PAROLE VIOLATION AMONG MICHIGAN CSPs AS RELATED TO GROUP THERAPY VS. IMPRISONMENT

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ABSTRACT

PAROLE VIOLATION AMONG MICHIGAN CSPs AS RELATED TO GROUP THERAPY VS. IMPRISONMENT

by Roger O. Olive

The problem investigated concerned the relative impact of imprisonment at the State Prison of Southern Michigan (SPSM) vs. group psychotherapy at the Ionia State Hospital (ISH) upon the parole violation rates of Criminal Sexual Psychopaths (CSPs). The findings of two previous studies, Cook (1947) and Trembath (1952), reporting no significant difference in parole violation rates for the two institutional programs for CSPs in Michigan were used as a direct background. The subjects were all CSPs paroled in Michigan from July 1953 through June 1961. The individuating characteristics which distinguish or liken them to the general population were sketched.

Based on institutional residence, a method was devised for establishing two experimental groups. The environments in which they were involuntarily placed were described. It was inferred, although impossible to prove, that "qua" environments it would be difficult to assess which institution supplied the greater amount of negative incentive.

It was hypothesized that the hospital group exposed to the process of a group therapy program would attain greater success on parole than would be associated with imprisonment. The outcomes of analysis of parole violations in the groups disclosed a much lower rate of parole violation for the ISH CSPs (21% vs. 49%) thereby supporting the central hypothesis.

As a further check on the stability of these findings a corollary

hypothesis consisting of three parts was made. In the SPSM group, parole violations were predicted to be inversely related to group therapy experience. This hypothesis was supported in two subsequent comparisons. In the hospital group the mean length of time in group therapy for parole violators vs. non-parole violators was not found to differ significantly.

It would appear that the group therapy program contributed importantly to parole successes. Limitations of the research design precluded, however, a precise evaluation of the possible interaction between the hospital environment and the absence of the group therapy variable. Generally, the results support the opinion underlying P.A. Act 165 (Michigan 1939) that deviated sexual behavior is sometimes a symptomatic expression of personality disturbance which is amenable to psychological treatment. Additionally, due to significantly longer imprisonment for SPSM parole violators, Cook's conclusion regarding the extent of the therapeutic effects of imprisonment was discounted as a significant factor influencing his findings.

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By

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INTRODUCTION

In the state of Michigan, as in many other places, individuals who exhibit abnormal sexual behavior, alarm the public. A certain proportion of these persons are apprehended by legal authorities and become institutionalized. Afterwards, how best to approach the problem of sexual deviation depends on what view is adopted regarding the significance of these acts. A conclusion reached by the Governor's commission on the deviated criminal sex offender (Michigan 1951) was that deviated sexual behavior is symptomatic of a personality disturbance which is amenable to psychological treatment. However, what constitutes adequate treatment has been a controversial issue. The purpose of this paper is to examine the consequences of the two principal treatment forms used with involuntarily hospitalized sexual offenders in the state of Michigan.

Legal Aspects of Commitment

In 1939, the Michigan Legislature passed Public Act 165, which established legal procedures for individuals designated as Criminal Sexual Psychopaths (CSPs). Persons falling within the provisions of the Act were committed to the Department of Mental Health (DMH) for an indeterminate time period. The residence of these individuals was left to the discretion of the DMH, which designated the Ionia State Hospital (ISH) as the appropriate institution. At the hospital, due mainly to pressures for bed space, approximately half of these individuals were transferred to the State Prison of Southern Michigan (SPSM). At ISH the treatment method consisted of intensive individual psychotherapy, and in 1953, due to increases in commitments and shortages in the Psychiatric Staff, group therapy was adopted as the main treatment method. At SPSM they underwent the process of imprisonment with, originally at least,

monthly psychiatric interviews. In March 1958, the Supreme Court ruled that transfer of CSPs to a prison was not in keeping with the intent of the Act to provide appropriate care and treatment in a psychiatric setting.

Legal vs. Psychiatric Views of the CSP

The concept of Criminal Sexual Psychopathy may be compared with the psychiatric category of psychopath, sociopath, or character disorder. The main divergence between the legal and psychiatric criteria for psychopathy, as regards treatment, appears to be that the legal approach is more optimistic than the latter. CSPs are sent into a hospital rather than a prison because the court concurs with the view that sexual maladjustment is a symptom of underlying conflict which may be corrected through suitable treatment. Legally, CSPs are described as individuals afflicted with a mental disorder. They are not feebleminded or insane, but have criminal propensities for the commission of sex offenses. If sexual motivation is believed involved in a crime, the criminal may be remanded for examination by three psychiatrists approved by the DMH. They, as expert witnesses, report their findings to a judge, who makes the final decision regarding commitability.

Psychiatrically, the mental status of the CSPs spans the range of the classical diagnostic categories. Current observations are consistent with those of Lieberman and Siegal (1957) that as a group they are composed of psychotic, feebleminded, neurotic, sociopathic, brain injured, convulsively disordered, alcoholic, and some who could be considered only severely maladjusted. The inclusion of feebleminded as one of the diagnostic categories may seem incongruous since by legal definition they are excluded. However, Trembath (1952) found that 1.4% are defec-

tive and 8.3% are borderline defective, as determined by psychodiagnostic examination with the Wechsler-Bellevue. Legally, CSPs are classified according to the offense committed, as in cases of gross indecency, indecent exposure or indecent liberties. These categories do not accurately describe the act in its psychological significance as homosexual, exhibitionistic or pedophilic in nature. The range of deviated sexual behavior of this population is comparable to that listed in almost any abnormal psychology textbook that contains a section in this area. The reader is referred to Coleman (1956) whose treatise is brief but excellent for general purposes.

Parole Success: The Criterion of Treatment

In reference to the CSPs, the ISH accepts a twofold responsibility; (a) to provide treatment, and (b) to discharge only when the individual is no longer considered a menace to the community. At the completion of treatment, successful adjustment for a three-year parole period is required as evidence of recovery from psychopathy. In special cases, the 3-yr. period may be lengthened or shortened. In the case of infractions of rules set up to govern conduct they are returned as parole violators. The general rule governing parole is that patients remain under the jurisdiction of the DMH, and may be returned without question at its disposition. Patients are most generally supervised by psychiatrists or social workers of the DMH, and may be returned at their discretion. On rare occasions paroled CSPs return voluntarily for further treatment. In most cases, parole violation means, however, that hospitalization has been reinstated as a result of a criminal offense, a justifiable complaint, or in anticipation of the latter. Parole violation offenses consist of: sex, 77.5%, drunk, 7%, absconded, 6.5%, homicide, 1.1% and miscellaneous, 7.9%.

