The Therapeutic Alliance and Personality Dysfunction in Offending Behaviour Programs

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Research Outputs Arising From This Thesis

Publications


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Thesis Overview

The justice system attempts to respond to criminal behaviour by implementing measures that both contain offenders (e.g., imprisonment, court orders) and provide opportunities for rehabilitation (e.g., education, vocational training). The delivery of offending behaviour programs has, in recent years, become an important means by correctional agencies in Australia (and elsewhere) to rehabilitate offenders. Significant funding is currently dedicated to program delivery in each of the States and Territories. While numerous studies demonstrate that the successful completion of an offending behaviour program is associated with a reduction in re-offending, there remains much room for improvement in relation to program effectiveness, particularly in those programs that are offered to serious violent and sexual offenders.

This thesis is concerned with one aspect of program delivery that, it is argued, is likely to be critical to rehabilitation outcomes – the nature of the relationship that therapists develop with program participants. There have been relatively few investigations of this topic, making it hard to describe effective practice in this area, although various opinions have been offered. In this thesis it is suggested that progress has been further hampered by the lack of coherent theory. This thesis seeks to address this gap in knowledge through the development of a program delivery framework which has its foundations in the notion of the therapeutic alliance. It is suggested that this framework can usefully inform effective program delivery and be used to support the training and supervision of professional staff.

The opening chapters of the thesis present the rationale for the research. First, Chapter One offers a brief overview of offending behaviour programs, the challenges posed to effective intervention by the presence of personality dysfunction amongst offenders, and current understandings of how therapists should engage with offenders. It is concluded that there is a need to apply knowledge of effective treatment processes more broadly if difficulties with attrition and a lack of engagement are to be overcome.

Chapter Two examines what is currently known about effective therapist behaviour in psychological treatment more broadly. It is argued that this literature can help those who work in the correctional setting to better understand issues relating to clinical competency. The notion of the therapeutic alliance is introduced as a defining feature of effective mental
health practice, and identified as a construct that can meaningfully guide the delivery of effective rehabilitation.

The available research on the therapeutic alliance in relation to offending behaviour programs is then critically examined in Chapter Three. This research, although inconsistent, suggests that the therapeutic alliance is generally related to treatment gain but also with client motivation to change. It is concluded that despite the methodological limitations of existing research, the formation of a strong alliance may well be associated with better rehabilitation outcomes. Due to the high prevalence of personality disorder in correctional populations and the challenge that traits of personality dysfunction pose to the alliance, treatment issues relating to this population are also considered.

Chapter Four provides an overview of a number of different psychotherapeutic approaches developed to treat personality disorder, including specialist offending behaviour programs. It is suggested that the alliance may be a necessary condition for the successful treatment of clients who demonstrate severe personality dysfunction, but that particular personality traits, client attitudes to treatment, and less collaborative treatment approaches present significant threats to the alliance. An important next step then is to examine the relevance of the therapeutic alliance to treatment provided in the correctional context, given that treatment is often mandated, and delivered through program manuals to many clients who demonstrate personality dysfunction.

These ideas are examined in the first two studies of the thesis which present an analysis of the perspectives of correctional treatment providers and offenders on these issues. Chapter Five reports the findings of the first empirical study, a qualitative investigation of therapist perspectives on the therapeutic alliance in offending behaviour programs using a grounded theory methodology. The analysis revealed significant variability between therapists in how they understood the goals of treatment and, therefore, the specific strategies that they used to develop the alliance. Although some clearly saw their role as providing therapeutic responses to facilitate a process of change, others were more focussed on the delivery of program material. These differences appeared to be related to their training and the type of support that was available from their workplace. All participants identified particular challenges in working with certain types of offender, notably those who present with traits that are commonly associated with personality
disorders. Specific consideration was given to the ways in which they responded to these challenges.

The second study, described in Chapter Six, considers the role and importance of the therapeutic alliance from the perspective of offenders who have completed an offending behaviour program. Employing a similar methodology, the analysis identified similar themes to the first study. Participants identified both client (e.g., low motivation and high levels of hostility) and therapist (e.g., lack of experience and being judgemental) characteristics as critical to the rehabilitative process. Offenders highlighted the importance of therapists demonstrating positive characteristics to support and encourage participation, along with valuing opportunities for self-reflection and positive behaviour change.

The findings of the qualitative studies informed the development of a model of the therapeutic alliance in offending behaviour programs that is described in Chapter Seven. This model aims to explain how therapists employ a range of approaches based on their skill, confidence, training, and experience. Three different modes are described which elicit varying responses to clients who demonstrate personality dysfunction: in the educative mode therapists focus on enforcing appropriate boundaries; in the engagement mode they adjust program content to accommodate client dysfunction; and in the therapeutic mode therapists draw on the therapeutic relationship to intervene in here-and-now experiences of dysfunctional client traits. It is suggested that the therapeutic mode has considerable value as it offers clients insights into problematic behaviours related to their offending.

Chapter Eight reports the findings of the third and final study of the thesis, a quantitative study designed to test the extent to which the model can be operationalised. Segments of videotaped offending behaviour programs were coded to ascertain whether the alliance modes outlined in the model could be reliably identified. This revealed that therapists predominantly used strategies characterised as engagement in their delivery of treatment. While educational strategies were also utilised, therapeutic methods were rarely observed. Markers of therapeutic ruptures were then identified and an analysis presented of therapist responses. Both demonstrations of antisocial (confrontation) and social avoidance (withdrawal) ruptures commonly occurred in treatment sessions, although therapists were less likely to respond to client withdrawal.
The final chapter of the thesis discusses the implications of this research and how these findings make a contribution to current knowledge. It does this in two ways. First, by considering how mainstream theories of psychological treatment should be used to inform the delivery of offending behaviour programs; and second by discussing the potential advantages and disadvantages of adopting this model of program delivery in terms of the required training and supervision of program facilitators. Finally, a future research agenda is proposed to establish the connection between therapeutic process and rehabilitation outcomes.
A Note on Terminology

A range of different terms have been used in this thesis to describe those who deliver and receive offending behaviour programs. Whilst the choice of appropriate terminology will vary according to the context in which programs are offered, for simplicity the term ‘therapist’ is used throughout this thesis to describe the professional who is responsible for program delivery. This seems to be the most widely used term in the published literature although other terms, such as ‘facilitator’, are also used. Those who receive programs are generally referred to as ‘clients’, although the term ‘offender’ is also used.
CHAPTER ONE – Introduction

Overview

This chapter offers an overview of offending behaviour programs, the challenges posed to effective intervention by the presence of personality dysfunction amongst offenders, and current understandings of how therapists should engage with offenders. It suggests that there is a need to apply knowledge of effective treatment processes if difficulties with attrition and a lack of engagement are to be overcome.

