
Men’s Batterer Treatment Groups

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Objective: Fifteen treatment groups for men who abused intimate partners were evaluated. Method: 104 men took part, with a completion rate of 68.3%. Scores on social desirability were utilized to adjust totals on other self-report scales. Results: Group completers (n = 71) were no different from dropouts (n = 33) on the adjusted standardized measures or demographics. Group completion was associated with significant improvements on the adjusted variables of appraisal social support, self-esteem, perceived stress, attitudes toward marriage and the family, locus of control, and the marital relationship functions of roles, affective expression, and communication. Importantly, adjusted scores on both the Physical and Non-Physical Abuse subscales of the Index of Spouse Abuse were significantly reduced, the latter to below the clinical cutoff. No differences were found between court-mandated and non-court-mandated group completers. Conclusions: The utility of using social desirability to adjust scores is highlighted. The implications for group treatment are discussed.

With the acknowledgement that woman abuse is a serious problem in North America, treatment approaches for male perpetrators have proliferated, although not without considerable debate (Edleson, 1996; Edleson & Tolman, 1992; Gondolf, 1987; Gondolf & Russell, 1986). As early as 1984,
Feazell, Mayers, and Deschner identified 154 American programs for men who batter, while Pirog-Good and Stets-Kealey (1985) heard from 59 agencies that offered such programs. The number of batterer treatment programs across the continent has mushroomed since then. Social workers have often been central in the design, implementation, and evaluation of such programs.

Most authors advocate group treatment as offering the widest range of benefits for men who abuse their intimate partners (Edleson, Miller, Stone, & Chapman, 1985; Edleson & Tolman, 1992; Gondolf, 1985b; Pence & Paymar, 1993; Saunders, 1984). Edleson and Tolman (1992) suggested that group programs are less threatening than individual or couple therapy, reduce social isolation, and offer peer support. Saunders (1984) proposed that group programs can be helpful in teaching men that they are not alone and that others share the same problem. Furthermore, group members can often challenge others as directly and powerfully as the group leaders because they are aware of the patterns and the rationalizations that underlie abusive beliefs.

Although group treatment of men who batter their partners has been almost uniformly adopted as the major treatment modality for this population, there are variations in the group focus and style of intervention. Stordeur and Stille (1989) outlined three somewhat overlapping styles of groups for male batterers: anger management, psychoeducational groups, and coordinated community intervention.

Leaders of anger management groups utilize behavioral techniques such as relaxation therapy, cognitive restructuring, and anger logs to assist participants to learn to control angry feelings so that these do not become aggressive actions. The goals are to learn to reduce stress, to learn to accurately identify feelings, and to learn how to resolve conflict without resorting to violence. The exclusive use of anger management techniques has been criticized by Gondolf (1985a) and Gondolf and Russell (1986) for a lack of empirical support and because the connection between anger and wife abuse has not been conclusively formulated. Pressman (1989a) was concerned that although physical abuse may end, verbal abuse may continue. Nevertheless, anger management techniques are commonly integrated into other group formats.

Edleson and Syers (1990) described psychoeducational groups as relying heavily on lectures, videotaped and role-played demonstrations, and short group discussions, with the leader seen as a teacher. Similar to the previously described social learning perspective of anger management groups, the rationale for psychoeducational groups is that if violent behavior by men is learned and socially reinforced, changing this behavior requires reeducation rather than psychotherapy. The balance between education and group interaction tends to vary widely among different psychoeducational programs.
Across models of intervention with male abusers, the ideal is that men receive treatment as part of a range of services offered to both them and family members who have been affected by the abuse. These coordinated community interventions refer to men’s groups that are offered as one aspect of a larger community effort to reduce family violence. The groups may be associated with battered women’s shelters, women’s support groups, and groups for children who have witnessed family violence (Pressman, 1989b). In adopting this model, Pressman (1989a) recommended using feminist-informed counseling groups for both men who batter and their partners. The theoretical framework recognizes the impact of the social, political, and economic context, as well as attitudes and gender roles, on establishing conditions that condone men abusing their spouses. The primary goal in such men’s groups, to assist participants to take responsibility for their violent behavior and to learn more appropriate ways of expressing their feelings, is similar to the other models previously described.

Edleson and Syers (1990) described a fourth style of group format, self-help groups for male batterers, developed on the basis of the success of such widespread movements as Parents Anonymous. Their research suggested, however, that the self-help groups were significantly less effective than either educational groups or combined educational and self-help formats. Fully 64.3% of the self-help group members were reported (by partners) to have been violent at the 6-month follow-up and 73% to have used “terroristic” threats. In comparison, only 20% of the men in the education group and 26% of the men in the combined groups were reported violent at the 6-month follow-up.

A relatively novel focus was offered by Pressman and Sheps (1994), whose groups for men draw on a wide range of theoretical models, including a strong feminist view of woman abuse. This is the model evaluated in the current research. The men are provided with “affective education [that] helps them to resolve their childhood traumas, provides a therapeutic group environment for learning new problems solving skills, and, above all, emphasizes their ending violent and controlling behaviors” (p. 477). The rationale for this focus is a concern that men’s treatment has neglected to incorporate either an understanding of men’s trauma histories and the resulting shame, or the cultural, sociopolitical context that influences men’s attitudes and gender roles, establishing conditions that condone men abusing their partners (Pressman, Cameron, & Rothery, 1989). With research identifying that a high proportion (50% to 80%) of men who abuse their intimate partners were themselves witness to their mothers being abused by fathers or were physically abused by them (Tutty, 1999), men may react violently in situations in which they lack
control or feel powerless. Nevertheless, it is important that this not be construed as an excuse for abusive behavior.

A central component of these groups is family-of-origin therapy to allow group members to reflect on their early experiences of violence (Sakai, 1991) in the hope that they may more readily identify and empathize with their partners’ experiences. Connecting with the pain of their childhood trauma and verbalizing vulnerable emotions such as sadness, fear, and hurt in group sessions is one step toward learning new ways to see and interact in nonviolent ways with their families. Throughout the group process, partners are contacted and any incidents of violence or controlling behavior are brought to group and take precedence over any other agendas. As mentioned earlier, these groups are offered as one aspect of a coordinated community response to woman abuse, with concurrent support groups for abused women.

It should be clear by this point that the differing format and goals of men’s treatment groups are not mutually exclusive and that elements of various styles of group are often combined. Nevertheless, although program models may not have identical priorities, this review indicates that a number of treatment objectives are common, many of which are well represented in the programs evaluated in this study. The most frequently utilized goals are to bring an end to the violence, to increase the member’s sense of responsibility for his abusive behavior, to foster improved problem-solving skills as alternatives to aggressive behavior, to assist batterers to identify and express their feelings, especially anger, to reduce member’s isolation, and to develop better communication skills (Edleson et al. 1985; Gondolf, 1985b). Jennings (1990) divided these primary treatment objectives into behavioral and attitudinal categories, which, he argued, more adequately acknowledge the complexity of the expectations for change placed on assaultive men and the group leaders who offer treatment.

**Outcome Research on Groups for Perpetrators**

In 1990, Geffner and Rosenbaum noted that relatively few evaluations of the men’s group treatment programs had been reported in the literature. In 1997(b), Gondolf counted 30 published single-site program evaluations in total, many with methodological shortcomings such as exploratory research designs. The most important outcome criterion remains whether physical violence ceased during and after the group. Studies have consistently described violence decreasing for a proportion of men immediately postgroup (54% in Edleson et al., 1985; 61% in Shupe, Stacey, & Hazelwood, 1987; 67% in Edleson & Grusznski, 1989) and at follow-up 4.5 months to 1 year after completion of the group (in 55% to 67% of the men in Edleson &
Grusznski, 1989; Shupe et al., 1987). In their reviews, Edleson and Syers (1990, 1991) found that shorter, more structured groups were more effective, with less partner-reported violence or threats of violence reported at 6-month and 18-month follow-up.

Few of the reviewed studies measured whether the cessation of physical violence corresponded with the development or the continued use of other, less direct forms of abuse such as verbal and sexual harassment, or overcontrol of the wife’s behavior. Researchers such as Follingstad, Rutledge, Berg, Hause, and Polek (1990) have written that psychological abuse including threats to harm the partner, children, or pets, or intimidating and degrading remarks can have as negative an impact on partners as physically violent acts. Edleson and Grusznski (1989) found, significantly, that whereas physical violence decreased, verbal abuse including threats remained problematic for 36% to 43% of women in two follow-up studies. In contrast, Russell and Jory (1997), who studied the efficacy of a group format with 45 abusive men and a comparison group of 16 nonabusive men found that group participation was associated with reduced psychological abuse. Physical abuse, low to begin with, did not significantly change, nor did self-esteem. Gondolf (1987) has also emphasized the need to measure indirect forms of abuse.

A major concern in evaluating the efficacy of men’s programs for partner abuse has been the suspicion that the men minimize and deny their abusive behavior, as has been identified in some studies (Palmer, Brown, & Barrera, 1992; Szinovacz & Egley, 1995). Such denial raises questions about the use of self-report scales, supporting more objective measures such as recidivism rates. Chen, Bersani, Myers, and Denton (1989), who looked at recidivism as measured by police rearrests, concluded that the number of group sessions attended has a significant impact on whether the group was effective on this variable. They found that men who attended fewer than 75% of the sessions were significantly more likely to be rearrested for assault against their spouses after the group, suggesting that it is important to collect data on group attendance. Similarly, both Palmer et al. (1992) and Dutton (1986) found significantly higher recidivism rates (police reports) on men in control conditions compared with those who had completed men’s groups.

Saunders (1996) compared the characteristics of men with a history of partner abuse in relation to two group approaches. He randomly assigned 218 men to either feminist cognitive-behavioral or process-psychodynamic groups. The recidivism rates and partner reports 2 years postgroup for the 136 men who completed the programs (a dropout rate of 38%) did not differ depending on the group model, nor were they expected to. However, better outcomes were reported for men with antisocial personalities in the feminist
cognitive-behavioral groups. Men with dependent personalities did better in the process-psychodynamic model.

A recent study (Gondolf & Associates, 1998) compared four batterer intervention programs, finding no differences between the treatments at 15 month follow-up on such variables as reassaults, rearrests, or the victim’s quality-of-life satisfaction. Interestingly, there were no differences between the two groups that lasted only 3 months and another that was conducted over 9 months. Furthermore, those who completed the programs were significantly less likely to reassault than dropouts, even when controlling for demographic characteristics.

When possible, it is recommended that researchers use partner reports or the congruence of the two partners’ scores as more valid indicators of the extent of the abuse or the effectiveness of the group (Gondolf, 1985a, 1987; Petric, Gildersleeve-High, McEllistrem, & Subotnik, 1994). However, obtaining reports from victims may not only be difficult (Edleson & Syers, 1990) but may place women at risk for further abuse (Petric et al., 1994). Furthermore, men may no longer be in relationships with their partners (Palmer et al., 1992). An alternative strategy to ensure the validity of the men’s reports is to collect data on social desirability, measuring the extent to which individuals are attempting to “look good” and using this as a context within which to interpret self-report data (Saunders & Hanusa, 1986).

Researchers have utilized outcome measures other than cessation of physical abuse or recidivism, although, because physical violence reportedly continues in one third to one half of the group members’ relationships (Gondolf & Associates, 1998), this factor is obviously critical to monitor. Other relevant variables that have been included in outcome research on the characteristics of male batterers and the efficacy of men’s treatment include anger (Hamberger & Hastings, 1988; Saunders & Hanusa, 1986), depression (Hamberger & Hastings, 1988; Saunders & Hanusa, 1986), attitudes toward women (Grusznski & Carrillo, 1988; Poynter, 1989; Saunders & Hanusa, 1986), self-esteem (Faulkner, Stoltenberg, Cogen, Nolder, & Shooter, 1992; Russell & Jory, 1997), locus of control (Faulkner et al., 1992), need for control (Petrik, Petrik Olson, & Subotnik, 1994), and assertiveness (Faulkner et al., 1992).

The fact that violence against women occurs primarily in the context of intimate relationships and that a large proportion of men cohabit with partners while attending the treatment groups suggests that positive changes in the dynamics of the marital dyad may be an appropriate outcome variable (Barrera, Palmer, Brown, & Kalaheer, 1994). Measures of the spouses’ interaction patterns after participation in a group may demonstrate whether the
changes claimed by group members generalize to the marital relationship (Poynter, 1989; Rynerson & Fishel, 1993).

One of the key questions about batterer treatment programs is the extent to which court-mandated men benefit or do not benefit. Traditionally, involuntary clients are seen as poor risks for counseling as they appear to have little personal motivation to change. Feazel et al.'s (1984) study suggested that even non-court-mandated men tend to be sent to groups by spouses or by shelter workers more often than being self-referred. This implies that denial and minimization may be common to virtually every batterer who requests help. Chen et al. (1989) found that almost 37% of the men in a court-mandated treatment program attended fewer than 75% of the sessions. Hamberger and Hasting's (1988) research reported that 22 of 36 dropouts were court- or probation-mandated men. The results of these studies suggest that men who are court mandated may be no less involuntary than other group members. Second, unless courts are willing to consistently respond to breaches in court-mandated treatment, this method of ensuring attendance will not be effective. Nevertheless, treatment may be successful for court-mandated men who complete the groups as is illustrated by the research of Edleson and Syers, whose 1991 empirical comparison of six treatment conditions found, at 18-month follow-up, that men involved with the courts had lower levels of violence than voluntary group members.

In a recent overview of the research on men's treatment groups, Gondolf (1997a) noted that there is no firm evidence for their efficacy because of methodological limitations and the exploratory nature of most of the research designs. He did, however, conclude that at this point the success rates of batterer programs are comparable to others such as drunk driving, drug and alcohol, and sex offender programs. Nonetheless, because many women remain living with potentially dangerous partners in the hope that they will change as a result of group treatment (Gondolf & Russell, 1986), it is essential to assess the efficacy of interventions with male batterers, particularly models that differ from the commonly offered anger-management and cognitive-behavioral approaches.

**METHOD**

**Perpetrator Treatment Group Model**

Three agencies within Kitchener-Waterloo, Cambridge, and Guelph, Ontario, Canada offered perpetrator treatment groups using the model
described by Pressman and Sheps (1994). The agencies were members of the Coordinated Family Violence Treatment Network, which also offers support groups for battered women (Tutty, Bidgood, & Rothery, 1993, 1996). Ten of the men’s groups were closed-ended, ranging from 10 to 12 weeks duration with sessions ranging from 2 hours (for 12-week groups) to 3 hours (for 10-week groups). Five groups were open-ended, recruiting new members as spaces became available. Although there was more emphasis on process in these groups, the formally stated objectives did not differ substantially from their closed-ended counterparts.

The group leaders were primarily social workers. The professional qualifications of other leaders included marriage and family therapists and counselors with special training in family violence. The majority of groups (11) were led by female and male cotherapists, teaming a more senior with a less formally trained leader.

The men were referred from a variety of sources including the courts, probation and parole services, counseling agencies, shelters, hospitals, child protection services, and physicians. Group members were charged a fee ranging from $0 to $20 per session (calculated on a sliding scale dependent on income). Each man was assessed for 1 to 2 hours by one of the group leaders. Whenever possible, both perpetrator and partner (who may have been considering participating in the women’s support groups also offered by the agencies) were seen together by a team including a male treatment group leader and a female support group leader. The assessment topics typically included the frequency, duration, and severity of abuse, family of origin violence, methods of coping with anger and frustration, and assessment of motivation for change. Individuals were excluded from group membership for substance abuse, psychosis, and refusal to accept responsibility for violent behavior. Unfortunately, no data on the number of men excluded from the groups were available. Once assessed, the men were typically put on a waiting list for anywhere from 3 to 6 months. There were no formal provisions for keeping in touch with those on the waiting list; however, in one location therapists telephoned potential members once a month and in another, waiting-list members were sometimes linked with a past treatment group graduate.

Measures

Group members completed an assessment package at three points (pre-test, posttest, and 6 month follow-up) to estimate change over time. In addition, the group leaders rated each group participant on Likert-type scales that corresponded to the self-report outcome measures at the beginning and completion of group (pretest and posttest). The group leader ratings were an
attempt to provide additional evidence to validate the men’s self-reports of change.

The assessment package was compiled in response to the terms of reference for the study, dictating that the data should be collected by pencil-and-paper self-report instruments. The package included both measures on outcome measure hypothesized as important in the terms of reference and additional variables that were identified as critical considerations from the literature on intimate partner assault interventions.

The assessment package included a section on demographic information (age, income, marital status, family configuration), program involvement (sessions attended, sessions missed, recontracting), and an array of outcome measures that are outlined below.

**Social support and social isolation.** The Interpersonal Support Evaluation List (ISEL), developed by Cohen, Mermelstein, Kamarck, and Hoberman (1985), measures four areas of social support: tangible, appraisal, self-esteem, and belonging. The version adopted for this study is a four-alternative ISEL with a self-esteem subscale removed to prevent redundancy with the Coopersmith self-esteem scale. The authors of the instrument cite numerous studies that have reported that the measure possesses good internal consistency for each of the subscales (Appraisal, .70-.82; Belonging, .73-.78; Tangible, .73-.81; Self-Esteem, .62-.73) and adequate test-retest reliability (Cohen, 1985). ISEL subscale scores range from 0 to 30, with higher scores representing greater social support.

**Locus of control.** Rotter’s (1966) Internal-External Control Scale (I-E scale) measures the degree to which an individual perceives reinforcement as contingent upon his actions. The original instrument contained 29 forced-choice items and was reported to possess adequate internal reliability and test-retest reliability. A number of authors have conducted further factor analyses on the I-E scale. In particular, Feldman (1983) expanded on the work of Mirels (1971) and found that one factor of the I-E scale (personal control) was instrumental in differentiating between subcategories of abused women—those who remain in abusive situations and those who leave. In light of this information, the personal control factor used by Feldman (1983) was adopted for use in this study. Scores range from 0 to 9, with higher scores indicating more external locus of control.

**Self-esteem.** The Coopersmith Self-Esteem Inventory (SEI) (Coopersmith, 1990) is a commonly used measure of self-esteem consisting of 25 items that clients rate as either “like me” or “unlike me.” Developed
from the psychometrically sound children’s version, the author reports that the adult SEI has acceptable internal consistency (alpha = .81) and is significantly related to other measures of self-esteem (Bedian et al., 1977, as cited in Coopersmith, 1990). Raw scores range from 0 to 25, and are multiplied by 4 for comparison with the published norms. Higher scores signify greater self-esteem.

Perceived stress and coping. Cohen, Kamarck, and Mermelstein’s (1983) Perceived Stress scale measures the degree to which individuals perceive life as uncontrollable, unpredictable, and overwhelming. Conversely, it also serves as a measure of perceived ability to cope with stressful life events. A four-item short form has acceptable internal and test-retest reliability (Cohen et al., 1983). Total scores range from 0 to 12, with higher scores representing greater stress and a diminished belief in one’s ability to cope.