Review of the Literature

A ten year review of the literature revealed few studies specifically relating to a comparison of treatment methods using an external criterion as an index of success. Earlier studies emphasized structure, dynamics, or describe a specific program in a particular site. None was found that used the present criterion as an assessment of two programs. The sexual offender is increasingly being assigned to state and other mental hospitals for treatment: i.e., at the Atascadero State Hospital (Kivisto, 1958); the Mendocino State Hospital (Lieberman and Siegal, 1957); the Henry Phipps Psychiatric Clinic, (Yalom, 1961); St. Elizabeth's Hospital, (Cruvant, Meltzen, and Tartaglino, 1950) and the Metropolitan State Hospital, (Caheen and Coleman, 1961). At most of these places, group therapy is designated the treatment of choice around which all other treatment activities are oriented. These sources report favorably regarding the positive effects of this treatment form in promoting constructive personality changes. These positive nonsystematic reports emphasized the need for more definitive investigation of the impact of the group method upon community adjustment.

Imprisonment vs. Psychotherapeutic Treatment

Two studies directly relevant to the issue have been completed at ISH (Cook, 1947 and Trembath, 1952). These investigators were concerned about the relative efficacy of imprisonment versus psychotherapy, but concurred that the outcomes of both programs were roughly equivalent in terms of parole violations. The statistics derived from their populations are parameter values established over a period of 12 years. Trembath's (1952) population included Cook's (1947) and was largely an extension of the latter. The number of patients was, 155 and 69 respec-

tively. Two marked trends are noted in Trembath's study, (a) an increasing incidence of commitments, and (b) an increasing proportion of patients transferred to the prison. These previous studies were an invaluable aid in establishing basic guide lines for comparison and describing the population.

Cook's Study. At the time of this study, a total of 69 patients had been paroled from the beginning of CSP commitments in 1939. By 1947, 12 patients, or 17% had violated parole. Of these, 6 had been released from the hospital, and the other 6 from the prison. A nearly equal rate of parole violations, (17.1% from the prison and 17.6% in the hospital group) was observed.

The latter finding served as the basis for Cook's equation of the two programs. He states that, "Imprisonment is a very valuable therapeutic implement in treating certain types of CSPs" (Cook, 1947, p. 6). The general criterion used for retention or transfer of patients was, "Those showing better than average evidence that they might benefit from hospital treatment are retained at the hospital. Those who seemed unlikely to gain from active therapy were sent to the prison", (Cook 1947, p. 6).

In addition to the general criterion outlined above, other very practical considerations were used by the staff to attain these ends. The following individuals were usually kept at the hospital: (1) Those with physical handicaps or illnesses requiring continuous medication or special care, (2) others felt to be approaching a psychotic break which might by precipitated by the transfer; (3) the comparatively young; (4) those evaluated as sincere in the desire to correct a sexual deviation, but viewed as readily susceptible to pressures to continue deviant prac-

tices. The following were, in most cases, transferred from the ISH to SPSM: (1) individuals who had been actively treated, paroled, and had returned; (2) those who became engaged in antisocial acting-out; and (3) when bed space was strongly in demand, except when strongly counterindicated, almost anyone who had been evaluated at a diagnostic staff.

Cook's most controversial conclusion, which he emphasized by restating three times, may be paraphrased as follows: that as far as treatment outcomes were concerned, imprisonment was considered equivalent to intensive individual psychotherapy, if care was exercised as regards selection for treatment.

Several questions may be addressed to Cook's (1947) report. It may be reasonable to assume that negative incentives are more effective therapeutically in some cases than in others, but more systematic criteria for selection should be made. His concept of "punitive therapy" seems insufficient to account for his findings (Cook 1947, p. 7). The equivalence of parole violation rates was interpreted as stemming mostly from his evaluation that the punitive aspects, or negative incentives of the prison environment were greater than those at the hospital. He suggests that negative incentives were equivalent, for certain unspecified individuals, in the attainment of parole success as a more positive therapeutic approach. It is clear that all of the relevant variables impinging on his findings were not systematically investigated.

Trembath's Study. This paper's emphasis is on the general characteristics of CSPs. Those measures specifically used by Trembath relating to parole success have been reformulated to coincide with the statistical presentation of the current study.

Concerning treatment, group therapy is mentioned as one among sever-

al available to CSPs. At the time of his study, however, group therapy was not actually practiced at ISH. It is assigned no special priority, and is included in the same context with individual psychotherapy, chemotherapy, electroshock, and luetic medication. Inasmuch as his parole success measures are very similar to Cook's (1947) he agrees that, "The effects of incarceration are considerable with certain types of patients. The value of such motivation in therapy is obvious in theories of learning" (Trembath, 1952, p. 17).

It is noted that prior to January 1952, there were 426 commitments, showing a mean annual rate of 35.5 individuals. He observes that in 1940, 45% of the yearly commitments were transferred to the prison. By 1950, the proportion of transfers had risen to 60%. His statistics regarding the incidence of parole success are based on a population of 159 patients, of whom 4 had died. Of the 88 individuals in residence at the hospital, 13 or 14.8% violated parole. Of the 67 persons who had been transferred to the prison, 16 or 23.9% had violated parole. Neither the Cook nor the Trembath study found a statistically reliable difference in the incidence of parole violation as measured by Chi Square statistic between parole violators (PVs) vs. non-parole violators (NPVs) in either the hospital or prison program.

Important Differences Between the Prior and Present Studies

Individual psychotherapy, due to vicissitudes in the Psychiatric staff, was gradually discontinued shortly after Trembath's (1952) study. The group therapy program started in the latter part of 1953.

The annual discharge rate jumped from 15.9 patients, in the 1939 - 1949 period, to 53.2 individuals, during the 1953 - 1961 interval. The previous studies report on a total of 155 paroled patients, and 29 PVs

the present one with 427 paroled patients and 196 FVs.

As a result of the Supreme Court decision, 156 CSPs were returned from the prison within the year, and of these, 119 were received within 5 months. These large numbers of transfers required considerable readjustment, and extension of the group therapy program with unmeasurable consequences. Individual interviews, with the psychologists, designed to enhance group therapy effects, have been sharply reduced since that time.

