The correlation between group members' perception of effective leadership and their perception of treatment modality efficacy

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This study presents a congruent approach to working individuals completing group therapy in a respective treatment modality. Common statistics explain that 30% of individuals do not return after the first session group therapy. A correlation study was used to link the group members’ perception of their leader and their perception of treatment modality efficacy. Results of the research indicate that men are twice as likely to perceive their treatment modality effective when they perceive their leader effective in group social work. There is a statistical significance of .039 between perception of leader and treatment modality. The implication of the correlation provides an understanding as to the therapeutic alliance of leader and client. This research would aid in increasing retention rates when working with clients receiving group services in mental health.
THE CORRELATION BETWEEN GROUP MEMBERS’ PERCEPTION
OF EFFECTIVE LEADERSHIP AND THEIR PERCEPTION
OF TREATMENT MODALITY EFFICACY

A THESIS
SUBMITTED TO THE FACULTY OF CLARK ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF MASTER OF SOCIAL WORK

BY
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I would like to acknowledge the Lord for giving me the strength, wisdom, and ability to accomplish my academic goals. I want to honor my mother, Sarah Davis and stepfather, William Thomas for helping me throughout the years. I’d like to give honor to the late Eric Thomas for believing in me and supporting me. I want to thank my faculty advisors, Dr. Susan Kossak and Dr. Robert Waymer for helping me complete my thesis. I give thanks to my field supervisor, Kimberly Underdue of Underdue Social Services, for a great intern placement and my faculty field supervisor, Dr. Foster, for being supportive. Thank you to all my peers and faculty members of Clark Atlanta University for being there throughout the process.
TABLE OF CONTENTS

ACKNOWLEDGEMENTS.................................................................................................................ii

LIST OF TABLES..........................................................................................................................v

CHAPTER

I. INTRODUCTION.........................................................................................................................1
   Statement of the Problem...........................................................................................................1
   Purpose of the Study..................................................................................................................6
   Research Question.....................................................................................................................7
   Hypothesis..................................................................................................................................7
   Significance of the Study...........................................................................................................8

II. REVIEW OF LITERATURE.........................................................................................................10
   Historical Perspective...............................................................................................................10
   Therapeutic Approaches..........................................................................................................15
   Efficacy of Treatment Modality..............................................................................................17
   Afrocentric Perspective............................................................................................................18
   Theoretical Framework.............................................................................................................19

III. METHODOLOGY......................................................................................................................21
   Research Design.......................................................................................................................21
   Description of the Site..............................................................................................................22
   Sample and Population............................................................................................................22
   Instrumentation.......................................................................................................................22
   Treatment of Data....................................................................................................................23
   Limitations of the Study...........................................................................................................24

IV. PRESENTATION OF FINDINGS...............................................................................................25
   Demographic Data....................................................................................................................25
   Research Question and Hypothesis.........................................................................................29

V. DISCUSSION OF FINDINGS.....................................................................................................41
   Summary of the Study...............................................................................................................42
   Implications for Social Work....................................................................................................44
# TABLE OF CONTENTS

(continued)

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPENDICES</td>
<td>47</td>
</tr>
<tr>
<td>Appendix A. Survey Questionnaire</td>
<td>48</td>
</tr>
<tr>
<td>Appendix B. SPSS Program</td>
<td>50</td>
</tr>
<tr>
<td>Appendix C. IRB Approval Letter</td>
<td>48</td>
</tr>
<tr>
<td>Appendix D. Informed Consent Form</td>
<td>50</td>
</tr>
<tr>
<td>Appendix E. Agency Approval Letter for Study</td>
<td>48</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>57</td>
</tr>
<tr>
<td>TABLE</td>
<td>PAGE</td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>1. Demographic Profile of Study Participants (N=33)</td>
<td>26</td>
</tr>
<tr>
<td>2. Leader displays high levels of trust worthiness and competency (N=33)</td>
<td>28</td>
</tr>
<tr>
<td>3. Leader inspired and motivated members with their vision (N=33)</td>
<td>29</td>
</tr>
<tr>
<td>4. Leader clarified content which helped us as a group communicate clearly (N=33)</td>
<td>30</td>
</tr>
<tr>
<td>5. Leader individualized members by understanding their personal needs and goals (N=33)</td>
<td>32</td>
</tr>
<tr>
<td>6. Overall, I perceive this treatment modality to be effective (N=33)</td>
<td>33</td>
</tr>
<tr>
<td>7. Overall, I benefitted having participated in this type of therapeutic intervention (N=33)</td>
<td>35</td>
</tr>
<tr>
<td>8. Cross tabulation of the computed variable (PERCEPT) of perception of group leader and overall perception of treatment modality (N=33)</td>
<td>36</td>
</tr>
<tr>
<td>9. Cross tabulation of group members’ perception of leader and perception of treatment modality efficacy as it relates to ethnicity (N=33)</td>
<td>38</td>
</tr>
<tr>
<td>10. Cross tabulation of group members’ perception of leader and perception of treatment modality efficacy as it relates to gender (N=33)</td>
<td>39</td>
</tr>
</tbody>
</table>
CHAPTER I
INTRODUCTION

It has been estimated that several hundred therapeutic approaches exist ranging from psychoanalysis to Zen meditation. The new buzz, beginning in 2001, has been evidence-based research and evidence-based practice. There has been a significant emphasis on those treatment modalities, which will produce an outcome or desirable effect working with mental health patients.

Relative to other psychosocial services, groups have been thought to offer a particularly compelling effective treatment modality for many mental health patients. Group interventions provide a range of therapeutic processes, both general and specific (Burlingame, Mackenzie, & Straus, 1995). Groups offer a sense of belonging, a forum for support and a means of sharing one’s personal experiences and struggles. Participants may derive hope by witnessing others face the challenge of illness with resourcefulness, or they may experience renewed self-worth by helping others who are faring more poorly than they are (Leszcz & Goodwin, 1998). Peer support and modeling also may contribute to new coping resources and self-efficacy, perhaps more effectively than is possible in individual therapy (Fawzy, Fawzy, & Wheeler, 1996).

A person exposed to group therapy might benefit in various modalities including: cognitive behavioral therapy, mindfulness-based psychotherapy, solution focused
therapy, support groups, and self-help groups, all designed to modify a behavior or process one’s concern.