Australasian Jurisdictions: An Overview

Australia, with a total population of just over 22 million, is divided into eight states and territories. Imprisonment rates exceed those of many other western countries (Sarre, 2009), although considerable variation exists between the states and territories (Carcach & Grant, 1999). Overall, however, imprisonment rates have doubled since the 1980s from 89.8 per 100,000 adults in 1982 (Carcach & Grant, 1999) to 188 per 100,000 in 2014 when there were almost 90,000 adult persons serving corrections orders (Australian Bureau of Statistics, 2014). Just over one third of these orders are served in prison. With the expansion of legislation to allow mandatory minimum sentences, indefinite sentences, post-sentence supervision and detention, and increased maximum penalties these trends are expected to continue.

Parliamentary authority for the delivery of correctional services across Australia changes markedly from jurisdiction to jurisdiction, sometimes appearing in the relevant criminal statutes, sometimes in correctional legislation, and sometimes in the various Acts related to sentencing. Overall, however, policy specifics dictating the manner in which program delivery occurs is largely left to departmental development and implementation (see Heseltine, Day, & Sarre, 2011). The similarities in service provision between States and Territories in Australia in their approach to offender rehabilitation are, however, great. Most, if not all, offer programs that are dedicated towards reducing risk in sexual and violent offenders, as well as addressing more general causes of offending. Over the last ten years in particular, it has been observed that there appears to be an increased confidence, and indeed success, in moving from theory to policy and through to practice, especially in
relation to the delivery of intensive sexual and violent offender treatment programs (Heseltine et al., 2011). To illustrate, in 2009 four Australian jurisdictions offered intensive violent offender treatment programs (over 180 hours face-to-face contact), with some also offering moderate intensity programs (between 100 and 130 hours). Each jurisdiction offered sexual offender treatment programs, with specialist programs also available for offenders with cognitive disabilities, Indigenous offenders, and those who deny committing their offences (Heseltine et al., 2011). This is demonstrative of correctional services making efforts to accommodate particular offender groups by providing programs that are designed to be responsive to their specific needs.

Although evaluation remains firmly on the agenda for all Australian correctional agencies, very few local program evaluations have been completed or at least reported publicly (Heseltine et al., 2011). Thus, the rationale for service delivery relies on evidence from international studies which show that programs are typically effective in reducing re-offending (see Andrews & Bonta, 2010). Lipsey, Landenberger and Wilson (2007), for example, in a meta-analysis of 58 treatment outcome studies which examined the effects of cognitive-behavioural treatment for offenders, reported an average recidivism rate of 30% for treated groups which equated to an additional reduction in recidivism of 25% for those who received this type of treatment. There has been widespread adoption of the cognitive-behavioural approach as the treatment method of choice in offending behaviour programs in Australia, although the effect sizes associated with treatment are often small and significant variability exists between programs. Indeed, Lipsey and colleagues found that a range of different factors appear to influence program outcomes, including the length of the program, participants’ risk of re-offending, and the quality of program implementation. Many questions remain about the quality and efficacy of local implementations.

Offender Rehabilitation: Service Delivery Frameworks

The work of Canadian researchers (see, for example, Andrews & Bonta, 2010) has been integral to the development of offender rehabilitation in Australia. Each jurisdiction has endorsed identified practice principles to guide program delivery based on the results of their research syntheses. Three principles, those of Risk, Need, and Responsivity (RNR), have become highly influential in describing the features of programs associated with the best
outcomes (Andrews & Bonta, 2010). First, the risk principle poses that offender rehabilitation programs should be targeted at offenders who are assessed as at a moderate or high risk of re-offending. The higher the risk, the greater the intensity of programs required. The need principle proposes that programs will more effectively assist in reducing re-offending if offence-specific needs are targeted. These are sometimes referred to as ‘criminogenic needs’ (or dynamic risk factors), and are those areas of functioning amenable to change through intervention that are closely associated with the actual offending behaviour. Examples include substance use, attitudes, beliefs and values that support offending, and association with other offenders. The responsivity principle is concerned with ensuring that the delivery of programs matches the characteristics of offenders and it is in this context that the research reported in this thesis has been framed. Andrews and Bonta note that only a few of the many possible responsivity variables have been studied in any detail.

In order to work in a way that is consistent with the responsivity principle, therapists are expected to ensure that program content and the manner in which it is delivered is personally and culturally relevant and accommodates the emotional and cognitive capacities of participants. A failure to do so, it is suggested, is likely to impact significantly on how group members respond to treatment, including whether or not they complete programs. This is a particularly critical issue for correctional providers as there is evidence that higher risk offenders who drop out of treatment are at greater risk of re-offending than those who have not undertaken any treatment (McMurran & Theodosi, 2007). Why this should be the case, however, is less clear. A meta-analysis by Olver, Stockdale and Wormith (2011) that examined 114 studies that looked at predictors of treatment attrition, including violent and sexual offender treatment, is instructive here. They reported an average attrition rate of 27.1% across all programs, and noted that the recidivism rate for those who did not complete treatment was 10-23% higher than for those who did complete. Olver et al. identified a range of offender characteristics that were associated with non-completion, including being younger, higher risk, or demonstrating severe pathology such as a diagnosis of personality disorder, psychopathy or psychosis. They also identified a number of within-treatment behaviours that predicted attrition, such as disruptive behaviour during sessions, having a negative attitude towards programs, and denial. They did not, however, consider how offender characteristics and treatment process issues interact. It may be, for example, that attrition occurs as a result of treatment triggering difficult experiences (such as shame,
resentment, anti-authoritarian attitudes, and anger), which are not adequately resolved by either the therapist or the offender. In addition, other client personality features may impinge on the process of treatment, such as high levels of hostility which may result in group members feeling intimidated and coerced. One of the most significant features identified by Olver and colleagues as impacting on program completion was personality disorder and how this influences effective program delivery. Accordingly, an examination follows of why such individuals might pose particular challenges for therapists delivering offending behaviour programs.

