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Community Resocialization via Instillation of Family Values Through a Novel Group Therapy Approach: A Pilot Study

David F. Allen, Marie Allen Carroll, Victoria S. Allen, Keva Y Bethell, and James A. Manganello

Author Note

Affiliations

David F. Allen, The Allen Institute of Training & Research, Nassau, Bahamas; Marie Allen Carroll, The Allen Institute of Training & Research, Nassau, Bahamas; Victoria S. Allen, College of the Bahamas; Keva Bethell, The Allen Institute of Training & Research, Nassau, Bahamas; James A. Manganello, The Allen Institute of Training & Research, Nassau, Bahamas.

Person to Contact

Correspondence concerning this article should be addressed to David F. Allen. E-mail: dfallen43@gmail.com; telephone (242) 327-8719

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Conflicts of Interest

Dr. David Allen has no conflicts of interest.

Abstract

Set within a fragmented community, The Family: People Helping People (Family) project is a group therapy model that aims to facilitate cultural resocialization through personal transformation. The Family models a nuclear family, and employs a novel, open discussion approach to address various psychosocial issues within the context of the Bahamian society. A pilot study investigated changes in disenfranchised individuals who participated in The Family over a six-month period, and revealed some significant changes in emotional and behavioral trends after treatment. Statistical analysis of the pilot study showed significant decreases in feelings of depression, suicidality, anger and vengefulness, and increases in significant feelings of self-esteem and intimacy with others. Negative behaviors, such as illegal activity and participation in abusive relationships, decreased, while the quality of family relationships and benevolence increased. Gratitude and forgiveness were recurring themes expressed by participants in the study, suggesting their key role in resocialization. This Family group therapy model may be applicable to different populations, and may be a useful tool in fostering community resocialization.

Key words: resocialization, group therapy, family, community, disenfranchised

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Introduction

The Bahamas is an archipelagic nation with a population of approximately 350,000 people, the majority of which are under 50 years of age. Once under British rule, it has been an independent country for the past 41 years, with a largely tourism-based economy and a deeply spiritual Christian culture. Located just north of Cuba and southeast of Florida, the Bahamas is situated between the world's largest source of cocaine (South America) and the primary consumer market (US). As a result, the Bahamas, as a transshipment area, has faced major issues in drug trafficking and addiction. The introduction of marijuana in the 1970s and the crack cocaine epidemic of the 1980s, (Hanna, 2011; Griffith, 1996) paired with the recent socioeconomic downturn, has led to widespread social fragmentation due to the disintegration of family, community and socio-cultural values. The resulting unequal distribution of wealth has created certain underprivileged and marginalized areas with higher unemployment, increased criminal activity, poor education, and reduced work ethic (Hanna, 2011; United States Senate Caucus, 2012). According to Shaw and McKay, these areas may be referred to as zones of transition, likely formed by a combination of individual choice and a crime-enhancing environment (Shaw & McKay, 1942). This regional culture of violence has adversely affected all levels of the Bahamian society, and contributes to extensive family and community fragmentation (Jekel et al., 1986).

Families have a powerful influence on shaping the attitudes, cultural values, and behavioral patterns of the entire community. Disintegration of family values leads to the increased influence of external environmental factors, such as peer pressure. Family dysfunction—thought to exacerbate drug abuse—include prolonged or traumatic parental absence, harsh discipline, failure to communicate on an emotional level, and parental use of drugs. Lack of household stability triggered by low and irregular income and unemployment may increase stress on the family and its vulnerability to drug abuse (United Nations Drug Control Program, 1995).

Increasing rates of murder and violent crime are indications of worsening social and economic conditions, including race relations, poverty, and social isolation (Hanna, 2011; Clarke & Neville, 1986). Uncontrolled drug use leads to psychoses, acute intoxications, and periods of violent bizarre behavior due to the disinhibition and release of aggression (Clarke & Neville, 1986). The breakdown of family values and the eventual fragmentation of the community increase these negative behaviors.