Attitudes Towards Marriage and the Family (ATMF). This scale was designed to measure traditional gender role attitudes in three distinct areas of marital and family life: domestic, social, and sexual (Feldman, 1983). Studies have found that the measure possesses high internal reliability as well as content validity. The validity of the measure has been further established by studies that have found strong positive relationships between the ATMF and the Attitudes Towards Women Scale (Spence, Helmreich, & Stapp, 1975). It consists of 29 items and scores range from 0 to 87, with higher scores indicating a more traditional gender role orientation.

Marital relations. The Family Assessment Measure–Dyadic Relationship (FAM-DR) (Skinner, Steinhauer, & Santa-Barbara, 1983) served as the measure of marital functioning for this study. The seven subscales include Task Accomplishment, Role Performance, Communication, Affective Expression, Emotional Involvement, Control, and Values and Norms. The total scale consists of 42 items—6 per subscale. Raw FAM-DR scores are changed to standard scores (0-100) for each subscale. The scale has cutoff scores indicating strength (scores between 30 and 40), average functioning (40-60), and problem areas (60-70), with higher scores indicating more dysfunction. The coefficient alpha of the total scale is excellent (.95), and those for the subscales are respectable (Skinner, 1987).

Abusive behavior. Hudson and McIntosh (1981) developed the Index of Spouse Abuse (ISA) to assess the magnitude of physical and nonphysical
abuse inflicted against women by their partners. The scale consists of 30 items, 11 referring to physical abuse and 19 pertaining to nonphysical abuse. Total ISA scores and Physical and Nonphysical subscale scores are the sum of the weighted responses expressed as a percentage of the highest possible abuse scores. Higher scores indicate more severe abuse. Clinical cutoff levels are 10 for the Physical Abuse Scale and 25 for Nonphysical Abuse. A factor analysis provided strong support for the factorial validity of the subscales (Hudson & McIntosh, 1981). Alpha coefficients for both subscales are over .90.

Social desirability. Reynolds (1982) developed a 13-item short version (Form C) of the Marlowe-Crowne Social Desirability Scale that has acceptable internal reliability and significantly correlates ($r = .93$) with the original measure. The items were randomly interspersed within the Coopersmith (1990) SEI to mask the scales’ integrity as a measure of social desirability. Scores range from 0 to 13, with higher scores representing greater social desirability.

Client satisfaction. To assess client satisfaction, a three-item scale by Larsen, Attkisson, Hargreaves, and Nguyen (1979) was utilized. The items had been identified by factor analysis as appropriate for a short version global measure of satisfaction. Scores range from 0 to 9, with higher scores representative of greater program satisfaction.

Data-Gathering Procedures

Participants completed the assessment package during the first hour of the initial group session. The members in the open-ended groups were assessed in the same time frame as those in the closed-ended groups for comparison purposes at the initial session and 12 weeks later. The collection of the assessment information was a shared responsibility between the research team and the group leaders; one or both were present to answer questions during the assessment period. The leaders routinely completed their assessments of group members on the same day as or prior to the next weekly session. Posttest assessment procedures mirrored those at the beginning of group treatment.

The group leaders telephoned group members 6 months after the completion of the group program to ask them to complete the follow-up assessment, which was then mailed to them. They also initiated reminder phone calls.
Data Analysis

The data analysis utilized chi-square and independent $t$ tests on the demographic information. All scores on the self-report standardized measures were adjusted according to each member’s total on the Marlowe Crowne Social Desirability test, using the procedure suggested by Saunders (1991). These adjusted scores were then utilized in all subsequent analyses, including independent $t$ tests (comparison of group completers and dropouts at pre-test), dependent $t$ tests (preposttest analysis of changes in group completers; preposttest therapist ratings) and regression analyses (comparison of posttest scores of court-mandated and non-court-mandated group members, with pre-test scores as a covariate).

Because of the number of statistical comparisons utilized in the data analysis, with 16 subscales involved in each analysis, a procedure to control the overall error rate was utilized (Ott, 1984). For tests with one-tailed hypotheses (prepost comparison of group completers; prepost comparison of group leader’s ratings; comparison of court-mandated and non-court-mandated group members), to approximate an alpha of .10, a $p$ value of .007 is necessary to establish statistical significance. For tests with two-tailed hypotheses (comparison of completers vs. dropouts at pretest), to approximate an alpha of .05, a $p$ value of .003 is necessary to establish statistical significance.

Limitations and Strengths of the Study

The major design limitations are the absence of a control group and random assignment to conditions. To date the only published research with a control condition has been Palmer et al., (1992) and Russell and Jory (1997), although Edleson and Syers (1990, 1991), Saunders (1996) and Gondolf & Associates (1998) compared different models of groups. The current exploratory design means that one cannot conclude that any improvements in the men’s scores are attributable to the groups rather than some other intervention (e.g., courts, police, other counseling) or a major life change (e.g., marital separation). Rather, it would be more accurate to assert that client participation in the program was associated with a particular set of outcomes.

Despite this limitation, the current investigation has much to distinguish it as a research initiative in family violence treatment interventions. The scope of the study makes it somewhat unique; the evaluation of 15 groups over 18 months serves as a model of mutual collaboration between researchers and direct service providers. The research is also noteworthy in using scores of social desirability to adjust the self-reported information from the men on the standardized scales, using the procedures suggested by Saunders (1991).
Furthermore, the men completed a broader-than-usual array of standardized measures that provide normative and descriptive data on this population, especially with regard to relationship dynamics beyond the abusive behaviors about which men are typically asked to provide information. This is important, given the relatively high proportion of men (over half) who remained living with their partners.

RESULTS

Demographics

The total sample consisted of 104 men, 80 new and 24 recontracted group members. The men ranged in age from 20 to 58 years with an average of 34.9 years ($SD = 8.9$). Almost 70% (or 62 men) were married or in a common-law relationship. At the outset of the program, 53.8% (or 56 of 96 who answered the question) still resided with their spouses. Of the 37 group members who were separated, 76% (28 men) hoped to reunite with their partners. Eighty-seven percent of the group members were parents. The average monthly income reported was $1,948.20 ($SD = $1,175.82); however, information about this variable was provided by only 55% of the total sample. At the beginning of the group, 4 (4.5%) of the 87 men who answered this question admitted that his spouse had required medical attention within the past month as a consequence of marital violence. Reportedly, none of these injuries necessitated hospital treatment.

The group leaders provided information on the proportion of members who confided that they had experienced domestic violence in their family of origin. Forty-eight men (56.5%) reported some form of violence in childhood: 9 (8.7%) had observed wife assault, 24 (23.1%) had been abused as children, although none sexually, and 2 men (1.9%) had experienced multiple forms of violence. Twelve men noted that their wives had been sexually abused as children and 1 partner had observed wife abuse. As such, the exploration of family-of-origin violence as a focus in group received some support based on the experiences of the group members.

Seventy-one of the 104 participants (68.3%) completed the treatment group, and 64 of these completed measures on both the pretest and posttest assessment. The attrition rate of 31.7% (33 men) is less than would be predicted by the rate of 40% to 60% described by Gondolf (1997a) across several studies, including a rate of 40% from an American national survey (Pirog-Good & Stets-Kealy, 1985). The drop-out rate in the current study is more comparable with the 36% in Grusznski and Carrillo (1988) and the 30%
reported in Palmer et al. (1992) for groups conducted in a nearby Canadian center.

Size and Attendance in Treatment Groups

Each of the groups was convened with less than 10 members, the minimum prescribed membership for a group in the program’s terms of reference. The average treatment group size was 6.7 members (range of 8 to 6). Two groups were initiated with 8 members; four with 7 and four with only 6. A review of the group leaders’ records revealed that in at least half of the groups, anywhere from 1 to 3 clients who were assessed did not actually attend. This proportion is somewhat better than that reported by Cadsky, Hanson, Crawford, and Lalonde (1996), who found that only 41% of the men recommended for treatment attended even a single session, and Rosenbaum (1986), who reported that 50% dropped out prior to session one. Furthermore, every group experienced an attrition of 1 or 2 clients over the duration of the intervention. By the end of the program, the size of the groups averaged 4.8 members (ranging from 7 to 4 members).

The overall attendance rate (66.9%) fell below the previously suggested benchmark figure of 75% (Chen et al., 1989). The attendance rates varied widely across groups. Five of the groups either closely approached or exceeded the benchmark figure. One group fell within the 60% to 70% range. Four of the groups exhibited attendance rates in the 50% range.

Premature terminations were also a significant factor in explaining the attendance rates for treatment groups. In most groups, there were 1 or 2 clients who attended a small number of sessions then dropped out. Nevertheless, in comparison to some other research, the proportion of men who completed the groups (68%) was notable. For example, Cadsky et al. (1996) reported that only 25% of 526 men recommended for treatment completed the 10-week program.

Comparison of Dropouts to Group Completers

In comparing the 71 men who completed the group with the 33 who dropped out, statistical tests of the pretest scores adjusted by social desirability revealed no difference on any of the standardized measures. Furthermore, dropouts were no more likely than completers to be court mandated to attend, to be living with their partner, to wish to reunite, to have a lower income, or to see the violence as being caused by others rather than accepting responsibility.
Comparison of New and Recontracted Members at Pretest

Because groups included both new members \((n = 50)\) and some who had already completed one group and had recontracted for a second \((n = 14)\), it was of interest to examine whether those who had already had one group experience were significantly different from those who were new at pretest. As can be seen from Table 1, the only significant difference between the two subgroups was that the men who recontracted had lower average adjusted scores on Nonphysical Abuse, just above the clinical cutoff level of 25. Notably, the average scores on most of the outcome variables (exceptions being self-esteem, involvement, and value/norms) were more in the desired direction for the men who had recontracted. With only one significant difference, and because we were interested in changes within individuals irrespective of whether members were new or recontracted, these subpopulations were combined for the subsequent analyses.

The Impact of the Perpetrator Treatment Group Program

The summary of group members’ scores on the outcome measures for the pretest and posttest periods is provided in Table 2. Each of these scores was adjusted for social desirability as rated on the Marlowe-Crowne scale. To illustrate the effect of this, before the adjustment the average scores on the Physical Abuse subscales were 21.8 at pretest and 11.9 at posttest. After the adjustment the average scores were raised to 29.2 at pretest and 15.4 at posttest.

With this procedure in mind, the treatment groups were associated with statistically significant reductions in the frequency and severity of abuse as measured by both the Physical and Nonphysical Abuse subscales, representing a high proportion of the variance explained by each. Notably, although most of the men in this study reported the continuation of some abusive behavior at the end of treatment, the average Physical Abuse scores remained above the clinical cutoff, whereas Nonphysical Abuse was reduced to just below the clinical cutoff. Such movement from the clinical into the normal range, especially in conjunction with statistically significant improvements, has been described as representing clinically significant change (Jacobson, Follette, & Revenstorf, 1984).

Treatment group members demonstrated significantly higher social support at the end of group on the Appraisal Support subscale of the ISEL. This analysis supports the premise that the treatment groups were instrumental in diminishing social isolation by significantly altering their appraisal of their
### TABLE 1: Comparison of New and Recontracted Group Members’ Pretest Scores Adjusted by Social Desirability

<table>
<thead>
<tr>
<th>Variable</th>
<th>New Members (n = 50)</th>
<th>Recontracted (n = 14)</th>
<th>t</th>
<th>p</th>
<th>PVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score</td>
<td>SD</td>
<td>Score</td>
<td>SD</td>
<td></td>
</tr>
<tr>
<td>Index of Spouse Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Physical</td>
<td>31.6</td>
<td>11.9 (n = 49)</td>
<td>23.5</td>
<td>10.5 (n = 12)</td>
<td>2.15</td>
</tr>
<tr>
<td>Non-Physical</td>
<td>37.4</td>
<td>15.7 (n = 48)</td>
<td>26.7</td>
<td>4.2 (n = 12)</td>
<td>4.12</td>
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<tr>
<td>Interpersonal Support Evaluation List</td>
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<td></td>
<td></td>
<td></td>
<td>.225</td>
</tr>
<tr>
<td>Appraisal</td>
<td>14.1</td>
<td>6.3</td>
<td>16.4</td>
<td>4.6</td>
<td>1.3</td>
</tr>
<tr>
<td>Tangible</td>
<td>19.4</td>
<td>5.0</td>
<td>21.4</td>
<td>4.3</td>
<td>0.8</td>
</tr>
<tr>
<td>Belonging</td>
<td>15.9</td>
<td>5.8</td>
<td>17.4</td>
<td>5.4</td>
<td>1.3</td>
</tr>
<tr>
<td>Perceived Stress</td>
<td>9.9</td>
<td>1.9</td>
<td>8.8</td>
<td>1.5</td>
<td>2.1</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>29.8</td>
<td>17.5</td>
<td>27.9</td>
<td>11.4</td>
<td>0.4</td>
</tr>
<tr>
<td>Locus of Control</td>
<td>3.2</td>
<td>1.8</td>
<td>4.2</td>
<td>2.1 (n = 13)</td>
<td>1.9</td>
</tr>
<tr>
<td>Attitudes Towards Marriage and Family</td>
<td>29.3</td>
<td>9.5</td>
<td>23.3</td>
<td>11.9</td>
<td>1.96</td>
</tr>
<tr>
<td>Family Assessment Measure</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles</td>
<td>64.0</td>
<td>9.5</td>
<td>63.2</td>
<td>13.1</td>
<td>0.23</td>
</tr>
<tr>
<td>Tasks</td>
<td>64.7</td>
<td>11.4</td>
<td>64.3</td>
<td>12.9</td>
<td>0.88</td>
</tr>
<tr>
<td>Control</td>
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<td>11.7</td>
<td>66.7</td>
<td>11.6</td>
<td>0.39</td>
</tr>
<tr>
<td>Involvement</td>
<td>67.4</td>
<td>10.7</td>
<td>68.8</td>
<td>11.6</td>
<td>0.42</td>
</tr>
<tr>
<td>Affective Expression</td>
<td>69.0</td>
<td>10.1</td>
<td>68.5</td>
<td>11.4</td>
<td>0.16</td>
</tr>
<tr>
<td>Communication</td>
<td>65.7</td>
<td>10.4</td>
<td>65.4</td>
<td>11.9</td>
<td>0.12</td>
</tr>
<tr>
<td>Values/Norms</td>
<td>62.5</td>
<td>11.6</td>
<td>64.8</td>
<td>12.5</td>
<td>0.64</td>
</tr>
</tbody>
</table>

NOTE: PVE = the proportion of the variance explained by the significant statistical analysis.

a. Indicates significance for these two-tailed tests: To approximate an alpha of .05, a p value of .003 is necessary.
### TABLE 2: Changes in Treatment Group Members’ Scores Adjusted by Social Desirability

<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest Mean</th>
<th>Posttest Mean</th>
<th>t</th>
<th>p</th>
<th>PVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Score (SD)</td>
<td>Score (SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Index of Spouse Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical ((n=53))</td>
<td>29.2 (10.9)</td>
<td>15.4 (9.8)</td>
<td>8.6</td>
<td>&lt;.000a</td>
<td>.59</td>
</tr>
<tr>
<td>Non-Physical ((n=52))</td>
<td>36.5 (15.3)</td>
<td>23.2 (10.0)</td>
<td>6.3</td>
<td>&lt;.000a</td>
<td>.44</td>
</tr>
<tr>
<td>Interpersonal Support Evaluation List Total ((n=64))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal</td>
<td>14.6 (5.9)</td>
<td>17.9 (5.0)</td>
<td>4.7</td>
<td>&lt;.000a</td>
<td>.26</td>
</tr>
<tr>
<td>Tangible</td>
<td>19.8 (4.9)</td>
<td>19.8 (5.1)</td>
<td>0.02</td>
<td>.97</td>
<td></td>
</tr>
<tr>
<td>Belonging</td>
<td>16.2 (5.7)</td>
<td>18.1 (5.7)</td>
<td>7.4</td>
<td>.009</td>
<td></td>
</tr>
<tr>
<td>Perceived Stress ((n=63))</td>
<td>9.7 (1.9)</td>
<td>8.3 (1.7)</td>
<td>4.9</td>
<td>&lt;.000a</td>
<td>.28</td>
</tr>
<tr>
<td>Self-Esteem ((n=64))</td>
<td>29.9 (16.3)</td>
<td>35.4 (16.8)</td>
<td>2.3</td>
<td>.024</td>
<td></td>
</tr>
<tr>
<td>Locus of Control ((n=61))</td>
<td>3.34 (1.9)</td>
<td>2.44 (2.1)</td>
<td>3.95</td>
<td>&lt;.000a</td>
<td>.21</td>
</tr>
<tr>
<td>Attitudes Towards Marriage and Family ((n=64))</td>
<td>27.9 (10.3)</td>
<td>26.3 (10.1)</td>
<td>1.92</td>
<td>.059</td>
<td></td>
</tr>
<tr>
<td>Family Assessment Measure ((n=54))</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles</td>
<td>62.8 (9.9)</td>
<td>60.3 (11.8)</td>
<td>1.64</td>
<td>.107</td>
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</tr>
<tr>
<td>Tasks</td>
<td>63.6 (10.8)</td>
<td>62.6 (10.8)</td>
<td>0.52</td>
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<tr>
<td>Control</td>
<td>66.8 (11.2)</td>
<td>57.9 (11.5)</td>
<td>6.42</td>
<td>&lt;.000a</td>
<td>.44</td>
</tr>
<tr>
<td>Involvement</td>
<td>66.9 (11.2)</td>
<td>66.8 (12.1)</td>
<td>0.02</td>
<td>.98</td>
<td></td>
</tr>
<tr>
<td>Affective Expression</td>
<td>68.4 (10.2)</td>
<td>62.5 (11.2)</td>
<td>4.21</td>
<td>&lt;.000a</td>
<td>.25</td>
</tr>
<tr>
<td>Communication</td>
<td>64.6 (10.2)</td>
<td>57.9 (10.3)</td>
<td>4.58</td>
<td>&lt;.000a</td>
<td>.28</td>
</tr>
<tr>
<td>Values/Norms</td>
<td>62.2 (11.8)</td>
<td>63.9 (11.16)</td>
<td>1.06</td>
<td>.29</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** PVE = the proportion of the variance explained by the significant statistical analysis.

a. Indicates significance for these one-tailed tests: To approximate an alpha of .10, a p value of .007 is necessary.
situation. The groups were less effective in increasing either the sense of belonging or the concrete resources available to individuals; however, the latter was not a group goal.

