DOCUMENT RESUME

ED 101 266 CG 009 567

AUTHOR Kilmann, Peter R.
TITLE Marathon Group Therapy with Female Narcotic Addicts.
PUB DATE 74
NOTE 16p.; Paper presented at the Annual Meeting of the American Psychological Association (82nd, New Orleans, Louisiana, August 1974)
AVAILABLE FROM Peter R. Kilmann, Dept. of Psychology, University of South Carolina, Columbia, South Carolina 29208

EDRS PRICE MF-$0.76 HC-$1.58 PLUS POSTAGE
DESCRIPTORS *Behavior Change; *Drug Addiction; Drug Therapy; Females; *Group Therapy; *Institutionalized (Persons); Problem Solving; Research Projects; *Self Control
IDENTIFIERS *Personal Orientation Inventory

ABSTRACT

This study evaluated the impact of structured and unstructured marathon therapy on institutionalized female narcotic addicts. Subjects were randomly assigned to one of five groups: two structured therapy groups, two unstructured therapy groups, and a no-treatment control group. The Personal Orientation Inventory, the Adjective Check List, and a measure of self-ideal congruence were selected as the dependent variables. Results showed that marathon participants, when compared with the control subjects, became more interested in their obligations (i.e., "Self-control") and made greater efforts to be more successful (i.e., "Achievement). Because narcotic addicts have difficulty in impulse control and lack of persistence in working on their problems, it seems reasonable to assume that the addicts who participated in the marathon groups experienced therapeutic change. The results of the comparison between the structured and unstructured treatment conditions did not produce any significant results. Highly positive verbal feedback was received from the marathon participants directly after the postmeasures were administered. (Author/PC)

MARATHON GROUP THERAPY WITH FEMALE NARCOTIC ADDICTS[1]

Peter R. Kilmann[2]

University of South Carolina

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The impact of marathon group therapy on "normal" participants has been widely documented. (Bach, 1966, 1967a, 1967b, 1967c; Mintz, 1967, 1969; Schutz, 1967; Stoller, 1967, 1968, 1970a, 1970b.) The claims of these early marathoners are based upon anecdotal and descriptive accounts of the experience, rather than on empirical data. Recent studies, however, have found evidence of therapeutic growth after just one extended session. For example, the marathon has enabled the participants to perceive themselves and others in more positive ways (Foulds, Girona, & Guinan, 1970) and resulted in increased levels of self-actualization (Guinan & Foulds, 1970; Young & Jacobson, 1972).

Unfortunately, all of these marathon outcome studies have used volunteer student populations. Although it is conceivable that the "normals" who participated in these studies were experiencing difficulties in adjustment of varying degrees, it seems logical that the most valid test of marathon therapy would lie in its ability to alleviate pathological modes of functioning in a clinical population.

Narcotic addicts have a poor therapeutic prognosis and are highly resistant to traditional therapeutic approaches (e.g., Coleman, 1972). Because the marathon helps the participants to successfully penetrate defense machanisms of denial, rationalization,

and intellectualization (e.g., Stoller, 1967, 1968, 1970a, 1970b), it appears logical that the time-extended format would confront directly the psychopathic tendencies that are characteristic of this population (e.g., Gilbert & Lombardi, 1967) and increase the probability of therapeutic growth as a function of the impact of the intense emotional experience.

This study evaluated the impact of structured and unstructured marathon therapy on institutionalized female narcotic addicts. Subjects were randomly assigned to one of five groups: two structured therapy groups, two unstructured therapy groups, and a no-treatment control group. The two structured marathon groups were so designated on the basis of the predetermined sequence of group exercises[3] used by the therapists in each of the two groups. Participant freedom was limited to each participant giving feedback as to how she was affected by the exercise; this occurred systematically after each exercise had been undertaken. Thus, the goals, methods, and time devoted to each component of group function were controlled by the therapists.

By contrast, the two unstructured marathon therapy groups were so designated on the basis of the therapists' relinquishing the major responsibility for the group's functions to the group members. Thus, the therapists did not depend upon any preconceived schedule but delt with whatever material was most important to the participants at any given time. The therapists attempted to create and

maintain a psychological climate of safety and trust in which each participant might feel increasingly free to explore and express her feelings, and relate more honestly with other group members. Therapist efforts were concerned with facilitating present feelings though past events and feelings were dealt with as they arose. Other general goals were to assist participants to become aware of their manipulative behaviors and incongruent communications, as well as fostering behavioral flexibility. In essence, the group members were afforded ample opportunity to control the format of the marathon. From the groups' inception, participant responsibility for the format was stressed.

METHOD

Subjects

The subjects were 84 female narcotic drug addicts in residence at the California Rehabilitation Center, Patton, California. The facility functions similarly to a halfway house in that it is an intermediary placement between prison and eventual release into the community. By their residence at this institution, the subjects had been judged to have considerable potential of becoming rehabilitated. All of the subjects were completely without withdrawal symptoms.

The subjects' mean age was 25.6 years; the range was from 18 to 43 years. On the average, subjects completed a junior high school level of education; the range was from the 6th grade to 5

years of college.