Personality Disorder as a Key Responsivity Factor

The term ‘personality disorder’ (PD) is not easily defined. Although there is no agreed definition, Livesley (2001) does point to a number of critical features, including chronic difficulties with interpersonal relationships and problems with self or identity. The Diagnostic and Statistical Manual of Mental Disorders (DSM) proposes that these concepts are central to the assessment of personality disorder, but is considering a move to conceptualising the categorical assessment of these disorders to one that is more dimensional (American Psychiatric Association, 2013). At present, however, categorical assessment utilising DSM criteria has been retained, and is the most common approach to diagnosis in the forensic setting (Andrews & Bonta, 2010). Those categorised in this way demonstrate a number of the features that are likely to impinge on client motivation, affect, cognitive and interpersonal experiences. For example, those with Antisocial PD are likely to lack the motivation to adhere closely to program content due to their anti-authoritarian attitude. Individuals with Borderline PD are likely to demonstrate high levels of affect dysregulation such that program content that elicits shame is likely to result in extreme emotional responses. Those with Narcissistic PD will find responding to the authority of treatment providers challenging, due to their high levels of grandiosity. It is suggested, however, that most clients will not meet the full diagnostic criteria for a PD but may demonstrate a range of dysfunctional personality traits which significantly impinge on meaningful treatment engagement. Such traits therefore pose significant responsivity issues in relation to some of the problematic behaviours that are observed in groups as well to the therapist skills that are required to engage those who demonstrate these traits.
Perhaps the most commonly encountered characteristics demonstrated by offenders are antisocial personality traits and antisocial attitudes. These are not only common in inmate populations, but represent two of the ‘central eight’ risk factors identified by Andrews and Bonta (2010) as directly associated with recidivism. Studies that have examined the prevalence of psychiatric disorders in inmate populations have shown that Antisocial PD is a characteristic of between 21% and 35% of all prisoners (e.g., Black, Gunter, Loveless & Sieleni, 2010; Veysey & Bichler-Robinson, 1999), although other studies have reported considerably higher rates (see Blackburn, 2000). Given that Antisocial PD appears to be associated with higher rates of treatment drop-out in offenders (Moore, Bergman & Knox, 1999), it is an important responsivity issue and well as a criminogenic need in its own right (Howells & Day, 2007). A related but also important diagnostic category is psychopathy. The Psychopathy Checklist-Revised (Hare, 2003), perhaps the most common method of assessing this personality type in forensic settings, assesses two main factors: antisocial behaviour; and personality traits that have strong narcissistic features (e.g., callousness, lack of remorse, grandiosity). Within correctional settings, ‘psychopaths’ represent a sub-set of Antisocial PD offenders, and due to their propensity to re-offend at higher rates than other offenders (see Hart, Kropp & Hare, 1988) are a particularly important group to engage in treatment.

A range of other PDs are also present in offending populations and co-morbidity with other forms of mental illness is common (Blackburn, 2000). For example, Sansone and Sansone (2009) reported that the majority of studies they reviewed found at least 25% of prisoners could be diagnosed with Borderline PD (with rates for female offender populations being considerably higher than those for males). Blackburn, Logan, Donnelly and Renwick (2003) found a wide range of PD diagnoses in offenders detained in high security hospitals, and (apart from Antisocial PD and Borderline PD) these included Narcissistic, Schizoid, and Paranoid PDs. It is worth re-stating, however, that a considerable number of correctional clients will not meet the full criteria for a PD but demonstrate significant traits of these disorders, which influences their ability to engage meaningfully in treatment. This points to the need, therefore, to consider not only categorical diagnoses of PD, but also the way in which dysfunctional personality traits influence engagement in offending behaviour programs. Some of these traits which are likely to pose particular challenges to treatment include:
• Behaviour that might be disruptive within treatment sessions, such as disregarding the rights of others (Antisocial PD), irritability and aggressiveness (Antisocial PD), and problems with controlling anger (Borderline PD)

• Behaviours that might impede the development of a therapeutic relationship with therapists and group members, such as unstable interpersonal relationships (Borderline PD), social detachment (Schizoid PD), a mistrust of and reluctance to confide in others (Paranoid PD), deceitfulness (Antisocial PD), grandiosity (Narcissistic PD), and a sense of entitlement (Antisocial PD and Narcissistic PD)

• Problems with emotional states likely to be elicited within the treatment experience, such as impulsivity (Antisocial PD/Borderline PD) and affective instability (Borderline PD), but also a restricted range of emotional expressiveness (Schizoid PD)

In summary, personality disorders are not only pervasive in correctional populations, but features typically found within these disorders are likely to be important to the content of treatment (e.g., impulse control, changing antisocial thinking) and the way in which it is delivered (e.g., responding to client difficulties in relating to others, aggression and emotional instability). Attending to these latter factors by ensuring clients can manage the emotions elicited in treatment and helping them to improve relationships with therapists and other program participants are likely to help reduce rates of program attrition.

Therapist Characteristics

It seems clear that not only do therapists need to have an extensive knowledge of both offending (criminology) and offenders (psychology) if they are to deliver effective rehabilitation, they must also have the ability to relate well with offenders. Just what relating ‘well’ or ‘poorly’ means in this context is, however, somewhat unclear. It might, for example, be argued that relating well can involve ‘befriending’, which has the potential to increase client dependence and reduce self-efficacy while also reinforcing antisocial beliefs and attitudes. Conversely, an aggressive and intimidating interpersonal style may lead to client antipathy, increase rates of program attrition, and encourage disengagement from program content.
There is a lack of consistent guidance about the interpersonal approach that therapists should adopt in their work with offenders. While some have suggested that it is important to develop a strong bond with offenders (e.g., Livesley, 2007), others suggest that therapists should remain emotionally detached (e.g., Hare & Wong, 2005). Livesley (2007), for example, suggests that a generic component of treatment with high-risk offenders who demonstrate personality disorders has two parts: the treatment relationship; and the therapeutic frame - the latter determining the therapeutic tasks that are required for change. Livesley acknowledges that problems in trust and co-operation are defining features of PD, but suggests that these can be built over time and develop as a result of effective treatment. A somewhat different position, however, is offered by Hare and Wong (2005) who suggest that a 'functional working alliance' should be developed when working with clients who have psychopathic tendencies. This places more emphasis on the tasks and goals of the program and less on the development of an emotional relationship. In their view this is because psychopathic characteristics, such as being manipulative and lying, will impede the ability to form a close emotional bond. Downplaying this element of the therapeutic relationship may also safeguard the therapist from exploitation. A tension exists, therefore, in relation to the extent to which the therapist stance should focus on the development of a strong emotional bond or on implementing pro-social boundaries and delivering content strictly ‘by the book’.