Although members’ involvement in the treatment groups was associated with higher self-esteem scores, this increase was not statistically significant. In comparison with the norms of the Coopersmith (1990) scale for adult men (68.4, $SD = 18.5$), the self-esteem of group members remained significantly low. There was, however, statistically significant positive movement on the locus of control score over the two time periods such that the men had, on average, more personal control than previously. The men reported a statistically significant reduction in perceived stress over the program duration, symbolizing an increased belief in their personal ability to cope with stressors. Attitudes toward women and the family became less traditional but not significantly so.

Treatment group membership was associated with significantly improved marital relations scores on several of the subscales of the FAM-DR: reductions on the Control, Affective Expression, and Communication subscales. Positive movement was noted on the remaining four subscales (Roles, Tasks, Emotional Involvement, and Values/Norms); however, the changes did not reach statistical significance and with the adjustment for social desirability, five of the subscales remained in the clinical range at posttest. The adjusted scores of only two subscales, Control and Communication (notably, two that had changed significantly), fell from the clinical to within the normal range (40–60).

**Court Mandated Versus Voluntary Clients**

A regression analysis was conducted to determine if there were differential program impacts for clients who were voluntarily referred to the groups ($n = 48$) compared with those who were court ordered ($n = 10$) to attend treatment, using pretest scores as a covariate. Table 3 summarizes the adjusted posttest scores for these two subpopulations, revealing only one statistically significant difference, on the Perceived Stress scale such that the court-mandated men reported significantly more stress at posttest. The adjusted scores of the voluntary group members had moved from the clinical to the normal range on the Nonphysical Abuse of Partner subscale, to slightly above the clinical cutoff suggested for the Physical Abuse of Partner subscale and out of the clinical range on the Roles, Control, and Communication subscales of the FAM. Such change was evident for the court-mandated group members on only the Affective Expression and the Communication subscales of
TABLE 3: A Comparison of Voluntary Versus Court-Ordered Group Completers at Posttest

<table>
<thead>
<tr>
<th>Variable</th>
<th>Court-Ordered (n = 10)</th>
<th>Voluntary (n = 48)</th>
<th>t</th>
<th>p</th>
<th>PVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Index of Spouse Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>22.3 (n = 7)</td>
<td>15.5 (n = 42)</td>
<td>1.65</td>
<td>.22</td>
<td></td>
</tr>
<tr>
<td>Non-Physical</td>
<td>30.1 (n = 7)</td>
<td>22.7 (n = 42)</td>
<td>1.02</td>
<td>.31</td>
<td></td>
</tr>
<tr>
<td>Interpersonal Support Evaluation List</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appraisal</td>
<td>16.3 (n = 7)</td>
<td>18.6 (n = 42)</td>
<td>1.27</td>
<td>.21</td>
<td></td>
</tr>
<tr>
<td>Tangible</td>
<td>18.9 (n = 7)</td>
<td>20.4 (n = 42)</td>
<td>1.09</td>
<td>.28</td>
<td></td>
</tr>
<tr>
<td>Belonging</td>
<td>16.9 (n = 7)</td>
<td>18.4 (n = 42)</td>
<td>1.49</td>
<td>.14</td>
<td></td>
</tr>
<tr>
<td>Perceived Stress/Coping</td>
<td>9.7 (n = 7)</td>
<td>8.2 (n = 42)</td>
<td>2.98</td>
<td>.005^a</td>
<td>.14</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>32.7 (n = 7)</td>
<td>36.6 (n = 42)</td>
<td>1.42</td>
<td>.16</td>
<td></td>
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<tr>
<td>Locus of Control</td>
<td>2.1 (n = 9)</td>
<td>2.4 (n = 47)</td>
<td>.256</td>
<td>.80</td>
<td></td>
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<tr>
<td>Attitudes Towards Marriage and Family</td>
<td>33.3 (n = 7)</td>
<td>24.0 (n = 42)</td>
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<td>.052</td>
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<td>Family Assessment Measure—DR</td>
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<tr>
<td>Roles</td>
<td>63.2 (n = 7)</td>
<td>58.9 (n = 42)</td>
<td>1.76</td>
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<tr>
<td>Control</td>
<td>62.5 (n = 7)</td>
<td>61.8 (n = 42)</td>
<td>0.09</td>
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<td>Emotional Involvement</td>
<td>60.9 (n = 7)</td>
<td>57.3 (n = 42)</td>
<td>0.18</td>
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<td>Affective Expression</td>
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<td>67.2 (n = 42)</td>
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<td>58.8 (n = 7)</td>
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<td>0.69</td>
<td>.49</td>
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<td>Social Desirability</td>
<td>54.5 (n = 7)</td>
<td>57.9 (n = 42)</td>
<td>0.37</td>
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<td>Values/Norms</td>
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<td>62.5 (n = 42)</td>
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<td>.86</td>
<td></td>
</tr>
<tr>
<td>Client Satisfaction</td>
<td>8.3 (n = 7)</td>
<td>7.5 (n = 42)</td>
<td>1.44</td>
<td>.16</td>
<td></td>
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</tbody>
</table>

NOTE: PVE = the proportion of the variance explained by the significant statistical analysis; DR = dyadic relationship.

^a Indicates significance for these one-tailed tests: To approximate an alpha of .10, a p value of .007 is necessary.
the FAM. These data suggest that both court-ordered and voluntary clients can expect to benefit equally from participation in the men’s treatment groups.

**Client Satisfaction and Follow-up Assessment**

The treatment group members, with few exceptions, reported high levels of program satisfaction. Forty-nine group members (77.7% of the 63 who answered these questions) reported that the program had met most or almost all their needs, 60 (95.2%) reported that they were mostly or very satisfied with the program, and 61 (96.8%) would think about or would definitely refer a friend in need of similar help to the program.

The men’s treatment group participation rate for the follow-up testing period was extremely low (17, or 23.9%). This small number of follow-up cases cannot be considered representative of the sample of clients who began the program or even those individuals who successfully completed the group intervention. Therefore, this investigation chose not to analyze the data as to whether the client gains made during the program duration were maintained at 6-month follow-up.

**Leaders’ Ratings of Client Change**

The group leaders were asked to rate each of the variables on which the men made self-reports based on their experiences of the men in group treatment and also to indicate how confident they felt about each of these ratings. The group leaders were typically confident in the client ratings that they made; at pretest 73.8% reported that they were either very sure or sure about their responses and 92.1% at posttest.

Table 4 provides a summary of the group leader ratings for 53 men. Clearly, the leaders believed that the men had made significant positive change on several of the outcome indicators, corroborating the positive changes self-reported by the men on the variables of physical and nonphysical abuse and coping ability (perceived stress). On two dimensions (self-esteem and attitudes toward women), the leaders estimated significant change although the men’s self-reports on parallel indexes were more conservative. The group members self-reported significant changes on two dimensions of their couple relationship (affective expression and communication) that the leaders did not perceive as having changed significantly.
<table>
<thead>
<tr>
<th>Variable</th>
<th>Pretest Mean</th>
<th>Posttest Mean</th>
<th>Rating</th>
<th>SD</th>
<th>Rating</th>
<th>SD</th>
<th>t</th>
<th>p</th>
<th>PVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse (n = 53)</td>
<td>3.4</td>
<td>3.9</td>
<td>0.97</td>
<td>0.48</td>
<td>3.40</td>
<td>&lt;.000</td>
<td>.001</td>
<td>.18</td>
<td></td>
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<tr>
<td>Verbal abuse (n = 51)</td>
<td>2.4</td>
<td>3.1</td>
<td>0.92</td>
<td>0.92</td>
<td>4.61</td>
<td>&lt;.000</td>
<td>.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlling behavior (n = 52)</td>
<td>2.3</td>
<td>2.8</td>
<td>0.91</td>
<td>0.82</td>
<td>3.68</td>
<td>.001</td>
<td>.21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accepts responsibility (n = 53)</td>
<td>2.2</td>
<td>1.8</td>
<td>0.91</td>
<td>0.92</td>
<td>3.80</td>
<td>&lt;.000</td>
<td>.22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Traditional view of women (n = 53)</td>
<td>2.0</td>
<td>2.6</td>
<td>0.87</td>
<td>0.89</td>
<td>4.43</td>
<td>&lt;.000</td>
<td>.27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-esteem (n = 53)</td>
<td>3.1</td>
<td>2.7</td>
<td>0.78</td>
<td>0.85</td>
<td>3.41</td>
<td>.002</td>
<td>.18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coping ability (n = 52)</td>
<td>2.6</td>
<td>2.3</td>
<td>0.89</td>
<td>0.94</td>
<td>1.86</td>
<td>.001</td>
<td>.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Decision making (n = 53)</td>
<td>2.6</td>
<td>2.8</td>
<td>0.80</td>
<td>0.87</td>
<td>1.35</td>
<td>.45</td>
<td>n.s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social desirability (n = 53)</td>
<td>2.4</td>
<td>2.7</td>
<td>1.01</td>
<td>0.84</td>
<td>1.74</td>
<td>.17</td>
<td>n.s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital communication (n = 34)</td>
<td>2.4</td>
<td>2.0</td>
<td>0.86</td>
<td>0.90</td>
<td>2.36</td>
<td>.05</td>
<td>n.s.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expression of feelings with partner (n = 41)</td>
<td>2.9</td>
<td>2.5</td>
<td>0.68</td>
<td>0.87</td>
<td>2.70</td>
<td>.05</td>
<td>n.s.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: PVE = the proportion of the variance explained by the significant statistical analysis.
DISCUSSION AND APPLICATIONS TO SOCIAL WORK PRACTICE

This evaluation of the Coordinated Family Violence Treatment Program in the Waterloo Area revealed a number of statistically significant improvements and some clinically significant changes associated with participation in the perpetrator treatment groups similar to other exploratory evaluations of group treatment programs for men who abuse their partners. The findings were strengthened by utilizing social desirability scores to adjust the self-reported measures, a technique that few have used since Saunders described the process in 1991.

Of critical importance is the significant reduction in both self-reported physical and nonphysical abuse. With the adjustment for social desirability, however, the levels of physical violence remained just within the clinical range such that some women partners continued to be hurt. The significant improvement in locus of control with group members reporting an increase in personal control may be an important variable in being able to utilize strategies, such as time-out, that have the potential to prevent violent behaviors. Collecting data on couple interactions using the FAM dyadic scale was particularly important given the high proportion of men who were living with their partners while attending the group. The three subscales that significantly improved, Control, Affective Expression and Communication, are particularly germane to improved couple interactions. Furthermore, there is convergence on several of the members’ and group leaders’ estimates of change on the outcome criteria.

Nevertheless, because of research design limitations and the fact that corresponding data was not collected from the partners of the group members, the results must be seen as providing only initial support for this innovative group model. Further research is warranted, especially considering the risk of overselling the groups to women, who may continue to live with partners without adequately protecting themselves from continued abuse.

The evidence from this study suggests that if men can be successfully recruited, participate in, and complete the perpetrator treatment groups, they are likely to experience a number of positive changes, although the research does not speak to the impact of these changes on intimate partner relationships in the long term. This analysis did not identify significant differences between those who completed the groups and those who dropped out after only a few sessions. We contend that it is essential to see the men’s groups as only one aspect of a coordinated community response to woman abuse, one that also provides support and safety planning for partners. Although most authors recommend that couples separate while the men receive group
intervention, many couples stay together or reunite after gender-specific
groups. In either case, couples group intervention may be important in con-
solidating the learning (Brannen & Rubin, 1996; Johannson & Tutty, 1998).

Despite over a decade of research into interventions addressing abuse in intimate partner relationships, social workers still have much to learn about who, when, and how to assist abusive men in ways that do not leave partners more vulnerable to abuse. Continuing to evaluate our practice with such clients should be a priority, even when we cannot utilize empirical research designs.

REFERENCES


Cognitive-Behavioral Therapy of Grief: A Review and Application

Ruth Malkinson
Tel-Aviv University

This article reviews outcome studies of grief therapy, with special attention to the cognitive perspective. Based on those studies, three observations on bereavement interventions are offered: (a) development of psychotherapy interventions has been strongly linked to theoretical conceptualizations and definitions of what constitutes normal, pathological, and chronic grief at different times after bereavement; (b) in most reported studies, generic non-bereavement scales were applied for measuring reduction of symptoms. By using such measures, a link between a decrease in symptoms and "recovery" following treatment may be suggested, while neglecting to assess the bereaved's worldview using grief-specific measures; (c) in reviewed outcome studies, behavioral (desensitization, social reinforcement) and cognitive-behavioral (exposure, guided mourning) interventions are included among effective treatment modalities in cases of complicated grief. It is observed that although similar interventions have been applied, theoretical adherence has changed, implying a change not in the intervention itself but rather in the expected outcome.

Grief following loss through death is considered a universal, normal human reaction as well as a highly individual one. Death of a loved one constitutes a major life cycle event encountered frequently by social workers whose roles inherently include close involvement in family and individual interventions. Treatment with bereaved persons has undergone significant changes related to development in both theoretical and applied fields. A wealth of literature has described in detail the course of grief as stages (Bowlby, 1980), phases (Ramsay, 1979; Sanders, 1989), components (Bugen, 1977), tasks (Worden, 1991), or tracks (Rubin, 1981, 1993). In the normal grieving process, reactions are expected to intensify immediately following the loss and to decrease over time (Parkes, 1975; Rando, 1993; Sanders, 1989, 1993). Grief has traditionally been seen as a healthy process that is aimed at decathexis, abandoning or letting go of commitment to one’s relationship to the deceased, a process known as “grief work” (Freud, 1917/1957).

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Characteristic to the grief work model is its identified sequence of stages, through which the bereaved person goes toward recovery, resolution, and acceptance of the reality of the loss. According to these models, successful grief work refers to a gradual detachment (breaking the bonds) from the deceased and reestablishing new relationships with others. More recent approaches of bereavement are reexamining the necessity of finality as a component of successful bereavement resolution. The bereavement process is viewed from these perspectives not as one leading to recovery, closure, or resolution but rather as an accommodation, whereby one continually adapts one’s preexisting knowledge, emotions, and experiences to the new reality. Rather than breaking the bonds with the deceased, the idea of “continuing bonds” is proposed (Malkinson & Bar-Tur, 1999; Rubin & Malkinson, 2001; Silverman, Klass, & Nickman, 1996). The latter approaches have shifted from expecting a predetermined course and outcome of bereavement to emphasizing that there is no one predictable pathway through grief and regarding it as an idiosyncratic process (Neimeyer, 1999; Neimeyer, Keese, & Fortner, 2000). Similarly, the time framework of what is considered normal grief work has shifted from the “mythological” 12-month period resulting in individuals resuming “normal life” on its completion, and it is now recognized as a far more complicated process. Complicated grief is described as the intensification of grief that does not lead to assimilation of the loss but instead to repetitive stereotypic behavior as well as impaired functioning (Malkinson & Witztum, in press). Risk factors connected to complicated grief include traumatic circumstances of the death, which in turn can result in additional reactions such as depression, anxiety states, and post-traumatic stress disorder. Often, these coexist and overlap, stressing the importance of assessment prior to applying treatment. Research studies have set the stage for differentiating complicated grief (obsessional preoccupation with the deceased, crying, persistent yearning, and searching for the lost person) from depression (clinical signs of depression with preoccupation with self) (Prigerson et al., 1995). The implications of these findings lend themselves to differential treatment interventions for grief (psychotherapy with a focus on caring and support) and for depression (combined psychotherapy and psychopharmacology).

An outline of a cognitive behavioral model of intervention will be presented, followed by a review of outcome studies evaluating treatments for grief and a detailed illustration of the application of a cognitive approach to loss through death and the ensuing grief reactions, processes, and outcomes. Furthermore, a distinction will be made between functional and dysfunctional bereavement processes, as related to different belief systems (rational and irrational), emphasizing the importance of assessment prior to treatment.
Assessing the bereaved’s rational and irrational beliefs can constitute a source for identifying possible primary emotional disturbance (e.g., complicated grief) as well as secondary symptoms (e.g., anxiety, avoiding the pain involved in grief). Treatment interventions within cognitive behavioral therapy (CBT) will be described in cases of acute and prolonged grief.

THE COGNITIVE MODEL OF BEREAVEMENT

From the cognitive perspective, a loss through death is an adverse external event over which one has no control but which nevertheless changes one’s belief system and its related emotions and behaviors. Grief, then, is not only an emotional process but also one of cognitive and behavioral adaptation to the consequences of the loss. However, the role of cognitions has typically been viewed as less central than that of emotions, perhaps due to the latter’s overt nature as opposed to cognitions’ more covert nature as well as that emotions often have a flooding effect during the acute crisis following a death. Particularly when the cause of death is more sudden, stressful, or traumatic (i.e., homicide, suicide, accidents, and natural or man-made disasters), emotions seem to dominate over cognitions, especially during the acute phase.

In traditional therapies, the emotional dimension of the process of grief is the focus of intervention: The presence or absence of anger, depression, shame, and guilt reactions have customarily been crucial indicators for understanding and evaluating short- and long-term bereavement outcomes as well as normal and complicated forms of bereavement (Rando, 1993). According to traditional models, an exaggerated emotional response, the absence of these emotions, and avoiding their expression are all indications of complicated grief (Worden, 1991). For this reason, most traditional interventions apply cathartic techniques to help the bereaved person alleviate the intensity of these emotions (Volkan, 1981; Worden, 1991); cognitions are seen only as the byproducts of emotional disturbance. The tendency of therapists to emphasize emotions as central to the process of grieving has led them to neglect its cognitive aspects (Rando, 1984).

In contrast, the cognitive perspective emphasizes the relationship between one’s emotions and behaviors and one’s cognitive evaluations about oneself, the world, and the future (Beck, 1976; Gauthier & Marshall, 1977; Gluhosky, 1995). The death event is assumed to have a profound impact on a person’s most fundamental assumptions (Janoff-Bulman, 1992) or assumptive world (Parkes, 1975, 1993), his or her fundamental cognitive structures or schemata about the self and the world (Beck, 1976; Horowitz, 1986; Janoff-Bulman, 1992), and his or her belief system about the self, others, and the world (Ellis,
A death event deconstructs the existing views that a person holds about life and relationships, requiring a painful internal process of cognitively reorganizing what has been shattered following the external event; of modifying one’s knowledge, thoughts, and feelings; of giving up old meanings to one’s life and forming new ones (Gluhosky, 1995; Horowitz, Bonano, & Holen, 1993; Kavanagh, 1990; Neimeyer, 1999). The loss event is new information that has to be processed and then assimilated (revising and processing new information into preexisting cognitive structures) or accommodated (adapting preexisting knowledge to the new reality) (Epstein, 1993; Piaget, 1950; Warren & Zgourides, 1991). Whether primarily cognitively processed or emotionally experienced, the cognitive perspective asserts that the more traumatic the event is the greater its impact on one’s belief system and other cognitions. Thus, the cognitive approach upholds that for the grieving process to take an adequate course toward functional and satisfying outcomes, grief-related cognitions should be identified, included, assessed, and treated as an equal part of intrapsychic processes (Gluhosky, 1995; Kavanagh, 1990; Rando, 1988). Bereavement is viewed as a process that includes coping with the stress evoked by the death event on one hand and ongoing relationships with the deceased on the other (Rubin, 1993; Stroebe & Schut, 1999).