Unexplored Areas of the Prison and Hospital Program

The two studies cited above made no attempt to examine the length of time individuals were exposed to either intensive individual psychotherapy or imprisonment. An exploration of the temporal dimension may provide more definitive information concerning the therapeutic direction of either program. It seems important to inquire whether the incidence of parole success for the prison group varies as a function of the length of time in group therapy. There were individuals in the prison group who were not incorporated into the therapy groups. Do these individuals differ from the full or partial participants? If, as has been alleged, prison time is punitively therapeutic, a reasonable deduction would be that the successful parolees from prison spent a longer time in that environment than the non-successful ones. Lastly, do the time relationships which are to be observed for the prison group, obtain for the hospital group.

The Differentiating Variable: Group Psychotherapy

It is hypothesized that the group therapy variable will contribute more positively to parole success than the prison program. A brief definition of group therapy in this setting is that: it is the type of pa-

tient-centered group discussion which, as a learning experience, aims at modifying or transforming unacceptable emotional urges, irrational ideas, attitudes and beliefs which underlie unacceptable sexual acting-out. In the process, the individual is expected to acquire some understanding of underlying motivations and the relationship of his sexual symptoms to others, so that he may return to the macrocommunity to live within legal sanctions.

Statement of the Problem

The impetus for the present investigation is an unsystematic observation that group psychotherapy has a more beneficial impact on subsequent behavior of CSPs on parole than does imprisonment. Isolation of the group therapy variable from the institutional matrices and precise specification of it's influence, although desirable from the standpoint of experimental design, may not be possible within the institutional setting. Instead, these circumstances will be approximated as closely as possible. The group psychotherapy program is clearly the major innovation in treatment at ISH since the studies of Cook (1947) and Trembath (1952). Also, it is the principal distinction between treatment at ISH and SPSM. It is hypothesized that CSP participants in the group therapy program at ISH will show a lower rate of parole violation than CSPs who receive the more punitively oriented treatment at SPSM.

In line with the obvious fact that psychological rehabilitation takes place in a time continuum, a corollary hypothesis consisting of three parts is ventured: (A) In the prison group, parole success will be positively related to the length of time in group therapy. (B) Length of imprisonment will be inversely related to parole success. (C) In the hospital group, the time factor for the group therapy variable will not

vary significantly.

Description of the Present Study

The present study concerns itself mainly with two groups of CSPs, one completed a hospital program including group psychotherapy. The other group was transferred to a prison where treatment consisted of imprisonment exclusive of group therapy. All of the subjects used in this study initiated institutional residence at ISH. After imprisonment, they were returned to ISH prior to parole for varying lengths of time during which some of the prison group received group therapy.

The prison and hospital groups are subdivided into PVs and NPVs, and comparisons will be made of the rate of parole successes and failures.

The Time Dimension: Four Comparisons. Parole Violator and NPV groups will be contrasted as regards the mean length of time in group therapy and imprisonment. A comparison of the group therapy participants vs. non-participants will be made. Lastly, the time dimension for the hospital group will be analyzed.

Four Qualitative Descriptions. The CSPs are described in several places and their psychosocial characteristics detailed.

The two environments (ISH and SPSM), where the CSPs spent an average of about 33 months, will be contrasted to examine Cook's (1947) evaluation that the punitive aspects were more severe at the prison than at the hospital.

The group therapy program will be sketched, peripherally, to justify the emphasis placed upon it as an instrument for rehabilitation.

Introductory Remarks

This part of the paper focuses on the physical and psychosocial characteristics of the two institutions. Although recognizing that it is impossible to quantitatively assess the positive and negative characteristics of these two institutions, the aim of this section is to give some fuller picture of them with respect to their positive and negative traits. It is noted that Cook (1947) appraised the punitive atmosphere to be much more severe at the prison than at the hospital.

The State Prison at Southern Michigan

General Considerations

The State Prison at Southern Michigan contains the largest number of individuals within walls of any correctional institution in the world. Individual treatment therefore, becomes an almost impossible task to carry out. As long as custodial problems do not present themselves, the inmate is generally allowed to pursue whatever schedule he selects. At the prison, a CSP wishing to escape unfavorable attention may readily take advantage of the easily available anonymity to avoid counseling or other forms of therapeutic activity. Therefore, the extent to which the individual engaged in rehabilitative activities was largely left to his own initiative.

Positive Aspects of the Prison

The CSP "Visitors" (by "Visitors" was meant that the CSPs were still considered patients, and remained under the jurisdiction of ISH) underwent the same classification procedures as the rest of the population. They were placed in the various occupational positions as their abilities allowed, and received economic remuneration commensurate with their

placement. They were at full liberty to take advantage of the recreational and educational facilities. The counseling facilities of the prison were available, and those with alcoholic complications were encouraged to become members of Alcoholic Anonymous. All of the rehabilitative facilities which were at the disposal of the inmate were open to the patient. In addition, at least initially, from 1939 to 1946 they were interviewed once a month by a hospital psychiatrist. As the number of CSPs increased, however, the frequency of these interviews decreased.

Negative Aspects

It was Cook's (1947) view that the transfer tended to intensify the pain attendant on the condition of indeterminacy since they were one more step removed from the desired goal, parole status. In addition, the fact that CSPs were considered "Visitors" at the prison, compounded their rejection. For the most part, the CSPs were looked upon with suspicion and bias at the prison. Many inmates erroneously believed that all CSPs were homosexuals. Fraternization attempts by SPSM inmates were often viewed by CSPs as instigated by homosexual purposes. These approaches were generally distasteful to the CSPs since they had either been advised to attempt to break homosexual practices, or had no problem of this kind. The identity of the CSPs at the prison was distinctive, since on their cell doors appeared the label, "CSP" instead of the five-digit number which identified the regular inmate. The other inmates often directed deeply condemnatory and villifying remarks toward the CSP. Social interactions were primarily confined to each other. Transfer to the prison was often traumatic in itself, inasmuch as most of them considered the added designation of "convict" detrimental to employment placement in the open community.

Environmental Aspects of the Ionia State Hospital

General Considerations

The Ionia State Hospital for the Criminally Insane is a maximum security institution which incorporates the features of a hospital and a prison. The patient body is a highly complex microcommunity consisting of (a) Individuals charged with a crime and legally insane, (b) A number of individuals who have been behavior problems, sometimes homicidal, from other state institutions, (c) Commitments under Public Act 165 and (d) Emergency probate court commitments. Many have acted-out their aggressive feelings with very serious consequences, and have therefore been sent to ISH. Because of such circumstances, ISH operates under a system of rules which are strictly enforced. In comparison to the average mental hospital, the main departures would be a drastic reduction in freedom of movement and increased supervision and observation.

