

Treating Major Depression in Reentering Prisoners:
A Proposed Interpersonal Psychotherapy Intervention
Alexander Belser, M.Phil.

7th Annual Morton Deutsch Awards for Social Justice

29 January 2011

Treating Major Depression in Reentering Prisoners:
A Proposed Interpersonal Psychotherapy Intervention

More than half a million prisoners in the United States meet the criteria for major depression (James & Glaze, 2006). When these men and women return to their families and communities, research has shown that the reentry transition can pose tremendous psychological strain for returning prisoners and disproportionately high rates of depression and suicide (Binswanger, et al., 2007). There are important public health consequences, as each year about 600,000 adults are released from jail or prison and reenter their communities (Petersilia, 2009). The presence of major depression in this population is associated with poor reentry outcomes and increased recidivistic offending, but many depressed returning prisoners remain untreated (Eaves, Tien & Wilson, 2000).

In the past decade, criminal justice policy in the United States has been shaped by a focus on reentry outcomes as seen in the passage of the Second Chance Act in Congress. There is a renewed commitment to improve levels of desistance and long-term public health outcomes for men and women making a fresh start in their communities. Interpersonal Psychotherapy (IPT), an evidence-based therapy for depression, may provide an appropriate intervention for major depression in returning prisoners. Research demonstrates that strong interpersonal relationships are correlated with higher employment, lower drug use, and less criminal activity among reentering prisoners (Nelson, Dees, & Allen, 1999, executive summary; La Vigne, Visher & Castro, 2004). Considering the variety of interpersonal psychosocial stressors facing returning prisoners (e.g. familial, economic, and living situation role transitions, strained relationships, and social isolation), an interpersonal psychotherapeutic approach seems well matched to the reentry

context. As the content of IPT seems particularly suited to address the challenging context of reentry, the development and investigation of a group adaptation of IPT may be warranted.

Overview of Major Depression in the Reentry Population

Prevalence

Individuals reentering their communities from prison and jail are disproportionately burdened by mental health problems (Hammett, Robert, & Kennedy, 2001). A Bureau of Justice Statistics (BJS) study of mental illness among incarcerated individuals found that in 2005, more than half had a mental health problem, or over 1.2 million prisoners (James & Glaze, 2006). Compared to prisoners without mental problems, state prisoners with a mental problem tended to have more prior probation or incarceration sentences, higher rates of violent past offenses, and tended to serve longer sentences (four months longer than prisoners without mental illness) (James & Glaze, 2006).

The prevalence rate for major depression in prisoners is three times as high when compared with rates in the general population (James & Glaze, 2006). For example, three times as many state inmates (24%) reported symptoms that met the criteria for major depression compared to the general population (8%) (James & Glaze, 2006). Over half a million incarcerated individuals (542,124) meet the criteria for major depression in the United States (James & Glaze, 2006).

Screening & Treatment Disparity

Screening for major depression and other mental disorders usually only occurs upon initial intake to a facility and rarely at discharge (Beck & Maruschak, 2001). Approximately 30% of prisons do not screen for mental disorders at intake (Beck & Maruschak, 2001). Many authors have criticized screening in prisons and jails as inadequate; it creates a system in which

major depression often continues undetected and untreated, with lingering consequences for community integration (Visher & Mallik-Kane, 2007; Teplin, Abram & McClelland, 1997; Patterson & Greifinger, 2007).

There is also some evidence that depression is not be taken seriously by correctional mental health systems. Teplin and colleagues (1997) conducted a longitudinal study of incarcerated women (n = 1272), and found that of the axis I diagnoses, depression was the diagnosis least likely to be treated (Teplin, Abram & McClelland, 1997). They also found that women diagnosed with major depression *and* a comorbid substance abuse disorder were 12 times more likely to receive services than women diagnosed with major depression alone (Teplin, Abram & McClelland, 1997). Correctional systems and reentry agencies such as parole and community corrections are forced to confront and manage issues arising from substance abuse, manic behavior, antisocial aggression, and psychopathic behaviors. Addressing the lack of priority placed upon the treatment of depression, the authors remark, “Perhaps depressed detainees are overlooked in the chaos of the jail milieu” (Teplin, Abram & McClelland, 1997, p. 607). Against these highly salient disorders, the less salient problems of major depression may fade into the background.

Barriers to Treatment, Discharge Planning, and Coordination of Care

Although treatment rates are low in correctional settings (Travis & Visher, 2005), they may be even lower after release. In the Returning Home study (Visher & Mallik-Kane, 2007) of released male prisoners (n= 838), 12.8 % of respondents reported having depression. While in prison, 59% of depressed men received treatment for depression. In a two month post-release follow-up measure (n=665), less than half (45%) of men reporting depression were receiving treatment, indicating that post-release treatment for depression fell by about 25% (Visher &

Mallik-Kane, 2007).