A similar discussion about therapist stance can be found in relation to the treatment of general offenders. There are those who, for example, strongly advocate the use of behavioural methods to respond to challenging client behaviour rather than methods that promote relationships. Milkman and Wanberg (2007), in their review of cognitive behavioural treatments offered within correctional environments, advise that “the provider must approve (reinforce) the client’s anti-criminal expressions and disapprove (punish) the client’s pro-criminal expressions” (p.13). Milkman and Wanberg further specify the need for clinicians to articulate their disapproval and report violations to correctional providers. This language suggests that a particular manner and tone is required from those who deliver offending behaviour programs when transgressions occur within groups. From a different standpoint, in relation to the treatment of perpetrators of intimate partner violence, Taft and Murphy (2007) make the observation that overly confrontational treatment techniques can limit therapeutic effectiveness by failing to acknowledge issues related to victimisation and by modelling ways of behaving that are abusive.
Exploration of these issues has also occurred in relation to sex offender treatment (see Glaser, 2003; Marshall & Serran, 2004; Ward & Brown, 2004). Marshall and colleagues have been highly influential in this regard, particularly in terms of the impact of their research to empirically identify those therapist characteristics that are associated with positive treatment outcomes. They conclude that therapists who display empathy, warmth, understanding, rewardingness and directiveness are all likely to achieve enhanced therapeutic outcomes (Marshall & Serran, 2004). These attributes perhaps suggest the importance of therapists balancing relationship development with behavioural techniques that attend to the contingencies around offending and within-treatment behaviour.

Some evidence has been provided by Dowden and Andrews (2004) to support the notion that the therapist stance should balance boundary setting with the development of a therapeutic bond. Based on a meta-analysis of 273 studies examining rehabilitation program outcomes, Dowden and Andrews proposed five dimensions of ‘staffing factors’ that are characteristic of effective correctional programming: effective use of authority, appropriate modelling and reinforcing of anti-criminal attitudes and behaviours, fostering problem-solving skills, use of community resources, and relationship factors. Three of these five dimensions relate to the use of behavioural techniques (e.g., implementing boundaries, the use of reinforcement, modelling appropriate behaviour) to support clients in the process of change. The two exceptions are the use of community resources (therapist efforts to engage other services), and relationship factors, which relate to the ability of staff to demonstrate warmth and openness. All of the factors, except for community resources and effective disapproval (a sub-set of appropriate modelling and reinforcement) were positively associated with treatment effect size. This supports the notion that a stance that encompasses (at least) both behavioural strategies and attending to the therapeutic relationship is likely to be the most effective. Dowden and Andrews do comment, however, on the lack of information about staff characteristics reported in program evaluations and this placed significant limitations to their analyses and the robustness of their conclusions.

Based on the findings of their meta-analysis of studies that looked at the causes of program attrition, Olver et al. (2011) suggest that correctional therapists should focus on developing strategies to retain high risk and high needs clients in treatment if they want to achieve better outcomes. These, they suggest, might include responding more effectively to
difficult interpersonal interactions and monitoring their own responses to these behaviours while implementing motivational interventions. Olver et al. also note that specific skills are required to respond to those who demonstrate high levels of defensiveness, anti-authoritarian attitudes, disruptive behaviour, as well as the range of other psychopathologies that are present in offender populations. It seems then that to best respond to offenders who demonstrate difficult behaviours, therapists should be educated on a range of client presentations and be able to utilise a variety of strategies to respond helpfully to these. Along these lines, Andrews and Bonta (2010) suggest that if clients demonstrate difficulty in their cognitive and interpersonal skill level (such as having problems in empathy, self-regulation and intelligence), then interventions that are verbally and interpersonally demanding should be avoided. They also suggest that confrontational and intense interpersonal discussion should be avoided when clients experience interpersonal anxiety, and that high levels of structure are required for those who present with high levels of antisocial personality traits. For clients who demonstrate sensation-seeking tendencies, programs should provide novel and exciting opportunities. Like Olver et al. (2011), they also suggest the importance of using motivational interviewing techniques. What might be concluded from these suggestions is that a balance needs to be struck between being personable and being purposeful.

While many of the strategies described above are intuitively sound and broadly consistent with the RNR model, there is little empirical evidence to support their implementation. For example, there is only limited research on the rehabilitative effects of motivational interviewing techniques with offenders (see McMurran, 2009 for a review). This approach, which emphasises the avoidance of confrontation and encourages offenders’ own exploration of their situations, however, does hold promise as a means of responding productively to a range of challenging client presentations in treatment. Similarly, the Good Lives Model (Ward & Stewart, 2003) in offender rehabilitation emphasises a strengths-based approach that promotes the acquisition of basic human needs while avoiding confrontation and shaming clients. In addition to those advocating the use of behavioural strategies (e.g., Andrews & Dowden, 2005), Marshall and Burton (2010) have emphasised the importance of attending to process issues in treatment. Specifically, they identify the development of a strong therapeutic alliance and positive group climate as critical to effective treatment delivery. These concern, first, the extent to which therapeutic interactions are collaborative
between therapists and clients, as well as, second, the extent to which group members work cohesively. These concepts are elaborated further in the next chapter.

Finally, concerns have been expressed that offender treatment has become so structured that therapists are unable to respond to individual participant needs as they arise (see Serran, Fernandez, Marshall, & Mann, 2003). Marshall (2009), in particular, has argued that detailed manuals require treatment to be more psycho-educational and, as a consequence, more likely to encourage therapists to adopt a confrontational style. He points to the importance of therapists adopting a general psychotherapeutic approach so that a close connection develops, and laments that treatment manuals typically fail to convey the process by which this should occur. Similarly, McMurray and Duggan (2005) point to the importance of what they refer to as ‘clinical competence’ in the delivery of manualised treatment for personality disordered offenders, whilst also suggesting that manuals offer support and structure to the less experienced therapist. Manuals that are highly prescriptive and provide substantial detail and guidance in relation to program content have been touted by some as a critical means of achieving treatment integrity. Milkman and Wanberg (2007) suggest that detailed manuals allow for the overall treatment philosophy to be defined, session goals and objectives for each session to be clearly outlined, and exercises aimed at skill development provided. Hollin, Palmer and Hatcher (2013) also argue that program manuals are integral to the delivery of effective offending behaviour programs, including those that outline the theoretical bases of programs, those that guide program evaluation and how to recruit and train staff, as well as those that aim to direct each session within a program. Mann (2009) similarly argues that manualised treatment is likely to be superior, particularly as a means of promoting treatment integrity and facilitating evaluation.