The high incidence of murder in the Bahamas affects the family members and friends of victims, who become covictims of the crime. Many in the Bahamian community have experienced the violent death of family members, intimate partners, or close friends (Hanna, 2011). These patterns of fear and disenfranchisement may become embedded within the wider Bahamian culture. Facing the hardships and community fragmentation, many Bahamians are denied the right to grieve as a result of the predominant belief that it is a sign of weakness. This disenfranchisement of grief invalidates the traumatic experiences of individuals, and leads to exclusion, anger, and lack of closure. For example, many experience incidences of sexual abuse,

incest, loss of a child, or murder of a loved one, and never seek therapy or assistance. Neglect of the right to grieve is considered a serious cultural failure, and results in further collective social alienation (Attig, 2004).

In response to the social crisis in the Bahamian community, The Family is a group-based resocialization intervention designed to confront the prevailing community chaos. The Family is based on a group process model. In theory, the group creates a therapeutic replica of a home-based family, allowing members to confront their issues in a safe and nonjudgmental environment. The Family provides support and advocacy for its members, allowing them to discover themselves and grow as individuals. Importantly, The Family offers a sanctuary from the normal Bahamian culture, and encourages the expression of emotions that are normally taboo (such as grief, empathy, love, and hope). The primary goal is to improve socialization despite high rates of crime, family disintegration, and economic impoverishment. The form of therapy used, the contemplative discovery pathway theory, is a form of positive psychology involving a mixture of cognitive behavioral therapy and traditional psychodynamic analytic therapy, along with an important spiritual component (Allen et al., 2014).

While encouraging emotional development through open discussion, The Family also offers healing and support, guidance with coping, newly learned positive behaviors, and opportunities for improvement in communication, social skills, and relationships. Topics addressed in The Family include socialization, interpersonal skills, self-esteem enhancement, anger management and conflict resolution, revenge elimination, community bonding, affective learning, and the development of mature spirituality. The Family strives to improve socialization by promoting positive emotions (such as gratitude and forgiveness) and addressing negative

emotions (such as anger and vengeance) through therapy (Allen, 2012).

The efficacy of The Family model was evaluated in a study to investigate differences in Bahamians who participated in The Family throughout the course of therapy, and to determine whether this therapeutic intervention helps improve different aspects of life for disenfranchised individuals. We hypothesized that participation in The Family would decrease the prevalence of negative emotions such as anger, vengefulness, depression, and destructive behaviors. We also expected to observe increases in positive emotions such as gratitude, hope, and self-esteem, identified with positive behaviors such as intimacy, spiritual well-being and benevolence. Although The Family had been active for a several years, the pilot study involved persons who had participated in the Family for one or more years. These participants were evaluated at two 6-month intervals (Phase 1 and Phase 2) throughout one year, the results of which are presented in this paper.

Methods

Participants

While all members of the Bahamian community were eligible to enroll in The Family, particular emphasis was placed on recruiting victims of violent crime and the socio-economic crisis. Participants attended weekly two-hour group therapy sessions facilitated by a trained therapist, during which they shared recent experiences and progress. The sessions were open and free, and new participants were welcome to join or leave at any time. Sessions were conducted in a large circle. Singing, silence, meditation, mindfulness and prayer were often employed to facilitate healing and coping. At the end of a meeting, the therapist provided a summary and gave a psychological/spiritual teaching to foster education, growth, and character development. A

unifying song was often sung to end the sessions and provide spiritual closure.

Separate groups for adults and teenagers provided therapy to enhance interpersonal skills and promote mental and spiritual healing. The pilot study focused on the adult group, which discussed parenting skills, anger management, and practical information on issues, such as HIV/AIDS, insurance, legal issues, and social supports provided by the government.

The pilot analysis consisted of 37 participants from Phase 1 and 32 participants from Phase 2 (14 of these completed both phases). Participants originated from all social classes, ages, genders, occupations, education, and income brackets (Figure 1). Almost half of participants had experienced some juvenile behavioral problems, and approximately 60% indicated some previous abuse. Many participants had family members who had experienced depression, alcohol and/or drug abuse, or medical problems, but few had been in a substance abuse program themselves. Almost 50% of participants had received some sort of psychiatric, psychological or emotional counseling, but less than 20% had received medication for such issues. Approximately 20% of participants had family members who had attempted or committed suicide. Similarly, approximately 87% of participants knew at least one person who had been killed violently. Incidences of violent crime or burglary were common.