In part, this drop in treatment rates may reflect a lack of effective discharge planning upon release. Only 65% of correctional facilities report providing depressed inmates with information regarding community mental health services (Beck & Maruschak, 2001). Additionally, formerly incarcerated individuals may be averse to seeking mental health treatment. Parolees fail to access available treatment because they “fear institutionalization, deny that they are mentally ill, or distrust the mental health system” (Travis & Visher, 2005, pp. 32-33; Schoeni & Koegel, 1998).

Inadequate discharge planning is a barrier to adequate treatment, as lapses in care and breaks in treatment continuity can occur (Hammett, Roberts & Kennedy, 2001). In a study of 51 state and federal prisons, 73% of these facilities made referrals for psychosocial support, but only 24% made an appointment for releasees with specific treatment providers (Hammett, Harmon, & Maruschak, 1999). In this study, the authors define the provision of a mental health “referral” broadly; the inclusion of a list of public health clinics in an inmate’s packet upon release was considered sufficient. In city and county jails, the level of referral support was lower. Of 41 city and county jail systems, only 54% reported providing psychosocial support referrals, and only 27% made an appointment for releasees (Hammett, Harmon, & Maruschak, 1999). Although mental health needs are seen as important, during reentry they may be trumped by more immediate needs, such as finding stable housing, obtaining a driver’s license, and procuring food and clothing (Hammett, Robert, & Kennedy, 2001).

Among released inmates with major depression, there are significant complications posed by comorbidities (Greifinger, 2007). A history of incarceration is often comorbid with axis I disorders (Veysey, 2002), substance abuse disorders (Belser, 2005), HIV infection (Hammett,

Robert, & Kennedy, 2001), and homelessness (Hoge, 2007). There are many barriers to effective treatment for dually and triply diagnosed releasees. Barriers may include inadequate access to community mental health facilities, substance abuse treatment facilities, housing agencies, fragmentation of community providers, insufficient inter-agency coordination, and non-integrated service delivery (Hammett, Robert, & Kennedy, 2001, p. 405).

Upon release, there are issues of access and coordination of care between the various governmental and community agencies that provide services (Lamon, Cohen, & Broner, 2002). Community-based mental health care often falls short of meeting the needs of individuals returning home from prison or jail (Hammett, Roberts & Kennedy, 2001). There are few public mental health services available, and depressed individuals may have difficulty navigating benefits services and accessing these services, in addition to tasks of securing stable housing, employment, and facing other transitional challenges (Petersilia, 2009). Surveying the state of transitional mental health care, Hoge concludes: “Though the quality of institutional care remains woefully inadequate in many jurisdictions, it has become increasingly apparent that community-based care is an urgent necessity” (2007, p. 461). These studies suggest that reentering individuals with major depression may be overlooked and underserved by correctional, probation, parole, and community corrections mental health systems.

Recidivism and Desistance

The risk factors of recidivism are dynamic, and factors such as “the role of current events and psychological state” are of central importance to the causation of new offenses (Eaves, Tien & Wilson, 2000, p. 143). As criminogenic needs are dynamic, they may provide points for effective intervention and recidivistic interruption. These are “critical junctures on the path back to a former non-adaptive mode of behaviors” (Eaves, Tien & Wilson, 2000, p. 144). Recidivistic

behavior can be understood as a lapse of coping behaviors; it therefore suggests a point of intervention to bolster coping skills, to avoid criminogenic situations, to seek out supportive environments, and to maintain adaptive behaviors throughout periods of transition such as the reentry process.

Cognitive behavioral therapy (CBT) is widely used in correctional settings because of its manualized nature, low cost, and demonstrated effectiveness (National Research Council, 2007). In studies of criminal recidivism, meta-analyses of CBT programs have shown CBT to be very effective in reducing recidivism rates, especially among higher risk, hard-to-reach offenders (Landenberger and Lipsey, 2006; Lipsey & Cullen, 2007; National Research Council, 2007). In mentally ill populations, intensive case management “can delay recidivism, increase community tenure and decrease time spent in prison” (Eaves, Tien & Wilson, 2000, p. 146). Therefore, there is some evidence that well designed psychotherapeutic interventions and clinical management are associated with reductions in recidivism and improved outcomes.

The Importance of Interpersonal Relationships in Reentry

The strength of interpersonal relationships may be a critical factor in criminal offending. Sellars and colleagues (1993) state “it seems likely that the relationship between depression and criminal behavior is mediated by social factors, *especially those concerned with close personal relationships*” (Sellars, Hollin & Howells, 1993, p. 97; see also Prins, 1986). Research has shown that prisoners with close family ties have lower recidivism rates than those without such attachments (La Vigne et al., 2004; Sullivan et al., 2002). On the other hand, maladaptive social support from primary social network members may have the opposite effect; suicidal behavior, alcohol abuse, and arrest among primary social network members were associated with suicidal behaviors (Ivanof & Hayes, 2001).