These differing perspectives suggest there is a lack of consensus about how to support staff in the delivery of offending behaviour treatment, and some disparity and limited empirical support in relation to an appropriate treatment stance to respond to challenging behaviours (see Day, Kozar & Davey, 2013).
Conclusion

Therapists who deliver programs should not only have an extensive knowledge of the causes of offending, but also the ability to relate to and positively influence clients in group treatment. There appear to be significant challenges in effectively engaging offenders in treatment, particularly those with particular personality characteristics. Whilst it can be concluded that program manuals do have an important role to play in guiding session content, they are limited in the type of guidance that they can offer therapists when faced with challenging client behaviours. Rather, there is a need to integrate clinical skills and professional judgement with evidence-based program content if offender rehabilitation programs are to be effective. An integrative model, which draws on key concepts from the general psychotherapeutic literature, is likely to inform this process. This literature is reviewed in Chapter Two.
CHAPTER TWO – Psychological Treatment

Overview

This chapter examines what is currently known about effective therapist behaviour in psychological treatment more broadly. It is argued that this literature can help the correctional practitioner to understand issues relating to clinical competency. The notion of the therapeutic alliance is introduced as a defining feature of effective mental health practice, and identified as a construct that can usefully guide the delivery of effective rehabilitation.

Psychotherapy, as a process in which clients voluntarily seek out a therapist to assist in the resolution of difficulties in their lives, can be traced back to the start of the last century (Freud, 1958). While treatment techniques have proliferated since this time, a number of researchers have argued that there are some key characteristics of effective psychotherapy. Wampold (2007), for example, argues that there are two critical elements. The first is the premise that change is possible because the client is seeking a more adaptive explanation of his or her difficulties. The means by which this is achieved is the verbal interaction between therapist and client. The second is that treatment leads clients to engage in activities such as thinking differently about their situation, increasing their social networks, communicating more effectively, and so on. Wampold reviews the research evidence which shows that psychotherapies have been remarkably effective in assisting clients to effect positive change and that a range of treatment types are similarly efficacious. He argues that although clients present with a diversity of issues (as well as their own understanding of what treatment is and how it might help with their problems), the critical factor in treatment is not treatment type, but engagement.

Meichenbaum (2008) similarly concludes that the most critical feature of evidence-based treatment is not the specific treatment technique but the quality of the therapeutic alliance. This includes fostering a bond, collaborating in the development of treatment goals, and addressing any ruptures or strains. These latter occur when difficulties emerge in the treatment relationship, such as when clients disagree with the approach therapists are taking or an interpersonal problem occurs (e.g., the perception that therapists are being judgemental or aloof). He also identifies a range of other key tasks, such as educating clients...
about their problems, instilling hope that change is possible, ensuring clients have adequate coping skills, trying out different ways of behaving, and constructing new meaning within their lives.

It would appear, then, that practitioners such as Wampold (2007) and Meichenbaum (2008) suggest that good therapeutic practice involves the therapist engaging in a range of tasks to strengthen relatedness within the therapeutic dyad. This allows a dialogue to occur in which an explanation for clients’ problematic behaviours is developed. Throughout this process, clients should be inspired to try out new behaviours and develop an alternative sense of self. Psychotherapeutic intervention must, at a minimum, engage clients whereby they participate in the process of treatment to achieve their intended goals. Arguably, the importance and relevance of a therapeutic program to a client is lost if therapists are unable or unwilling to make a personal connection during the delivery of treatment. The therapeutic alliance is therefore seen by many as critical to this process, so further analysis and explanation of this concept is provided.

The Therapeutic Alliance

Therapists have reflected on the nature of therapeutic relationships and the key processes at play within therapeutic encounters that assist the change process since the days of Freud (1958). The therapeutic alliance (TA) (or ‘working alliance’ or ‘helping alliance’ as it is also known) describes a therapist and client's meaningful and collaborative work towards therapeutic change. It has been widely used to understand some of the most important features of the therapeutic process and is a concept that pervades the psychotherapeutic literature. It is worth noting that the attachment experiences of clients will shape how interactions occur within treatment, as this describes their style of relating to others based on experiences with previous caregivers and how they have achieved relationship needs (Bowlby, 1982). Clients’ approaches to treatment will, therefore, be informed by relationships with significant figures in their lives, such as parents, siblings, and partners, although the TA is concerned with clients’ interactions with therapists in negotiating the process of treatment.
Horvath and Luborsky (1993) have distinguished two schools of psychodynamic thought in relation to the alliance. There are those who conceptualise the therapeutic relationship as comprising both the alliance and transference (in which the client will transfer or displace their experiences from important relationships in their past onto the therapist) as distinguishable constructs which the client will vacillate between (e.g., Greenson, 1965). Others have suggested that the alliance is a form of transference (e.g., Hatcher, 1990, as cited in Horvath & Luborsky, 1993), and as such the process of engaging in therapy will result in the client’s unconscious projections (or aspects of the self that are not recognised as such) always being placed onto the therapist.

More recent conceptualisations of the alliance have focussed on the common factors responsible for therapeutic gains across theoretical orientations, and thus posited that the alliance is pantheoretical. Luborsky (1976) suggested that the alliance is dynamic, and the relative emphasis of the client experiencing the therapist as helpful versus engaging in a joint struggle to overcome the client’s problems will vary based on the phase of treatment. Bordin’s (1979, 1994) conceptualisation of the alliance is also considered pantheoretical, as it places emphasis on the positive collaboration with the therapist in responding to a client’s pain and self-defeating behaviours.

Bordin’s (1979, 1994) model of the TA has been examined across a broad range of contexts, including the delivery of offending behaviour programs, so further description of this model is warranted. Bordin conceived of the TA as comprising three inter-related elements: tasks, or negotiation of the specific activities that need to be undertaken to facilitate change in psychological therapy; goal, the development of a goal that most centrally relates to achieving therapeutic change; and bond, the development of trust and an ability to negotiate within the therapeutic relationship (Bordin, 1979). According to Bordin (1994), the TA is the critical factor that fosters psychological and behavioural change and it requires that the client is active within the change process and hence motivated to participate in the treatment process, although the negotiation of tasks and goals not only becomes critical in building the alliance but also in being able to withstand difficulties, or therapeutic ruptures, within this process. The extent to which therapists can motivate clients into undertaking the tasks of therapy on the basis that this will achieve the agreed goals is thought to be a key determinant of treatment effectiveness (Bordin, 1979). The development of a bond is also considered critical, but something that should naturally
evolve as a part of the process of negotiating goals and completing the tasks required to achieve those goals. The bond thus describes the quality of the relationship required to work collaboratively on identified change goals (Hatcher & Barends, 2006), and for some theorists not only provides a framework from which treatment can be delivered, but rather is the treatment (e.g., Miller, n.d.). In this respect, the ability of the therapist to make an emotional connection with the client through purposive goal-oriented therapy is regarded as a necessary, if not sufficient, condition for change. Therapists achieve a TA, therefore, when clients participate in treatment to develop a mutual understanding of the clients’ problems, agreement on the activities required to address these issues, and an ability to identify and respond to strains that emerge within this process.