According to the cognitive approach, psychopathological grief takes the form of distorted thinking, where an excessive emotional reaction (such as depression) is related to negative cognitive evaluations (automatic thoughts) of oneself, the world, and the future. For example, bereaved persons with distorted thinking may interpret loss as an intended rejection (“How could he or she have done this to me”) (Beck, 1976) or as a confirmation of being worthless (“I am guilty and a worthless person for not saving his or her life”) (Malkinson & Ellis, 2000). During stressful life events, people often use maladaptive cognitive processes, referred to by Beck (1976, 1989; Beck, Wright, Newman, & Liese, 1993) as cognitive distortions and by Ellis (1962) as irrational beliefs. According to rational-emotive behavior therapy (REBT), overreaction and lack of reaction to the death of a loved one are not in themselves “right” or “wrong,” or preferred or undesirable, but rather are related to a specific set of beliefs (cognitions) that are functional or dysfunctional (adaptive or maladaptive). In the case of loss through death, negative emotional reactions (e.g., sorrow, sadness) may be regarded as relating to adaptive cognitions (e.g., “Life has changed forever, and it’s sad and painful;” “The doctors did all they could do to save my child; I don’t blame them;” “I know we did everything to keep him alive, but it didn’t help, and he died”). Complicated grief, on the other hand, is seen as a negative emotion related to and maintained by maladaptive cognitions (e.g., “Life is not worth living
without my loved one,” “I can’t stand my life without my loved one”). Thus, from a cognitive perspective, complicated grief is defined as persistence over time of distorted, irrational beliefs as the dominant set of cognitions affecting the emotional consequences in the form of depression or anxiety (Malkinson & Ellis, 2000).

A REVIEW OF THE LITERATURE ON BEHAVIOR THERAPY AND CBT IN GRIEF

Treatment with bereaved persons has undergone significant changes, and the development of psychotherapy has been strongly linked to theoretical conceptualizations and definitions of what constitutes normal, pathological, and chronic grief at different times after bereavement. From a time-limited process, with the individual resuming “normal life” on its completion, grief is now recognized as a far more complicated and lifelong process of struggling to find the balance between what was and what is (Malkinson, Rubin, & Witztum, 2000; Rubin & Malkinson, 2001). The result of this approach is that normal grief work is no longer expected to be completed within a 12-month period, which was formerly the recommended time framework. Moreover, the notion that grief is a linear process that ends with the bereaved’s acceptance of the loss has not been empirically supported (Artlet & Thyer, 1998).

Understandably, the interventions applied have been related to the theoretical models from which they derived. Grief therapy was then aimed at assisting the bereaved to work through the grief and to reach a completion so that a full resumption of life could take place. For example, the stages models, which were based on the assumption that bereavement has a predetermined course leading to completion, explain the development of treatment interventions aimed at grief resolution and “letting go” of the dead person (Vander Hart, 1987) by influencing the definition of what was then regarded as normal, complicated, pathological, or chronic grief. Grief therapy was a tool to facilitate this restoration (Malkinson, in press). Similarly, viewing the loss of a loved one as a crisis involving loss of a relationship, and possibly loss of social networks, made the unavailability of support a predicting variable for negative outcomes of bereavement (Raphael, 1983). Hence, providing help for all those experiencing loss has become a routine preventive treatment. There were considerable variations in the timing of intervention (during the acute phase at 12 months or later, in cases described as pathological grief), the type (individual, family, and group intervention), and the form of support (professional, nonprofessional, and self-help). Interventions were not
necessarily evaluated. Shifts away from these models have led to redefining the process of dealing with loss to include a meaning reconstruction at the intrapersonal level, as well as attention to the emotional and interpersonal life of the bereaved and the psychosocial context in which the process is being experienced (Malkinson & Bar-Tur, 1999; Malkinson, Rubin, & Witztum, 2000).

A few studies dealing with evaluation of treatment following the loss of a loved one have recently been published. The four reviews which will be referred to (Jacobs & Prigerson, 2000; Kato & Mann, 1999; Litterer Allumbaugh & Hoyt, 1999; Schut, Stroebe, van den Bout, & Terheggen, 2001) all point to methodological problems of the studies reviewed, in terms of assignment procedures, lack of control groups, recruitment of participants, attrition, adherence, wide range of time elapsed since the loss, and use of generic measures. Neimeyer and Hogan (2001) raised an additional issue pertaining to most of these studies reporting use of nonspecific bereavement scales. In their review of measurement of grief, they revealed that in a large number of studies of bereavement, researchers have used generic or psychiatric symptomatology. Moreover, in many reported studies evaluating treatment interventions, programs were aimed at reducing symptomatology as measured pretreatment and posttreatment. The use of generic measures assumes a link between reduction of symptoms and a “recovery” from acute or pathological grief. Rubin (1981) in his research formulated the Two-Track Model suggesting that bereavement occurs along two main tracks. The first track relates to how the bereaved’s functioning is affected following loss, and the second addresses how people maintain their inner relationships with the deceased. The implications of such a model enable clinicians and researchers to measure dimensions of functioning with generic scales and dimensions of relationship with the deceased, using grief-specific measures.

The reviews will be briefly mentioned, and the readers are referred to these reviews for more details. Kato and Mann (1999) in their article titled “A Synthesis of Psychological Interventions for the Bereaved” outlined four major theories of bereavement and assessed outcome studies associated with these theories, comparing individual and group treatment. The authors found that most studies suffered from “methodological flaws.” Computation of the effect sizes of the studies revealed small size effect, suggesting that either interventions are not effective or that methodological problems prevented effects from being detected. In another review, Litterer Allumbaugh and Hoyt (1999) conducted a meta-analysis to determine how effective grief intervention is and for whom. Computation of the effect size showed that no-treatment control groups improved less than those in treatment groups. According to Litterer Allumbaugh and Hoyt, a factor contributing to effect
size was whether participants were self-referred or recruited by investigators. In their review, Schut et al. (2001) questioned the viability of comparing treatment efficacy in reported studies because of the differences between them. In line with Caplan’s (1964) crisis theory, Schut et al. categorized their review of efficacy studies into three types of interventions: (a) general (primary preventive) interventions, (b) preventive interventions for high-risk populations (secondary prevention), and (c) interventions for treatment of complicated grief (tertiary prevention). They concluded that “the more complicated the grief process appears to be or become, the better the chances of interventions leading to positive results” (p. 731). These authors also raise questions about the efficacy of treatment in relation to factors of recruitment (self-referral versus help being offered) and the timing of intervention. Although reviewers differ regarding the efficacy of treatment immediately following loss (Litterer Allumbaugh & Hoyt recommended that intervention be applied soon after loss; Schut et al. were against it), there seems to be a greater consensus as to the efficacy and hence the need for interventions in cases of complicated grief. Jacobs and Prigerson’s (2000) review of the psychotherapy of traumatic grief supports this, in their important contribution and in its elaboration on the definition of traumatic grief, proposing criteria for traumatic grief as a new diagnostic entity. This in turn will result in more refined interventions for bereaved populations with complicated grief. According to Prigerson et al. (1995), the recommended mode of treatment in complicated grief is grief psychotherapy, as opposed to medication in the treatment of depression.

All in all, the literature on grief therapy is in agreement that caring, support availability, and empathy are central ingredients that go above and beyond a specific mode of intervention (Raphael, Middelton, Martinek, & Misso, 1993). In addition, all forms of intervention, regardless of their theoretical adherence, focus on the loss and are typically structured and time limited (e.g., the more traditional psychodynamic treatments, Raphael, 1983; Raphael et al., 1993; or treatments based on coping and stress responses, Horowitz et al., 1993). Although outcome studies of grief cognitive behavioral interventions are limited, those carried out are cited as effective ones, especially with complicated forms of grief. I will elaborate on selected studies with particular attention to exposure intervention and how its application has evolved over the years in accordance with changes in theoretical conceptualizations of grief process and its desired outcomes.

Although it originated from the psychodynamic framework, Ramsay’s (1979) pathological grief model was one of the first reported behavioral models to be applied effectively in individual therapy with pathological grief. Grief therapy from a psychodynamic perspective views the relationship that
develops between the client and the therapist as central in the treatment process and aims at reworking the relationship to the deceased. Like many other behavior therapists, Ramsay did not regard the relationship between the therapist and client as centrally essential, as is the case in psychodynamic grief therapy. The focal point of intervention in Ramsay’s model was the employment of flooding techniques to enable the expression of painful feelings. His model is an excellent example of carefully assessing and planning a gradual in vivo in-session exposure, assisting the client to confront avoided situations or other cues, with homework between sessions, “so that extinction could take place” (p. 227). Grief work can be carried out after extinction has occurred, leading to reintegration and resolution. Gauthier and Marshall (1977); Mawson, Marks, Ramm, and Stern (1981); and Sireling, Cohen, and Marks (1988) carried out 3 separate studies, each of which combined guided mourning and systematic desensitization for patients with morbid grief (see Table 1).

Gauthier and Marshall’s (1977) assumption was that pathological grief is maintained largely through social reinforcement of the bereaved’s repeated pattern of behavior. They proposed the use of flooding procedures and rescheduling of social reinforcement as a treatment strategy to reduce the emotional distress: “If grief responses are encouraged by social reinforcement, or if social reinforcement is not consistently given for alternative behavior, the grief will be maintained” (p. 42). The notion of completion of grief and breaking the bonds with the lost person was grounded so strongly in grief therapy that “at no time was sympathy shown by the therapist for display of distress on the part of the patient” (p. 43). Gauthier and Marshall reported successful treatment with 4 women patients suffering from pathological grief. Treatment included six sessions, three of which were devoted to assessing the problem and making arrangements for behavioral desensitization. In the remaining three sessions, exposure techniques were employed and resulted in marked changes in behavior. Also noteworthy is the outcome study by Mawson et al. (1981) on the behavioral “guided mourning” approach (exposure therapy to assist the bereaved with relinquishing ties with the lost person), which involved reliving avoided painful memories and feelings related to bereavement, as well as the use of homework. The reported results showed improvement among the guided mourning patients (n = 6) after three 60- to 90-minute sessions conducted over a period of 2 weeks, which they maintained through a follow-up 28 weeks later (as compared to the control group whose members were instructed to avoid grief and painful memories of bereavement). Another reported study, that of Sireling et al. (1988), repeated exposure procedures similar to those used in the study of Mawson et al. In Sireling et al.’s study of 26 patients, 14 patients were
<table>
<thead>
<tr>
<th>Author</th>
<th>Number of Participants</th>
<th>Research Design</th>
<th>Outcome Measure</th>
<th>Treatment</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gauthier and Marshall (1977)</td>
<td>4 psychiatric patients</td>
<td>3 sessions for assessment, and 3 sessions of flooding; pre-post; control</td>
<td>Self-report on changes in behavior and symptoms; psychiatrist's report</td>
<td>Social behavior modification; flooding (exposure)</td>
<td>Decrease in emotional and physical symptoms; at 6 months, improvement maintained</td>
</tr>
<tr>
<td>Mawson, Marks, Ramm, and Stern (1981)</td>
<td>12 psychiatric patients</td>
<td>60- to 90-minute session, three times a week for 2 weeks; pre-post 28 weeks; control</td>
<td>Self rating at Weeks 0, 2, 4, 8, 12 for pathology of grief, depression, anxiety, fear, compulsion, and social adjustment</td>
<td>Guided mourning and antixposure to control treatment</td>
<td>Guided-mourning patients improved significantly in Week 4 compared with controls on three measures; improvement maintained 10 to 28 weeks compared with controls</td>
</tr>
<tr>
<td>Sireling, Cohen, and Marks (1988)</td>
<td>26 patients</td>
<td>60- to 90-minute session over 10 weeks; pre-post 1, 3, &amp; 9 months; control</td>
<td>Independent assessors</td>
<td>Guided mourning and antixposure to control treatment</td>
<td>Guided-mourning patients improved significantly on reduced avoidance; Improvement maintained at 9 months</td>
</tr>
<tr>
<td>Brom, Kleber, and Defares (1989)</td>
<td>112 selected individuals experiencing PTSD</td>
<td>Pre-post and 3 months later; control</td>
<td>General symptoms SCL-90, State-Trait Anxiety Inventory, State-Trait Anger Inventory, Impact of Events Scale, and personality questionnaire</td>
<td>Randomly assigned to 15 sessions of hypnotherapy, 18 sessions of dynamic therapy, A reduction in symptoms of intrusion-avoidance in treatment groups; reductions of scores on general symptoms in</td>
<td>(continued)</td>
</tr>
<tr>
<td>Author</td>
<td>Number of Participants</td>
<td>Research Design</td>
<td>Outcome Measure</td>
<td>Treatment</td>
<td>Result</td>
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<td>---------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Schut, de Keijser, van den Bout, and Stroebe (1996)</td>
<td>67 individuals</td>
<td>Pre-post and 4 months later; control</td>
<td>General health questionnaire</td>
<td>CMGT: twelve 2-hour sessions of behavior therapy, eight 2-hour art therapy sessions; Control: regular therapy for complicated grief</td>
<td>Diminishing distress in both groups, more stable for CMGT; some relapse at follow-up, larger for control group</td>
</tr>
</tbody>
</table>

NOTE: PTSD = post-traumatic stress disorder; SCL-90 = Symptom Check List–90; CMGT = cross-modality grief therapy.
randomly assigned to guided-mourning treatment and 12 to anti-exposure control treatment. Patients who received guided-mourning treatment improved more than the controls in terms of reduced avoidance symptoms. In all three studies, the treatment with forced prolonged exposure was aimed at “curing” patients of morbid grief. There was a difference in the application of the exposure treatment procedures, as used by Ramsay (1979), and those used in the three other reported studies. Ramsay’s flooding techniques appeared to be more confrontive and forceful during the session, compared to what appeared to be more instructive and less confrontive in the remaining three studies.

Exposure therapy, or guided mourning as it was first applied in cases of grief, originated from behavior therapy that focuses on changes in observed behavior and gives less attention to cognitive components of grief process. It seems that the application of exposure interventions in grief has undergone changes that clearly reflect those that have occurred in the field of psychotherapy in general, as well as those within the field of grief and bereavement. Definitions of normal and complicated grief and what is to be expected on completion of the process have affected grief interventions. For example, chronic grief was assessed in cases where patients continued to be preoccupied with the deceased for a longer period than that regarded as normal, usually 12 months. From the same time perspective, pathological grief was approached in a similar way to phobic reactions (Gauthier & Marshall, 1977; Mawson et al., 1981; Ramsay, 1979; Sireling et al., 1988). It was assumed then that in both cases, a stimulus or a cue was provoking the distress followed by avoidance. By the same token, a prolonged preoccupation with the deceased was assessed as a form of “morbid grief” (Mawson et al., 1981). Desensitization and prolonged exposure to avoided stimuli were found to be effective interventions in diminishing avoided behaviors, then regarded as positive outcomes. In line with the theoretical stage framework applied at that time, successful completion of the process of bereavement was associated with the detachment of relationship from the deceased.

Over time, the study of stressful life events has expanded to include man-made and natural disasters, violence, and so forth, with enhanced professional understanding of coping processes and leading to a distinction between normal and pathological reactions. One such study—exploring the effectiveness of different therapeutic modalities for reducing traumatic distress (trauma desensitization, hypnosis therapy, and psychodynamic therapy)— was applied by Kleber, Brom, and Defares (1992). The study comprised 112 individuals who experienced traumatic loss (at the start of the study, no more than 5 years had elapsed since the loss) and were screened for one of four treatment modalities (dynamic therapy, hypnotherapy, desensitization, and a waiting
list) with the number of sessions ranging from 12 to 16. All three treatment interventions resulted in an improvement and were shown to be very effective in reducing stress response symptoms (although substantially less effective in psychosomatic ones). This study provides evidence of the treatment’s efficacy in reducing distress symptoms, regardless of the theoretical framework, but no indication was provided on the degree of grief resolution achieved as a result of intervention. A study designed to assess the efficacy of an integrated behavior and art group-therapy program for individuals who suffered from complicated grief was conducted by Schut, de Keijser, van den Bout, and Stroebe (1996). The cross-modality grief therapy group comprised 52 individuals referred to a health care center, and the control group was made up of patients undergoing regular treatment provided by the center. Cross-modality grief therapy treatment combined behavior therapy (systematic desensitization and cognitive restructuring) with art therapy (visualization and symbolizing the deceased in paint, clay, etc.). The model was based on Worden’s (1991) task model of grief in which an important task is to “emotionally reorient the deceased and move on with life” (p. 16). The treatment included twenty 2-hour sessions (12 sessions of behavior therapy and 8 sessions of art therapy) over a 3-month period (no details were given regarding the control group). Results at 3- to 4-months follow-up showed that both treatment programs were efficacious (there was a relapse between discharge and follow-up), but the experimental treatment was more effective with regard to the outcome measure applied (General Health Questionnaire).

Several reviews of outcome studies that are cognitively oriented for treatment following adverse traumatic events were reported and found to be effective. CBTs were reported to be particularly effective with individuals suffering from post-traumatic stress disorder, depression, anxiety, and chronic or traumatic grief (Black, Newman, Harris-Hendriks, & Mezey, 1997; Clark, 1986; Kavanagh, 1990; Kubany & Manke, 1995; Resick & Schnicke, 1993; Richards & Lovell, 1997). Cognitive therapies focusing on the individual’s belief system and the related consequences (emotions and behaviors) were found suitable and effective (Kleber et al., 1992). Cognitive therapy (CT) and CBT are based on the premise that emotional disturbance and behavioral symptomology are maintained as a result of distorted thinking, which can be modified with the use of a variety of cognitive, emotional, and behavioral techniques, not only during the sessions but also between sessions, in the form of homework assignments. It is not surprising, then, that in cases of acute and prolonged grief following death, there is increasing use of CT and CBT—combining guided imagery, exposure techniques, thought-stopping, cognitive restructuring, breathing exercises, and skill acquisition—all aimed at assisting clients to cope with loss and to reorganize their relationship with
the living and the dead (Beck et al., 1993; Ellis, 1995; Mahony, 1991; Rubin & Malkinson, 2001). A major focus of recent CT interventions has shifted from assisting bereaved persons to adapt to a new reality that excludes the deceased toward assisting them to reconstruct new meanings (Neimeyer et al., 2000).