The organizational structure of the hospital lends itself to very close observation of the total adjustment spheres of the patient. The social interactions and idiosyncracies of the patient come under close scrutiny. The lack of life space tends to elicit in broader relief the personality traits of the patient, whether aggressive or passive, gregarious or withdrawn, guarded or frank. In some cases, individuals superficially well controlled become acutely disturbed. Sexual adjustment can, in most cases, be fairly well determined. Fluctuations in eating, sleeping or work habits are often reliable indices of the emotional state of the patient. Attempts are made to gauge the degree of acceptance or resistance to authority. It is possible in some instances to evoke reactions to frustrating conditions. If the patient has previously manifested undue instability, stressful situations are sometimes in-

duced to assess gains made in this area.

Positive Aspects of the Hospital

Except for differences in location, the CSPs undergo basically the same diagnostic, medical, psychological, and social work procedures as the psychotic patients. They are recommended for medical, occupational, or recreational therapy in much the same way. Essentially, they are integrated into all of the departments of the hospital. The group therapy program was initiated specifically for the CSPs, and they are strongly urged to participate even when strong disinclinations to attend are manifested. Personal interviews with their ward physician are granted on request whenever possible, but are sharply limited by staff shortages.

Since 1939, the CSPs have made great strides in establishing their worth by positive contributions to the hospital community. They have shown competency in handling assignments too varied to describe here. In many cases there is sympathetic understanding of the problems of the psychotic patient. While it would be a misstatement to imply that all CSPs are "therapeutic carriers", the more rational and socially oriented psychotic patients prefer to associate with the CSPs rather than with other psychotic patients.

Negative Aspects of the Hospital

Criminal sexual psychopaths have been coming to the hospital for 22 years. At the start, there was relatively slight established knowledge concerning their characteristics. Their potential for destructive acting-out was grossly overestimated. Initially they were literally "personae non grata." Even today this attitude persists, in only slightly modified form, in the behavior of almost all hospital employees.

The CSP initiates his residence in the hospital on a different ward

than the psychotic patient. The intake wards are on the same floor of the same building, and are separated only by a metal door, which is for the most part, locked. During the quarantine period these patients eat together, but after the two-week period is over, they go to meals with their respective wards. Criminal Sexual Psychopaths soon learn that there are two distinct groups, i.e., those who are considered insane or psychotic, and the minority group to which they belong.

Some employees manifest hyperawareness of the difference, and find it difficult to understand that individuals who are seemingly well should take up bed space intended for psychotic patients. Because CSPs are more intellectually alert, they are more apt to question the policies and regulations of the hospital, and sometimes enhance existing negative staff attitudes. Many patients and employees still believe that the term "CSP" is synonymous with homosexuality. Psychotic patients, recommended for group therapy in almost all instances, request not to be placed in groups that contain CSPs, since such identification is fraught with anticipated derogation. Many CSPs are informed in court that residence at the hospital ranges from 14 to 90 days. When they learn that the average length of confinement is approximately three years, it is not only disillusioning, but also tends to engender mistrust of hospital personnel. Work is classified as occupational therapy, but the limit earnable on an assignment is three candy bars or the equivalent value in tobacco.

Some favorable statements have been used to describe the progress of the CSPs. They still, however, experience considerable discomfort and conflict in their efforts to satisfactorily integrate the therapeutic attitude with the restriction of movement and privilege. Initially, a

commonly held expectation is that the therapeutic approach must of necessity be accompanied by only positive incentives in the form of overly permissive freedom, loose regard for rules, and above average subsistence. In time, the insightful come to realize that only within an atmosphere of positive and negative incentive, pleasurable and painful experiences which are part and parcel of all existence, is it possible to work through problems of the severity which they, in most cases, present.

Summary of Conditions at ISH and SPSM

In both institutions the condition of indeterminacy of commitment is operating. In either place, CSPs were a well marked minority group. Strong cultural biases and fear of deviated sexual practices are not mitigated in either institutional setting. Custodial security is greater at the hospital than at the prison. The latter factor would appear to be associated with greater restriction of movement and increased negative incentive. Economic remuneration for work assignments, an important advantage from the perspective of those institutionalized, is greater at the prison than at the hospital. As regards treatment at the prison, it was left largely to individual initiative. At the hospital, a definite treatment program was operating for almost every CSP.

The point of view adopted in this paper regarding environment, is that neither an excessively punitive or permissive atmosphere is optimal for personality growth. In addition, the environment, as such, has positive or negative influences on the patient's adjustment, depending on his individual characteristics. Dependent individuals, for the most part, accept the rigid institutional life as a relief from the frustrations involved in assuming responsibility. On the other hand, the independent, self-reliant individual chafes and rebels against strict con-

trols represented by an institution. Therefore, whether the institutional environment, in the long run, becomes a negative, positive, or neutral force for rehabilitation depends upon the patient's ability to come to terms with the prevailing conditions and to integrate them into his ideational and emotional rehabilitation.

The Group Therapy Program

Theoretical Predispositions

The two therapists interacting with the patients groups, herein reported, have been eclectic since there has been no compulsion or pressure to follow any systematic orientation. As they observed and listened to the experiences of the patients at varying levels of awareness, it was sensed that certain concepts best described what was being empirically observed. For example, strong resistance has been encountered, Yalom (1961) calls it recalcitrance, in one form or another in almost every patient. And as they haltingly or glibly relate episodes in their lives, they defend in innumerable ways against the pain entailed in frankly discussing happenings that are deflating or reveal superego deficiencies. Invariably the therapist or others in the group become objects of the narrator's positive or negative emotional reactions to relatives, friend or significant acquaintances. Most patients admit that if nothing else, pent-up emotions are alleviated; in other words, "I got it out of my system." In many cases, a particular sexual pattern may have symbolic meaning extending far beyond mere sexual motivation, i.e., a deviated sexual act may be a compensatory expression of virility for feelings of inadequacy, an aggressive act against a parental figure, or vicarious gratification of incestual wishes.

As many contributing factors as possible are elicited and worked

through, so that the most characteristic defense of the patient may not be missed. Concepts like introversion, or extroversion, or inferiority complex, or unconscious motivation are, in many cases, already known to the patients, and are sometimes useful in interpreting developmental processes.