Procedures

The pilot study was completed in two treatment phases, referred to in this report as Phase 1 and Phase 2. Participants' progress was assessed through a background questionnaire and a battery of previously validated quantitative measures that assessed different aspects of well-being. The battery included the Beck Depression Inventory (Beck et al., 1961), the Buss-Durkee

Hostility-Guilt Inventory (Buss & Durkee, 1957), the Gratitude Questionnaire–Six Item Form (GQ-6) (Wood, Maltby, Stewart, & Joseph, 2008), the Hope Scale (Pattengale, 2002), the Self-Deception Questionnaire (Gur & Sackeim, 1979), the Internalized Shame Scale (ISS) (Rybak & Brown, 1996), the Spiritual Well-Being Scale (SWBS) (Diener, Emmons, Larsen, & Griffin, 1985), the Satisfaction with Life Scale (SWLS) (Watkins, Woodward, Stone, & Kolts, 2003), and the Transgression-Related Interpersonal Motivations Inventory–18-Item Version (TRIM-18) (McCullough, Root, & Cohen, 2006) (Table 1).

The questionnaire and the test battery were given at the end of both phases to measure baseline and change, respectively. Subjects responded to the baseline questionnaire regarding feelings and behaviors on a Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree), and results were analyzed for significance using a two-tailed *t*-test. For each measured parameter, sample size varied (depending on whether participants filled out that section or left it blank). Participants were also grouped into participation time in The Family: zero to three months, four to twelve months, and more than one year. The results were analyzed for significance using a one-way ANOVA.

Statistical analysis

Statistical significance on questions using either a "score" or an ordinal response ("strongly agree", "agree", etc.) was tested one of two ways. For comparisons within the same group of patients between two different time periods (before joining The Family vs. after), a paired *t*-test was used. This involved calculating the difference for each respondent in their two responses and testing whether the mean difference was significant. Cohen's d statistic was used

to estimate the effect size for both paired and two-sample *t*-tests. For comparisons between groups of patients (i.e., by length of time in The Family), the usual two-sample *t*-test on means was used. Statistical significance on the difference in proportions was done using a chi-squared test.

Results

Overall, trends indicate that the participants experienced improvements in many emotional and psychological areas after joining The Family. Participation in The Family preceded many improvements in cognitive health. Data demonstrated that persons who participated longer in The Family (four to twelve months) had significantly less depression compared to those who participated for a shorter duration (zero to three months) (t = -3.71, p = .0099, Cohen's d = -2.001) (Figure 2). Similarly, significantly fewer participants reported contemplating suicide (t = -2.91, p = .013, Cohen's d = -.808) and being in abusive relationships (χ^2 = 4.0775, p = .0435) after joining The Family (Figure 3).

Data analysis demonstrated that after joining The Family, subjects felt significantly less anger toward others (t = -2.83, p = .0142, Cohen's d = -.756). Subjects also showed significantly decreased desire for vengeance (t = -3.32, p = .0061, Cohen's d = -.922), and experienced significantly fewer thoughts of both violent and nonviolent revenge (t = -2.28, p = .0437, Cohen's d = -.658). There was also a significant decrease in loneliness (t = -3.17, p = .0074, Cohen's d = -.846) (Figure 3). These significant trends were consistent when comparing results from Phase 1 and Phase 2.

Participation in The Family also preceded many improvements in personal relationships. Significantly more participants reported having at least one person to talk to about personal

issues after joining The Family, ranging from the beginning of Phase 1 to the end of Phase 2 (χ^2 = 4.8581, p = .0275) (Figure 3). A significant increase in self-esteem was observed (t = -2.16, p = .0446, Cohen's d = 1.604) (Figure 2). Trends analysis showed decreases in illegal activity and increases in the quality of family relationships and the presence of role models. A very slight upward trend was observed in employment and living status (Figure 4).