One treatment modality, Cognitive Behavioral Therapy (CBT) psychotherapy groups, is one form of group therapy known to be extremely effective in modifying cognitions, assumptions, beliefs and behaviors, with the aim of influencing disturbed emotions. The general approach developed out of behavior modification, Cognitive Therapy and Rational Emotive Behavior Therapy, has become widely used to treat various kinds of neurosis and psychopathology, including mood and anxiety disorders. The particular therapeutic techniques vary according to the particular kind of client or issue, but commonly include keeping a diary of significant events and associated feelings, thoughts and behaviors; questioning and testing cognitions, assumptions, evaluations and beliefs that might be unhelpful and unrealistic; gradually facing activities which may have been avoided; and trying out new ways of behaving and reacting. Relaxation and distraction techniques are also commonly included. CBT is widely accepted as evidence- and empirically-based, cost-effective psychotherapy for many disorders and psychological problems. It is sometimes used with groups of people as well as individuals, and the techniques are also commonly adapted for self-help manuals and, increasingly, for self-help software packages (Rackman, 1997).

Another effective form of group therapy is Dialectical Behavioral Therapy (DBT). This treatment modality was developed by Marsha M. Linehan specifically to treat individuals with borderline personality disorder. While DBT was designed for individuals with borderline personality disorder, it is used for patients with other diagnoses as well. In this form of therapy, a therapist and client would discuss issues that
come up during the week, recorded on diary cards and follow a treatment target hierarchy. Self-injurious and suicidal behaviors take first priority, followed by therapy interfering behaviors. Then, there are quality of life issues and, finally, working toward improving one's life generally. During the individual therapy, the therapist and client work toward improving skill use. Often, skills group is discussed and obstacles to acting skillfully are addressed. The group normally meets once weekly for about 2-2.5 hours, in which clients learn to use specific skills that are broken down into four modules: core mindfulness skills, emotion regulation skills, interpersonal effectiveness skills and distress tolerance skills.

One of the components of DBT is mindfulness-based psychotherapy, which is a module used in DBT practice derived designed to help individuals learn to overcome the present moment of suffering and develop an awareness of everything from diet, sound, the body, and breathing. Other treatment modalities, such as support, self-help, and behavioral therapy groups all play some part in helping a client reach their goal.

Statement of the Problem

The delivery of brief evidence-based effective interventions and self-help for people with common mental disorders is a concern and problem in working with mental health patients. Patients have many options in terms of the type of treatment and interventions most accessible for their care. Unfortunately, a large proportion of individuals suffering from mental illness do not seek professional help (Kessler, Nelson, McGonagle, Edlund, Frank, & Leaf, 1996).
Second, another problem is retention rates in therapeutic programs. Mental health professionals still fail in gaining better retention and compliancy rates regardless of whatever treatment modality patients sought. Many patients who undergo group therapy have more than 40% retention loss in keeping those patients throughout the entire program. In one particular CBT group therapy study involving heroine and meth addicts in Germany, only 60% of the 71 participants were willing to continue further group psychotherapy. Of the 114 program participants eligible to participate in the program, 35 dropped out after the first day and six others withdrew from the CBT-based program six weeks into the study (Woody, et al., 1996). In solving this problem, it is imperative to not only recruit patients to such group therapy programs and treatment centers, but make sure they complete the program and benefit from the therapeutic intervention.

A final problem continues to be the lack of training styles and competency of the clinician utilizing the DBT and/or CBT modules. If the mental health professionals were competent in their knowledge and effective in their leadership, then retention rates would increase and patients’ compliance to work toward treatment goals might be noted.

The research in this area is very slim; especially the database concerning peer-led self-help groups is quite limited (Barlow, Burlingame, & Fuhriman, 1999). Treatment modalities differ widely with respect to characteristics of the participants, level of impairment or distress, duration of treatment, training of the leaders, specific interventions employed, underlying theoretical model, and outcome domains assessed.
Purpose of the Study

The purpose of the study is to determine if a significant relationship exists between effective leadership and intervention modality efficacy in group practice. In turn, this study may provide an understanding as to which treatment modality and leadership characteristics work well for a given population of people.

Research Question

The research question addressed in this study is:

Research Question 1: Is there a relationship between group member perceptions of effective leadership and their perceptions of treatment modality efficacy?

Hypothesis

The null hypothesis of the study is as follows:

Hypothesis 1: There is no statistically significant relationship between group members’ perceptions of effective leadership and their perception of efficacy in treatment modality.

Significance of the Study

It is the significance of this study to determine a relationship between effective leadership and efficacy of treatment modality. This relationship may demonstrate which patients are most responsive to which types of treatment modality and/or leader. The study may reinforce the belief that relationships are vital in therapeutic interventions.
CHAPTER II

REVIEW OF LITERATURE

Historical Perspective

The roots of contemporary group psychotherapy are often traced to the group education classes of tuberculosis patients conducted by Joseph Pratt in 1906; the exact birth of social group work cannot be easily identified (Kaiser, 1958; Schleidlinger, 2000; Wilson, 1976). Social group work approaches are rooted in the group activities of various social agencies that arose in the latter part of the 19th century and the early years of the 20th century.

Specifically, Dr. Pratt, a Boston internist, worked with tubercular patients at the Boston Dispensary and observed that patients' emotional reactions, their feelings of shame and discouragement because of their illness, often interfered with their capacity to adhere to self-care regimens. In Pratt’s groups, initiated July 1, 1905, his goal was to help patients understand the “nature of their illness, to teach them how they could contribute to their own recovery, and to inspire them to sustain their courage in living with a chronic ailment” (Durkin, 1971). Dr. Pratt wanted to have a large number of patients meet at the hospital to share their treatment related goals, which would be considered a group format or therapy.
The authoritarian style of Dr. Pratt was even more prominent in the work of Dr. A. A. Low. Dr. Low, in the 1920s, organized Recovery, Inc., an organization of post-hospitalized psychotic patients. Its purpose was to enable former mental patients to offer each other support in managing their lives in the ordinary community. Each chapter was under the leadership of a patient and other designated officials similar to army units. The rank-and-file patients were required to have approval of the head of their "chapter" before they could arrive at any decision about their lives or make any move in carrying out their plans. Members of the upper echelon in a rigid hierarchical officialdom were not available to a member involved, except in cases of appeal. Only in extreme instances, when all the other officials could not resolve a matter, could the case come before Dr. Low for a final decision. "Recovery" chapters were initiated in Chicago, and the organization has since spread to several Mid-Western states and beyond and is still in operation (Durkin, 1971).

In the 1930s, among the early social workers with small groups along the lines of relationship group practice, were Helen E. Durkin and Henriette F. Glatzer at the Brooklyn Juvenile Protective Association, the name of which was later changed to Brooklyn Psychiatric Centers. Their work with children began in 1937 and with mothers in 1938 (Durkin, 1971).

Another prominent group social worker in the 1940s was Dr. Alexander Wolf. Dr. Wolf gave his group members more leadership roles and responsibilities. Dr. Wolf closely adhered to psychoanalytic principles but added to the regular sessions with him what he termed "alternate sessions", i.e., meetings of patients in his absence. He labeled his method "The Psychoanalysis of Groups."
Another social worker in group practice, Grace Coyle, presented an early theoretical framework for group social work articulating the need for a democratic value base (Coyle, 1935), identifying the role of the worker as a group builder (Coyle, 1937), and noting the benefits of ‘esprit de corps’ or group morale (Coyle, 1930). As the editor of several small group research compendiums, Hare (1976) would later point out, “many of her insights about group process were ahead of her time” (p. 388).