Within CBT and cognitive behavioral modalities (which nowadays are used synonymously, reflecting resemblance rather than differences) such treatments—using prolonged exposure, stress inoculation training, cognitive restructuring (Foa & Rothbaum, 1998), and cognitive-processing therapy (Resick & Schnicke, 1993)—were reported to be effective ones. As can be seen, the efficacy of interventions, in particular exposure and desensitization, has not diminished and has remained constant throughout the years. What has changed is the framework within which they are applied, which is aimed at assisting the bereaved in reconstructing a new meaning for the ever-changing reality.

In addition to the methodological problems identified in the review literature (Neimeyer, et al. 2000; Schut et al., 2001), two additional ones associated with the studies and the reported findings are observed: (a) Apparently, preoccupation with the deceased is dissimilar to the avoidance of stimuli, which is characteristic of phobic reactions. Extinction is not pertinent; rather, prolonged preoccupation with the deceased resembles depression reactions. And, what might be observed as avoidance behavior is more likely to be the withdrawal behavior frequently reported by bereaved persons (Kavanagh, 1990). (b) Breaking the bond assumption was not supported: On the contrary, the assumption of continuing bonds was validated (Silverman et al., 1996). Thus, from a cognitive perspective, continuing bonds with the deceased are not in themselves a form of complicated grief. Rather, persistence over time of distorted (irrational) beliefs results in dysfunctional emotional and behavioral consequences. Exposure intervention, therefore, is aimed at confronting and challenging distorted beliefs that lead to “excessive” emotions. Another form of complicated grief resembling phobic reactions is avoiding painful thoughts and refraining from any reminder of the loss or the deceased.

The Adversity-Beliefs-Consequences (ABC) Model of REBT Applied to Grief and Bereavement

Several treatments have been developed within CBT that can be applied effectively with grief. Characteristic to the different CBT models is that they all view cognitions as central in the process of grief. One such model is the ABC model, a cognitive theoretical model originated by Ellis (1962, 1976, 1985, 1991) that may be directly applied to our understanding of grief and
bereavement. Like other cognitive models, the REBT model emphasizes the centrality of cognitive processes in understanding emotional disturbance following an adverse event. However, it distinguishes between two sets of cognitions, rational and irrational ones, and their related emotional and behavioral consequences that differ qualitatively and marks the difference between healthy and unhealthy adaptation to undesirable events (Ellis, 1994). Applying this model to bereaved persons enables the distinction between healthy reactions to loss and prolonged dysfunctional grief, provides guidelines for the assessment of bereaved individuals’ interpretations of their experiences of loss, and offers cognitive, emotional, and behavioral strategies for facilitating a healthier course of bereavement in cases of loss. Assessment based on the ABC model, treatment of acute grief, and CT for prolonged dysfunctional grief will be outlined and clinical illustrations will be provided.

The REBT perspective distinguishes between healthy and unhealthy consequences of one’s belief system in reaction to loss. Grief is a normal and healthy reaction to a very stressful event. As distinguished from depression, grief is a process of experiencing the pain of the loss and searching for a new meaning to life without the dead person, and it is also a process of restructuring one’s irrational thinking into a more rational, realistic mode. Unlike depression, it is a process of searching for alternatives to life without the loved one who is the center of the pain and yearning. It is oscillation between grieving the loss and having to make choices regarding the reality of the loss (Neimeyer, 1999; Neimeyer et al., 2000; Stroebe & Schut, 1999).

Cognitively, it is also oscillation between “devastating” thoughts (“How could he have left me?” “How could she do it to me?”) and “sad” thoughts (“It is hard to accept that he will never be here any more”). Grief within the REBT conceptual framework is a process that helps the bereaved person organize his or her disrupted belief system into a form of healthy acceptance. Grief that has a healing effect and that adapts to the sad reality, which no longer includes the deceased, involves pronounced negative emotions such as sadness, frustration, and pain. Yet, it minimizes unhealthy, self-defeating feelings of depression, despair, horror, and self-deprecation.

In addition, although those individuals who have functional beliefs are still traumatized and feel very badly about their loss, those with dysfunctional beliefs tend not only to feel continuously devastated but also to create secondary symptoms about their primary bad feelings. Particularly following a traumatic death event, persons tend to have not only some self-defeating (irrational) evaluations of the event but also self-defeating evaluations about their disturbed emotions (secondary symptoms or disturbances) (Walens, DiGiuseppe, & Dryden, 1992). In such cases, an irrational pattern of
response is often more dominant than a rational one (Malkinson, Kushnir, & Weisberg, 1997).

The REBT model stresses that irrational beliefs are dysfunctional because they are exaggerated evaluations of events over which the person has less control, as compared to the choice of interpretation of the event that the person can exert. The belief-consequence connection, according to this model, will most probably result in the case of overreliance on irrational beliefs in dysfunctional emotional and behavioral consequences, which in turn will increase stress and reduce the individual’s coping resources. Like other CBT and CT models, the REBT uses a variety of interventions—cognitive (disputation, thought restructuring, and reframing), emotional (guided imagery), and behavioral (practicing skills as homework assignments)—so as to improve the person’s coping, reduce emotional disturbance, and increase self-control especially when circumstances are uncontrollable. In the following illustrations of my clinical work, I highlight the cognitive aspects of the interventions, under the assumption that behavioral changes of the cognitive modifications will follow.

**COGNITIVE ASSESSMENT THROUGH REBT**

For purposes of determining the healthiness or unhealthiness of an individual’s response to a death event, it is important to conduct an accurate and comprehensive assessment of the bereaved person’s perception of his or her loss. In addition to the details about the activating event, the individual’s beliefs, emotions, and behaviors are also assessed (DiGiuseppe, 1991).

To formulate a hypothesis regarding the client’s thinking and its interaction with emotions and behaviors (Beck, 1976; DiGiuseppe, 1991; Kavanagh, 1990), the social worker should first seek to explore details concerning the activating event (A in the ABC model), unlike other types of REBT interventions where too many details about the adversity may be redundant (Malkinson, 1993). The client’s detailed perception of the death event should be elicited during the intake sessions, in conjunction with the collection of general demographic information and the person’s underlying schema or assumptions about the self, others, and the world so as to elicit the individual’s irrational beliefs (DiGiuseppe, 1991). A detailed assessment of the client’s perceptions of the activating event (A) will assist the social worker in identifying the client’s loss-related irrational beliefs (B) that underlie specific emotional consequences (C) (Malkinson, 1996) and will also enable the social worker to distinguish between functional and dysfunctional responses (B, C) to the death. This distinction is especially pertinent to
sudden, traumatic events, which are characteristically negative and overwhelming. As Ellis (1994) emphasized, dysfunctional thoughts about the adverse event (“How could she have done it to me? I will never forgive her for leaving me,” “It shouldn’t have happened to me,” “This absolutely shouldn’t have happened at all,” or “I should have prevented it”) coexist with functional, healthy thoughts (“It’s so painful, but I did all I could to help her”).

In addition, exploring the death event in detail may have a cathartic effect because telling the “story” includes one’s interpretation of the event and how one feels about it, offering an opportunity to express irrational thoughts the client may have about the event itself or thoughts about the self, others, or the circumstances surrounding the loss (Malkinson, 1996). It is essential to explore with the client the personal meaning of the loss event (e.g., “She was all my life; my life is worthless without her”) and of the lost person (e.g., “He was the only one that cared for me”) (Freeman & White, 1989). This includes how the loss is verbalized and what specific words (e.g., “I am tired of life”) do or do not mean to the client. These will assist the social worker in proposing alternative interpretations, paying special attention to the person’s linguistic style. In addition, written self-report measures can be included to assess loss and grief cognitions. I will mention two such scales. They are both self-report pencil-and-paper Likert-type scales. The Texas Revised Inventory of Grief (Faschingbauer, 1981) has two subscales: Part 1 includes 8 items focusing on past behavior, and Part 2 consists of 13 items focusing on present feelings to assess emotional responses indicative of unresolved grief (“I can’t avoid thinking about the deceased,” “I am unable to accept the death”). The participant responds on a 5-point Likert-type scale. The Texas Revised Inventory of Grief also includes questions as to the nature of the relationship, closeness to the deceased, and length of time since the death. Another useful scale that focuses on changes in cognitions about the traumatic event is the World Assumption Scale (Janoff-Bulman, 1992). It is a 32-item scale that assesses assumptions about the world. The three subscales were derived from three basic assumptions identified by Janoff-Bulman (1992): benevolence of the world, meaningfulness of the world, and self-worth. It is a 6-point Likert-type scale. Both scales can be used for initial assessment and may also be repeated at the end to evaluate treatment outcomes (premeasure and postmeasure). The client can take an active part in the evaluation.

Acute-Phase Intervention Through REBT:
From Experiencing Anxiety to Experiencing Pain

An important element in grief therapy is dealing with the pain of coming to terms with one’s loss (Malkinson, 1996; Malkinson & Ellis, 2000;
Sanders, 1993). This element of pain is similar to the catastrophic misinterpretation observed in panic disorders and post-traumatic stress disorder (Clark, 1986; Moore, 1991; Warren & Zgourides, 1991). The REBT approach legitimizes pain and sadness as functional (healthy) negative emotions that are a normal part of coming to terms with traumatic and tragic loss. Pain is the emotional expression of the understanding and recognition of death. Moreover, the process of giving up old beliefs regarding the dead person and adopting new ones based on the new reality cannot be experienced without pain and sadness.

In dysfunctional, acute grief as well as in prolonged grief, a secondary symptom (e.g., stress, anxiety) regarding pain may stem from irrational beliefs (demandingness) such as “This death is so sad in itself that it shouldn’t also be painful,” or “I must be able to control the pain or else I’ll go crazy.” In some cases, people even demand of themselves that they must experience great pain, especially when they blame themselves for possibly forgetting the deceased. In all, the human quest to avoid pain and increase pleasure is seriously disturbed when experiencing a traumatic event such as that of death (Ellis, 1962, 1985; Epstein, 1993).

REBT based for the acute-phase interventions has four aims:

1. identifying irrational beliefs (demandingness directed to self, others, and the world) and their emotional (e.g., anxiety), behavioral (e.g., avoidance), and physiological (e.g., breathing difficulties, heart palpitations) consequences;
2. explaining and teaching the connections between beliefs (B) and consequences (C);
3. identifying and assessing individual specific consequences, (i.e., specific language to describe emotions, behaviors, and specific physiological reactions);
4. teaching and practicing appropriate, healthier (rational) cognitive, emotional, behavioral, and physiological grief responses (Ellis, 1994; Ellis & Dryden, 1997; Malkinson, 1996).

The following clinical illustration of acute grief demonstrates how clients’ beliefs and consequences in terms of the ABC model can be identified. A women requested therapy some months after the sudden death during military service of her 18-year-old son. According to her, the decision to come to therapy occurred when she realized that her initial decision to be strong and carry on with life “as if nothing had happened” turned out to be too difficult, painful, and in fact, impossible.

Client: I don’t understand what is happening with me. I have difficulties in concentrating at work, at home. And, I force myself to function, only to realize that it doesn’t work.

Therapist: What do you tell yourself about not being able to concentrate?
Client: I tell myself that I must concentrate because I promised myself that life must go on as if nothing happened. I hate myself for not being able to control myself. . . . I am a weak person. I’ve lost my appetite, and I can’t sleep well.

This bereaved mother was experiencing dysfunctional acute grief and needed intervention to help her grieve in a healthier way, beginning with identifying her irrational thoughts (Aim 1) (e.g., “I must not cry because if I do, I am a weak person,” “I must be strong and in control”), and to explain to her the connection between each of these thoughts and their different consequences (Aim 2), whether emotional (e.g., feeling anxious when crying), behavioral (e.g., avoiding situations that might elicit crying), or physiological (e.g., choking, panic attacks, and sleep disturbances). The irrational beliefs and consequences expressed in her idiosyncratic way were explored (Aim 3) during the intake sessions, revealing the mother’s other distorted interpretations referring to self (e.g., “I must not give up; strong is my motto”) and the unrealistic expectation that life could proceed unchanged despite the loss.

Additional idiosyncratic avoidant behaviors were also identified, involving reminders of the dead son: refraining from mentioning the son’s name, moving his photographs, or avoiding driving near the cemetery where he was buried. The irrational belief underlying this avoidance was discerned as, “This way, I don’t have to confront the overly painful reality of my son’s death. Also, it’s my way of keeping my son alive. I don’t want to think of him as dead.”

Avoidance of talking or refraining from certain behaviors several months after a sudden and traumatic death, as in the above illustration, is common among grieving persons and is an example of irrational thinking according to the REBT model on the primary level. It is a way of cognitive construction to deal with a reality that is “too painful.” The mother also created a secondary symptom (a disturbance about the disturbance) by putting herself down for not preventing herself from overreacting to the pain, for being a weak person rather than the strong one she must be. Her demandingness (B) might have stemmed from the family’s decision to continue with life “as if nothing has happened.” Avoidance (C), as interpreted by the bereaved mother, became “functional” in escaping from experiencing the unbearable pain, and when her efforts “to be strong as she must be” failed, she was critical and self-damning and became anxious. The cycle of events includes the woman’s demandingness that she must not experience the pain; however, based on her accumulated experience, she anticipated her failure in avoiding pain, which in turn increased her fear of loss of control, and the consequence was anxiety.

The fourth aim of intervention was to teach the mother the difference between her irrational self-demandingness, “I must not cry,” and her feelings
of anxiety if she cried, as compared to more rational thoughts such as “I wish I wouldn’t cry,” which would only lead to feeling frustrated if she did cry. Training and practicing rational thinking (e.g., “I cry because I am sad, not because I am weak”) were initiated to help the mother acquire healthier grief responses.

In general, REBT therapy for this bereaved mother comprised two major processes: First, to help the client change her self-damning thoughts to ones of self-acceptance (from demandingness that she must be able to control her pain, to a less critical view of her efforts to cope with the pain), she learned to differentiate between functional and dysfunctional beliefs and their related consequences. She realized that her “functional” avoidant behavior not only did not prevent her suffering but actually added to her pain whenever she encountered an unfortunate external event, a stimulus over which she had little control.

Second, to guide the client in helping herself experience unavoidable bearable pain and in overcoming her anxiety attacks, intervention focused on teaching this mother to increase her sense of control, both cognitively and physically, over her pain. Cognitive and behavioral strategies were employed to increase the client’s sense of control over her pain, as well as the use and rehearsal of rational emotive imagery (Maultsby, 1971). Rational emotive imagery (Ellis, 1993) is a forceful emotive strategy wherein the client is asked to let herself experience a very dysfunctional feeling and change it to a more functional one. Routinely, this is preceded by the therapist’s exploring with the clients their various emotions, explaining the differences between emotions that are healthy (sadness) and unhealthy (depression), identifying the cognitions that go with each, and practicing the changes many times. Cognitively, the mother was taught and rehearsed the distinction between unbearable (anxiety) and bearable pain, a distinction that helped her determine her own level of pain tolerance and have much more control over her feelings. By telling herself that although she would have preferred not to have the pain, she could withstand it, anxiety became a bearable pain. In addition, behavioral strategies were prescribed as homework assignments (each time she felt like crying, to detect her thoughts and write them down) and were used throughout the therapy.

Particularly significant for the bereaved mother was overcoming her avoidance of driving past the cemetery, the mere thought of which caused panic attacks with pronounced physiological responses, including choking sensations, numbness, and irregular breathing. Using rational emotive imagery and rehearsing the details of the route, the worst thoughts about what she feared and the most intense feelings of pain she imagined she would experience (the B-C connection), the client was trained to use coping statements to
stop “awfulizing” and to continue driving. She also was taught to use thought-stopping as a way of preventing herself from panicking: “Telling yourself that you can’t stop thinking about your failure to prevent pain, increases your anxiety; so you are going to tell yourself to stop thinking this thought each time it goes through your mind.” Breathing exercises were added to help her overcome her choking sensations.

When the client felt confident that she was able to control her thoughts and emotions, she agreed to drive on the road passing the cemetery. She reported crying and being very sad while driving her car. She said she forcefully used the coping statements and breathing exercises, and she did not choke that time. When describing her experience in the session, she described a feeling of being at peace with herself. She added that she wished she never had to drive past the cemetery but felt a lot less tense because she had done so. As can be seen, the mother’s irrational expectations and beliefs about driving past the cemetery were changed to rational, healthier grieving responses.

Similar procedures were undertaken to overcome the mother’s avoidance of thoughts about doing or actual avoidance of certain behaviors that in her mind were associated with her son’s memories or the pain involved in thinking of him as dead. These involved a careful monitoring of her activities: cooking her late son’s favorite food, looking at his photographs, talking about him with other family members, entering his room, and so on.

In sum, the range of strategies employed with this client in the acute phase of grief included cognitive strategies related to the ABCs of the REBT model with special attention to the following: identifying and learning to differentiate between rational and irrational beliefs, focusing on the emotional consequences, seeing the connections between thoughts and emotions, and using rational emotive imagery to practice changing dysfunctional emotion to functional emotion and, by the same token, changing an irrational belief to a more rational one. Other CT strategies were aimed at increasing the sense of control over pain, learning and practicing the cognitive distinction between unbearable and bearable pain, using and rehearsing rational emotive imagery, thought-stopping, and breathing and relaxation exercises. As can be seen, cognitive strategies are central to the intervention because they help regaining a sense of control over a shattered reality; it is assumed in the REBT model that behavioral changes will follow cognitive ones. Practicing between sessions in the form of homework assignments is an essential strategy in the REBT model (Ellis & Dryden, 1997) to increase the effect of the cognitive, emotional, and behavioral changes. During acute grief, it is particularly important to assess the client’s physical reactions and address them in the course of therapy because loss through death involves physiological reactions as part of grief (Sanders, 1989). Learning appropriate breathing and
relaxation techniques can be most beneficial in facilitating a healthier course of grief, especially in the case of panic-stricken individuals. Teaching progressive relaxation (Jacobson, 1938) is often of special importance because it has the potential to improve the bereaved’s functioning and sleeping.

This case illustration of cognitive grief therapy focused on the distinction between grief as a healthy process involving functional negative emotions, as opposed to a disturbed, unhealthy process that is maintained by adopting distorted interpretations resulting in dysfunctional emotions. Part of the healthy process involves normalizing and legitimizing pain as a normal part of coming to terms with traumatic and tragic loss. Such was the case with the bereaved mother who as therapy progressed became less anxious and less depressed but was sad, grieving, and significantly less avoidant of her pain. She resumed previously avoided activities, brought out her son’s photographs, and was able to look at them and talk about him and the loss with family members and friends, while fully accepting herself with her “weak” pain and crying. Therapy lasted 6 months with weekly 1-hour sessions, and the outcome was a healthier, although painful and sad, process of grief. The therapy was a process of regaining partial control and of reestablishing an acceptable equilibrium between mind, feeling, and behavior.