Discussion

The Family model employs a unique therapeutic approach that combines different treatment paradigms in new ways to address many of the broader psychological issues that result from a breakdown of family harmony. Functioning as a powerful focus group, The Family pinpoints key problems in Bahamian society, and provides an excellent opportunity to study trends, analyze issues, and work toward meaningful solutions. This is the first time that this type of group therapy model has been implemented in the context of the fragmented Bahamian community. Rather than a formal therapy setting, The Family therapy groups are designed to mimic the family unit, which is thought to be instrumental in molding the culture and socialization of a community. This therapeutic method could potentially be adapted to different clinical settings, and could be beneficial for other populations, such as juvenile delinquents, criminals, and the elderly.

Results of the pilot study show evidence of resocialization, which suggests efficacy of The Family model. Significant participant-reported improvements in anger, revenge, and depression suggest a decrease in vengeful feelings and negativity, making them more receptive to resocialization. Additionally, increases in areas such as hope, benevolence, and overall life satisfaction indicate positive changes and gradual improvements in self-perception.

Although extensively studied in Westernized countries, trials of psychotherapy-based interventions in less affluent countries are sparse and have been largely clinic-based rather than community-based. In one community-based, randomized controlled trial conducted in rural Uganda, it was found that group interpersonal psychotherapy significantly reduced depression and functional impairment in treated patients. In addition to the substantial treatment benefits found immediately following the intervention, mental health benefits were maintained up to six months after the end of formal treatment. Cultural factors were an essential consideration for the effectiveness of therapy and were key determinants of the treatment approach (Bass et al., 2006).

Interpersonal transgressions result in feelings of avoidance and revenge, and also decreased acts of goodwill. People who feel vengeful or unforgiving after transgression are more prone to depression, phobia, anxiety, and panic. Changing attitudes toward interpersonal transgressions may lead to improved relationships and increased psychological health (McCullough, Root, & Cohen, 2006). Trends analysis in the pilot study showed decreases in feelings of irritability, negativism, resentment, and shame in proportion to increased time in The Family. The duration of the pilot study was not long enough to detect differences in the levels of assault, aggression, and suspicion. More time may be needed to detect significant and consistent changes.

Grateful and forgiving responses to interpersonal events are linked to enhanced levels of well-being and positive cognitive changes in disposition (Wood, Maltby, Stewart, & Joseph, 2008; Watkins, Woodward, Stone, & Kolts, 2003; Toussaint & Friedman, 2009). Results from the Family pilot study indicated many positive changes in self-assessment after joining The Family. Gratitude and increased forgiveness were recurring themes in the study, and may be key

factors in resocialization. In the pilot study, a significant increase in self-esteem was observed. Trends analysis revealed an upward trend in hope, gratitude, benevolence, and general satisfaction with life in proportion to increased time in The Family. Additionally, increases in trust and satisfaction with life were observed after joining The Family. This may be indicative of an increase in feelings of goodwill and charity towards transgressors. However, these outcomes take longer to achieve, and a longer observation period is needed to obtain statistically significant results.

In the preliminary study, although some people initially had significant positive scores in depression, spirituality and shame, these drastic improvements waned over time with therapy. This pattern is often observed in the course of psychotherapy, where initial bursts of well-being are followed by the revelation of deep-seated and painful shame elements, leading to depression. This only changes if patients continue to work through their hurt trail and shame core over a prolonged period of time, at which point a gradual steady improvement is observed. Similarly, although The Family incorporates faith-based teachings, noticeable decreases were observed in the overall mean spiritual well-being between the study two phases. Despite high spirituality scores in the early part of the Family, the confrontation of limitations, inconsistencies and failures of the self unveils a more realistic worldview.

In the initial part of therapy, shame (“I am a mistake”) scores tend to rapidly decrease, but rise again with deeper therapy. As therapy continues, the shame scores steadily decrease again, but guilt (“I made a mistake”) typically increases with more awareness of mistakes and failures. To support this theory, the pilot study found that participants who remained longer with The Family trended toward lower levels of self-deception, which indicates decreased levels of

denial. Similarly, unexpected upward trends in feelings of guilt over time of participation could stem from increased self-awareness learned through The Family discussions. Increased discussion about personal issues may uncover suppressed emotions, leading to peaks of negative feelings before the commencement of healing.