In 1964, the Committee on Practice of the Group Work Section of the National Association of Social Workers proposed that group work was applicable for the following purposes: corrective/treatment and prevention normal social growth and development; personal enhancement; and citizenship indoctrination (Hartford, 1964). Common needs addressed by social work groups include coping with major life transitions; the need to acquire information or skills; the need to improve social relationships; the need to cope with illness; and the need to cope with feelings of loss or loneliness; amongst other reasons (Gitterman & Shulman, 2005; Northen & Kurland, 2001).

Current research in group social work practice suggests opportunities for mutual aid to be found in the group encounter offer, the major rationale for the provision of group services by social workers. Gitterman (2006), a social work educator and group work scholar, has elaborated on the role of mutual aid in the small group noting that “as members become involved with one another, they develop helping relationships and become invested in each other and in participating in the group” (p. 93).

The concept of open and closed group activity is another theoretical piece. Most conceptualizations of group development are predicated on the belief that the group is
closed, with unchanging membership (Schopler & Galinsky, 1990). The findings of an exploratory study conducted by Schopler and Galinsky (1990) concluded that movement beyond beginnings is possible. However, the impact of open membership is likely to result in a more cyclical pattern of group development with regression occurring when members enter and/or leave the group (Schopler & Galinsky, 1990).

**Therapeutic Approaches**

The purpose of presenting this literature review is to identify types of therapeutic approaches used to work with mental health patients and provide qualitative data outcome. The literature serves to distinguish what type of treatment modalities are working in the context of group therapy and which populations are being served. In the literature review, there were similarities amongst the findings. Emerging new forms of group practice, such as Dialectical Behavioral Therapy, provided a helpful insight into its role in dealing with mental health patients, and another effective therapeutic approach derived from Cognitive Behavioral Therapy. In the literature review, researchers practicing with a DBT group model demonstrated strong outcomes after completing sessions with a population of sex offenders, individuals with borderline personality, and young people aging out of the Department of Children and Family Services.

In the literature review, there were many differences amongst the researchers. First, although addressing similar behavioral problems among mental health disorders, differed in their approach or context in which they would provide evidence of its efficacy in group practice as the review indicated.
First, Jones and McDougal (2007) co-authored a study which involved a dual effort to tour the Washington State, USA. The author reports on a visit to the Behavioral Research and Therapy Clinic, internationally recognized centre of excellence, to observe the use of dialectical behavioral therapy for people with borderline personality disorders (Jones & McDougal, 2007). The writer reports effective use of the treatment modality and group work working with borderline patients.

Next, Bock’s (2007) study examines the effects of social-behavioral learning strategy intervention on the social interaction skills of four elementary school children with Asperger syndrome (AS). The study investigated the effect of group training on the abilities of four children with AS to participate in cooperative learning activities, play organized sports games, and visit with their peers during lunch. A multiplied baseline across settings design was used to analyze social behavior during fourth or fifth grade social studies cooperative learning activities, noon recess, and lunch. The participants benefitted from the intervention working collaboratively. They presented increased percentages of time spent learning cooperatively, playing organized sports games, and visiting during lunch when training began (Bock, 2007).

Subsequently, Brunswick and Banaszak’s (1996) research discussed the growing rates of HIV infection and AIDS requiring urgency for developing ethno-gender specific models for changing behaviors that are placing those groups at risk. The researchers were seeking what type of ethno-gender specific models could be put in place to help individuals reduce spreading rates of HIV/AIDS. Their work does look at how individual perception of vulnerability and personal efficacy helps in their desire to practice safe sex and take precaution. In their study, they compute variables on HIV as they relate to
knowledge, attitudes, and perceptions reported by an urban community sample of African American and formulated as components of the Health Belief Model (HBM) against HIV avoidance practice, using both structural equation and OLS regression analysis (Brunswick & Banaszak, 1996). Both multivariate approaches identified perceived vulnerability as a significant negative predictor and additionally for women, a positive relationship with generalized sense of personal efficacy (Brunswick & Banaszak, 1996).

Even more, Nemets, Nemets, and Apter’s (2006) study of Omega 3 fatty acids found that there is a relationship when they worked with a population of youth in group practice. They looked and discovered beneficial treatment in reducing symptoms of depression in pre-adolescent children. A 16-week double blind, placebo-controlled pilot study of 28 children (ages 6 through 12) revealed the outcome when a group study was completed (Nemets, et al., 2006). The findings were limited by the small sample size, short duration, and use of olive oil as placebo, yet did show benefits when working with this population.

Next, Epstein’s (2005) literature found benefits of integrating mindfulness meditation with cognitive and behavioral therapies, namely MBCT and DBT, focusing in particular on the challenge of integrating acceptance versus change-based strategies. Initial outcome studies have demonstrated the efficacy of both approaches when working with clients in group practice. There were research limitations to assess the unique contribution of mindfulness meditation in DBT.

Moreover, the researchers, Renger, Steinfelt and Lazarus (2002), presented a plan to develop, implement, and evaluate a community-based effort addressing the problem of physical activity. The research did help those individuals understand the importance of a
steady work out routine and increase positive perceptions about their body after participation. Group member perceptions were noted using Prochaska’s Tran Theoretical Model as a guide. Community members developed television and worksite media messages focusing on the benefits and barriers of physical activity and increasing self-efficacy (Renger, Steinfeldt, & Lazarus, 2002). The media campaign was effective in working with a population of individuals who were obese or overweight. The research discovered changing perceived barriers, perceived benefits, and self-efficacy surrounding physical activity and had an unexpected effect of changing behavior (Renger, Steinfeldt, & Lazarus, 2002).

Subsequently, Rakfeldt’s (2005) study explored the efficacy of Dialectical Behavior Therapy (DBT) for young people aging out of the Department of Children and Families system. The project was conducted with participants at a residential program for “transitional youth” who have serious emotional disturbance and emerging mental illness (Rakfeldt, 2005). The findings concluded that members of the DBT group improved from pre-test to post-test, and when judged against the comparison group, improvement was in terms of global functioning, social relationships and productive use of time (Rakfeldt, 2005).

Efficacy of Treatment Modalities

Numerous treatment modalities exist which have proved effective in working with clients with mental health and addictive disorders. Many of the modalities are covered in the review. Some of the problems with working with clients are highlighted, as well as barriers to treatment. Middleman and Wood (1990) have proposed that for
practice to qualify as social work with groups, four conditions must be met: the worker should focus attention on helping the group members become a system of mutual aid; the group worker must understand the role of the group process itself as the primary force responsible for individual and collective change; the group worker seeks to enhance group autonomy; the group worker helps the group members experience their groupness upon termination (Middleman & Wood, 1990).