CT for Prolonged Dysfunctional Grief

Dysfunctional grief is defined by REBT therapists as persistence over time, with no diminishing effect, of dominant irrational (distorted) beliefs regarding the loss event, the deceased, and the self (Malkinson, 1996). The client’s difficulty, failure, or refusal to reconstruct an alternative “assumptive world” (Parkes, 1993) or belief system are manifested as crying, anger, and protest. From the REBT perspective, prolonged dysfunctional grief is related to the circumstances of the loss event and mediated by the individual’s cognitive tendencies: “This loss should have never happened to me, and I’ll never get over it”; “Life is not worth living”; “I would rather die than go through this terrible pain” are such typical cognitions (Ellis & Dryden 1997; Malkinson, 1996, Malkinson & Ellis, 2000).

According to the REBT approach, during the acute phase of grief, the bereaved require help in accepting their grief and pain through general cognitive behavioral strategies (e.g., using coping statements, thought-stopping, cognitive rehearsal, and cognitive reframing), combined with information giving. In contrast, in cases of prolonged dysfunctional grief, challenging irrational beliefs is more timely and appropriate, as well as the employment of rigorous “disputation” interventions, combined with behavioral strategies (Ellis, 1994) and diverse cognitive behavioral methods (Ellis, 1994; Kubany
Changing irrational beliefs is known in REBT as disputation, which refers to challenging the client’s dysfunctional belief system using cognitive, emotive, and behavioral strategies (Walen et al., 1992). In prolonged dysfunctional grief, REBT interventions will most likely include rigorous logical, empirical, and pragmatic disputation combined with employing other forms of empirical disputation (i.e. thought-stopping, reframing, practicing rational statements, and alternative behaviors). The wide range of strategies in CT has been described at length by Ellis and Dryden (1997), Beck (1976), Freeman and White (1989), and Meichenbaum (1986).

The “As If” and Other Cognitive Strategies Applied to Prolonged Grief

Using the “as if” cognitive strategy has been found to be effective when working with the bereaved, especially in cases of prolonged grief (Ellis & Dryden, 1997; Malkinson, 1996; Van der Hart, 1987). In line with the REBT tenet of normalizing grief responses, the application of this strategy provides a means to legitimately allow the bereaved to express otherwise unexpressed “crazy” thoughts or secrets that he or she may hold or experience, sometimes taking the form of an inner “as if” dialogue with the deceased (Raphael, 1983). “As if” strategy can be applied in a similar manner but structured so that thoughts directed at the deceased are externalized and verbalized (Malkinson & Ellis, 2000). The following case illustrates usage of this strategy and others.

A female client in her late 20s requested therapy because, as she said, she felt depressed, cried a lot, gave up her work, and had lost interest in life. The client revealed that 1 year prior to her requesting therapy, her brother had committed suicide. According to the client, she and her brother were very close, and she felt guilty because she did not prevent her brother from jumping to his death (“It’s my fault”). Anger was also expressed at her brother for killing himself the way he did (“How could he have done it to me?”), and she feared she would never be able to forgive him. But, even more painful were her guilt feelings for not saving her brother and the awful feeling of having to live with the thought that he would never forgive her. She was convincing herself of how bad a person she was for neglecting her brother’s call for help. Prolonged grief was assessed as related to the cyclical interaction between irrational beliefs (demandingness) and disturbed emotions (depression), apparently preventing a healthier course of grief. It seemed from the client’s disclosures that the brother was “present” within her, and the way she was thinking about and remembering him could explain some of the irrational beliefs she clung to. In intervention with this client, alongside logical
disputation, the “as if” technique (Ellis & Dryden, 1997) was the main strategy employed to explore her cognitions and her “if only” thoughts or interpretations about these facts (“If only I had stayed with him as I should have” or “If only he had asked me”).

Talking to him in an “as if” manner, as if he were here, telling him all the thoughts that she wished she could have said, was a way of assisting her in verbalizing those “terrible and wicked” thoughts that were running through her mind. The imagined dialogue was rehearsed and practiced with a focus on functional, healthy emotions (sadness, pain, and frustration). She practiced the difference between rational and irrational thoughts and was able to emotionally experience sadness as distinct from depression. As sad as the death event was, and obviously had remained, it was the client’s evaluation of it that had to be modified into a healthier one.

Because the anniversary of her brother’s death was approaching and she planned to go to the cemetery, a homework assignment to write an “as if” letter to her brother was prescribed. She would go to the cemetery with someone of her choice and read the letter aloud as if to her brother. The homework was prescribed as a way of practicing rational (functional) thinking and also as a leave-taking ritual (Van der Hart, 1987; Witztum & Roman, 1993).

In the following session, the client described her writing the letter as if to her brother and her visit, with her sister, to the cemetery. In the letter, she told her brother all the thoughts and feelings she experienced following his death, her concern and love for him, and her regret that she was not sensitive enough to see the pain he went through. She cried in the session and said she felt very sad, although less angry toward him. She was emotionally overwhelmed to find that for the first time since his death, she could visualize her brother the way she remembered him prior to his death, as a healthy young man. After two more sessions, when it was apparent that the client had adapted and internalized a more rational mode of experiencing her brother’s death, therapy was terminated.

Three months later, in a follow-up session, the client reported being less depressed, saying that although she felt the pain of her brother’s death, she also realized that it was his choice and that she probably could not have prevented it. She said, “I know my brother loved me and was very concerned over my depression. I think he forgives me.”

CONCLUDING REMARKS

Considerable changes have taken place regarding the grief process in defining its positive and negative outcomes and the necessity, timing, and
type of treatment. The growing literature of clinical and empirical studies offers social workers a variety of treatments, of which cognitive ones are found to be effective in helping bereaved people who are in need of professional help. Complicated grief, as distinct from depression, refers to prolonged preoccupation with the deceased (irrational thinking) and therefore requires a specific treatment that deals not only with the symptomatology (i.e., stress in coping with life following the loss) but also assists the bereaved to cognitively construct a more balanced (rational) inner relationship with the lost person. Interventions such as exposure, guided mourning, or guided imagery, which are empirically considered effective in cases of complicated grief, involve a difficult task for the social worker, that of taking the bereaved through the most painful thoughts that tend to be avoided but paradoxically have a long-term healing effect. These interventions call for a thorough assessment and carefully applied interventions, remembering that the impact of loss continues throughout life. Expected “positive” bereavement outcomes are not necessarily detachment from the deceased but weaving the loss event into the continuing life. More outcome studies that focus on the cognitive component of exposure interventions to the loss event using grief-specific scales will make social workers’ treatment of the bereaved more effective and targeted.

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Objective: This study was intended to validate a Spanish adaptation of the Multi-Problem Screening Inventory (MPSI), which was developed by Hudson and McMurry for assessment in social work practice. Method: Research was based on the cross-cultural equivalence model and included a content judgment study followed by a field test with a sample of 313 Puerto Rican university students. Results: Findings regarding internal consistency as well as item, factorial, discriminant, and convergent analyses of the Spanish MPSI were similar to those of the English version; items were found to be relevant for Puerto Ricans. Conclusions: Content, technical, and conceptual equivalence of the Spanish and English versions of the MPSI were supported, and thus its valid use in social work practice with the study population.

The Multi-Problem Screening Inventory (MPSI) was developed by Hudson as an assessment tool to measure 27 different areas of personal and social

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functioning of clients. It has been field tested and there is evidence of good to excellent psychometric properties with student and Desert Storm veteran populations (Hudson & McMurtry, 1997; D. L. Murphy, personal communication, June 16, 1994). The MPSI can be used for initial assessment of client problems, it can provide an indication of change over the course of treatment (progress, stability, or deterioration), and it can help to determine service outcomes at case closing or follow-up. Given that social work practice increasingly emphasizes the person-in-environment and ecological systems models and that accountability demands the need to provide evidence of practice effectiveness, a tool such as the MPSI can be very useful for human service practitioners.

Unfortunately, the MPSI has only been tested with U.S. mainland (USM), nonminority study samples, and the information on the validity and reliability available is not applicable to nonacculturated minority populations. For this reason, the author of the scale warns practitioners of the ethical implications of using the MPSI with such minorities (Hudson, 1990a). Hispanics, therefore, have been excluded from the benefit of using the MPSI.

According to the U.S. Bureau of the Census (1994), there are 22.8 million Hispanics, which constitutes 8.9% of the total U.S. population. Among Hispanics, Mexicans are the largest group, representing 64.3%. The mainland Puerto Rican population is approximately 10.6% (2.7 million), and Cubans represent 4.7% (U.S. Bureau of the Census, 1994). Central and South Americans make up 13.4%, and there is another category of Hispanics who are primarily from Spain but include people who identify themselves as Hispanic, Latino, Spanish-American, Spanish, and so on (7.0%). Not included in these statistics are the Hispanics residing in Puerto Rico who, according to the U.S. Bureau of the Census (1994), number 3.5 million.

There are 15,216,298, or 68% of all Hispanics, who do not speak English at home (U.S. Bureau of the Census, 1990). In addition, 50.7% reported that they do not speak English “very well.” In Puerto Rico, Spanish is the dominant language. In addition to language, Hispanics have distinct cultural characteristics that need to be considered in their psychosocial assessment.

At present there is no validated instrument for Spanish-speaking Hispanics, such as the MPSI, to screen for psychosocial problems or to assess progress in problem resolution. The validated MPSI could be utilized for screening psychosocial problems, assessment, and evaluation of services to Hispanic clients and their families.

This article describes the translation and adaptation into Spanish and validation of the MPSI with a sample of Puerto Ricans. The study was based on the cross-cultural equivalence model that integrates these processes. The model applied in this study included attaining semantic, content, technical,
and conceptual equivalence between the original scales and the Spanish version. Technical and conceptual equivalence were determined in part by replicating the classical testing theory methods used by the author of the scales. In addition, a content judgment analysis (content validity study) of the scales was conducted that had not been done on previous studies of the MPSI. Nevertheless, the study was not intended to make improvements to the instrument. This effort represents a first step toward validating this instrument for Hispanic populations served by social work practitioners. Also, the results of this study are expected to contribute to the knowledge base in cross-cultural research because it applied a cross-cultural model in adapting and validating the MPSI to Spanish.

CONCEPTUAL FRAMEWORK

The literature on cross-cultural research on the translation and validation of measurement instruments provided the conceptual framework for the work with the MPSI (Brislin, 1970, 1986; Burman, Karno, Hough, Escobar, & Forsythe, 1983; Ellis, 1991; Hambleton & Bollwark, 1991; Hui & Triandis, 1985; Hulin, 1987; Poortinga & Van de Vijver, 1987; Prieto, 1992). More specifically, the cross-cultural equivalence model (Bravo, Canino, Rubio-Stipec, & Woodbury-Fariña, 1991; Flaherty, 1987) guided this study. Cross-cultural studies can assume different perspectives, which have been described as the “emic-etic paradigm” (Brislin, 1986; Poortinga & Malpass, 1986; Triandis, 1972). The emic perspective looks at phenomena from within the culture to achieve a contextual understanding. On the other hand, the etic approach focuses on the universality of phenomena across cultures. The cross-cultural equivalence model assumes both perspectives: “This model is based on the premise that human behavior as well as psychopathologic phenomena are universal yet considerably influenced by the socio-cultural context in which they occur” (Bravo, Woodbury-Fariña, Canino, & Rubio-Stipec, 1993, p. 331).

In applying the cross-cultural equivalence model, researchers have used different perspectives and procedures. In this study the authors chose to follow the approach used by Bravo et al. (1991, 1993) as it was successfully applied in translation and adaptation studies with other Puerto Rican populations. This approach included translation and back translation by professional translators, the use of a bilingual committee, and empirical studies to assure equivalence between the English and Spanish versions of the MPSI. The reliability and validity studies were integrated in this approach. Equivalence was assessed along four of the five dimensions of the model which,
based on the work by Flaherty (1987) and Bravo et al. (1993), are defined as follows: semantic equivalence—each item has similar meaning in the languages involved; content equivalence—the content of each item is relevant to the population under study; technical equivalence—similar effect is obtained when the same measuring technique is used with the different cultures; criterion equivalence—the interpretation of the scores is similar when evaluated with the established norms of each culture (not tested in this study); and conceptual equivalence—the theoretical constructs being assessed are the same in the different cultures involved.

This model was well suited for the work with the MPSI; it guided the work on the first phase of the project in adapting the scales into Spanish and served as justification for the second phase that included replicating the methodology used by Hudson and McMurtry (1997) to test whether technical and conceptual equivalency had been achieved. The conceptual foundations of the MPSI itself were established by Hudson and McMurtry (1997) following the principles of the domain sampling model of measurement as described by Nunnally (1978) and by Hudson (1990a) in explaining the microtheory of human problems.

DESCRIPTION OF THE MPSI AND PRIOR RESEARCH

The MPSI is a battery of 27 scales that Hudson had created and refined over time. It is a paper-and-pencil, self-report measure that contains 334 items that are answered in a 7-point frequency scale ranging from 1 (none of the time) to 7 (all of the time). The instrument requires 30 to 45 minutes to complete. The original Hudson scales, as they were sometimes called, were characterized as simple-to-administer assessment instruments consisting of 25 items, with clinical cutoff scores of 30. Over time, they were published as a compiled set of scales. The first set was the Clinical Measurement Package (CMP) that was published in 1982 and included 9 scales (Hudson, 1982). The second set, called the WALMYR Assessment Scales (WAS), was developed 8 years later and expanded the number of scales to 22 (Hudson, 1990b). Hudson (1982, 1990b) reported validity and reliability data that supported their use for clinical practice.

The MPSI, with its 27 scales, was first tested with 331 undergraduate and master’s-level students, whom we will refer to as the USM study sample for the purposes of this study, in seven schools of social work (Hudson, 1990a, Hudson and McMurtry, 1997). Respondents had a mean age of 32.4, were
predominantly female (79%), White (80%), unmarried (59%), and had, completed an average of 16.4 years of schooling. The MPSI manual (Hudson, 1990a) and the study conducted by Hudson and McMurtry (1997) describe the reliability and validation procedures for the following scales: Depression, Self-Esteem, Partner Problems, Sexual Discord, Child Problems, Mother Problems, Father Problems, Personal Stress, Friend Problems, Neighbor Problems, School Problems, Aggression, Work Associates, Family Problems, Suicide, Non-Physical Abuse, Physical Abuse, Fearfulness, Ideas of Reference, Phobias, Guilt, Work Problems, Confused Thinking, Disturbing Thoughts, Memory Loss, Alcohol Abuse, and Drug Abuse. Reliability estimates indicated that 26 of the scales had alpha coefficients of .80 or greater, 16 of which were .90 or greater, and only the scale of Aggression had a value of .71 (Hudson, 1990a). The scales’ standard error of measurement values ranged from 0.55 to 4.89, which is considered small for scores that can range from 0 to 100. Scale means were relatively low as expected for a nonclinical population, ranging from a low 0.5 for Physical Abuse to a high of 30.4 for Neighbor Problems (Hudson & McMurtry, 1997). Hudson (1990a) and Hudson and McMurtry (1997) reported validity evidence that supports the use of the MPSI with the population studied.

Murphy (personal communication, June 16, 1994) administered the MPSI to 1,459 veterans (83.6% male) participating in the Persian Gulf Family Support Program in 39 VA medical centers from October 1992 to May 1993. The study sample was mainly White, with a mean age of 32.4 years for males, 34.3 years for females, and overall gross family income below $20,000 per year. Alpha coefficients ranged from .80 to .97. Twenty-one of the scales (78%) had coefficients of .90 or higher. Eighteen scales had higher alpha coefficients than those reported in the MPSI manual, 5 were the same, and 4 were slightly lower. The alpha coefficient of the Aggression scale was .88, which was much higher than the coefficient of .71 obtained in the original reliability study.

The MPSI had not been translated nor validated for Hispanic populations (Hudson, 1990a). The MPSI scales were originally designed and the psychometric research to standardize them was conducted for use with participants who had grown up or lived primarily in Western culture. Thus, its author (Hudson, 1990a) alerted users that “it may not be suitable for use with individuals from different cultures” (p. 4). The adaptation into Spanish using cross-cultural methodology was an essential first step toward testing the MPSI’s psychometric properties among the Puerto Rican Spanish-speaking population.
Adaptation of the MPSI Into Spanish

The cross-cultural equivalence model guided the work in achieving equivalency between the English and Spanish versions of the MPSI. The dimensions of the model were addressed by using three techniques: translation, back translation, and the use of bilingual committee (Bravo et al., 1993). To assure equivalency, an independent, professional, experienced translator carried out the initial translation into Spanish. The bilingual committee reviewed this translation to assure that the terms of each item were appropriate or meaningful within the Puerto Rican–specific cultural context. Inappropriate terms were substituted for others that would convey the intent of the item. All meetings were taped and all substitutions of terms were documented.

A bilingual independent translator different from the one that did the translation into Spanish carried out the back translation. The bilingual committee compared the back-translated version with the original English version to identify discrepancies, determined the cause of the discrepancies, consulted the author of the MPSI scales, and made corrections as necessary to the target Spanish version. Special efforts were made to avoid regionalisms, which required the use of the official dictionary of the Spanish Royal Academy that standardizes the use of words not only in Spain but Latin America as well.

A sample of 25 veterans of outpatient psychiatry clinics at the San Juan VA Medical Center voluntarily participated in testing item comprehension of the MPSI Spanish version. After obtaining informed consent, interviewers instructed participants to read each of the items and asked whether they understood them. Problems in item understanding were identified, discussed with the participant, and their recommendation for item clarity was elicited. A summary of participant responses to items presenting difficulty was made available to the bilingual committee, which determined the changes that would facilitate item understanding.

The bilingual committee process was repeated three times for the 334 items of the MPSI: after initial translation to Spanish, after the back translation, and finally after field testing with the veterans. Finally, to assure that the MPSI translation was grammatically correct, a Puerto Rican university professor with expertise in linguistics reviewed the MPSI, and corrections were made where necessary.

Once a Spanish version was obtained, it was decided to test the MPSI for technical and conceptual equivalency using the same methodology and type of population (social work students) as used by Hudson and McMurtry (1997). In addition, the authors of this project expanded the original methodology
used with the MPSI by including a content judgment study (Crocker, 1997) to assess content equivalency.

Hypotheses

The general hypothesis for the study was that the validation procedures for the 27 scales of the MPSI would support its cultural equivalency for use with Puerto Rican student populations. In addition, based on the original MPSI study results, the authors established the following working hypotheses:

- **Hypothesis 1:** The alpha coefficients for the translated MPSI scales would be comparable in magnitude to those of the USM population.
- **Hypothesis 2:** In factorial analysis (item analysis), over 90% of the items would correlate more highly with their own scale total scores than with total scores of other scales.
- **Hypothesis 3:** There would be nonsignificant or low correlations between the majority of scale scores and the following demographic variables: gender, marital status, age, years of education, income, number of times married, years with spouse or partner, number of children or family size.
- **Hypothesis 4:** The magnitude of scale means, standard deviations, and the standard errors of measurement would be similar in the USM and the Puerto Rican student samples.
- **Hypothesis 5:** In the content judgment study, over 90% of the items would be judged as relevant for measuring the intended construct.