Results from an Urban Institute study of a Chicago reentry cohort of 400 male prisoners four to eight months after release demonstrate that families of released prisoners are a crucial source of both emotional and material support for people returning from prison or jail (La Vigne, Visher & Castro, 2004; La Vigne, Visher & Travis, 2001). Participants cited family as the most important factor in helping them stay out of prison, and most frequently cited mothers and stepmothers as the family member to whom they felt closest (La Vigne, Visher & Castro, 2004). More than two-thirds of released inmates slept at a family member or friend's home on the first night out of prison, and 88% were living with family four to eight months after release. Additionally, 92% reported getting financial support from someone in their family (La Vigne, Visher & Castro, 2004).

Reentry research demonstrates that positive interpersonal support is correlated with employment and desistance. Among returning inmates, those with an intimate partner (e.g., spouse, girlfriend) reported having been employed for more weeks on average (30% more) after release compared to those without a partner (La Vigne, Visher & Castro, 2004). The likelihood of recidivism was related to a number of factors, including negative family relationships. Additionally, a study conducted by the Vera Institute of Justice involving individuals released from New York prisons and jails (N = 88) further substantiates the value of healthy interpersonal relationships. The authors conclude that “supportive families were an indicator of success across the board, correlating with lower drug use, greater likelihood of finding jobs, and less criminal activity” among returning prisoners (Nelson, Dees, & Allen, 1999, executive summary).

Strong interpersonal attachments, such as having an intimate partner or spouse, may confer a protective benefit to returning prisoners. Longitudinal research on criminal offending shows that marriage may promote desistance for criminal behaviors (Sampson, Laub & Wimer,

2006). However, for these individuals, the potentially protective benefit conferred by marriage may be jeopardized by (1) the presence of depression and (2) the fraught process of family reunification. Both major depression (Whisman, 2007) and family reunification after incarceration (Sullivan, Mino, Nelson, & Pope, 2002) have been associated with increased levels of marital distress. These research findings suggest that maintaining strong interpersonal bonds and addressing psychosocial stressors are necessary for successful reentry outcomes.

The Content of Interpersonal Psychotherapy and the Context of Reentry

Interpersonal Psychotherapy (IPT) is an evidence-based, symptom-focused psychotherapy with a relatively brief duration (usually 16 weeks) that has been shown to be an efficacious treatment for depression triggered by “acute psychosocial stressors” (Weissman, Markowitz, and Klerman, 2000; Parker, Parker, Brotchie & Stuart, 2006, p. 8). IPT focuses on current difficulties, disputes, hopes, and expectations as experienced in the interpersonal context, and relates these triggers to the depressed patient’s mood (Weissman, Markowitz, and Klerman, 2000).

Although IPT has been called “broadly comparable to CBT” in terms of outcome, there are important differences (Parker, Parker, Brotchie, & Stuart, 2006, p. 8). Unlike cognitive behavioral therapists, IPT therapists do not administer forms such as mood monitoring reports or dysfunctional thought records. Instead of identifying and evaluating cognitive distortions and modifying behaviors (as in CBT), the IPT therapist helps the patient to improve symptoms and interpersonal functioning by focusing on current interpersonal relationships, incongruent social expectations, and avenues for change. Through specific techniques and problem-focused strategies, the IPT therapist interrupts social isolation and addresses the helplessness and

hopelessness of the depressive episode. The therapist helps the patient to identify new options, access sources of interpersonal support, better communicate desires and expectations, and improve interpersonal functioning (Weissman, Markowitz & Klerman, 2007).

In the past couple of decades, IPT has been adapted and tested in a number of randomized controlled trials (RCTs), and has been found to be an efficacious treatment for use with many different depressed populations (Weissman, Markowitz, & Klerman, 2007).

Adaptations of IPT have been formulated and tested in RCTs for use with depressed adolescents (IPT-A) (Mufson et al., 2004); as a preventive intervention for adolescents at risk for depression (Young, Mufson & Davies, 2006); with depressed older adults (Reynolds, 1999; Hinrichsen, 2008); with depressed primary care patients (Schulberg et al., 1996); with depressed pregnant women (Spinelli & Endicott, 2003); and with HIV-positive patients (Markowitz, et al., 1998).

Adapting IPT for Depressed Reentry Populations

Although IPT and CBT have been broadly applied and have “come to be regarded as definitive psychotherapies for depression” (Parker, Parker, Brotchie & Stewart, 2006, p.2), each therapeutic intervention requires specific adaptation to the context in which it is applied (Rude & Rehm, 1991). An intervention must also be demonstration of efficacy and effectiveness in a unique population, such as a reentering prisoners with major depression. McBride and colleagues (2006) remark that there is “a very small literature addressing the match of patient and therapy,” and they suggest that in order to optimize treatment for major depression, further research should aim to tailor treatment to the specific characteristics and context of the patient (p.1052).