In Cognitive Behavioral Therapy in social work practice, Dr. Childs-Clarke (2007) examines the effects of providing CBT for patients with common mental health problems in primary care settings. The research reveals that Cognitive Behavioral Therapy (CBT) treatment modality is quite useful for various psychological maladies.

Research conducted by Vostanis, Graves, Meltzer, Goodman, Jenkins, and Brugha (2006) discusses a relationship between parental styles and psychiatric disorders. Vostanis’, et al. (2006) research discusses how parenting attitudes, ways of punishment and consequences have all shaped in contributing to a psychiatric disorder in children. His findings suggest although parents may be using less physical strategies than in the past, non physical punishment is strongly related to mental health problems.

Even more, Vostanis, et al. (2006) discuss that children who practice healthy habits in terms of hygiene, caring for themselves, physical activity, positive play, and persistence tend to continue these habits later on in life. Dr. Vostanis explained that if the child is well grounded early in life, he or she is much more likely to continue those healthy behavior patterns through his or her teen years and the adulthood years. He further describes ways of teaching young people things in terms of caring for themselves
and respecting others. His research looks at the importance of teamwork and working toward a goal.

Conner and McLaughlin (2000) investigated a correlation between measures of proactive and reactive aggression subtype, and the severity and frequency of overt aggression and psychiatric diagnosis in clinically referred sample of children compared to a non-referred community comparison group free of psychiatric diagnosis. The research supports the need to consider “development of psychosocial and psychopharmacological treatment interventions specifically targeting excessive maladaptive aggression when working with patients” (Conner & McLaughlin, 2000, p. 12).

Other researchers, Whalen and Schreibman (2003), proved that joint attention behaviors were effectively trained and targeted behaviors generalized to other settings. Positive changes were noted using social validation measures. The psychologist, Dr. Jo Shingler, describes how a treatment technique designed for use with a specific client group could have applicability to sex offenders (Shingler, 2004). The DBT techniques are described and told how they could be used with sex offenders. Shingle’s findings suggest that Dialectical Behavioral Therapy was designed as a way of treating a challenging and “high risk” client group with cognitive-behavioral strategies. She discusses the philosophies and techniques are well suited for use with sexual offenders. Dr. Shingler states “most therapists working with the sexual offenders within the criminal system are working within the boundaries of accredited programs” (p. 117).

Dr. Rakfeldt’s (2005) study explored the efficacy of Dialectical Behavioral Therapy (DBT) for young people aging out of the Department of Children and Families
system. The project was conducted with participants at a residential program for “transitional youth” who have serious emotional disturbance and emerging mental illness (Rakfeldt, 2005). The findings concluded that members of the DBT group improved from pre-test to post-test, and when judged against the comparison group improvement was in terms of global functioning, social relationships and productive use of time (Rakfeldt, 2005).

Another CBT modality researcher, Dr. Javier Escobar (2007) seeks to address the assistance patients receive when they enter a hospital setting with medically unexplained physical symptoms. The physicians in the journal tested the effectiveness of a Cognitive Behavioral Therapy intervention delivered in primary care for patients with medically unexplained physical symptoms. Patients were either assigned the CBT intervention plus a consult letter or the usual clinical care plus a letter. The findings revealed the time limited, CBT-type intervention significantly ameliorated unexplained physical complaints of patients seen in primary care and offers an alternative for managing these common and problematic complaints in primary care settings. Dr. Escobar’s research suggests that CBT intervention was effective in helping a patient having problems in their health. His research does not suggest that CBT take the place of consulting with one’s physician (Escobar, 2007).

In contrast, Yang Tan Siang’s (2007) article covers the appropriate and ethical use of prayer including inner healing prayer and Christian approach to Cognitive Behavioral Therapy (CBT) and how prayer and scriptures can be explicably used in Christian CBT and the results of outcome studies on its efficacy are mentioned (Yang, 2007). Differing, Professor Childs-Clarke’s (2007) research, mentioned earlier, reveals
that Cognitive Behavioral Therapy (CBT) is recommended for a range of problem, including depression and anxiety, but patients seen in primary care with common mental health issues often present with co morbidity and have psychosocial problems as well (Childs-Clarke, 2007).

In contrast, Cognitive Behavioral Therapy (CBT) in which Dialectical Behavioral Therapy gains its origin is primly compared by Epstein, et al. (2005). Epstein’s, et al. literature found two efforts of integrating mindfulness meditation with cognitive and behavioral therapies, namely MBCT and DBT, focusing in particular on the challenge of integrating acceptance versus change-based strategies. Epstein’s, et al. (2005) initial outcome studies have demonstrated the efficacy of both approaches. There were research limitations to assess the unique contribution of mindfulness meditation in DBT.

Afrocentric Perspective

The Afrocentric perspective with Humanistic Values and the Autonomous Social Work Practice have been a part of the Whitney M. Young, Jr., School of Social Work (WMYJSSW) history since the 1960s. The Afrocentric perspective asserts that differences in culture, worldview, and historical experiences exist between African Americans and European Americans just as there are differences between other people of color and Europeans (CAUSSW, Manual 2007, p. 11). The Afrocentric perspective serves as a worldview to assist others in understanding the African American experience from Africa to America, “which though fractured, is nevertheless not to be neglected” (CAUSSW, Manual 2007, p. 11).
Many individuals experiencing group counseling for the first time, especially in the African American culture, have never done so before due to fear, stereotypes related to receiving services, excessive medication, and racial problems presented to African Americans receiving mental health services in the past. African American perspective teaches many to rely on their strengths, family, spiritual basis, and resilience when coping with a mental health problem. The mere Afrocentric perspective identifies this migration from Africa to America as a horrid experience which propels African Americans to not seek mental health services.

From the experience, it is the role of the group leader to assist the client in working through such barriers and develop an alliance with the client to ensure his trust. The spiritual basis in African American culture has replaced group counseling. That is, there is a vibrant belief that there is a spiritual force to ail of life and that the spiritual dimension is the connective link to the mental and physical spheres of human kind (Myers, 1988; Nobles, 1986). It would take more than the group social worker to provide a perception of trust and assurance that alleviates cultural barriers especially when working with African Americans.

Within the Afrocentric world view, the highest value lies in the interpersonal relationship between human beings. This priority on the value of the relationship places a premium on the authenticity of the person (Petersen, 1983). It is the relationships that we build within the larger family/community of people that are accorded prominence. Social workers should help clients to work toward reconnecting those interpersonal relationships when working in the group context.
Theoretical Framework

The theoretical basis for this study is the Social Constructivism Theory. Social Constructivism Theory uncovers the ways in which individuals and groups participate in the creation of their perceived social reality (Schriver, 2004). It involves looking at the ways social phenomena are created, institutionalized, and made into tradition by humans. Socially constructed reality is seen as an ongoing, dynamic process reality which is reproduced by people acting on their interpretations and their knowledge of it.