The initial population of this study consisted of 96 volunteers who were solicited from a total possible population of over 200 female residents. Before pretesting, the subjects were told that the experimental procedure required that some of them would be chosen to participate in the experimental session while others would not. They were reassured that this choice would be made on a mathematical basis for non-personal reasons. The subjects were not aware of their group assignment until pretesting was completed.

On the day of the experiment, one volunteer in the control group and one volunteer in one of the two unstructured groups became ill and did not participate. Seven volunteers withdrew from the experiment reporting reasons such as fatigue and physical illness; these dropouts occurred before the midway point of the 23-hour experience. Finally, three control group members were angry because they had not participated in the marathon groups and they refused to respond to the postmeasures, thus leaving a total of 84 subjects.

Specifically, 14 subjects completed each of the two structured groups. Sixteen subjects completed one unstructured group, twelve subjects completed the other; and 28 control subjects completed the experiment.

Therapists

Four psychologists with Ph.D.'s functioned as primary therapists, one in each of the four marathon groups. One master's level junior

therapist was also in each marathon group. Three of the junior therapists were predoctoral candidates in clinical psychology and the fourth held a master's degree in social work. All of the therapists were males.

The assignment of the primary therapists to one of the two types of treatment i.e., structured and unstructured, was based on each therapist's expressed level of comfort and compatibility with the treatment format. The assignment of the junior therapists was based upon the same criterion as well as on the additional contingency that the junior therapist had had prior experience as a co-therapist with the respective primary therapist.

The role of the primary therapists was to take full responsibility for the treatment format while the junior therapists were to function as adjunct facilitators. None of the therapists were informed of the purpose of the experiment, but they were informed of the experimenter's expectations of the format of their respective marathon groups.

Test Instruments

The Personal Orientation Inventory (Shostrum, 1966), the Adjective Check List (Gough & Heilbrun, 1965), and a measure of self-ideal congruence (Howell, 1969) were selected as the dependent variables. The criterion scales on these instruments were chosen on the basis of what is generally known about the personality characteristics of male and female narcotic drug addicts. Male

addicts have been described as exhibiting passive-aggressive traits and sociopathic tendencies (Coleman, 1972; Gilbert & Lombardi, 1967). Although there is a lack of research that has focused on female addicts, prevailing clinical impressions suggest that female addicts also reflect sociopathic tendencies, such as a strong resistance against social convention and established institutions, difficulty with impulse control, and an inability to postpone gratification. Thus, it seemed reasonable to make the assumption that male and female narcotic addicts reflect similar personality characteristics. From this framework unidirectional predictions were made on the criterion scales.

Personal Orientation Inventory (POI). The POI was developed by Shostrum (1966) to measure personality characteristics associated with "positive mental health". The test consists of 150 two-choice comparative value statements which form 14 scales. The two main scales (i.e., Time Competence and Inner-Directed Support) that include all the items were used as global indices of self-actualization. Positive movement on these scales from pretesting to posttesting was the objective criterion of member growth.

Adjective Check List (ACL). The ACL, developed by Gough & Heilbrun (1965), consists of 300 commonly used adjectives which form 24 scales primarily based upon Murray's need-trait system. On the basis of each scale's relevance to experimenter expectancies of member growth for this population, 11 of the 24 scales were

chosen as the criterion variables.[4] An increase in score on these scales was assumed to indicate that therapeutic change had occurred.

Self-Ideal Congruence. Howell (1969) constructed a 60-scale nine point semantic differential (graphic bipolar rating scale) that has been used with college students. There are two forms of the instrument, each form suggesting a different response set. The first form asks the subject to respond to his concept of Actual Self ("actual you"), while the second form asks the subject to respond to his concept of Ideal Self ("the way you would like to be--the way you wish you were").

With attention to the personality characteristics of narcotic addicts (e.g., Coleman, 1972), 47 of the 60 scales were selected as the criterion scales of member growth. A Pearsonian correlation was computed between each subject's Actual and Ideal Self on the 47 scales for each of the two testing periods. An increase in the correlation coefficient (greater congruence) between each subject's Actual and Ideal Self after therapy was considered to be evidence that growth had occurred.

Procedure

The experiment began on a Friday evening at 6:30 p.m. At this time, 94 of the preselected 96 volunteers responded to the pre-treatment measures in the main dining room of the California Rehabilitation Center. When all the subjects had completed the battery, the examiner instructed the subjects in the four marathon

groups, one group at a time, to report to four separate and relatively isolated rooms where the respective therapist dyads were waiting. After the subjects in the four marathon groups had left the dining room the examiner instructed the remaining control subjects to return at 7:00 p.m. the following night.

Because the counselors at the California Rehabilitation Center felt that subjects in one condition might become dissatisfied if they discovered that they didn't receive the same therapist attention or benefits as other subjects, it was decided to administer the post-measures immediately after the 23-hour session, irrespective of the probability that the marathon participants would be more fatigued than the control subjects at this time. Thus, 56 marathon subjects and 28 control subjects returned to the main dining room and responded to the postmeasures directly after the 23-hour period.