A belief has developed from the many cases that have been reviewed, that single events, except in rare instances, are not usually of sufficient import to determine most serious problems. Instead, attention is focused on repetative patterns of behavior. It is these complex sequences which are believed to be the basic elements of personality configurations. A summary of theoretical orientation would concede that the various theoretical positions, whether psychoanalytic, behavioristic, or gestalt, have contributed many concepts and emphases which can be implemented to understand individuals with pathologic sexual problems.

Group Therapy: History and Structural Development

The group therapy program was initiated at the ISH on request of the Medical Superintendent in the latter part of 1953. At first it was under the immediate direction of one of the psychiatrists. Several approaches were attempted, i.e., group projections onto the TAT cards and detailed, but brief, testimonials of the specific offense committed by the individual. For various reasons, these methods were subsequently modified or discarded.

In the early part of 1954, the Psychiatric Staff, overburdened by added pressures, asked the Psychology Department to continue the activity. Both therapists were in substantial agreement that many of the principles which apply to individual dynamic psychotherapy can be applied to the group, therefore, each member of the group was requested to

discuss his life history. Once the idea was accepted, this mode of procedure has become standard. Group members are encouraged to make observations, relate the on-going content to their lives, or to offer interpretations. The group meetings are of one hour duration.

The first group consisted of 12 persons; at present there are 18 groups with an average number of 18 persons per group. In the beginning there was concern about the optimal size of the group, and it was attempted as much as possible to restrict them to a range of 8 to 12. At the time of the 1957 Supreme Court decision, large numbers of CSPs were returned from the prison, and the size of most groups was increased to 20. These larger groups do not differ to any great degree from the smaller ones.

Smaller groups are more desirable since they provide several benefits. There is no predetermined time span within which a patient must complete his narration. In smaller groups individuals would assume this role much sooner than is now the case. The range of attention maintained by the therapist would be narrowed over a smaller field. This would result in closer observation of unverbalized reactions. Individuals who rationalized their silence with the statement that large groups frighten or embarrass them, would lose one more plate of their defensive armor. In-group feeling is slower to develop in a large group than in a smaller one. Abreaction would be facilitated since fear of breaches of confidentiality would be decreased.

Open vs. Closed Groups

The groups have always been open. There is a constant influx and discharge of patients. As soon as one individual leaves a group, there is another to take his place. Locally, open groups lend themselves more

readily to the continuity of in-group feeling. They accelerate the time element in the therapeutic process since there are always individuals at various levels of sophistication who pass on to the newer members the methods of critical analysis and interpretation acquired in their own experiences. Members convinced of the merit of group therapy frequently become valuable allies of the therapist, and in many instances confront differences with other patients on a more equalitarian peer basis, and with more telling effect.

Time Phases of Group Interaction

In general, three phases of an individual's development within the group are perceived. In the first period, the individual learns what is expected regarding relevant experiences. He is conditioned to accept constructive criticism of the others so that when he fills the narrator's status, which is the second stage, he will not feel so severely threatened. In the third sequence, he contributes maximally as a result of the understanding gained from his personal experience. The narrator is asked, as much as possible, to present material to the group chronologically.

Homogeneous vs. Heterogeneous Structure

From the beginning, every attempt has been made to apply the principle of homotherapy. The significance of homogeneity in enhancing this principle has been undergoing transformation gradually but consistently. At first, groups were considered homogeneous because all the members were CSPs. The first indication that the patients did not consider the groups homogeneous bodies was that some of the members who had committed one type of sex offense complained that they were different than those with an unlike sexual problem. There was general agreement that full

benefit could not be derived unless there was maximal freedom of expression, which could not be achieved in mixed groups.

These communications made it easier for further applications of the principle. Now groups are differentiated on the basis of age, type of sexual problem, intelligence, recidivism and physical handicap. As yet, there has been insufficient time to determine whether the specific groups exhibit marked variance in modal personality or dynamics.

The Role of the Therapist

In introducing this section, the reader should bear in mind that these remarks apply to involuntarily committed, and in some cases, severely disturbed individuals who do not possess the conventional selection criteria for psychotherapy; they neither admit that a problem exists, or express a desire for treatment. There is no selection of cases; group therapy is prescribed in almost every case by the Psychiatric Staff. It is considered the treatment of choice for sexual deviates. The exceptions consist of individuals who are handicapped by age or physically so that it makes locomotion or communication difficult. At the present time there are approximately 350 sexual offenders attending one or another of the groups.

The area of the qualifications of the therapist is a controversial one, but aside from academic requirements, the therapist must be ethical, impartial, and able to withstand considerable stress. Elaboration of these concepts could provide sufficient material for another paper.

The question of directiveness versus nondirectiveness must, to a certain extent, be viewed from the perspective of the expediencies of time and the group welfare. In a feebleminded group it is often necessary to be directive. There are instances when the narrator becomes re-

calcitrant and will not utter a word even in response to direct questioning. In other groups, even if it were wished, it would be difficult to be directive because of the spontaneous interaction, spirited inquiry, good humor, high tolerance for traumatic material, and insightful level of interpretation. In other groups, especially adolescent ones, changes from one role to the other are advisable depending on the climate exhibited, i.e., whether the group is inhibited, disorganized, or outgoing. Institutional incidents change atmospheres, so that sensitivity to the predominant mood characterizing the then current situation calls for adaptive flexibility on the part of the therapist.

The principle of nondirectiveness is applied whenever possible for several reasons. More than the directive approach it encourages independent critical thinking. If the patient feels that he shares almost equally in the tasks of uncovering significant material, decreasing the strength of ineffective defenses, or reinforcing the process of reality awareness, his self-esteem is raised. In the process of contributing, some patients sharpen their allocentric perceptions and reformulate their consciences. Too directive an approach fosters undue dependence on authority figures, lowers the level of communication by inhibiting verbalization, or merely echoing the opinion of the therapist. Ingroup feeling is delayed since the patients do not as readily get to know one-another.

The therapist must guard lest he shirk responsibility for the progression of the group. He defines and maintains boundaries within which the groups operates, i.e., discourages to the fullest extent breaches of confidentiality, keeps to a minimum descriptively obscene language, opens and closes meetings as much as possible on schedule, and keeps to

a minimum, general and "gripe" sessions.