Social Constructivism Theory is a psychological theory of knowledge which argues that humans generate knowledge and meaning from their experiences. According to Wertsch (1977), Piaget believed that knowledge is internalized by learners. He suggested that through processes of accommodation and assimilation, individuals construct new knowledge from their experiences. When individuals assimilate, they incorporate the new experience into an already existing framework without changing that framework.

According to the theory, accommodation is the process of reframing one's mental representation of the external world to fit new experiences. Assimilation is to merge or absorb (Wertsch, 1997). Key components are: the learner as a unique individual, the importance of the background and culture of the learner, the responsibility for learning, the motivation for learning, the role of the instructor, instructors as facilitators. All parts are designed to assist a person in reframing their experience and perceived outcomes (Schriver, 2004).

A lens of this theoretical framework is the strengths-based perspective. Things are generally socially constructed to be perceived as good if one highlights the strengths
instead of the weaknesses. We are socially constructed to perform better if we think and feel things are better. The strengths-based perspective presents a different way of looking at a person, family or community. A person is seen in light of his/her capacities, talents, competencies, visions, values, and hopes. The strengths accounts for what a person knows and can do (Schriver, 2004).

Serving as the basis for this study, the social constructivism theory suggests that individuals will perform either negatively or positively to a concept ultimately based on how they perceived it. Similar to the study, it suggests that if the person has a thought of things should be going well, then he/she will succumb to their perception and believe without a doubt that things are going well.

Social constructivist scholars view learning as an active process where learners should learn to discover principles, concepts and facts for themselves, hence the importance of encouraging guesswork and intuition. From the social constructivist viewpoint, it is thus important to take into account the background and culture of the learner throughout the learning process, as this background also helps to shape the knowledge and truth that the learner creates, discovers and attains in the learning process. Wertsch (1997) argues that reality is constructed by our own activities and that people, together as members of a society, invent the properties of the world.
CHAPTER III

METHODOLOGY

Chapter III presents the methods and procedures that were used in conducting the outcome evaluation. The following topics are described: research design, description of the site, sample and population, instrumentation, treatment of data, and limitations of the study.

Research Design

The exploratory research design was used in this study. The study was designed to obtain data in order to explore and explain if a relationship exists between group members' perception of their leader and their perception of treatment modality.

Description of the Site

There were five locations selected for this study. Each site provided one of five types of treatment modalities needed to make appropriate comparisons in this study. Underdue Social Services’ Cognitive Behavioral Therapy groups, a 12 step support group at Ridgeview Institute in Smyrna, Georgia, a Mindfulness Group in DeKalb County, and a DBT group in Smyrna, Georgia were selected for this study. A major reason for the diverse selection of groups was to gather different treatment modalities needed to make comparisons in the study.
Sample and Population

The priority population for this research was composed of female and male participants who recently completed some form of group therapy. A total of 33 surveys were provided. Seven of the participants indicated they completed a CBT group, three completed mindfulness group, 17 completed a support group, five completed a DBT group, and one specified “other” as their treatment modality.

All participants were asked which type of treatment modality they were currently in or have completed within the last 30 days. After completing the demographic questionnaire all participants were given a pen. Total of 34 participants participated in the evaluation.

Instrumentation

The study utilized a questionnaire to collect the data. The information obtained from the questionnaire included participants’ demographic data and opinion responses from the questionnaire was used to gauge each person’s perception of their respective treatment modality and leader. A completed questionnaire was obtained from each participant. The questionnaire was designed to be analyzed by the Statistical Package for Social Sciences (SPSS).

Treatment of Data

The research employs quantitative methods using statistical analysis from the SPSS software. Data from the surveys will be used to evaluate the outcome from all treatment modalities. This analysis utilized descriptive statistics, which included measures of central tendency and frequency. A demographic profile was developed on
the participants. A Likert scale (Strongly Disagree, Disagree, Agree, and Strongly Agree) was utilized to generate frequency distribution in order to analyze participant perceptions. Cross tabulation was utilized to calculate chi square, which was used as the test to determine statistically significant relationships between the main variables of the study. Cross tabulations were conducted utilizing the four variables of effective leadership and crossing this with treatment modality effectiveness.

Limitations of the Study

There were two main reasons why the study was limited. The first limitation was the disproportionate ratio of participants to the type of modality used in the study. It would have been more beneficial to gather a larger number and allow equal ratios of 20 participants each per modality. The second limitation was the length of time in the program. Some members' responses were skewed being new to the group and not understanding the group dynamics. Furthermore, some participants stated random responses just to quickly complete the survey. The level of participation and accuracy will definitely affect their perception. Also, the researcher could have been bias, not obtaining proportionate responses from all members in attendance.
CHAPTER IV

PRESENTATION OF FINDINGS

The purpose of this chapter was to present the findings of the outcome evaluation. The surveys were administered to women and men in five different group modalities in Cobb, DeKalb, and Fulton Counties of Georgia. The purpose of the study was to determine if a relationship exists between group members’ perception of the leader and their overall perception of their respective treatment modality. The findings of the study are structured into three sections; demographic data, research question, and hypothesis.

Demographic Data

A demographic summary was developed of the study participants. The demographic profile included: age, sex, race, and type of treatment modality experienced. The study was composed of 34 participants between the ages of 14 through 50 years old. There were 13 females and 20 males. Participants indicated they were part of a CBT Group (21.2%), Mindfulness Psychotherapy Group (9.1%), DBT Group (15.2%), Support Group (51.5%), and other forms of group therapy (3%). The ethnicity of the participants were African-American (60.6%), Caucasian (33.3%), and Hispanic (6.1%).

Table 1 is a profile of the study participants. It presents the frequency distributions of the demographic variables.
Table 1

Demographic Profile of Study Participants (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14-17</td>
<td>19</td>
<td>57.6</td>
</tr>
<tr>
<td>22-25</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>26-29</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>30-33</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>34-40</td>
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<tr>
<td>41-45</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>20</td>
<td>60.6</td>
</tr>
<tr>
<td>Female</td>
<td>13</td>
<td>39.4</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>11</td>
<td>33.3</td>
</tr>
<tr>
<td>Caucasian</td>
<td>20</td>
<td>60.6</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td><strong>Treatment Modality</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CBT Group</td>
<td>7</td>
<td>21.2</td>
</tr>
<tr>
<td>Mindfulness Psychotherapy Grp</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>DBT Group</td>
<td>5</td>
<td>15.2</td>
</tr>
<tr>
<td>Support Group</td>
<td>17</td>
<td>51.5</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Table 1 is an overview of all the participants in the survey. All 33 participants completed a survey in one of the five treatment modalities; CBT, DBT, Mindfulness Group, Support Group, and Other form of group activity. The age range consisted of
participants 14 through 45 years of age. Approximately 61% of the participants were male, while 39% of the participants were female. Approximately 33% of the participants were African American, 20% were Caucasian, and 2% were of Hispanic ethnic background.