In selecting a psychotherapeutic intervention to address the needs of formerly incarcerated individuals with major depression, one should consider the considerable life

stressors faced by prisoners during the transition process, (e.g., frequent moves and housing instability, family reunification, financial hardship, unemployment, and high levels of social isolation; La Vigne, Visher & Castro, 2004). While IPT has been found to be generally effective for the treatment of outpatients with major depressive disorder (Elkin et al., 1989), research indicates that IPT may be particularly well suited to address depression triggered by life stressors (Markowitz, et al., 1998; Parker, Parker, Brotchie, & Stuart, 2006).

IPT's Four Problem Areas in the Reentry Context

The IPT therapist is trained to recognize four classes of depressogenic triggers, known as the four problem areas. They are (1) grief, (2) interpersonal disputes, (3) role transitions, and (4) interpersonal deficits (Weissman, Markowitz & Klerman, 2000). These problem areas may arise during the course of a depressed individual's process of reentry. The experience of grief (i.e. the actual death of a significant person in his or her life) by formerly incarcerated individuals may be substantively similar to the experience of grief in the general population, which has been discussed at length elsewhere (e.g., Weissman, Markowitz, and Klerman, 2000). As such, we will not address grief specifically in the following sections, but will rather focus on the latter three problem areas as providing an apt framework from which to address the problems encountered in the reentry context.

Role Transitions

What is termed "the reentry process" in the literature is often fraught with danger and elevated risk for returning individuals. It can be a rocky time of transition, as many releasees work to address their immediate needs, such as obtaining stable housing and a driver's license, procuring food and clothing, finding a job, and dealing with other transitional challenges (Hammett, Robert, & Kennedy, 2001; Petersilia, 2009). While incarcerated, the individual may

have had familiar social supports and attachments to other inmates, but on the outside, the separation and loss of these prison friendships constitute important interpersonal losses. During the reentry transition, the individual may assume new and unfamiliar roles in his or her family structure, and may be expected to fulfill unfamiliar obligations. Finding legitimate employment requires a new repertoire of social skills. All the while, the individual may suffer low self-esteem, struggle with the "double stigma" of incarceration and mental illness, and work to adjust to a new non-institutionalized life and identity (Hoge, 2007).

The period of transition from incarceration to community is associated with a high risk of death or suicide. Binswanger and colleagues (2007) conducted a retrospective cohort study (n = 30,237) of all inmates released from the Washington State Department of Corrections over a course of four years. During a follow-up period of two years, the adjusted risk of death for releasees was 3.5 times higher than that among other state residents. During the first two weeks out of jail or prison, the risk of death among former inmates was 12.7 times that of other state residents. Suicide was a leading cause of death in this population, with a relative risk of death that was 3.4 times greater than that of other state residents (Binswanger, et al., 2007). Other leading causes of death during this transitional period included cardiac arrest and drug overdose, both potentially mediated by life stress events. These findings suggest that the period of reentry is a significant life stress event that may trigger depressogenic vulnerabilities and contribute to an excess risk of suicide in returning individuals.

Binswanger and colleagues (2007) also found that the suicide rate for former inmates was *four times greater* than the suicide rate for current inmates (16 deaths per 100,000 person-years for current inmates vs. 70 deaths per 100,000 person-years for former inmates) (Binswanger, et al., 2007). This disparity between the period of incarceration and the post-incarceration period

suggests that the psychosocial stressors after incarceration (e.g. release, adjustment to new roles, family reunification issues, joblessness, and frequent moves) may be even greater than those endured while behind prison walls. Appropriately designed interventions may serve a prophylactic effect and reduce the risk of suicide or stress-related mortality.

Interpersonal Disputes

Another IPT problem area with relevance to a depressed reentry population involves interpersonal disputes. The reintroduction of the incarcerated individual into a family structure may cause strained communication. Marriages are often strained when a spouse is incarcerated and many dissolve (Hairston, 2001). Marriage discord and dissolution are also evident. Prison Fellowship estimates that only 15% of married couples remain together during a period of incarceration of one partner, and that only an estimated 3% to 5% are still married one year after release (Dallao, 1997).

The separation period of incarceration may strain familial and parental relationships with children (Hairston, 2001). In other cases, the reentry process may instigate relationship conflict and ensuing intimate partner violence (Oliver, 2004). Proper interventions may help to address these issues of family reunification, marital strain and dissolution, and intimate partner violence. The approach used in IPT to manage interpersonal disputes may help returning individuals recognize their complex emotions, implement strategies for managing disputes, and reduce impulsive behavior in the context of familial conflict (Weissman, Markowitz, and Klerman, 2007; Tripp, 2001).