A number of meta-analytic reviews have summarised the results of what is now a large number of studies that have investigated the influence of the TA on therapeutic outcome. These studies have found evidence for a moderate, but robust, association between the TA and treatment outcome across a wide range of individual psychotherapeutic interventions (e.g., Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Horvath and Symonds (1991), for example, in their analysis of 24 studies relating to the quality of the alliance found an effect size of 0.26, meaning that at least a quarter of the therapeutic change observed could be directly attributed to the TA. They reported that the alliance impacts on outcome across different types of therapy, lengths of treatment, and sample sizes. Martin, Garske and Davis (2000) in their meta-analysis of 79 studies reached similar conclusions (with a comparable but slightly lower effect size of 0.22). These studies included a variety of TA scales (summarised in Appendix 1), therapeutic orientations, and client presenting issues, although no significant differences were found between these factors. An ‘acceptable’ reliability index for the various scales was found, suggesting relative consistency amongst measures. There was no one scale that was determined to be more reliable than the others (and all but the Therapeutic Alliance Rating Scale, Marziali, Marmar & Krupnick, 1981, were associated with positive therapeutic outcomes). The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was identified as the most preferred for research projects as from a practical perspective it can be used with any client group and it is soundly based on Bordin’s model of the TA. The Pennsylvania Scales have also been widely used and are based on Luborsky’s (1984) concept of the TA as comprising two types of alliance. Type 1 signs are evident when clients experience the therapist as helpful, and Type 2 signs are when clients experience the treatment process as beneficial and work towards agreed goals with
the therapist. A number of scales have evolved to measure these aspects of the alliance, the most recent of these is the Helping Alliance Questionnaire Method (HAq; Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985). The California Psychotherapy Alliance Scales (CALPAS; Marmar, Gaston, Gallagher, and Thompson, 1989) have also commonly been used in previous research. They assess Gaston’s (1990) conceptualisation of the TA and includes the Patient Working Capacity scale, the Patient Commitment scale, the Therapist Understanding and Involvement scale and the Working Strategy Consensus scale.

Importantly, disagreements about the goals and/or tasks or strains in the bond are seen as an inevitable consequence of the therapeutic process. Genuine confrontation between the client and the therapist on their specific views, needs, and agendas is regarded as fundamental to therapeutic change. Bordin (1979) suggests in successful therapies both parties are required to work through difficulties that emerge in the relationship, given that the client brings things to the therapeutic process that parallel their experiences in other relationships. The resolution of these difficulties is seen by some as the most essential aspect of any therapy. Safran, Muran, Samstag and Stevens (2002), for example, argue that alliance rupture-repair episode patterns are important for different types of clients. It is thus not simply working collaboratively, but the processes invoked, in order to sort through the varying problems that arise within the therapeutic relationship, that are central to the mechanisms of change.

An overview of pertinent issues relating to alliance formation and repairing ruptures in the alliance, based on previous research in the general psychotherapeutic literature, is next presented. It is suggested that these might inform correctional treatment providers of the range of client and therapist factors that might influence the efficacious delivery of offending behaviour programs.

Alliance Formation

To develop a TA, clients are required to demonstrate a level of openness to collaboratively engage in the treatment process. A number of client factors are likely to impede this process, such as clients who have difficulties in developing a trusting relationship. These clients might respond with anger or defensiveness during therapists’ attempts to develop a therapeutic bond. Constantino, Castonguay and Schut (2002) suggest
that a number of threats to the TA, however, can be mitigated if they are identified within a therapeutic context. For example, they contend that to circumvent defensiveness, therapists might use techniques that facilitate ‘emotional deepening’, with exploratory methods used only following decreases in symptoms of distress. With clients who have a low education level and/or low psychological-mindedness, therapists might take the time to prepare clients and ensure their expectations are commensurate with the treatment on offer. These suggestions parallel those described by Howells and Day (2007) in addressing personality disordered offenders’ readiness for treatment. They also advocate developing very specific case formulations in relation to offending behaviour to ensure that the goals and tasks of treatment are clear. Beyko and Wong’s (2005) suggestion of behavioural contracting would also seem to be a practical means of establishing a strong TA. Contracts articulate the goals of treatment, the agreed tasks to be undertaken to achieve those goals, and expectations for the role of both clients and therapists. Part of the latter might include an agreement that work will be undertaken in a purposeful manner and involve providing genuine feedback to both parties.

The development of a TA commences with assessment. A thorough assessment should be conducted to ensure the learning style and abilities of the client are elucidated prior to treatment so therapists can be responsive to specific client needs (Marshall & Serran, 2004). Throughout this process, clients should be oriented to the process of therapeutic procedure and the nature and expectations of treatment (Constantino, Castonguay & Schut, 2002). Forensic clients in particular may benefit from this strategy, as they may not be familiar with therapeutic processes, are suspicious about what therapy in a correctional environment will involve, and/or will demonstrate a number of traits typically associated with poor alliance formation (e.g., defensiveness, hostility, affect dysregulation).