METHOD

Design

Figure 1 illustrates the full study design based on the cross-cultural equivalence model. Phase I included the adaptation into Spanish of the MPSI, as described previously. Phase II involved the test for content, technical, and conceptual equivalence between the English and Spanish versions of the MPSI (see definitions of these dimensions in the Conceptual Framework section). To assess the content equivalence, a content judgment study (traditionally called a content validity study) was carried out. According to the cross-cultural equivalence model, the goal of this dimension of the adaptation process was to determine whether the items of the MPSI were relevant to the population under study. In evaluating whether the Spanish scale items were culturally relevant, 13 judges individually rated each of the 334 items. All the judges selected were experienced Puerto Rican mental health
Figure 1: The cross-cultural equivalence model used in the adaptation of the Multi-Problem Screening Inventory (MPSI) into Spanish.
clinicians working for the VA Medical Center in San Juan. All judges were proficient in both written and spoken Spanish.

To assess for technical equivalence, Cronbach’s alpha was computed as a measure of internal consistency for each of the scales (Cronbach, 1951). This procedure permitted the research team to evaluate whether the Spanish-version reliability coefficients obtained were adequate for clinical purposes and whether they were comparable to the reliability coefficients obtained in the USM sample.

The MPSI is based on 27 theoretical constructs, and the task in establishing conceptual equivalence was to assess if the same constructs were evaluated by the scales in the USM (Hudson & McMurtry, 1997) and Puerto Rican populations. To achieve this, factorial analysis was carried out as had been done in the USM study. This approach consisted of testing the hypotheses that items would correlate well with the variables with which they were supposed to correlate and poorly with the constructs with which they were not supposed to correlate. For this task, Hudson (1990a) used the multiple group method of factor analysis as described by Nunnally (1978). This method uses item-to-scale and scale-to-scale correlations to produce a matrix of Pearson product moment correlation coefficients.

Content Judgment Study

The content judgment study consisted of having a panel of 13 judges independently rate the content relevance of each of the 334 items. Ratings were made on a scale ranging from 1 (irrelevant) to 4 (very relevant and precise). Analysis of the ratings consisted of computing the Content Validity Index (CVI) for each item (Lynn, 1986; Waltz & Barker-Bausell, 1981). The CVI is the proportion of judges that rated the MPSI item valid. All responses were dichotomized: Ratings of 3 or 4 were judged content relevant and ratings of 1 or 2 were judged not relevant. For each item a ratio was computed based on the recoded categories. The criterion for considering an item as content relevant was agreement by a minimum of 10 of the 13 judges. In this way, agreement by chance was controlled at an alpha level of .05. (Lynn, 1986; Sahai & Martinez, 1996).

Technical and Conceptual Equivalence Study

Sample. Participants were 313 social work students recruited from two accredited graduate and undergraduate social work programs of two universities in the San Juan metropolitan area. The sampling frame consisted of
232 graduate and 510 undergraduate students for a potential total of 742 participants. The sampling goal was to obtain a sample with sociodemographic characteristics similar to the study sample by Hudson and McMurtry (1997). We oversampled from graduate students to achieve as similar characteristics as possible. The rationale for this was to allow for comparison of the instrument’s psychometric properties across cultures.

Participants were predominantly female (87%) and unmarried (69%). The mean age of the sample was 26.9 years, the mean number of years of schooling was 16.5, and their average annual family income was $20,500. The mean number of times married was 1.1 years, the number of years living with current spouse of those married was 7.5, their average family size was 3.4, and the mean number of children was 1.4. A comparison of the Puerto Rican and USM sample demographic characteristics is summarized in Table 1. In general, the Puerto Rican sample was similar to the USM sample in terms of years of education and in their distribution by gender and marital status (single women). There were slight differences in the range of .5 or less in times married and number of children. The Puerto Rican sample differed from the USM sample in that on the average it was 6 years younger, had half the income, and had a family size twice as large.

The acculturation to the U.S. mean score was 1.7 on a scale of 1 to 5, indicating low acculturation. This mean was lower than the mean reported for a first-generation Hispanic group in the U.S. Mainland (primarily Mexican Americans and Central Americans with small samples of Cubans, Puerto Ricans, and South Americans residing in the United States; no specific

<table>
<thead>
<tr>
<th>Background Variable</th>
<th>Mean Mainland</th>
<th>Mean Puerto Rican</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (male = 1)</td>
<td>0.2</td>
<td>0.1</td>
</tr>
<tr>
<td>Marital status (married = 1)</td>
<td>0.4</td>
<td>0.3</td>
</tr>
<tr>
<td>Age</td>
<td>32.4</td>
<td>26.9</td>
</tr>
<tr>
<td>Education</td>
<td>16.4</td>
<td>16.5</td>
</tr>
<tr>
<td>Family income (in 1,000s)</td>
<td>40.0</td>
<td>20.5</td>
</tr>
<tr>
<td>Times married</td>
<td>0.7</td>
<td>1.1</td>
</tr>
<tr>
<td>Years married</td>
<td>6.1</td>
<td>7.5</td>
</tr>
<tr>
<td>Number of children</td>
<td>0.9</td>
<td>1.4</td>
</tr>
<tr>
<td>Family size</td>
<td>1.8</td>
<td>3.4</td>
</tr>
</tbody>
</table>

NOTE: For the variables of gender and marital status, mean values reported are the equivalent to the proportion of cases in the group coded 1.
geographic location was mentioned), which was 2.37 (Marin, Sabogal, Marin, Otero-Sabogal, & Perez-Stable, 1987).

The procedure for the selection of the sample was as follows: First, social work program directors were contacted by phone to explain to them the purpose and relevance of the study in an effort to enlist their support. The personal contact was followed by a formal written request to conduct the study at the two universities. Copies of the study protocol, instruments, and consent forms were included for institutional review board reviews at each of the sites. Once the study was approved at the sites, class programs and the number of all students enrolled in each course were requested. Faculty members were contacted and urged to motivate students to participate. Handouts with the study objectives were provided to students encouraging them to participate.

**Instruments.** Instruments consisted of a brief sociodemographic questionnaire, the MPSI, and an acculturation-to-the-U.S. scale. A brief questionnaire with no personal identifying information was used to gather background and demographic information, as was done in the original validation study of the MPSI. The variables of the brief questionnaire were gender, marital status, age, education, family income, number of times married, years with spouse or partner, number of children, and family size. Ethnicity was not a variable in this study and was replaced by measuring acculturation, a variable that serves as indicator of the extent that participants were Hispanic in cultural orientation.

The Short Acculturation Scale developed by Marin et al. (1987) was used as a measure of acculturation to the United States. According to these authors, the concept of acculturation has several dimensions, but their instrument covers only three: (a) language, (b) media, and (c) social relations. It is a 12-item scale designed for use with Mexican and other Latin American Hispanics. The item ratings fluctuate from 1 to 5, with higher numbers indicating greater acculturation. In a study conducted in the USM, first-generation Hispanics had a mean score of 2.37 and those classified as second generation a mean score of 3.42. The scale’s reliability was assessed in a primarily Mexican American and Cuban American sample. The alpha coefficient was .92, which is considered high. In the Puerto Rican sample of this study the alpha coefficient for these scale scores was .86.

The MPSI is a paper-and-pencil, self-report measure containing 334 items that requires an average of 30 to 45 minutes to complete (Hudson, 1990a). Respondents answer each item via a frequency scale ranging from 1 (none of the time) to 7 (all the time). A “does not apply” option is also provided. The
inventory is divided into 27 different scales ranging in length from 7 to 20 items, with each scale producing its own score. These scale scores are the main products of the MPSI; as a multidimensional inventory it does not produce a single, composite score. Instead, scale scores are used to develop a graphic profile of client problems that is then employed in assessment and treatment planning. The nature of each scale is described in a technical manual available for use with the instrument (Hudson, 1990a). The MPSI psychometric properties have been described earlier in the Prior Research section.

Procedures. Technical and conceptual equivalence was determined through the field test of the MPSI with the sample of social work students. Research assistants were trained to administer the research instrument. Program schedules were given to them and sample quotas of students assigned. To achieve comparability with the USM sample in age and education level, all 212 graduate social work students at both universities were targeted for inclusion in the study sample. Of the 510 undergraduate students, approximately 100 from each were targeted for inclusion. Test administration dates, times, and places were negotiated with each faculty member and group at both of the universities. Standard instructions were read to all students on how to complete the MPSI scales and on marking nonapplicable items or scales as specified in the MPSI technical manual (Hudson, 1990a). Informed consent was required from all participants. To assure confidentiality, students were instructed not to write any identifying information on the MPSI booklets. During the administration, the study staff was available to respond to any questions that the students may have had. All schedules were reviewed for completeness. Because all measures had been precoded, data entry was done directly from the instruments themselves, and all entries were checked for errors and corrected when necessary to assure the quality of data. Data analysis was done utilizing Statistical Package for the Social Sciences (SPSS) 8.0 for Windows.

RESULTS

Content Judgment Study

The content judgment study was aimed at determining the extent to which mental health professionals (psychiatrists, psychiatric nurses, psychologists, and social workers) of the same ethnic group as the respondents had consensus in considering each item of the MPSI relevant to the corresponding
construct being measured. The CVIs indicated that only 5 items (15, 16, 19, 88, and 289) did not meet the established criteria for content relevance. They represent less than 2% of all items. The remainder of ratings were distributed as follows: 251 (75.1%) had a CVI of 1.0, which indicates that all 13 judges agreed on the item relevance to the content being measured; 68 (20.4%) had a CVI of .92, indicating that only 1 judge rated these items as not relevant; and 10 (3%) had a CVI of .85, indicating that 2 judges considered them not relevant. Given the 98% success rate in judging the items content relevant we can readily conclude that except for 5 of the items mentioned, the items were judged relevant for measuring the intended constructs (content equivalence).

Technical and Conceptual Equivalence Study

*MPSI scores.* Mean scores for each of the 27 MPSI scales in the USM study (Hudson & McMurtry, 1997) and the Puerto Rican samples are illustrated in Table 2. There are striking similarities regarding sample means across the scales, with only slight differences of less than 5 points on most. The standard deviation patterns are similar, with overall small differences. The scales of Friend Problems, Family Problems, and Child Problems presented relatively large differences of 6 to 10 points. These mean scale differences might have been due to underreporting of problems or other unknown factors. As in the USM study, our data only provided an initial indication of normative scores for a nonclinical population such as social work students in each scale.

*Reliability.* Alpha coefficients and the standard errors of measurement for the Puerto Rican and the USM samples are shown in Table 3. In general, the internal consistencies of the scale scores were high but slightly lower in the Puerto Rican sample than in the USM sample. Hudson and McMurtry (1997) used a coefficient alpha of .80 or greater as a standard to evaluate the use of each scale for clinical practice. Twenty-five (93%) of the scales exceeded that standard; 10 (37%) exceeded .90; and only 2 (7%) did not meet the .80 standard. The Aggression scale scores, which had a coefficient of .71 in the USM sample, had an alpha coefficient of .84 in this study sample, thus meeting the standard. Scores corresponding to the Work Problems and School Problems scales had alpha coefficients of .77 and .68, respectively. The Work Problems scale should be evaluated further as it performed relatively well and had a standard error of measurement of 4.06. This scale might result in higher reliabilities in psychometric tests with a more heterogeneous population. The School Problems scale’s lower performance of .68 is further discussed in the
item analysis that follows but may actually perform better with a 1-item revision. It was also the impression of the authors that the School Problem scale may exhibit better psychometric properties if tested with school-age children.

As part of the reliability analysis, items were analyzed to determine their relative contribution to the internal consistency of their corresponding scale. This type of analysis was deemed particularly necessary to evaluate the psychometric performance of each item within a different cultural milieu, having been adapted to Spanish and used with the particular student population tested. All items with a corrected item-total correlation of less than .20 and that detracted from the alpha coefficient were evaluated. Five items

<table>
<thead>
<tr>
<th>MPSI Scale</th>
<th>Mainland</th>
<th></th>
<th>Puerto Rican</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>M</td>
<td>SD</td>
<td>n</td>
</tr>
<tr>
<td>Depression</td>
<td>306</td>
<td>25.4</td>
<td>8.6</td>
<td>311</td>
</tr>
<tr>
<td>Self-Esteem</td>
<td>303</td>
<td>27.1</td>
<td>8.3</td>
<td>306</td>
</tr>
<tr>
<td>Partner Problems</td>
<td>216</td>
<td>22.4</td>
<td>13.2</td>
<td>215</td>
</tr>
<tr>
<td>Sexual Discord</td>
<td>210</td>
<td>24.1</td>
<td>11.6</td>
<td>165</td>
</tr>
<tr>
<td>Child Problems</td>
<td>96</td>
<td>22.1</td>
<td>9.8</td>
<td>75</td>
</tr>
<tr>
<td>Mother Problems</td>
<td>261</td>
<td>25.5</td>
<td>13.6</td>
<td>282</td>
</tr>
<tr>
<td>Father Problems</td>
<td>216</td>
<td>25.5</td>
<td>14.2</td>
<td>238</td>
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<tr>
<td>Personal Stress</td>
<td>295</td>
<td>27.1</td>
<td>11.3</td>
<td>304</td>
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<tr>
<td>Friend Problems</td>
<td>298</td>
<td>20.6</td>
<td>11.2</td>
<td>300</td>
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<tr>
<td>Neighbor Problems</td>
<td>179</td>
<td>30.4</td>
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<td>School Problems</td>
<td>296</td>
<td>23.4</td>
<td>7.4</td>
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<td>Aggression</td>
<td>241</td>
<td>9.5</td>
<td>5.0</td>
<td>282</td>
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<td>Work Associates</td>
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<td>20.5</td>
<td>8.2</td>
<td>220</td>
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<td>Family Problems</td>
<td>299</td>
<td>29.4</td>
<td>16.3</td>
<td>302</td>
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<tr>
<td>Suicide</td>
<td>284</td>
<td>3.0</td>
<td>5.8</td>
<td>251</td>
</tr>
<tr>
<td>Non-Physical Abuse</td>
<td>174</td>
<td>5.9</td>
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<tr>
<td>Physical Abuse</td>
<td>218</td>
<td>0.5</td>
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NOTE: MPSI = Multi-Problem Screening Inventory.
(1.5%) of the item total were classified in that category (15, 80, 129, 259, and 315). The items were from the scales of Self-Esteem, Father Problems, School Problems, Phobias, and Alcohol Abuse. Scale reliabilities would improve to .87, .90, .76, .85, and .93, respectively, if the items were deleted. The most dramatic alpha increases would be in the School Problems (.08), Alcohol Abuse (.05), and Self-Esteem (.04) scales. The increase would be less for the Phobia Problem scale (.03) and the Father Problem scale (.02). The School Problem scale would improve significantly with the revision or substitution of item 129 and thus should be evaluated with other clinical and younger age groups. The lower performance of these items in these scales may be attributable to, among others, any or more of the following factors:

<table>
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<th>MPSI Scale</th>
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<th>Puerto Rican</th>
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</table>

NOTE: MPSI = Multi-Problem Screening Inventory.
original poor item construction, inadequate translation into Spanish; the item has no equivalency in Spanish, or it may not be pertinent to the population studied. Given the overall high reliabilities of the scales of which these items are part, we will make recommendations regarding their treatment once we discuss the factorial analysis.

**Factorial analysis.** In validating the Spanish version of the MPSI scales, a confirmatory factor analysis called the multiple group method by Nunnally (1978) was carried out. This was the method used by Hudson and McMurtry (1997), and its goal was to test the hypotheses that items correlate well with the constructs with which they are supposed to correlate and poorly with the ones with which they are not supposed to correlate. Hudson (1982, 1990a) conceived this method as a special form of item analysis because it is reduced to examining the correlation of any scale item with each scale’s total score. In eliminating the risk of having a distorted picture of the factorial analysis due to the correlation of the item with itself as part of the total scale score, all item-total correlations are adjusted to remove the unwanted item-self correlation (Nunnally, 1978).

In this analysis each of the 334 items were correlated to the scale it was part of (factor loadings) and to the remaining 26 scales of the MPSI. The statistic used was the Pearson correlation coefficient. This analysis generated 27 tables. Factorial validity evidence would be achieved for each scale if 90% of its items correlated higher with its scale score than with the remaining 26 scale scores. According to this method, items should not correlate well with total scores of other scales of the MPSI. A correlation equal to or greater than the item-to-scale-score correlation was used as a criterion to determine factor loading failures. The specific results of this analysis are included in 27 tables that are available from the authors, as space limitations preclude their inclusion in this article.

Table 4 summarizes the factorial analysis results of this and USM studies. The table indicates the percentages of factor loading failures across the scales in both study populations. These figures were obtained for each scale by adding the number of item-to-scale failures for all its items, dividing by the total number of correlations (adjusted item-total correlations), and multiplying by 100. The loading success rate is 100 minus the failure rate. The results indicate that all scales of the Puerto Rican sample met the established threshold of having a success rate greater than 90%. On the other hand, 18 scales presented factor loading failures as opposed to only 2 scales of the USM study. In spite of this, the overall success rate was greater for the Puerto Rican study (98.3%) than for the USM study (96.6%). The success rate is impressive when one considers that only 148 correlations out of 8,684 correlations
across the 27 tables did not achieve the criterion of having a higher correlation with their corresponding scale scores than with other scales’ scores.

Further item analysis was conducted to identify the ones contributing the greatest to the scale factor loading failures. Specific item analysis indicated that failure rates were inflated by a small number of items. The authors found 4 items that had failure rates exceeding 20%: Item 15 of the Self-Esteem scale had a failure rate of 76%, Item 80 of the Father Problems scale had a 23% rate, Item 259 of the Phobias scale had a 77% failure, and Item 315 of the Alcohol Abuse scale had a 73% rate. These 4 items contributed to 49% of the total

\[ \text{Mainland} \quad \text{Puerto Rican} \]

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<th>MPSI Scale</th>
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<th>Mainland Success (%)</th>
<th>Puerto Rican Failure (%)</th>
<th>Puerto Rican Success (%)</th>
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NOTE: MPSI = Multi-Problem Screening Inventory.
\(^a\) Values are based on total number of failures across all items on all scales.
item failures, and in the opinion of the investigators they warrant evaluation for deletion, modification, or substitution, as the individual scale factorial validity evidence would be improved. Thus, regarding the factorial structure of the scale scores, the authors conclude that the overall performance of the scales was excellent and that with minor item revisions in four of the scales it can be further improved.