These issues are even more pronounced in marginalized areas, where there is social fragmentation of the community and the family. Initially in therapy in the Family, there is a burst of improvement in mental health scores, but as time goes on, the negativity of the environment tends to bring the scores down. Only as we persist in the work on the inner life over a long period of time are persons able to counteract the negative effects of the environment to achieve longer-lasting changes. An extended study is needed to measure the achievement and maintenance of long-term spiritual well-being after treatment in The Family.

Study Limitations and Future Research

The pilot study has shown the effectiveness of many therapeutic processes in family therapy for participants who have lived through difficult, painful and destructive experiences. These include listening to and recounting authentic stories of participant pain and shame; role-playing hurtful experiences through psychodrama to identify and release deep shame (catharsis); reducing alexithymia; and the inspiration of hope and resilience through active support. Furthermore, instilling a spiritual component in marginalized communities is instrumental in assisting people who have a deep faith by allowing them to express their pain and shame through meditation, prayer and song, which engenders a sense of belonging and group coherence.

Although preliminary pilot study findings from The Family have identified key trends and needs, the results are based on a small number of participants over a relatively short time

frame. An extended three-year study with a larger number of participants is currently underway to assess long-term outcomes and further observe correlations between gratitude, forgiveness, and well-being. With this project in development, we hope to further The Family therapeutic model and demonstrate its efficacy in changing cultural perceptions and destructive behaviors in disenfranchised populations.

The test battery used in the pilot study to measure resocialization consisted of using nine international instruments. While having been validated individually, the use of the scale was cumbersome, time-consuming, and sometimes difficult to understand for persons in marginalized communities. As a result, questionnaire administration was often an arduous and inefficient process. Because of this, The Family project researchers are currently developing The Allen Resocialization Scale, a comprehensive evaluation tool to simply and effectively assess the degree of resocialization. This will greatly facilitate the ease of participant evaluation, and could potentially be modified for application within other populations.

Because of the disparity of wealth and the plight of persons in marginalized areas, providing psychotherapy in this diverse cultural context requires great flexibility and creativity. For example, the lack of availability of qualified professionals has inspired the development of the training component of The Family project, where laypeople are trained as therapist facilitators. The goal is to involve as many people from the community as possible, with the outcome of perpetuating mutual growth. The minimal enrollment in The Family is also a limitation of programs run in fragmented areas. However, the growth of The Family has also been aided by the willingness of many Family members who have benefited greatly from the program to present their story on national television. In addition to increasing their own self-

esteem and confidence, it has also been invaluable for increasing exposure for The Family to individuals in other Bahamian regions. In these ways, the community-driven aspect of The Family model is paramount to its success.

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Figure 1: Baseline Characteristics of Family Participants