As regards content, the idea is continually reinforced that greater expressiveness is desirable since it is symbolic of trust and self-understanding. The confronting of differences has been found to be inevitable. But from the confronting should emerge increased respect for each other's integrity. Differences of opinion are explained as founded on individuality, and are to be manifested with a minimum of personal involvement or fear of retaliation. The therapist should initiate discussion of pertinent points when by-passed as a result of apathy, resistance or concealed aggression toward him or each other. As often as necessary, misinformation stemming from distorted or inaccurate learning experience is corrected. Interpretations which do not fit facts evoked from the individual's life, must be reformulated. The more important instances which form the core of the maladjustive pattern must be integrated and summarized in language which can be readily understood by everyone.

In sexual maladjustment, group therapy aims to focus problems. Thus, it renders them a more realistic threat and alleviates undue anxiety. By specifying areas of conflict, inadequacy and competence, it makes possible the adoption of modified responses. As ingroup solidarity is brought about, the group technique highlights the universality of basic needs, the uniqueness of individual experience, and the necessity for exploring differences between surface sexual symptom and the dynamics underlying overt behavior.

Description of the Population

Trembath summarized the characteristics of CSPs in the following manner: "This group is in some respects similar to the general popula-

tion. This sample, at least, is quite similar in education and intelligence. More of them have experienced marital discord of their parents during their formative years, and have shown less capacity or desire for stable marital relationships of their own. They constitute a greater number of excessive drinkers than is found in the population at large." (Trembath, 1952, p. 8)

For the purposes of the present study it will be assumed that, in general, except for the youngest age group, the distribution of personality characteristics of the individuals in the prison and hospital groups are roughly equal, or randomly distributed. Supporting this assumption is evidence offered by Cook, (1947) and Trembath, (1952) that most of the traits they studied, i.e., intelligence, socioeconomic status, marital, education, parental relationship, degree of use of alcohol, or type of offense were not used systematically as a basis for either retention at the hospital or transfer to the prison. Further supporting this view are their findings of no significant differences between the incidence of PV in the prison and hospital groups.

Concerning age, Cook reports, "The average of successful paroles is 36 years, and parole violators, 26½ years (Cook, 1947, p. 4). Currently the mean age of the 143 SPSM PVs is 45.1, and of the 128 NPVs 43.0. The average age of the ISH PVs is 36.4, and of the NPVs 41.0. When the groups are combined as in Cook's (1947) study, the current age of successful parolees is 42.0, and PVs 43.0. In light of present findings, the age factor seems negligible in differentiating parole success from failure.

Selection of Subjects

The present study includes 427 CSPs discharged from ISH over a per-

iod of eight years from July 1953 through June 1961. However, indirectly, except for the period from January 1949 to June 1953, all of the discharged CSPs since 1939 have been used to trace the evolution of the treatment process. Four females have been committed within the history of the Act, but none is included in the current context, since none was discharged within the period under review. The subjects comprise the complete list of 446 discharges noted on the daily calendar sheets of the ISH in chronological sequence. Nineteen cases were set aside for the following reasons: Five returned voluntarily for further treatment; four died on parole after release from the hospital; three were sent directly to prison to continue serving a sentence; two were given an outright discharge by the court; one was returned as psychotic for psychiatric treatment; one was discharged directly to a U.S. Marshall and follow-up data is not available; in one case there was an incomplete record, so that the necessary information could not be obtained.

Afterwards, the personal records of the individuals were examined to determine placement in one of the several groups used in the various comparisons. The criteria for inclusion in the hospital groups were either full term residence at the hospital and participation, or non-participation, in the group therapy program. For the prison groups, the criterion was simply transfer to the prison before discharge from the hospital. The prison group is subdivided into a non-participant and participant groups. Within the groups, the subjects were separated into those returned from parole to continue hospitalization, and those remaining in the community.

In this study, the NPVs are currently in the open community. They are reporting as instructed by their supervisors and are generally con-

sidered to be making a satisfactory or marginal adjustment by the DMH. Parole violators have been so designated and returned; have absconded from parole; have a detainer placed upon them by the court; or have, without authorization, either left the state or are not reporting as scheduled. The last two descriptive phrases apply to only 6.5% cases.

Multiple Parole Violation

Altogether there have been 172 PVs. However, 22 patients returned twice and accounts for 44 of them. Only 150 cases will be used to assess the central hypothesis. This method of dealing with double entries has been adopted to comply with the requirements of statistical procedures. The PVs will be assigned to that group where they were situated at the time of their first PV in the first statistical analysis. In a subsequent comparison all 172 cases will be used to investigate possible fluctuations attendant on placement in a different, or the same, program.

This particular time sample was selected primarily because it encompasses the period in which the group therapy program was initiated. It signaled the newer concept in the treatment of the CSPs and affords an evaluation as comprehensive of the program as possible. Also, it coincides with the fiscal year limits of the State of Michigan, thus facilitating computation. The actual time period involved is somewhat greater than indicated above, since some of the patients who were discharged within this eight-year time span, were admitted to the ISH for varying lengths of time prior to their discharge. The ISH groups consisted of 156 patients. Of the latter group, 37 did not participate in the group therapy program, and have been used in a separate comparison. In the SPSH groups there were 271. In this latter group are included 20 cases which averaged 8.25 months at the prison and 24.1 months in group ther-

apy that are successfully continuing parole. These ambiguous cases were arbitrarily assigned to the number of those successfully adjusting on parole from the prison to permit a more rigorous test of the central hypothesis.

The criterion for the eventual return of the transferred patients to the hospital was the clinical judgement of a hospital psychiatrist who interviewed them at least once every six months. Return to the ISH did not constitute an automatic grant of parole status. On occasion, patients were returned to SPSM for additional imprisonment.

Recommendation for parole, in every instance, was relatively independent of the time element, but entirely dependent on the evaluation of the medical staff at ISH. The evaluation was based on the patient's verbalization to such considerations as the following: Does the patient understand how specific life experiences contributed to the development of the sexual problem? How has the total institutional facility been implemented to foster insight into his social breakdown? What gains or changes in personality have been made or acquired to prevent a recurrence of the sexual symptom? Are the consequences of the deviated sexual acts understood? Have realistic plans been made for the future? The staff attempts to estimate whether the potential for antisocial acting-out is sufficiently strong to render the patient a real threat to the open community. When decision is doubtful, further psychological testing is administered for additional leads.