**Discriminant and convergent validity evidence.** In the validation of the MPSI, Hudson and McMurtry (1997) also obtained discriminant and convergent validity evidence to establish construct validity of the scale scores. Discriminant evidence was determined by specifying a number of variables that theoretically should be unrelated to the MPSI scales. Hudson and McMurtry postulated that there was no good theoretical basis for believing that the respondents’ gender, marital status, age, years of education, income, number of times married, years with spouse or partner, number of children, or family size were related to any of the MPSI scales. (pp. 92-93)

Table 5 includes the bivariate correlations of those variables with MPSI scales in the Puerto Rican sample. The results were surprisingly very similar in that all but one of the 270 correlations were less than .30. The only bivariate pair at .30 was an inverse correlation between age and work problems, indicating that older students tended to have less work-related problems than younger ones. In this study gender was not related to drug abuse. We have no empirical evidence to explain these correlation differences except to speculate about cultural or sample differences. Nevertheless, the overall picture for the scales tends to confirm the discriminant ability of the MPSI in the Puerto Rican sample. This is further sustained by examining the row and column means of the table. The results are quite similar to the USM study with minimal differences in that no scale had an average correlation in excess of .13 with the background variables (.14 in the USM study) and no background variable exceeded an average correlation of .11 with the scales (.09 in the USM study). The average of all correlations was .08, the same as in the USM study. As in the USM study, the results of this analysis indicate acceptable discriminant evidence of validity for each of the MPSI scale scores.

Convergent evidence of validity was examined by correlating the MPSI scales’ scores with the variables with which they are theoretically supposed to associate. The data collected on the 27 scales permitted the research team to examine and test 351 bivariate relations. Table 6 shows the correlations between the scales of the MPSI. An advantage of having the correlation analysis for all scales in two cultural groups is that one can start exploring and
### TABLE 5: Bivariate Correlations Between Background Variables and Scales Scores

<table>
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<tr>
<th>MPSI Scale</th>
<th>Gender</th>
<th>Accult</th>
<th>Marital Status</th>
<th>Age</th>
<th>Educ</th>
<th>Income</th>
<th>Times Married</th>
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<th>Family Mean</th>
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<td>.16</td>
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<td>-.01</td>
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NOTE: MPSI = Multi-Problem Screening Inventory; Accult = acculturation; Educ = education.  
*p < .05, one-tailed.
comparing how the theoretical relations are similar or different between them. For example, the Depression scale scores can be expected to correlate moderately with scores in such areas as self-esteem, stress, suicidal thoughts, and guilty feelings, as was found in the USM study (Hudson & McMurtry, 1997). The data on the Puerto Rican sample confirms that self-esteem, stress, and guilty feelings are moderately related to depression but so are also problems with friends. Thus, it seems that there may be cultural differences on how problems with friends are associated with levels of depression in the Puerto Rican sample studied.

The data evidenced a broad range of relationships indicating the interaction between the problems measured by the MPSI. On the other hand, as Hudson and McMurtry (1997) pointed out, we must be cautious in the analysis of such data regarding the expected association between problem scales when using the MPSI with nonclinical samples with respect to its performance in clinical populations. In particular, we must consider the threats to external validity posed by having such a homogeneous group of participants in which the actual correlations between variables may be attenuated. That is, the correlations presented may be reflective of scales’ behaviors with student samples but not with client samples. Furthermore, cultural differences may further dictate how the constellations of relationships among the scales are played out. Nonetheless, the matrix of correlations presented in Table 6 provides us with initial evidence of discriminant and convergent validity of the MPSI scales scores with a non-USM population.

**Triangulation**

Having used more than one method to assess the adequacy of the items of the MPSI adapted into Spanish allowed triangulation, that is, the identification of items that did not meet the standards of the different procedures described above. Table 7 shows data across those analytic procedures that permit us to judge whether an item should be deleted, substituted, or revised in future studies aimed at improving the instrument. Item 15 of the Self-Esteem scale did not meet the standards of all the procedures. Items 80, 129, 259, and 315 detracted from their scale reliabilities and had a high percentage of factorial analysis failures. There are substantial increases in the coefficient alphas of both the School Problems and Alcohol Abuse scales when Items 129 and 315 are deleted. Moreover, Items 80 and 259 did not detract as much from the coefficient alpha of their scales and had a CVI index of 1.00. But the percentage of factorial failures of Item 259 was 77%. Thus, the authors recommend that Items 15, 129, 259, and 315 be considered for deletion or substitution from the Spanish version in future revisions.
### TABLE 6: Bivariate Correlation Between Scales for Puerto Rican Sample

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</table>

NOTE: Dep = Depression; Sel = Self-Esteem; Mar = Partner Problems; Sex = Sexual Discord; Chl = Child Problems; Mom = Mother Problems; Dad = Father Problems; Str = Personal Stress; Frn = Friend Problems; Nei = Neighbor Problems; Sch = School Problems; Agg = Aggression; Wkl = Work Associates; Fam = Family Problems; Sui = Suicide; Ab1 = Non-Physical Abuse; Ab2 = Physical Abuse; Fea = Fearfulness; Ref = Ideas of Reference; Pho = Phobias; Gui = Guilt; Wk = Work Problems; Con = Confused Thinking; Dis = Disturbing Thoughts; Mem = Memory Loss; Alc = Alcohol Abuse; Drg = Drug Abuse.
Theoretically, an item may produce a reliable but not valid score, as is the case of an item that consistently measures well but is irrelevant for the intended construct. In the content judgment analysis, Items 88 and 289 had low levels of agreement between judges regarding their relevance, but they did not detract from otherwise very highly reliable scales’ scores. Items 16 and 19 are marginal regarding their CVI of .77, but if deleted would detract slightly from their otherwise good scale reliability coefficients. Thus, the authors recommend deleting or substituting Items 88 and 289 of the Personal Stress and Confused Thinking scales and to further evaluate Items 16 and 19 of the Self-Esteem scale. Finally, we need to point that out of a total of 334 items, only 6 (1.8%) are being recommended for deletion or substitution from the Spanish version (15, 88, 129, 259, 289, and 315) in subsequent developments of the instrument.

**DISCUSSION AND APPLICATION TO SOCIAL WORK PRACTICE**

The application of the cross-cultural equivalence model (Bravo et al., 1991; Flaherty, 1987) to the adaptation of the MPSI into Spanish for use with Puerto Ricans permitted the evaluation of the psychometric properties of an instrument that was conceptualized and tested with a USM, non-Hispanic population. The results indicated that by using this conceptual model and its techniques, acceptable levels of reliability and validity were obtained in adapting the MPSI to another culture and language. The bilingual committee approach and a conscious effort to avoid the use of Spanish regionalisms are

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Scale</th>
<th>Corrected Item-Total Correlation</th>
<th>α if Deleted</th>
<th>α of Scale</th>
<th>Factorial Analysis Failures (%)</th>
<th>Content Judgment Agreement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15</td>
<td>Self-Esteem</td>
<td>.02</td>
<td>.87</td>
<td>.83</td>
<td>76</td>
<td>62</td>
</tr>
<tr>
<td>16</td>
<td>Self-Esteem</td>
<td>.48</td>
<td>.82</td>
<td>.83</td>
<td>4</td>
<td>77</td>
</tr>
<tr>
<td>19</td>
<td>Self-Esteem</td>
<td>.47</td>
<td>.82</td>
<td>.83</td>
<td>4</td>
<td>77</td>
</tr>
<tr>
<td>80</td>
<td>Father Problems</td>
<td>.19</td>
<td>.90</td>
<td>.88</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>88</td>
<td>Personal Stress</td>
<td>.54</td>
<td>.92</td>
<td>.93</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>129</td>
<td>School Problems</td>
<td>.13</td>
<td>.76</td>
<td>.68</td>
<td>12</td>
<td>100</td>
</tr>
<tr>
<td>259</td>
<td>Phobias</td>
<td>.03</td>
<td>.85</td>
<td>.82</td>
<td>77</td>
<td>100</td>
</tr>
<tr>
<td>289</td>
<td>Confused Thinking</td>
<td>.82</td>
<td>.91</td>
<td>.92</td>
<td>0</td>
<td>69</td>
</tr>
<tr>
<td>315</td>
<td>Alcohol Abuse</td>
<td>.04</td>
<td>.93</td>
<td>.88</td>
<td>73</td>
<td>92</td>
</tr>
</tbody>
</table>
expected to provide an assessment tool that can be tested with other Hispanic groups. To provide a fair test of an instrument from another culture it was necessary to obtain a similar sample and replicate part of the methodology used in the original study.

The MPSI Spanish version was found to exhibit similar psychometric characteristics as the English version. The means, standard deviations, and standard errors of measurement of the scales were strikingly similar in magnitude in both samples, providing an initial indication of normative scores for a nonclinical population. The hypothesis regarding alpha coefficients of the translated MPSI scale was also confirmed, with only two of the scales not meeting the .80 reliability standard. The overall pattern of internal consistency coefficients was slightly lower but consistent with the USM sample. The two scales that had alpha coefficients of less than .80, the work- and school-related problem scales, might have better coefficients with other populations. In addition, the MPSI scores had overall acceptable evidence of their validity.

As stated by the MPSI authors, additional work is still required to refine the information on the MPSI validity and reliability. In spite of the overall good-to-excellent performance of the Spanish MPSI, an in-depth item analysis allowed for the identification of six items that if deleted or substituted could improve validity and reliability evidence. Further work on the MPSI that needs to be developed includes assessing the psychometric properties with clinical Hispanic samples, testing the clinical cutoff scores, testing for validity using the known group methods, and correlating individual scales with other well-established scales.

The adaptation of the MPSI into Spanish for use with Puerto Ricans is a first step toward providing social work clinicians with a battery of standardized scales that they can use with their Spanish-speaking clients. Although special care was taken to avoid Spanish regionalisms, it seems reasonable to question whether the items of the MPSI would prove to be as effective with other Hispanic groups as with Puerto Ricans. It is possible that further modifications to the items may be required to adapt the instrument to diverse Hispanic groups. This is an empirical question for future research intended to develop a version of the instrument that would be culturally relevant across Hispanic groups. By having a validated Spanish version of the MPSI the quality of services to this client group is expected to improve by addressing issues of culture and language in the assessment process at intake and during and after treatment. In addition to its clinical uses, the authors recommend use of the MPSI for research purposes and evaluation of clinical practice.
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The dissemination of research for practice is always a challenging endeavor, but this book does an outstanding job of placing the issues, strategies, and methods for handling young people with emotional and behavioral difficulties within an evidence-based practice framework. Young people with emotional and behavioral difficulties have substantially more concerns than their peers because they often do not finish high school; are more likely to be unemployed, arrested, or become pregnant; have substance abuse problems; and experience homelessness. The authors address these challenges and provide compelling arguments for designing transition to independence processes (TIP) systems.

*Transition to Adulthood* has many strengths, including but not limited to the (a) research-based practice guidelines; (b) clearly presented, step-by-step strategies to develop practices, policies, and programs for TIP—the authors include innovative, state-of-the-art approaches; (c) integration of research for maximizing family and extended family supports while recognizing the autonomy of young adults—the authors incorporate social skills and employment research, multisystemic family approaches, and family involvement strategies; and (d) highly readable chapters that have been skillfully edited to appeal to a wide audience. The book is intended for educators, practitioners, researchers, and even mental health consumers and administrators who work in the child and adult mental health services systems, school and vocational rehabilitation, and substance abuse services and those interested in the outcomes of young people with difficulties resulting in significant functional impairment.

Drawing from their own research studies and those of the contributing authors, the book provides an application of promising practices in an area in which there is limited research, as well as suggesting areas of further research. Each of the 14 chapters acquaints the reader with intervention strategies that have been refined in the field and are currently being applied in areas of employment, education, living situation, and community-life adjustment. The book is divided into five sections entitled (a) Developmental and System Perspectives on Transition; (b) Transition System: Recommended Strategies and Practices to Facilitate Success Across Domains; (c) Young Adult and Family Perspectives; (d) System, Policy, and Financing Issues; and (e) Conclusions, which highlight relevant agendas for future development, including research essential to enhancing and improving transition outcomes.
The user-friendly text is integrated with best practice guidelines and with practical case examples. The case examples are from young people and parents on ways to facilitate successful transitions and self-sufficiency. Some of the young adults are coauthors of the chapters with the researchers. Skills for use in individual or group settings are presented such as social skills training, the behavioral principles, actions, and decision making to support and guide practitioners. Preemployment training skills are also presented as a developmental progression that reflects the level of work responsibility, the level of reward from the job, and in a way that monitors and supports the youth with the requisite skills. Using their research, the authors present in detail the five phases of responsibilities and supports for integrating young people into competitive job placements: (a) learning phase, (b) responsibility phase, (c) transition phase, (d) independent phase, and (e) employable phase. Excellent suggestions are given for monitoring and supporting youth in jobs that are not associated with the stigma of “job coach” at the work site. Other transition studies discussed include school completion, residential status, community membership, pregnancy, and institutional transition. In each case, TIP teaches community-relevant skills; encourages completion of secondary education; provides exposure to community-life experiences; promotes movement into postschool employment, educational opportunities, living situations, and community life; transcends the age barriers typical of child versus adult services; and respects the self-determination of young people.

The theme of the book is to promote youth independence functioning with a population that has received poor, or at best piecemeal, services as they transition into adulthood, and the authors provide us with a clear framework for doing so by working at the multisystem level. The authors acknowledge the continued piecemeal funding and services that exist and urge organizations to work collaboratively with researchers at all levels to advocate for the development and expansion of community TIP systems.

These efforts will allow people and systems to better assist young people with emotional or behavioral difficulties to become interdependent, self-sufficient adults who earn reasonable incomes, live in places of their choosing, believe that they are members of a community, have rich resources of friends and family, and can pursue their dreams. (p. 275)

This is a well-written, well-organized book that will appeal to a variety of audiences who are researching, working with, or planning programs for young people with difficulties transitioning to adulthood. Parents will also find the suggestions and strategies for advocacy helpful. Finally, the authors remind us that a great deal of research is still required to further refine the recommended practice and system strategies.

—Barbara Thomlison

*Florida International University*

*Making Choices* is a book that describes a comprehensive program through which children ages 6-13 can learn skills necessary for problem solving to gain social competence with peers and adults. This program represents a practical, integrated set of activities that those working with children should find quite useful. The authors describe an applied practice program that recognizes social and cognitive problem-solving deficits of children with aggressive behaviors, conduct disorders, and oppositional defiant disorders and how these problems in living interfere with social functioning and the formation of enduring, interpersonal relationships. The program offers a cognitively based, social problem-solving curriculum designed for early intervention with children to prevent maladaptive social behaviors. The program is structured for use by teachers, counselors, social workers, and other professionals who work with children. Fraser, Nash, Galinsky, and Darwin developed this program around the work of others who have researched the effectiveness and benefits of social informational processing with aggressive children.

This book is framed by an introductory chapter that informs the reader about the conceptual information processing and practice foundation of the program described in the text that follows. The introduction also includes information on how to plan, lead, and facilitate groups using this cognitive-behavioral program. The ensuing chapters are organized into seven units that describe skills building and the personal development activities that make up the core of the total program. The steps in the overall program are sequenced to accomplish program outcomes of social problem solving. Major units are logically organized, each with attendant activities and each building upon skills acquired throughout, in the following sequence: Unit 1, Learning About Emotions and Feelings; Unit 2, Encoding: Identifying Social Cues; Unit 3, Interpretation: Making Sense of Social Clues; Unit 4, Goal Formulation and Refinement: Setting Social Goals; Unit 5, Response Search and Formulation: Intervening Options; Unit 6, Response Decision: Making a Choice; and Unit 7, Enactment: Acting on Choices. Fraser et al. conclude with a summary, appropriate references, and an appendix with tables and figures.

*Making Choices* is an informative, practitioner-oriented description of a program designed for use in schools and other settings by social workers, teachers, counselors, and other professionals who work with small groups of children. Visibly, the description of the core steps in the program has merit, and these steps (each unit) provide a clear goal followed by skill-development objectives for each learning activity. Each unit is structured in a manner that provides the philosophical foundation and rationale for the unit, learning objectives, a review of previous curriculum and learning activities, a description and rationale for the activities in the unit, accompanying materials to work with school-age children, and an easy-to-digest summary of the major ideas.
in each activity. *Making Choices* provides a variety of relevant activities including stories, games, role play, and audio and videotaping.

This book has obvious strengths that speak to practitioners working with children. The targeted lessons in the various units of the program serve an important dual function. The curriculum includes actual questions for different developmental ages that encourage children’s participation and skill development in the total program. These questions are also designed to provide the program leader with information about developmental levels and social skills of children. The program and associated lessons in this book are based on literature that suggests that children with serious conduct problems are best treated within the context of children who can model prosocial skills. The description of unit objectives and suggestions for accomplishing these within the lesson activities are clear, readable, understandable, and appear to have rather wide application for all children, including those with no demonstrable social skills deficits. Teaching children to (a) pay attention to their feelings, (b) read situations, and (c) examine behavioral alternatives and consequences before reacting are important processes discussed by the authors in developing adaptive, prosocial behavior in children. The authors include both ecological and developmental perspectives that make the curriculum sequence useful for social work students in practice classes, field internships in a variety of settings, and for practice research projects as well. The importance of both parent and teacher involvement with children going through this program is emphasized as necessary for children to practice and maintain acquired prosocial skills. Fraser et al. also encourage booster sessions.

*Making Choices* includes citations of research from which this prevention and early intervention program curriculum was developed. There were some attestations about the research base without adequately documenting these claims in the extant literature. The authors state that the evaluation of this curriculum is in process. Thus, data to assess the effectiveness of the program is not available at this time. Although research documentation is included to reinforce the importance of many concepts and learning activities, the book is rather wanting in its research documentation to support the effectiveness of other recommended activities. Had the authors included a unit on how to evaluate the effectiveness of this program, they could have encouraged practitioners who employ their curriculum to gather data in keeping with evidenced-based social work practice.

This book is conceptually grounded, and it speaks simply, constructively, and rather clearly to practitioners who work with school-age children who have difficulties in social adjustment and who may exhibit aggressive behavior and experience peer rejection. The unit activities in the total program make sense and address both cognitive and behavioral issues and concerns in bringing about prosocial behavior change. Interestingly, the authors express the view that the program is best implemented with groups of children “where the balance of children are not viewed as at risk for problem behavior” and “in a setting in which the majority of children do not have conduct problems.” This makes sense. Children exhibiting maladaptive behaviors need positive peer role models from which to learn.
A potential use of this book and its curriculum is by social workers in the child welfare arena. The majority of children who have experienced maltreatment often lack role models who use prosocial means of solving problems. These children generally experience relationship and school difficulties that result in exhibiting maladaptive social behaviors. The program described in Making Choices provides an easy-to-understand approach to teaching children how to solve inevitable problems in social situations. These solutions are likely to promote prosocial behaviors valued by the social work profession and the larger society.

—Alberta (Bert) Ellett

*University of Georgia*
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