Table 2 is a frequency distribution of 33 group participants whom recently completed a group session in one of the treatment modalities indicated in Table 1.

Table 2
Leader displays high levels of trust worthiness and competency (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Agree</td>
<td>32</td>
<td>97.0</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 2, of the 33 respondents, 97% indicated their leader displayed high levels of competency and trust worthiness. Three percent disagreed, indicating that their leader was neither trustworthy nor competent.

Table 3 is a frequency distribution of 33 group participants enrolled in one of the four forms of treatment interventions who indicated whether or not their leader inspired and motivated them with their vision.
Table 3
Leader inspired and motivated members with their vision (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Agree</td>
<td>32</td>
<td>97.0</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 3, of the 33 respondents, 97.0% agreed that they were motivated while 3% disagreed.

Table 4 is a frequency distribution of 33 respondents enrolled in one of the forms of treatment interventions who indicated whether or not their leader clarified content which helped them as a group communicate clearly.

Table 4
Leader clarified content which helped us as a group communicate clearly (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Agree</td>
<td>32</td>
<td>97.0</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>
As shown in Table 4, of the 33 respondents, 97.0% agreed that the leader clarified content and communicated well during the group. Three percent did not agree.

Table 5 is a frequency distribution of 33 respondents enrolled in one of the treatment modalities who indicated whether or not their leader individualized members by understanding their personal needs and goals.

Table 5
Leader individualized members by understanding their personal needs and goals (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>3</td>
<td>9.1</td>
</tr>
<tr>
<td>Agree</td>
<td>30</td>
<td>90.9</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 5, of the 33 respondents, 90.9 agreed that the leader individualized their needs and goals and 9.1% disagreed indicating that they did not individualize their needs.

Table 6 is a frequency distribution of 33 respondents who completed or were enrolled in one of the treatment modalities and indicated whether or not they perceived this treatment modality to be effective.
Table 6
Overall, I perceive this treatment modality to be effective (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td>Agree</td>
<td>31</td>
<td>93.9</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

As shown in Table 6, of the 33 respondents, 93.9% perceived their treatment modality was effective, while 6.1% did not perceive their treatment modality effective.

Table 7 is a frequency distribution of 33 respondents who completed or were enrolled in one of the treatment modalities and indicated whether or not they benefitted having participated in this type of therapeutic intervention.

Table 7
Overall, I benefitted having participated in this type of therapeutic intervention (N=33)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>1</td>
<td>3.0</td>
</tr>
<tr>
<td>Agree</td>
<td>32</td>
<td>97.0</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>
As shown in Table 7, the majority of the respondents surveyed overall benefitted from their respective treatment modality. Of the 33 respondents, 97% agreed that they benefitted in this therapeutic intervention and 3% said they did not agree.

Research Question and Hypothesis

Research Question 1: Is there a relationship between group member perceptions of effective leadership and their perceptions of expected outcomes in group therapy?

Hypothesis 1: There is no statistically significant relationship between perceptions of effective leadership and efficacy of treatment modality by group members.

Table 8 is a cross tabulation of the computed variable using a combined total response from survey questions 5-8 dividing these by four to get a combined variable for perception of leader. This and overall perception of leader was computed utilizing a cross tabulation with perception of modality. It shows a relationship of (0.038) indicating a statistically significant relationship between perception of leader and treatment modality.
Table 8

Cross tabulation of the computed variable (PERCEPT) of perception of group leader and overall perception of treatment modality (N=33)

<table>
<thead>
<tr>
<th>Perception of Leader</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td>No</td>
<td>1</td>
<td>3.0</td>
<td>3.0</td>
<td>2</td>
<td>6.1</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>2</td>
<td>6.1</td>
<td>87.9</td>
<td>31</td>
<td>93.9</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>6.4</td>
<td>30</td>
<td>90.9</td>
<td>33</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Chi square= .038   DF=1

Table 8 indicates that of 33 respondents 30 or 90.9% agreed that there was a relationship between effective leadership and effective outcome. When the chi square was applied, the null hypothesis was rejected. As shown on Table 8, the chi square test indicated that there was a statistically significant relationship (.038) between effective leadership and treatment modality at the .05 level of probability.

Table 9 is a cross tabulation of the group members’ perception of leader and perception of treatment modality efficacy as it relates to ethnicity. It shows no statistically significant relationship (.108) in determining how ethnic groups relate to their leader and outcome of their treatment modality.
Table 9

Cross tabulation of group members’ perception of leader and perception of treatment modality efficacy as it relates to ethnicity (N=33)

Table 9 revealed that of 33 respondents 30 or 90.9% agreed that there was a relationship between effective leadership and effective outcome as it relates to ethnicity. As shown in Table 9, the chi square test indicated that there was no statistically significant relationship (.108) between how ethnic groups relate to their leader and outcome of their treatment modality at the .05 level of probability.

Table 10 is a cross tabulation of the group members’ perception of leader and perception of treatment modality efficacy as it relates to gender. It shows a statistically significant relationship (.024) in determining how gender groups relate to their leader and outcome of their treatment modality.
Table 10

Cross tabulation of group members’ perception of leader and perception of treatment modality efficacy as it relates to gender (N=33)

<table>
<thead>
<tr>
<th>Perception of Leader</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
<th>#</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Disagree</td>
<td>Agree</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>My gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>0 0.0</td>
<td>20 60.6</td>
<td>20 60.6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>3 9.1</td>
<td>10 30.3</td>
<td>13 39.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3 9.1</td>
<td>30 90.9</td>
<td>33 100.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Chi square = .024  DF=1

Table 10 revealed that there is a statistically significant relationship as it relates to gender (.024). Men are twice as likely as women to have a better perception of outcome in their treatment modality if they perceive the leader to be effective.
CHAPTER V
DISCUSSION OF FINDINGS

Summary of the Study

The study was designed to determine if a significant relationship exists between group participants' perception of their leader and efficacy of treatment modality. The study also compared various treatment modalities distinguishing if other variables such as ethnicity or gender played a role in determining perception of treatment modality and leadership effectiveness. The conclusion and recommendations of the research findings are presented in this chapter.

Research Question 1: Is there a significant relationship between group member perceptions of effective leadership and their perceptions of treatment modality efficacy?

A cross tabulation was conducted in order to determine if there was a relationship between the group member perceptions of effective leadership and their perception of expected outcome in group therapy. The effective leadership variable was added using questions 5-8 of the survey, divided this by four to get a sound response on effective
leadership. This was computed with the variable on overall perception of treatment modality in a cross tabulation.