FINDINGS

The total frequencies for the eight-year period are offered in table one in summary form to present a comprehensive picture of the various groupings. Cases of multiple parole violation are entered singly. The overall rate of PV for the 427 cases is 45.9%.

Table 1

The total sample and its distribution into the various comparison groups.

	ISH Number - 156				SPSM Number - 271			
	Group Therapy		Non-Group Therapy		Group Therapy		Non-Group Therapy	
	N	%	N	%	N	%	N	%
PV	29	24	24	64.9	143	52.8	69	74.2
NPV	90	76	13	35.1	128	47.2	24	25.8
Totals	119	100	37	100	271	100	93	100

Central Hypothesis

The 368 discharges abstracted for the present comparison yield the following frequencies. From the hospital group 115 received an uninterrupted course of group therapy, and 25 returned. This constitutes a 21% parole violation rate. Of the 253 from the prison group, 125 violated parole for a 49% return rate. When these frequencies are analyzed by Chi Square technique they yield a X^2 of 25.0 ($P < .001$).

Table 2

Incidence of PV and NPV between groups at ISH and SPSM.

	ISH	SPSM	Totals
PV	25	125	150
NPV	90	128	218
Totals	115	253	368

It was noted that 22 of the cases contributed 44 of the PVs. If either subsample, especially the prison group, were heavily weighted with assumed prognostically unfavorable individuals, the difference attributed to the influence of group psychotherapy might just as readily be considered to stem from bias inherent in the loading favoring ISH. When the initial frequencies are corrected for multiple parole violation, i.e., 4 added to ISH and 22 to SPSM, the following proportions are obtained: The PV rate of ISH increases from 21% to 24%, and for SPSM from 49% to 52.8%. However, the 28% difference (21% minus 49%) between the first percentages, is slightly less than the corrected difference of 28.8%.

Another possible source of error acting to bias results might be that NPVs and PVs for the current year (1960-1961) were used. It is reasonable to assume that a longer time period should be allowed to elapse for violation to occur. Differential rate of PV might materially alter the obtained significant difference. This eventuality is particularly relevant inasmuch as the mean length of time on parole is 16.6 months for the ISH group, and for SPSM 17.6 months. From July 1960 through June 1961 there were 7 PVs and 22 NPVs from ISH, and 9 PVs and

20 NFVs from SPSM. When these frequencies are subtracted from the appropriate cells, the FV rate of ISH is 20.9%, and for SPSM 52.3%. The difference between percentages in this case is 31.3%. Again, the latter difference is very similar, but slightly larger than, the original 28%. Thus, two corrections for bias, i.e., multiple FV and insufficient violation time, do not substantially modify the findings. Instead, they strengthen confidence in the reliability of the difference.

The most salient limitation of the present study has been the absence of a randomly selected control group large enough to serve as a check on the effects of ISH environment on FV ratios without the influence of group therapy. However, the 37 hospitalized, non-group therapy participants were not excluded from the groups because of any predetermined characteristic. Therefore random conditions may be operating. In this group there was a 64.9% FV rate, closely approximating that of the similar SPSM group.

The Corollary Hypotheses

Time in Group Therapy of SPSM Group

The mean length of time in group therapy of the 143 FVs was 8.9 months. The average time spent in group therapy for the successful discharges from the prison group was 12.45 months. The reliability of the difference between the means is reflected by a t ratio of 3.26 ($P < .01$) (Guilford, 1950).

Table 3

Comparison of time in group therapy of PVs and NPVs from SPSM.

	N	Mean Months	SD	t Value
PV	143	8.90	5.55	3.26*
NPV	128	12.45	11.05	

* $P < .01$

Group Therapy Participation vs. Non-Participation among SPSM Inmates

Of the 271 parole discharges from the prison group, 93 spent no time in group therapy, and 178 participated from 1-60 months. Parole violations among the no-therapy subgroup numbered 69, or 74.2%. There were 74 PVs, or a rate of 41.6%, from those receiving some group therapy. A Chi Square analysis of these frequencies as described in Table 4, yielded a X^2 of 26.08. ($P < .001$).

Table 4

Parole violation among SPSM subgroup as related to participation in group therapy.

	PV	NPV	Totals
Some group therapy	74	104	178
No group therapy	69	24	93
Totals	143	128	271

Parole Success, and Time Served at SPSM

A summary of time in prison of the 143 PVs was 31.7 months. For the 128 non-parole violators, the average time in prison was 25.8 months. The reliability of the difference between means is reflected by a t ra-

tic of 3.07. ($P < .01$).

Table 5

Temporal comparison of PVs and NPVs from SPSH

	N	Months	SD	t value
PV	143	31.7	20.4	3.07*
NPV	128	25.8	22.3	

* $P < .01$

Parole Success and Length of Participation in Group Therapy at ISH

To determine the degree of relationship between the time in group therapy of both hospital groups, a biserial correlation method was used. The mean time in group therapy of the 29 PVs was 25.62 months. For the 90 non-parole violators the mean time was 23.73 months. The resulting coefficient of -.09 is not statistically significant.

Table 6

Time relationships in group therapy of PVs and NPVs from the ISH.

	N	Mean Months	SD of Total Sample	r_{bis}
PV	29	25.62	12.48	-.09
NPV	90	23.73		

DISCUSSION

Environmental Implications of Non-Participation in Group Therapy

It will be recalled that there are two groups (one of 37 ISH patients, the other of 90 SPSM cases) reflecting the consequences of institutionalization without the influence of group therapy. The SPSM group of non-participants showed a parole violation rate of 74.2%. In the ISH non-participants the PV rate was 64.9%. The inference of hardly any difference between the two environments is supported by the findings. The attempt to isolate the group therapy variable from the institutional settings strengthened the viewpoint concerning the near equality of punitive effects. A reflection is added that the process of catalyzing personality change is a laborious and painstaking task, which is not voided by mere institutionalization.

Cook (1947) and Trembath's (1952) findings regarding the incidence of PV, 17% and 22% respectively, are markedly variant from the present combined total of 45.9%. The emerging trend was that as the number of admissions to the hospital, and transfers to the prison increased, there was a proportional increase in the number of parole violations. From 1939 to 1952 the mean annual admission rate was 35.5; from 1953 to 1960 it was 59.0. The percentages of transfers to the prison increased from a mean of 44.8% in 1940, to a mean of 61.6% from 1953 to 1956.