Interpersonal Deficits

Individuals returning from prison with major depression face higher rates of social isolation and may suffer interpersonal impoverishment. The Urban Institute study of 400 male

prisoners returning to their communities in Chicago found that formerly incarcerated individuals had a lack of close friends. Nearly half (48%) reported having no close friends four to eight months after release (La Vigne, Visher & Castro, 2004). . This research shows that returning individuals often struggle with social isolation.

Additionally, research has demonstrated that poor social problem-solving is associated with depression in prisoners (Biggam & Power, 1999a; 1999b; McMurrin & Christopher 2009). In a study of young Scottish prisoners adjusting to the prison regime, Biggam and Power (1999a) found that deficits in problem solving were correlated with higher levels of distress. Depression may further impair levels of functioning. Formerly incarcerated individuals with major depression often struggle with issues of motivation, medication adherence and keeping appointments (Eaves, Tien & Wilson, 2000). Individuals with interpersonal deficits may have chronic difficulty in developing and sustaining close relationships, or may have unfulfilling relationships, or they may have lingering symptoms that interfere with the development of healthy relationships (Weissman, Markowitz & Klerman, 2000).

It should be noted that individuals with high levels of attachment insecurity and attachment avoidance may make poor candidates for Interpersonal Psychotherapy (McBride, Atkinson, Quilty & Bagby, 2006). However, for individuals struggling with social isolation and interpersonal deficits, IPT may help them develop interpersonal coping and relational skills necessary to break isolative patterns and alleviate depression. The content addressed by IPT appears well suited to the context of depressed individuals making the transition from jail or prison back to their communities.

A Proposed Intervention:

Group Interpersonal Therapy for Prisoner Reentry (IPT-GPR)

IPT has also been developed as a group treatment (IPT-G) and has been found to be efficacious for binge-eating disorder (Wilfley et al., 2000), postpartum depression (Stuart, O'Hara & Blehar, 1998), and in South Uganda with depressed adults (Verdeli et al., 2003; Bolton et al., 2003; Verdeli et al., 2008). An adaption of IPT (IPT-GMS) has also been suggested as a suitable therapy for use with depressed military spouses (Verdeli et al., 2010).

Group Interpersonal Psychotherapy for Prisoner Reentry (IPT-GPR), a proposed adaptation of IPT, may provide an appropriate intervention to treat major depression in returning prisoners. An adaptation of IPT seems well-suited to address the triggers of depression experienced by returning prisoners, such as interpersonal disputes, a variety of role transitions, and the challenges of interpersonal deficits and social isolation.

Group Therapy Considerations

There is evidence substantiating the use of group therapy with former offenders. A review by the National Research Council of the National Academies (2007) indicates that among previously incarcerated individuals, (A) greater peer support is associated with less recidivism (Broome et al., 1996); (B) the presence of similarly situated peers has been shown to be more effective in achieving desistance than the involvement of clinical staff or correctional officers alone (Wexler, 1995); (C) peer group support may have a long-term salutary effect on recidivism rates (Jason et al., 2006); (D) group process is associated with higher rates of employment, suggesting a social networking effect (Jason et al., 2006); and (E) group therapy, group cohesion, and levels of client participation are important factors in improving client self-esteem and reducing symptomatology (Serran, Fernandez, Marshall & Mann, 2003). Also, because IPT can be

administered effectively in a group format (Verdeli et al., 2003), the intervention may prove less costly and more accessible than individual interventions.

Individual psychotherapies (as opposed to group therapies) with formerly incarcerated persons may pose certain difficulties. There may be issues of blaming, the “therapist behaving as ‘expert’” (Kozar, 2010), as well as the patient’s distrust of the mental health system (Travis & Visher, 2005, pp. 32-33; Schoeni & Koegel, 1998). Alternatively, a group psychotherapeutic process may circumvent these difficulties and may facilitate peer support and the sharing of common life experiences. In the IPT context, peers in group can validate the sick role attribution as well as provide opportunities for interpersonal interaction to socially isolated individuals.

There may be drawbacks to a group adaptation of IPT in a depressed reentry population. Due to the group process, less time would be devoted to individual problem areas during the course of therapy. This could be ameliorated by designing a hybrid of individual and group therapy; this hybrid approach would entail a couple of individual sessions during the initial phase to set the treatment contract and help identify individual problem areas, followed by individual weekly homework during the group sessions.

Steps to Adapt and Test IPT-GPR

There may also be criticisms of any program that encourages “ex-cons” to fraternize with one another, thereby increasing the risk of criminal affiliation and risk of reoffending. There may be some merit to these criticisms (e.g., “the peer-contagion dynamic” Hughes 1977: p. 87). However, at this time, state prisons, federal penitentiaries and local jails all rely as a matter of course upon community based support groups to provide necessary services to their probationers and parolees. Indeed, they commonly refer released individuals to local groups such as

Alcoholics Anonymous and Narcotics Anonymous, in which a group process and peer interaction are essential elements.