The research conducted clearly brings to light the advantage of therapeutic relationship when gaining a client's perception of the modality and leadership are taken into consideration. Due to the overwhelming results from the participants (87.9%) in the survey, it should be noted that most agreed to have a perceived better outcome in their modality due to the perceived effective leadership style of the person leading their group. Two respondents (6.1%) did not perceive their leader was effective even though they would anticipate an effective outcome.

Furthermore, the analysis indicated that 1 (3.0%) believed to have an effective outcome, but it was not due to their leader. In comparison, 1(3.0%) indicated they had an effective leader, but did not perceive the treatment modality effective.

The statistical measurement, chi squared, was employed to test the relationship between the variables effective leader and outcome. When the chi square was applied, the null hypothesis was rejected (.038) indicating that there was a statistically significant relationship between perception of leader and perception of treatment modality.

Implications for Social Work

It was noted that retention and compliancy rates among individuals in social work group programs remain a challenge. It is imperative for all clients completing group therapy to remain consistent with their attendance and follow through with all assignments and requirements in their respective program. Success, especially in treatment, is contingent upon their ability to remain in the program. In one study, 60% of
the participants did not return for CBT group meetings citing various reasons “from boredom, not liking the leader, lack of money, to simply not wanting to participate” (Woods, et al., 1983). The research further explained that 30% of clients do not return for services after the first session and ultimately do not benefit from the treatment for their mental health or addictive problem. For African Americans, 40% do not return for services citing problems related to stereotypes and historical problems related to individual undergoing group counseling.

The benefits of group social work are very important. The need for informed, disciplined, know-how social workers working with groups has been continuous and insistent. Utilizing the social constructivism theory, a person will generally perform well if they socially constructed their reality and change old thinking in hopes of a new learned experience. This new reality will take the assistance of a group leader (teacher) to help them develop a new learned perspective in regards to their perceived outcome and treatment.

Overall, group social work, since formally founded as the Association for the Advancement of Social Work with Groups in 1975, has emphasized the need for better alliance with the client, a need for continued trust, and improved relationship in group social work. This theoretical approach was done with individuals receiving services in CBT groups. Cognitive Behavioral group social work, for example, has been very effective in dealing with clients to help them modify and change poor thinking patterns. Once the individual changed and perceived their change to be true, they did better and stayed on course. If social workers, conducting these programs, retain their members and learn to increase their perception of experience, then the client would socially construct a
better experience and have success. Social workers should openly acknowledge their role as leader and work towards improving their perception of the program and themselves when working with vulnerable clients who bring numerous barriers and stereotypes to their first group experience. Group members should have the clear perception that their leader is trying to help them, can do no harm, and is promoting excellence in group work practice, education, field instruction, research, and publication.

As indicative from the study, social workers should be mindful when working with male and female clients. When a cross tabulation was completed in relating the association of perception of leader to expected outcome in a treatment modality, the study showed no relationship as it relates to ethnicity (.108). The study did indicate a significant relationship as it relates to gender. Men are twice as likely as women to perceive their treatment modality effective when they perceive their leader effective (.024). Thus, the implication for social work would suggest that men are more inclined to reject services or withdraw from a group if they do not perceive modality and leader to be effective. A social worker should be mindful of the challenge with working with male clients and skills necessary to increase their perception. The social worker leading the group would need to understand ways to gain greater perception from their male clients. Perhaps a female social worker would increase their perception.

Social workers should be mindful of their leadership style which could deter a participant from completing a treatment modality. Effective communication, understanding individual personal goals and needs, and trusting the group member all play a positive role, if a social worker will assume a leadership role in group practice.
Second, programs should be developed, which help group leaders distinguish if they are indeed a good fit to teach a particular treatment modality. Given the many types of treatment modalities, more training should occur to help social workers effectively train and learn in which type of group modality they would best perform. This would, in turn, increase the perception of his/her members. Definitively, if the social worker does not perceive they would be effective teaching a certain treatment modality, his or her group members will probably perceive his or her knowledge and trust limited in working with them on their problem.

Utilizing the results of this study, mental health professionals can play a major role in understanding the role they play providing services to mental health patients. The implementation of culturally sensitive best practices by social workers should play a role in making sure retention rates are improved in these services.
APPENDICES
APPENDIX A

SURVEY QUESTIONNAIRE

The correlation between group members’ perception of effective leadership and their perception of treatment modality efficacy.

Section I

Demographic Information

1) Gender
   Male _________ Female _________

2) Age
   14-17 _________
   18-21 _________
   22-25 _________
   26-29 _________
   30-33 _________
   34-40 _________
   41-45 _________
   46-50 _________
   Over 50 _________

3) Ethnicity
   Caucasian _________ African-American _________ Asian _________
   Hispanic _________ Other _________

4) Treatment Modality Used (Please Circle)
   CBT Group   Mindfulness Group   DBT Group   Support Group   Other
APPENDIX A

(continued)

Section II. Agree or Disagree

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
</table>

*Perception of Leader:

1) This leader displays high levels of competency and trustworthiness.
   Strongly Disagree Disagree Agree Strongly Agree

2) This leader inspired and motivated members with their vision.
   Strongly Disagree Disagree Agree Strongly Agree

3) This leader clarified content which helped us as a group communicate clearly.
   Strongly Disagree Disagree Agree Strongly Agree

4) This leader individualized members by understanding their personal needs and goals.
   Strongly Disagree Disagree Agree Strongly Agree

*Perception of Treatment Modality

5) Overall I perceive this treatment modality to be effective.
   Strongly Disagree Disagree Agree Strongly Agree

6) Overall I benefited having participated in this type of therapeutic intervention.
   Strongly Disagree Disagree Agree Strongly Agree
APPENDIX B

SPSS PROGRAM
PERCEPTIONS OF EFFECTIVE LEADERSHIP
Darren Davis - MSW Program

DATA LIST FIXED/
ID 1-3
GENDER 4
AGEGRP 5
ETNCH 6
TREATMT 7
LEADER 8
MEMBER 9
CONTENT 10
PERSONAL 11
EFFECTIVE 12
INTERVEN 13.

Data List will read 1 records from the command file.

Variable Rec Start End Format
ID 1 1 3 F3.0
GENDER 1 4 4 F1.0
AGEGRP 1 5 5 F1.0
ETNCH 1 6 6 F1.0
TREATMT 1 7 7 F1.0
LEADER 1 8 8 F1.0
MEMBER 1 9 9 F1.0
CONTENT 1 10 10 F1.0
PERSONAL 1 11 11 F1.0
EFFECTIVE 1 12 12 F1.0
INTERVEN 1 13 13 F1.0

COMPUTE PERCEPT = (LEADER+MEMBER+CONTENT+PERSONAL)/4.