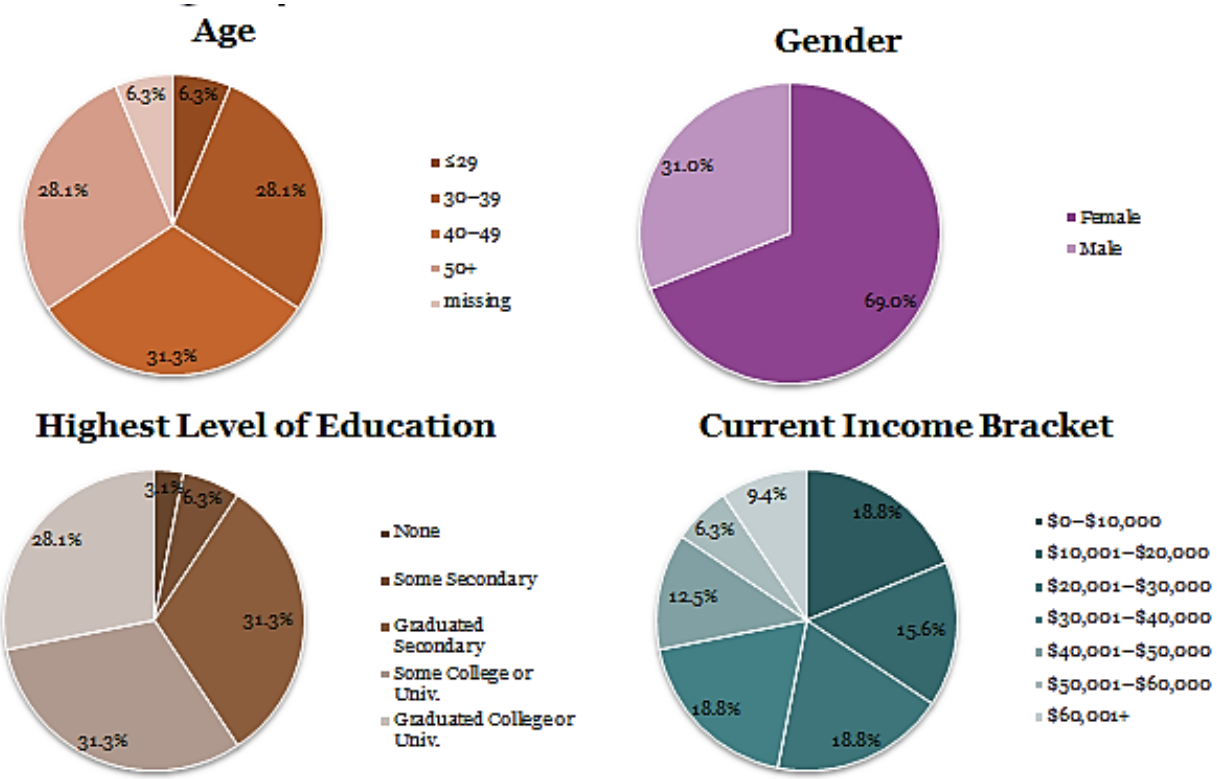


Figure 2: Significant Areas of Change with Increased Time