IPT-GPR may constitute what Parker and colleagues call a “therapeutic ecological niche” for interpersonal psychotherapy, that is, this therapy may prove to be a good match for these patients in this specific context (Parker, Parker, Brotchie & Stewart, 2006, p. 2). However, the appropriateness of a group interpersonal psychotherapeutic model for the context of a prisoner reentry population remains to be investigated.

In brief, research in this area might proceed as follows. The research process would begin by engaging a community dealing with issues of reentry, and with community support, initiating an assessment of the acceptability of the intervention within the unique circumstances of that community context. IPT should be tailored to the demands of the setting in which it is practiced to recognize relevant cultural issues. For example, Markowitz and colleagues have adapted a culturally specific form of IPT for the treatment of major depression in Hispanic patients in New York City (Markowitz et al, 2009). Important themes arose, such as the centrality of the family and conflicts due to migration and acculturation (Markowitz et al, 2009). This preliminary phase of research could proceed by working with community partners, key stakeholders, and by integrating findings generated by focus groups or mixed methods approaches.

Second, an open trial would be performed to evaluate the feasibility and acceptability of IPT-GPR for individuals recently released from jail or prison and diagnosed with major depression. Third, if data from the open trial indicate that IPT-GPR may be a successful intervention for major depression, then efficacy testing would be initiated. An RCT would be conducted to investigate the efficacy of IPT-GPR in a highly controlled, optimal setting with

well-trained therapists and a homogenous sample (Weissman et al., 2007). Finally, if IPT-GPR demonstrates efficacy, the next step would involve an effectiveness study, typically conducted in real-life clinic settings by community clinicians in a broader sample range with fewer exclusion criteria (Weissman et al., 2007). These progressive steps in the development of a psychotherapy (preliminary contextual research, open trial, efficacy testing, effectiveness study) are necessary to demonstrate that the intervention is a “feasible, ecologically-valid, non-stigmatizing, and effective treatment” (Verdeli et al., 2010, p. 2).

Conclusion

Major depression in reentering prisoners is highly prevalent and has substantial morbidity, including suicide attempts, substance abuse, poor reentry outcomes and recidivistic offending, but many depressed returning prisoners are untreated. The proposed research has the potential to produce a treatment modality that can be readily adopted by community mental health professionals and may significantly improve the psychological health of depressed individuals returning to their families and communities. The reentry process presents burdensome psychosocial stressors, which may adversely affect desistance and reentry outcomes. To date, despite a high prevalence rate of major depression in this population and significant public health and safety consequences, there is no published study of treatment addressing the needs of reentering prisoners with major depression. The proposed group adaptation of interpersonal psychotherapy, IPT-GPR, may provide an appropriate intervention for the unique conditions of the reentry transition. Further study regarding the feasibility and acceptability of the proposed intervention is warranted.

References

- Beck, A. J., & Maruschak, L. M. (2001). *Mental health treatment in state prisons, 2000*.
- Belser, A. (2005). *Doping the system: Stories of drug use by UK prisoners*. Cambridge University, Cambridge.
- Biggam, F. H., & Power, K. G. (1999). A comparison of the problem-solving abilities and psychological distress of suicidal, bullied, and protected prisoners. *Criminal Justice and Behavior, 26*(2), 196-216.
- Biggam, F. H., & Power, K. G. (1999). Social problem-solving skills and psychological distress among incarcerated young offenders: The issue of bullying and victimization. [Article]. *Cognitive Therapy & Research, 23*(3), 307.
- Binswanger, I. A., Stern, M. F., Deyo, R. A., Heagerty, P. J., Cheadle, A., Elmore, J. G., et al. (2007). Release from prison — a high risk of death for former inmates. *New England Journal of Medicine, 356*(2), 157-165.
- Bolton, P., Bass, J., Neugebauer, R., Verdelli, H., Clougherty, K. F., Wickramaratne, P., et al. (2003). Group interpersonal psychotherapy for depression in rural Uganda. *JAMA: The Journal of the American Medical Association, 289*(23), 3117-3124.
- Broome, K. M., Knight, K., Hiller, M. L., & Dwayne Simpson, D. Drug treatment process indicators for probationers and prediction of recidivism. [doi: 10.1016/S0740-5472(96)00097-9]. *Journal of Substance Abuse Treatment, 13*(6), 487-491.
- Dallao, M. (1997). Coping with incarceration. [Article]. *Corrections Today, 59*(6), 96.
- Eaves, D., Tien, G., & Wilson, D. (2000). Offenders with major affective disorders. In S. Hodgins & R. Muller-Isberner (Eds.), *Violence, crime and mentally disordered offenders:*