VARIABLE LABELS
ID 'Question Number'
GENDER 'Q1 My Gender'
AGEGRP 'Q2 My Age group'
ETNCH 'Q3 My ethnicity'
TREATMT 'Q4 Treatment Modality'
LEADER 'Q5 Leader displays high levels of competency and trustworthiness'
MEMBER 'Q6 Leader inspired and motivated members with their vision'
CONTENT 'Q7 Leader clarified content which helped us as a group to communicate c'
PERSONAL 'Q8 Leader individualized members by understanding their personal needs'
EFFECTIVE 'Q9 Overall I perceive this treatment modality to be effective'
INTERVEN 'Q10 Overall I benefited having participated in this type of therapeutic

VALUE LABELS
GENDER
1 'Male'
2 'Female'

AGEGRP
1 '14-17yrs'
APPENDIX B

(continued)

PERCEPTIONS OF EFFECTIVE LEADERSHIP
Darien Davis - MSW Program

<table>
<thead>
<tr>
<th>AGE</th>
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<th>5 '30-33yrs'</th>
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<th>7 '41-45yrs'</th>
<th>8 '46-50yrs'</th>
<th>9 'Over 50yrs'/</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>ETHNIC</th>
<th>1 'Caucasian'</th>
<th>2 'African American'</th>
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<th>4 'Hispanic'</th>
<th>5 'Other'</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>TREATMT</th>
<th>1 'CBT Group'</th>
<th>2 'Mindfulness psycho'</th>
<th>3 'Dbt Group'</th>
<th>4 'Support Group'</th>
<th>5 'Self Help Grp'</th>
<th>6 'Other'</th>
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<table>
<thead>
<tr>
<th>LEADER</th>
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<th>2 'Disagree'</th>
<th>3 'Agree'</th>
<th>4 'Strongly Agree'</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MEMBER</th>
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<th>2 'Disagree'</th>
<th>3 'Agree'</th>
<th>4 'Strongly Agree'</th>
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</thead>
</table>

<table>
<thead>
<tr>
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<th>3 'Agree'</th>
<th>4 'Strongly Agree'</th>
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</thead>
</table>

<table>
<thead>
<tr>
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<th>3 'Agree'</th>
<th>4 'Strongly Agree'</th>
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<table>
<thead>
<tr>
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<th>2 'Disagree'</th>
<th>3 'Agree'</th>
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</table>

<table>
<thead>
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<th>3 'Agree'</th>
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</thead>
</table>

<table>
<thead>
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<th>PERCEPT</th>
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<th>2 'Disagree'</th>
<th>3 'Agree'</th>
<th>4 'Strongly Agree'</th>
</tr>
</thead>
</table>
APPENDIX B

(continued)

PERCEPTIONS OF EFFECTIVE LEADERSHIP
Darren Davis - MSW Program

1 'Strongly Disagree'
2 'Disagree'
3 'Agree'
4 'Strongly Agree'/.

RECODE LEADER MEMBER CONTENT PERSONAL (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE EFFECTIVE INTERVENE (1 THRU 2.99=2) (3 THRU 4.99=3).
RECODE PERCEPT (1 THRU 2.99=2) (3 THRU 4.99=3).

MISSING VALUES
GENDER AGEGRP ETHNIC TREATMT LEADER MEMBER CONTENT PERSONAL EFFECTIVE INTERVENE 0.

BEGIN DATA
0012512343433
0021141433433
0031121343333
0041121343344
0051112133333
0062414344444
0071112133323
0081514334444
0091914333344
0101714433344
0111514433333
0122714444444
0131614333333
0142324333233
0152326333333
0162714111111
0171113433433
0182311444444
019211344444
0202113444444
0212113444444
0222113444444
0232113444444
0241114444444
0251114333333
0262124333243
0272424343333
0282424343333
0291114333333
0301114444444
0311114444444
0321114333333
0332712443333
END DATA.

FREQUENCIES
/GENDER AGEGRP ETHNIC TREATMT LEADER MEMBER CONTENT PERSONAL EFFECTIVE INTERVENE PERCEPT
APPENDIX C

IRB APPROVAL LETTER

CLARK ATLANTA UNIVERSITY
Institutional Review Board
Office of Sponsored Programs

December 11, 2008

Darren Davis <DarrenDavis14@aol.com>
School of Social Works
Clark Atlanta University
Atlanta, GA 30314

RE: Exploratory Study of Group Members' Perception of Effective Leadership and How this Relates to their Perception of Treatment Modality Efficacy.

Principal Investigators: Darren Davis
Human Subjects Code Number: HR2008-11-294-1

Dear Ms. Davis:

The Human Subjects Committee of the Institutional Review Board (IRB) has reviewed your protocol and approved of it as exempt in accordance with 45 CFR 46.101(b)(2).

Your Protocol Approval Code is HR2008-11-294-1/A

This permit will expire on December 30, 2009. Thereafter, continued approval is contingent upon the annual submission of a renewal form to this office. If you have any questions, please contact Dr. Georgianna Bolden at the Office of Sponsored Programs (404) 880-6979 or Dr. Paul I. Musey, (404) 880-6829.

Sincerely:

[Signature]

Paul I. Musey, Ph.D.
Chair
IRB: Human Subjects Committee

cc. "Dr. Susan Kossak" <skossak@cau.edu>
Office of Sponsored Programs, "Dr. Georgianna Bolden" <gbolden@cau.edu>

223 James P. Brawley Drive, S.W. * ATLANTA, GA 30314-4391 * (404) 880-8000
Formed in 1968 by consolidation of Atlanta University, 1865 and Clark College, 1869

44
APPENDIX D

INFORMED CONSENT FORM
CLARK ATLANTA UNIVERSITY

Informed Consent Form:

Your participation in this service is extremely confidential. Your name will not be a part of this survey. The primary purpose of this study is to relate group member's perception of their leader and outcome of treatment.

If you have any questions about the survey you may contact Darren Davis at 404-247-8677. Darrendavis14@aol.com

Agree to participate _________________________

Do Not agree _____________________________

Participant's Name ____________________________________________

Date ________________________________________________________
APPENDIX E

AGENCY APPROVAL LETTER FOR STUDY
Underdue Social Services, Inc.
Intensive Family Intervention Services

11/2008

To Whom It May Concern

Re: Group Participation

Mr. Darren Davis has permission to conduct survey research with groups receiving services with Underdue Social Services. It is understood that Mr. Davis is using this to fulfill thesis requirements for Clark Atlanta University Graduate School of Social Work.

Kimberly Underdue
CEO/Underdue Social Services

1673 Hearthstone Court Jonesboro, Georgia 30236 Phone 770.477.2551 Fax 770.477.2552

"Embracing Our Children For a Better Tomorrow"

46
REFERENCES