in The Family

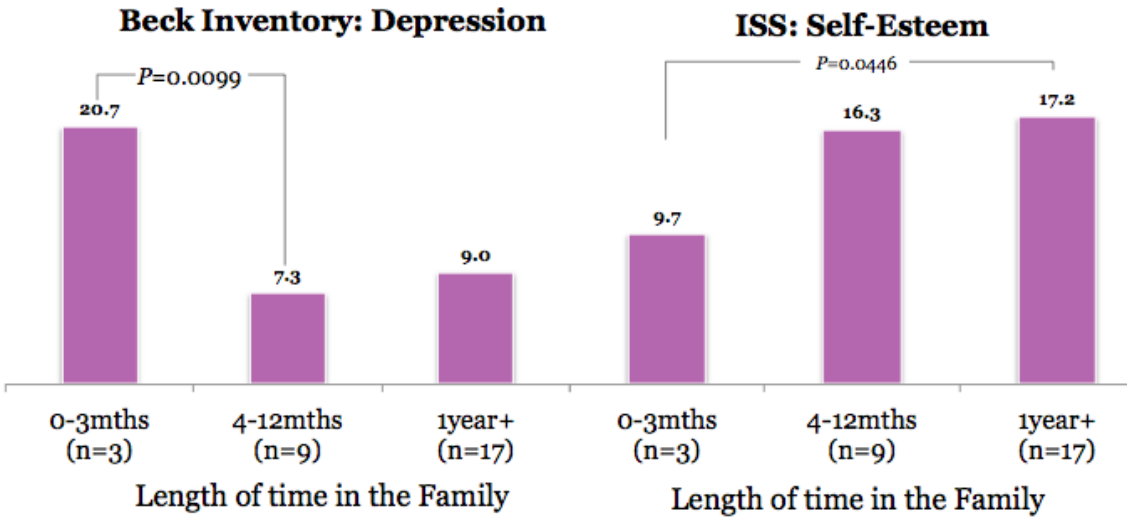
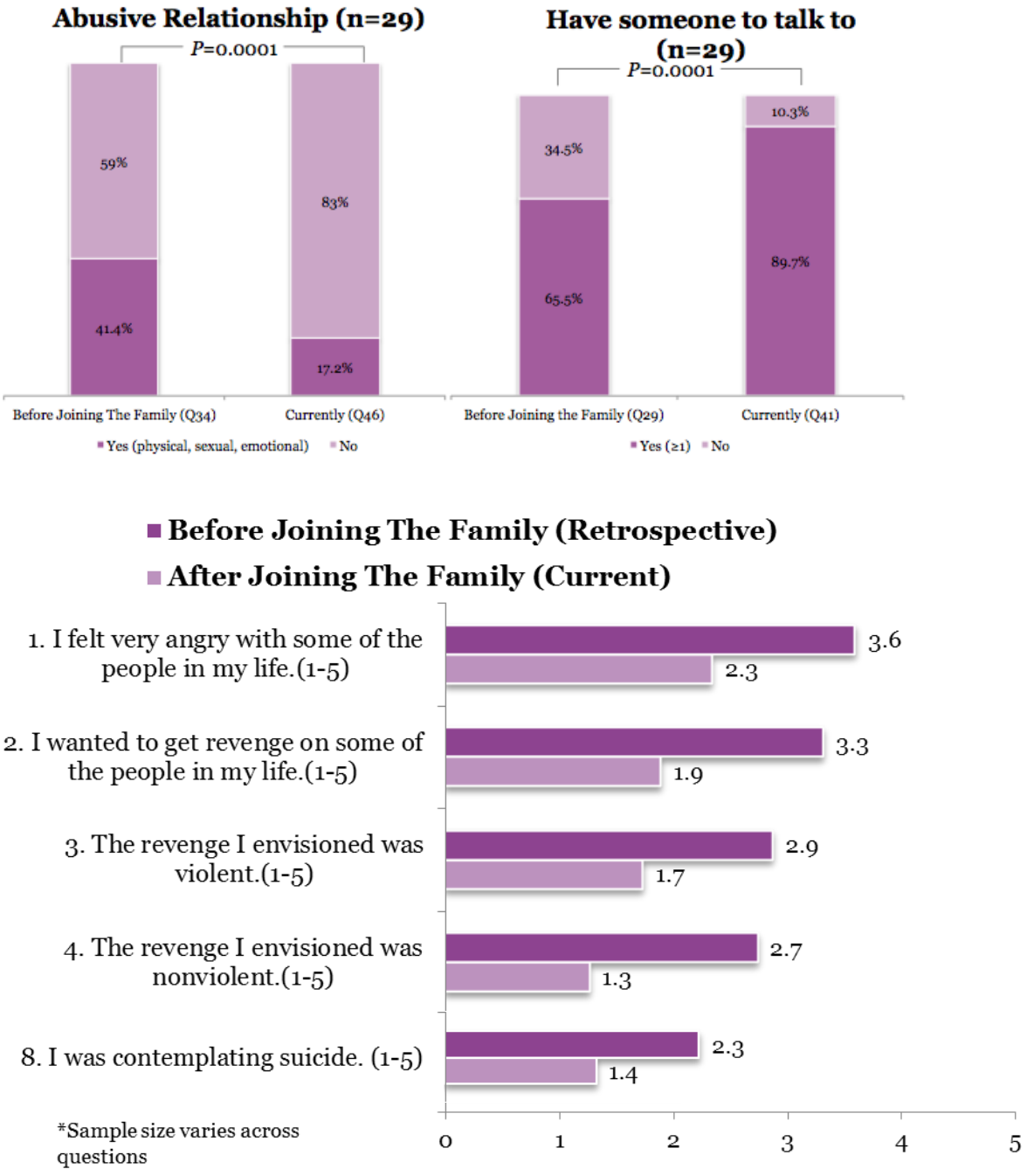