- Concepts and methods for effective treatment and prevention* (pp. 131-152). New York: John Wiley & Sons.
- Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., et al. (1989). National institute of mental health treatment of depression collaborative research program: General effectiveness of treatments. *Arch Gen Psychiatry*, 46(11), 971-982.
- Hairston, C. F. (2001). *Prisoners and families: Parenting issues during incarceration*. Retrieved from <http://aspe.hhs.gov/hsp/prison2home02/hairston.pdf>.
- Hammett, T. M., Roberts, C., & Kennedy, S. (2001). Health-related issues in prisoner reentry. *Crime & Delinquency*, 47(3), 390-409.
- Hinrichsen, G. (2008). Interpersonal psychotherapy for late life depression: Current status and new applications. *Journal of Rational-Emotive & Cognitive-Behavior Therapy*, 26(4), 263-275.
- Hoge, S. K. (2007). Providing transition and outpatient services to the mentally ill released from correctional institutions. In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 461-477). New York: Springer.
- Ivanof, A., & Hayes, L. M. (2001). Preventing, managing, and treating suicidal actions in high-risk offenders. In J. B. Ashford, B. D. Sales & W. H. Reid (Eds.), *Treating adult and juvenile offenders with special needs* (pp. 313-331). Washington, DC: American Psychological Association.
- James, D. J., & Glaze, L. E. (2006). *Mental health problems of prison and jail inmates: US Department of Justice*.

- Jason, L. A., Olson, B. D., Ferrari, J. R., & LoSasso., T. (2006). A randomized, longitudinal evaluation of communal housing settings for substance abuse recovery. *American Journal of Public Health, 96*(10), 1727-1729.
- Kozar, C. (2010). Treatment readiness and the therapeutic alliance. In A. Day, S. Casey, T. Ward, K. Howells & J. Vess (Eds.), *Transitions to better lives: Offender readiness and rehabilitation* (pp. 195-213). Devon, UK: Willan Publishing.
- La Vigne, N. G., Visher, C., & Castro, J. (2004). *Chicago prisoners' experiences returning home*. Washington, D.C.: The Urban Institute.
- La Vigne, N. G., Visher, C., & Travis, J. (2001). *Returning home: Understanding the challenges of prisoner reentry*. Washington, D.C.: The Urban Institute.
- Lamon, S. S., Cohen, N. L., & Broner, N. (2002). New York city's system of criminal justice mental health services. In G. Landsberg, M. Rock, L. K. W. Berg & A. Smiley (Eds.), *Serving mentally ill offenders: Challenges and opportunities for mental health professionals* (pp. 144-156). New York: Springer.
- Landenberger, N., & Lipsey, M. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. [Article]. *Journal of Experimental Criminology, 1*(4), 451-476.
- Lipsey, M. W., & Cullen, F. T. (2007). The effectiveness of correctional rehabilitation: A review of systematic reviews. *Annual Review of Law and Social Science, 3*(1), 297-320.
- Markowitz, J. C., Kocsis, J. H., Fishman, B., Spielman, L. A., Jacobsberg, L. B., Frances, A. J., et al. (1998). Treatment of depressive symptoms in human immunodeficiency virus-positive patients. *Arch Gen Psychiatry, 55*(5), 452-457.

- Markowitz, J. C., Patel, S. R., Balan, I. C., Bell, M. A., Blanco, C., Heart, M. Y. H. B., et al. (2009). Toward an adaptation of interpersonal psychotherapy for hispanic patients with dsm-iv major depressive disorder. *Journal of Clinical Psychiatry, 70*(2), 214-222.
- McBride, C., Atkinson, L., Quilty, L. C., & Bagby, R. M. (2006). Attachment as moderator of treatment outcome in major depression: A randomized control trial of interpersonal psychotherapy versus cognitive behavior therapy. [doi:10.1037/0022-006X.74.6.1041]. *Journal of Consulting and Clinical Psychology, 74*(6), 1041-1054.
- Mufson, L., Dorta, K. P., Wickramaratne, P., Nomura, Y., Olfson, M., & Weissman, M. M. (2004). A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. *Arch Gen Psychiatry, 61*(6), 577-584.
- National Research Council. (2007). *Parole, desistance from crime, and community integration*. Washington, D.C.: National Academies Press.
- Nelson, M., Deess, P., & Allen, C. (1999). *The first month out: Post-incarceration experiences in new york city*. New York: Vera Institute of Justice.
- Oliver, W., Williams, O. J., Hairston, C. F., & Crowder, L. (2004). Prisoner reentry and intimate partner violence in the African American community: The case for culturally competent interventions. *Journal of the Institute of Justice and International Studies, 4*, 147.
- Parker, G., Parker, I., Brotchie, H., & Stuart, S. (2006). Interpersonal psychotherapy for depression? The need to define its ecological niche. [doi: DOI: 10.1016/j.jad.2006.03.019]. *Journal of Affective Disorders, 95*(1-3), 1-11.
- Patterson, R. F., & Greifinger, R. B. (2007). Treatment of mental illness in correctional settings. In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 347-367). New York: Springer.