Because some client characteristics assist in the formation of positive bonds (e.g., quality of object relations stemming from appropriate attachment and bonding with parental figures, expectations of change), while others do not (e.g., avoidance, interpersonal difficulties), it is possible to anticipate when therapists will need to adapt their approach to foster a strong TA (Castonguay, Contantino & Grosse Holtforth, 2006). For example, a poor expectation of improvement has been associated with poor alliance formation (Constantino, Castonguay & Schut, 2002) in a variety of treatment contexts (Gibbons, Crits-Christoph, de la
Within criminal justice systems, treatment is most often delivered in a group treatment format rather than individually. Throughout the negotiation of group activities, it is important that interactions between therapists and clients are respectful and work towards positive therapeutic outcomes. Bordin (1997) emphasised that the change goal elicited during treatment must capture something central to the client’s concerns. In the forensic context, this will invariably be about the resolution of mechanisms that contribute to previous offending behaviour. Bordin suggested that the identification of these goals should in and of itself have great therapeutic benefit. Marshall and Serran (2004) suggest that strategies that are most effectual include asking open-ended questions, behaving genuinely, offering encouragement, demonstrating care and acceptance, and creating opportunities in group for behaviour to be rewarded. They suggest that ‘directiveness’, which involves suggesting possible directions or alternatives to observed behaviours, rather than ‘telling’ clients what to do, should be used judiciously. Luborsky, Barber, Siqueland, McLellan and Woody (1997) suggest very similar processes for improving the alliance based on Luborsky’s previous work around providing support and guidance on the client’s goals, and offering understanding and acceptance. They also emphasise the importance of conveying realistic hopefulness about the client succeeding, the recognition of progress toward the goals, and finding ways to encourage clients to express themselves on some occasions. The importance of achieving functional means of relating during treatment has also been emphasised by Ross, Polascheck and Ward (2008) who posit that the therapeutic task for the therapist is to have an awareness of their own schemas and how they interact with the clients’ to develop helpful ways of responding in group. Where clients have experienced difficulties in relationship formation previously, it stands to reason that difficulties in patterns of relating will continue in the therapeutic context, so therapists must be prepared to work through these issues. The deeper the pathology, particularly with respect to object relations (or the nature of thoughts and desires oriented towards others based on childhood experiences), the more time needs to be spent on forming the alliance (Bordin, 1997).

When therapist and client amicably negotiate a means of working together, an adequate TA has been formed. Horvath and Luborsky (1993) contend that this process not
only requires the client approving the therapist’s style but the therapist communicating the 
relevance of tasks to goals, and maintaining an awareness of a client’s commitment to 
therapy. They suggest that it is important to negotiate short and medium-term expectations 
to foster a strong alliance, but that the first phase of therapy is about developing trust and 
collaboration. Only once this has been achieved should therapists go on to challenge clients’ 
dysfunctional behaviour patterns. Exploratory strategies are required to undertake this 
work, but should only be attempted once a client’s distress or other problematic state has 
been resolved (Constantino, Castonguay, & Schutt, 2002).

Rupture Repair

There is a general view in the psychotherapeutic literature that the manner in which 
therapists respond to ruptures in treatment will significantly impact on whether difficulties 
are resolved. Ruptures are also considered to be a normal part of the therapeutic process; 
and if ruptures do not occur then that may be an indication of a lack of progress. Horvath 
and Luborsky (1993) suggest that in these situations, one of two things may be occurring: (1) 
the client is responding to the therapist in an idealised manner; or (2) that the therapist and 
client are simply coasting through treatment. In correctional environments where treatment 
is often guided, if not prescriptively driven, by program manuals the risk of the latter is high. 
In addition, pressure from correctional managers to have clients complete treatment and 
the desire to get through the required content, may mean that group process issues are not 
attended to let alone resolved. There may be some pressure on both therapists and clients 
to avoid confrontation so that participants get through the program or ‘pass the course’. 
This means that continual re-assessment of the therapeutic approach through supervision or 
peer review processes is required to ensure therapeutic integrity.

When situations arise that are indicative of problems between the therapist and the 
client, particular attention should be given to identifying and responding to these 
therapeutic ruptures. These may be evident in the form of clients communicating negative 
sentiments (e.g., that the therapist is not doing a good job), disagreement about tasks and 
goals (e.g., not wanting to discuss childhood experiences), non-compliance (e.g., not doing 
yome-work), avoidance (e.g., talking about a different topic to that raised by the therapist), 
and not utilising the therapeutic techniques on offer in treatment (Constantino, Castonguay, 
& Schut, 2002). Ruptures are defined as a breakdown in or failure to develop collaboration,
or periods of poor relatedness between therapist and client. A rupture may therefore occur in any of the three elements of the TA. Safran et al. (2002) suggest that repairing ruptures is a crucial but an often difficult task for therapists. The successful repair of ruptures, however, often results in a significant enhancement in therapeutic outcomes, more so than if no rupture presents.

Safran and Muran (2006) distinguish between two different types of ruptures – ‘confrontation ruptures’, where the client confronts the therapist about problems in the therapy or attempts to manipulate or control aspects of treatment and ‘withdrawal ruptures’, in which the client complies, defers or withdraws when he or she is experiencing difficulty such as by avoiding topics that are raised or providing minimal responses. They argue that it is negotiation of needs (rather than collaboration) that most aptly describes the constantly shifting properties of therapeutic interactions, done at both a conscious and unconscious level. They add that even the most subtle fluctuation in the quality of therapeutic interactions is worth exploring as it may assist in revealing and resolving clients’ relational schemas and self-defeating patterns. Failure to explore more dramatic ruptures can lead to treatment failure and dropout.

Client difficulties, of course, may not always be expressed through anger or hostility. Safran, Muran, Samstag and Stevens’ (2002) review of research suggests that many clients do not express their dissatisfaction with treatment, emphasising the importance of asking clients for feedback on their experiences of therapy. Therapists who become aware of clients’ negative reactions may either stick rigidly to their treatment model (rather than adapt their delivery based on client dissatisfaction), or express their own negative feelings defensively. Conversely, therapists who respond non-defensively and change their behaviour may improve the alliance. A TA is negotiated when there is a willingness and ability to stay in tune with a client while also accepting and responding to their difficulties.

Clients are likely to experience difficulties at certain stages within therapy. For correctional clients, ruptures may occur early in therapy in light of Marshall and Serran’s (2004) observation that forensic clients are often mistrustful of professionals running treatment programs. Marshall and Serran suggest that great skill is required to develop trust, requiring the therapist to model how to address others in the group, adjust their style to the needs of clients, and display self-awareness in relation to their own reactions to a
client's behaviour. Although research in this area is limited, there is some evidence that therapists who engage in some self-disclosure when faced with anger and hostility (rather than ignoring it or trying to avoid it) do better (Castonguay, Contantino & Grosse Holtforth, 2006). This is consistent with displaying the personal attributes of being genuine and transparent in treatment. Therapists who attempt to anticipate problems, provide clients a means of communicating dissatisfaction, and are open to dealing with ruptures as they occur are thus thought to be more likely resolve ruptures in the TA.