RESULTS

The data were entered into a two-way analysis of variance (Pre-Post x Treatment Conditions). In the comparison of the two structured groups with each other, only one significant difference ($p < .05$) emerged, that occurring for POI scale "Inner Directed". No significant differences emerged from the comparison of the two unstructured groups with each other. As only one of the 14 dependent variables showed a significant effect from these comparisons and, in this case the effect only accounted for a small percentage of the variance (5%), it was not unreasonable to combine the two

structured groups with each other, and the two unstructured groups with each other. Thus, there were 28 subjects within each of three treatment conditions (i.e., structured, unstructured, control).

The comparison between the marathon groups and the no-treatment control group yielded significant results in favor of marathon therapy on ACL scale "Self-control" ($F = 5.16$, $df = 1/78$, $p < .05$) and on ACL scale "Achievement" ($F = 4.11$, $df = 1/78$, $p < .05$). One finding, on POI scale "Time Competence", approached statistical significance in favor of marathon therapy ($F = 3.35$, $df = 1/78$, $p \simeq .07$). Thirteen of the 14 test performance changes favored marathon treatment: a sign test (Siegel, 1956) performed on these data indicated that this change in the direction of greater "mental health" was significant ($p < .002$).

Only one significant finding emerged from the comparison of the structured and unstructured treatment conditions, that being in favor of unstructured therapy on ACL scale "Nurturance" ($F = 4.11$, $df = 1/78$, $p < .05$). Eight of the 13 test performance changes favored unstructured therapy; however, the sign test for this directional tendency did not reach significance ($p < .10$).

DISCUSSION

When compared with the control subjects, this study found that the marathon participants: (a) became more interested in their obligations (i.e., "Self-control") (b) made greater efforts to be more successful (i.e., "Achievement"). Because naracotic addicts

have difficulty in impluse control and lack persistence in working on their problems (Gilbert & Lombardi, 1967), it seems reasonable to assume that the addicts who participated in the marathon groups experienced therapeutic change. The lack of additional significant Fs likely is a function of the difficulty in facilitating therapeutic growth in this population. However, it seems plausible that repeated extended sessions over a period of time may result in more pronounced personality changes.

The results of the comparison between the structured and unstructured treatment conditions do not permit any meaningful statements to be made with regard to the efficacy of one treatment over the other. Further comparisons of different therapist approaches with this population are needed so the intervention that most successfully penetrates the defensive structure typical of addicts can be specified.

A considerable amount of unsolicited, highly positive verbal feedback was received from the marathon participants directly after the postmeasures were adminstered. Many of these subjects individually thanked the experimenter for having had the opportunity to be involved in the experiment, and stated they felt the experience had a profound impact upon them. Many stated that the experience had been more meaningful in terms of self-understanding than any prior group experience, and that they would welcome the opportunity to participate in another extended session.

The eight therapists also shared the strong impression that therapeutic growth occurred for most of the subjects in their respective groups. Furthermore, verbal feedback from the counselors at the institution indicated that the marathon subjects generally seemed more enthusiastic about self-exploration in subsequent weekly group sessions than either the control subjects or the residents who did not participate in the experiment. Thus, it is reasonable to assume that the marathon groups predisposed the participants into achieving more substantial gains from subsequent therapeutic contacts.

These reports attest to the subjective impact of the extended group experience and concur with the impressions received by marathon therapists who also have found the participants to evaluate the experience in a highly positive light (e.g., Bach, 1966; Stoller, 1968, 1970a, 1970b). Future studies should investigate the long-range effects of participation in an extended session. Specifically, it must determined whether any immediate subjectively and objectively reported changes are long lasting, and whether these changes have a profound effect upon subsequent coping behavior. In this regard, further studies should incorporate independent assessments of change rather than relying upon outcome criteria of a self-report nature. It is by these efforts that we can hope to gain greater understanding of the impact of marathon group therapy on populations that are typically "immune" to therapeutic interventions.

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Footnotes

[1]Portions of this paper constituted part of the author's doctoral dissertation submitted to the Department of Psychology, Brigham Young University. The author wishes to express his appreciation to Jack Fox of Patton State Hospital and to the staff of the California Rehabilitation Center for their cooperation and assistance in conducting this study.

[2]Requests for reprints should be sent to Peter R. Kilmann, Department of Psychology, University of South Carolina, Columbia, South Carolina 29208.

[3]The exercises, taken from Otto (1970), were presented in the following order: (a) sensory awareness experiences (p. 312) (b) depth unfoldment experience (p. 25) (c) "I have a secret" method (p. 122) (d) slapping exercise (p. 320) (e) final slapping and sound exercise (p. 321) (f) strength acknowledgement; the multiple strength perception method (p. 50) (g) fantasy sentences (p. 371) (h) existential encounter method (p. 71) (i) relationship release method (p. 283) (j) minerva experience (p. 89) (k) sex fantasy sharing (p. 98) and (l) self-image projection experience (p. 118).

[4](1) Number of Favorable Adjectives Checked; (2) Self-Confidence; (3) Self-Control; (4) Personal Adjustment; (5) Achievement; (6) Endurance; (7) Order; (8) Intraception; (9) Nurturance; (10) Heterosexuality; (11) Deference.