Petersilia, J. (2009). *When prisoners come home: Parole and prisoner reentry*. New York: Oxford University Press.

Prins, H. (1986). *Dangerous behaviour, the law and mental disorder*. London: Tavistock Press.

Reynolds, C. F., Frank, E., Perel, J. M., Imber, S. D., Cornes, C., Miller, M. D., et al. (1999).

Nortriptyline and interpersonal psychotherapy as maintenance therapies for recurrent major depression. *JAMA: The Journal of the American Medical Association*, 281(1), 39-45.

Rude, S. S., & Rehm, L. P. (1991). Response to treatments for depression: The role of initial status on targeted cognitive and behavioral skills. *Clinical Psychology Review*, 11(5), 493-514. doi: 10.1016/0272-7358(91)90001-b

Sampson, R. J., Laub, J. H., & Wimer, C. (2006). Does marriage reduce crime? A counterfactual approach to within-individual causal effects*. *Criminology*, 44(3), 465-508.

Schoeni, R. F., & Koegel, P. (1998). Economic resources of the homeless: Evidence from Los Angeles. *Contemporary Economic Policy*, 16(3), 295-308.

Schulberg, H. C., Block, M. R., Madonia, M. J., Scott, C. P., Rodriguez, E., Imber, S. D., et al. (1996). Treating major depression in primary care practice: Eight-month clinical outcomes. *Arch Gen Psychiatry*, 53(10), 913-919.

Sellars, C., Hollin, C. R., & Howells, K. (1993). Mental illness, neurological and organic disorders, and criminal behavior. In K. Howells & C. R. Hollin (Eds.), *Clinical approaches to the mentally disordered offender* (pp. 71-86). West Sussex, UK: John Wiley & Sons.

- Serran, G., Fernandez, Y., Marshall, W. L., & Mann, R. E. (2003). Process issues in treatment: Application to sexual offender programs. *Professional Psychology: Research and Practice, 34*(4), 368-374.
- Spinelli, M. G., & Endicott, J. (2003). Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *Am J Psychiatry, 160*(3), 555-562.
- Sullivan, E., Mino, M., Nelson, K., & Pope, J. (2002). *Families as a resource in recovery from drug abuse: An evaluation of La Bodega de la Familia*. New York: Vera Institute of Justice.
- Teplin, L. A., Abram, K. M., & McClelland, G. M. (1997). Mentally disordered women in jail: Who receives services? [Article]. *American Journal of Public Health, 87*(4), 604-609.
- Torrey, E. F. (1995). Jails and prisons--America's new mental hospitals. *Am J Public Health, 85*(12), 1611-1613.
- Travis, J., & Visher, C. A. (2005). *Prisoner reentry and crime in America*. Cambridge: Cambridge University Press.
- Tripp, B. (2001). Incarcerated African American fathers: Exploring changes in family relationships and the father identity. *Journal of African American Studies, 6*(1), 13-29.
- Verdeli, H., Baily, C., Voursora, E., Belser, A., Singla, D., & Manos, G. (2010). The case for treating depression in military spouses. Manuscript submitted for publication.
- Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Lincoln, N., Bass, J., et al. (2003). Adapting group interpersonal psychotherapy for a developing country: Experience in rural Uganda. *World Psychiatry, 2*(2), 114-120.

- Verdeli, H., Clougherty, K., Onyango, G., Lewandowski, E., Speelman, L., Betancourt, T. S., et al. (2008). Group interpersonal psychotherapy for depressed youth in IDP camps in northern Uganda: Adaptation and training. *Child and Adolescent Psychiatric Clinics of North America, 17*, 605-624.
- Veysey, B. M., & Bichler-Robertson, G. (2002). *Prevalence estimates of psychiatric disorders in correctional settings*.
- Visher, C. A., & Mallik-Kane, K. (2007). Reentry experiences of men with health problems In R. B. Greifinger (Ed.), *Public health behind bars: From prisons to communities* (pp. 434-460). New York: Springer.
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York: Basic Books.
- Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy*. Oxford: Oxford University Press.
- Wexler, H. K. (1995). The success of therapeutic communities for substance abusers in American prisons. *Journal of Psychoactive Drugs, 27*, 57-66.
- Wilfley, D. E., MacKenzie, K. R., Welch, R. R., Ayres, V. E., & Weissman, M. M. (2000). *Interpersonal psychotherapy for group*. New York: Basic Books.
- Young, J. F., Mufson, L., & Davies, M. (2006). Efficacy of interpersonal psychotherapy-adolescent skills training: An indicated preventive intervention for depression. *Journal of Child Psychology and Psychiatry, 47*(12), 1254-1262.