It was previously noted that, initially, an ISH psychiatrist interviewed the patients at the prison once a month. At first, he was able to review almost all of them in the allotted time. It seems possible that these therapeutic contacts accounted, to a considerable degree, for the earlier equivalence of the SPSM program with that of the ISH. However, as the number of CSPs increased, it became impossible to provide

so much individual treatment. Concomitantly, the potential for deviated sexual acting-out of the relatively untreated CSPs, remained relatively high.

Another finding strengthening this explanation was that the 21% parole violation rate currently derived from the hospital group is not significantly higher than the proportions found by Cook (1947) and Trembath (1954); 17.6% and 14.8% respectively. It is noted that these three proportions occurred where direct contact with psychiatrists or psychologists was maintained. In contrast, the three ratios 17.1%, 23.9% and 49.3% of PVs from the prison groups yielded a Chi Square of 26.15, showing a significant increment in the incidence of parole violation.

Time in Group Therapy of the SPSM Group

The finding among the SPSM patients that the NPVs spent a longer time in group therapy than did the PVs, is congruent with prior speculation. It is, also, both a first step in substantiating the corollary hypothesis and offers further support for the central hypothesis. The mean time for successful parolees in group therapy at ISH was 23.7 months. For the successful SPSM group, the mean time in group therapy was 12.5 months. However, the PV rate for the latter group is 41.6%, substantially higher than the 21% PV rate among ISH participants, but much lower than the 74.2% rate found for the SPSM non-participants. The findings suggest that partial group therapy would improve the chances of parole success to some extent, but not as extensively as full participation.

Parole Success and Group Therapy Participation

The significant difference extracted from this comparison among the SPSM group uncovers the hypothesized relationship regarding the group

therapy variable. This comparison suggests that the incidence of parole success increased with participation in group therapy. Up to this point the following percentages of parole success are noted: full participation (ISH) 79%, partial participation (SPSM) 58.4%, non-participation (ISH) 35.1%, and non-participation (SPSM) 25.8%. The last rate suggests strongly that these individuals left SPSM with much the same personality configuration that was present when they entered. Since no systematic efforts were made to foster change, alteration in personality could not reasonably be expected.

Time in Prison

The finding that the length of time in prison is significantly longer for the parole violators of the prison group does not support Cook's (1947) conclusion regarding the effectiveness of imprisonment. A rather different process appeared to be operating. Generally, as the length of time increased, the incidence of parole violation concomitantly increased. It is suggested, instead, that the 17.1% parole violation earlier noted by Cook (1947), may have been largely attributable to psychiatric intervention. It would further seem reasonable to infer that those paroled from the prison in the beginning received a greater amount of therapeutic attention, whereas, many paroled during the time of this study received much less. In addition, residence at SPSM predisposed a growing body of prognostically unfavorable cases.

Time Relationships in the Hospital Group

The lack of a clear relationship between the length of participation in group therapy and parole success, or failure, was not entirely unexpected. The present data does not support the view that length of participation in group therapy, per se, is a significant factor in every

case. This emphasizes the importance of concern with the quality of group therapy participation as distinct from the sheer amount of sessions attended.

Implications for further Research

The factors on which parole violation are based, especially if an individual has maintained a therapeutic relationship, are complex. A crucial need aimed at the reduction of PV would be the development of a scale to measure quality of participation as related to measures of PV. Individuals differ markedly with respect to the temporal speed with which they verbalize understanding of their own, or the problems of others. Initially, most patients resist therapy, and absolve the self by minimizing, rationalizing, projecting blame onto social happenings or specific individuals, or eloping. Some have attended the groups for 3 or 4 years before they finally admit that their resistance was irrational and unwarranted. Sympathetic relatives, at times, reinforce the resistive process. From the start, some are obviously less accessible to therapy, depending on the severity of emotional, intellectual or physical disturbance. A greater than average number present alcoholic complications, Cook (1947) 22%, and Trembath (1952) 36.3%. In some of these latter cases, there is real doubt whether amnesia for committed offenses is feigned.

Further exploration is also needed (in the area of personality and intellectual testing) to investigate the relationships to parole violation rates, i.e., are there differences in parole violation among individuals of below average, average, and above average endowment. Do projective or other personality tests discriminate between those with a positive prognosis as opposed to a poor one. Traditionally, the younger

age group has been considered prognostically more favorable. Does this generally accepted principle hold true in this population. Are there differences in parole violation among the three most frequent sexual deviations, namely, exhibitionism, pedophilia and homosexuality. Finally, are there levels of insight, and to what extent can these be used to predict successful adjustment.

SUMMARY

The problem investigated concerned the relative impact of imprisonment at the State Prison of Southern Michigan (SPSM) vs. group psychotherapy at the Ionia State Hospital (ISH) upon the parole violation rates of Criminal Sexual Psychopaths (CSPs). The findings of two previous studies, Cook (1947) and Trembath (1952), reporting no significant difference in parole violation rates for the two institutional programs for CSPs in Michigan were used as a direct background. The subjects were all CSPs paroled in Michigan from July 1953 through June 1961. The individuating characteristics which distinguish or liken them to the general population, were sketched.

Based on institutional residence, a method was devised for establishing two experimental groups. The environments in which they were involuntarily placed were described. It was inferred, although impossible to prove, that "qua" environments it would be difficult to assess which institution supplied the greater amount of negative incentive.

It was hypothesized that the hospital group exposed to the process of a group therapy program would attain greater success on parole than would be associated with imprisonment. The outcomes of analysis of violations in the groups disclosed a much lower rate of parole violation for the ISH CSPs (21% vs. 49%) thereby supporting the central hypothesis.

As a further check on the stability of these findings a corollary hypothesis consisting of three parts was made. In the SPSM group, parole violations were predicted to be inversely related to group therapy experience. This hypothesis was supported in two subsequent comparisons. In the hospital group the mean length of time in group therapy for parole violators vs. non-parole violators was not found to differ signifi-

cantly.

It would appear that the group therapy program contributed importantly to parole successes. Limitations of the research design precluded, however, a precise evaluation of the possible interaction between the hospital environment and the absence of the group therapy variable. Generally, the results support the opinion underlying P.A. Act 165 (Michigan 1939) that deviated sexual behavior is sometimes a symptomatic expression of personality disturbance which is amenable to psychological treatment. Additionally, due to significantly longer imprisonment for SPSM parole violators, Cook's conclusion regarding the extent of the therapeutic effects of imprisonment was discounted as a significant factor influencing his findings.

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