Figure 3: Significant Areas of Change After Therapy in The Family



*Numbers of responders varied, depending on questions completed

Figure 4: Directional Trends Seen in The Family

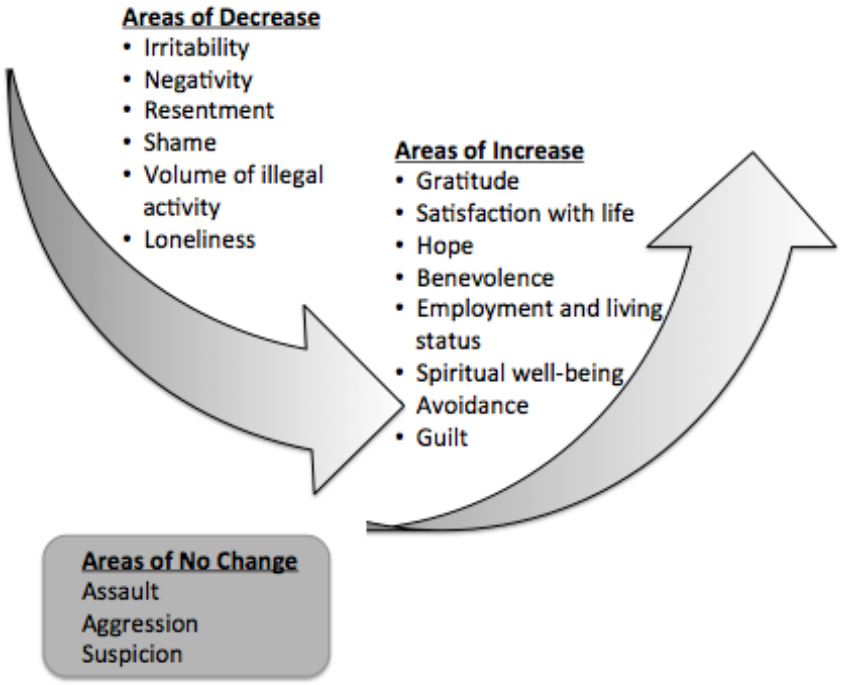


Table 1: Assessment Scales Used in The Family

Scale	Items	Assessment	Method
Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & ERbaugh, 1961)	21	Severity of depression, such as emotional, cognitive, and physical symptoms	Participants answer multiple choice questions with options ranging in intensity
Buss-Durkee Hostility–Guilt Inventory (Buss & Durkee, 1957)	75	Assault, indirect hostility, irritability, negativism, resentment, suspicion, verbal hostility	Participants answer true or false questions
Gratitude Questionnaire—Six Item Form (GQ-6) (Wood, Maltby, Stewart, & Joseph, 2008)	6	Emotional experience of gratitude, based on frequency, density, and intensity of grateful effect	Participants rate items from 1 (Strongly Disagree) to 5 (Strongly Agree)
Hope Scale (Pattengale, 2002)	12	Waypower and willpower: measures success and motivation	Participants rate questions from 1 (Definitely False) to 4 (Definitely True)

Self-Deception Questionnaire (Gur & Sackeim, 1979)	20	Level of personal self-deception	Participants rate items from 1 (Not At All) to 7 (Very Much So)
Internalized Shame Scale (ISS) (Rybak & Brown, 1996)	30	Extent to which the negative effect of shame becomes magnified and internalized. Shame and self-esteem subscales	Participants answer how frequently the item is experienced from 0 (Never) to 4 (Almost Always).
Satisfaction with Life Scale (SWLS) (Watkins, Woodward, Stone, & Kolts, 2003)	5	Global satisfaction with life	Participants rate questions from 1 (Strongly Disagree) to 7 (Strongly Agree)
Spiritual Well-Being Scale (SWBS) (Diener, Emmons, Larsen, & Griffin, 1985)	20	Religious and existential well-being	Participants rate 10 religious and 10 existential well-being questions from 1 (Strongly Agree) to 5 (Strongly Disagree)
Transgression-Related	18	Forgiveness through sentiments of avoidance,	Participants rate questions from 1 (Strongly Disagree)

Interpersonal Motivations Inventory–18-Item Version (TRIM-18) (McCullough, Root, & Cohen, 2006)		revenge, and benevolence	to 5 (Strongly Agree)