A meta-analysis by Safran, Muran and Eubanks-Carter (2011) examining the relationship between rupture repair and treatment outcomes in general psychotherapeutic contexts included studies which documented changes in measures of the TA over treatment episodes and utilised self-report on the occurrence of ruptures within sessions (e.g., the post-session questionnaire; Muran, Safran, Samstag & Winston, 2004, as cited in Safran, Muran, Eubanks-Carter, 2011), and observer-based methods (e.g., the Collaborative Interactions Scale; Colli & Lingiardi, 2009; the Rupture Resolution Rating System; Eubanks-Carter, Muran & Safran, 2009, as cited in Safran, Muran, Eubanks-Carter, 2011). Only three studies met the criteria for inclusion (i.e., a quantifiable measure of outcome at the beginning and termination of treatment and quantitative criteria to identify rupture and rupture repair), but involved a total of 148 clients. The aggregated correlation between rupture-repair episodes and treatment outcome was .24; a medium effect size. The authors point to some of the methodological problems in the existing research that limited their analysis, which included the correlational nature of studies, and differences in treatment length, client populations, and treatment modality. Despite these limitations, they make a series of recommendations for therapeutic practice that includes therapists developing an awareness of clients’ therapeutic experiences, encouraging expression of negative feelings within treatment, and that if clients articulate difficulties that therapists respond empathically. They suggest that therapists should respond flexibly to assist rupture resolution such as by changing tasks or drawing links for clients between ruptures and out-of-session patterns of dysfunctional behaviour. They identify the micro-skills required by therapists to successfully negotiate the therapeutic tasks and goals, while maintaining a strong bond, as the most important next line of inquiry in this area (see also Safran & Muran, 2006).
Conclusion

The TA is highly influential in assisting clients to gain treatment outcomes in general psychotherapeutic treatment contexts. A range of client dysfunctional personality traits, such as hostility, poor interpersonal relationships, and avoidance, are likely to impede the process of alliance formation and/or trigger therapeutic ruptures in the alliance. These presentations require therapists to be particularly attuned to clients’ experiences and respond productively to facilitate the therapeutic process. While intuitively it would seem that the TA is a concept that is both relevant to the delivery of offending behaviour programs and can be used to guide therapists’ treatment approaches, a number of fundamental differences between general psychotherapeutic treatment contexts and correctional environments may challenge this assumption. The next chapter therefore considers a range of relevant issues in the application of the TA to the delivery of offending behaviour programs and then reviews the available outcome research on the TA for different offender groups.
CHAPTER THREE – The Therapeutic Alliance and Outcome in Offending Behaviour Programs

Overview

The available research on the therapeutic alliance in relation to offending behaviour programs is critically examined. This research, although inconsistent, suggests that the therapeutic alliance is generally related to treatment gain but also with client motivation to change. It is concluded that despite the methodological limitations of existing research, the formation of a strong alliance may well be associated with better rehabilitation outcomes. Due to the high prevalence of personality disorder in correctional populations and the challenge that traits of personality dysfunction pose to the alliance, treatment issues relating to this population are also considered.

The Role of the Alliance in Offending Behaviour Programs

Although a number of recent papers in the literature have suggested that attending to the therapeutic alliance (TA) within forensic practice may be an important step in advancing therapeutic interventions in the field, very little research on this topic has been conducted. This may be due partly to the relative infancy of correctional treatment (as compared to more traditional psychotherapies), but also because correctional practitioners have under-estimated the importance of the TA to rehabilitation outcomes. It is important to note, however, that there are a number of important differences between the correctional environment and those in which mental health treatment is typically offered. First, in correctional programs the goals and tasks of intervention are generally not determined by the individual client but relate to improving community safety. Client well-being is considered important, but secondary, to this goal. Second, offenders are often aware of the enormous amount of social control that treatment providers have over their lives. This may be in the form of information that they provide to parole boards or prison authorities about their behaviour in programs (which is then used to inform parole conditions and classification decisions), or to community correctional case managers (who are responsible for implementing conditions of community-based dispositions, and
therefore breach proceedings). Correctional therapists have various obligations relating to the legal context in which they work (e.g., reporting to parole boards, advising correctional case managers/prison staff on the progress of clients). Correctional procedures require some level of communication to staff, at the very least, around whether clients attend their program sessions and the quality of that participation. There will also be some level of expectation that information relating to antisocial activities undertaken by clients who are serving correctional orders (e.g., drug-taking, violent behaviour) will be reported to correctional managers if this behaviour comes to light during treatment. This means there are some critical differences in the nature of client’ relationships compared to situations in which clients participate voluntarily, and this will invariably impact on the nature of the TA. It is unavoidable that clients will be at least wary, if not outright suspicious, about what therapists will divulge to correctional staff about them and their participation in group. Developing an effective alliance with clients mandated into treatment therefore requires reconciling these dual roles. In essence, a dual relationship of care and control characterises much of the work that is undertaken in the correctional environment (see Skeem, Eno Louden, Polascheck & Camp, 2007). Above all, the extent to which clients feel coerced to attend treatment and comply with prison or community corrections’ requirements is likely to have a profound influence on the development of the TA.

The differences that exist between psychological treatment in the correctional and the mental health context suggest that therapists will need to continue developing and testing theories of change that are specific to the context in which they work (Magaletta & Verdeyen, 2005). There is much to do in this respect – it is even difficult to identify appropriate terminology to describe the role of corrections-based rehabilitation providers. Terms such as ‘therapist’, ‘clinician’, ‘counsellor’, ‘forensic psychotherapist’, and ‘program facilitator’ are all used to describe rehabilitation providers, and yet each has different connotations around the nature of the relationship that is formed with the offender. For example, implicit in the use of the term ‘therapist’ or ‘clinician’ is the idea that the development of a therapeutic relationship is relevant to the process of change, whereas the term ‘program facilitator’ suggests that a greater emphasis should be placed on client skill acquisition, and the vehicle to this is within the group process itself. Program provider roles are also ascribed by the type of program being delivered, so ‘treatment’ or a ‘therapeutic program’ might be delivered by a therapist or clinician and a ‘psychoeducational program’ might be delivered by a program facilitator. Regardless of terminology, however, what is
important to the present discussion is the extent to which particular types of relationship influence the development of an alliance and are associated with improved outcomes in correctional contexts.

A further consideration is that correctional programs are almost always delivered in a group rather than individual format, so the relevance of the TA as a construct when multiple clients are interacting with one or, typically, two therapists, is an additional issue to consider. For the most part, existing theory and research on the TA has examined dyadic therapy, and there may be some fundamental differences in the way in which therapeutic relationships develop in group settings (Horvath & Symonds, 1991). For example, it is widely accepted that effective group work should aim to develop positive relationships between group members (Jennings & Sawyer, 2003) given that difficulties between two or more participants (or a group member and a therapist) can create an anti-therapeutic environment for all group members. Therapists within offending behaviour programs, therefore, need to be concerned with not only the progress of individuals within a group, but also with how the group is functioning together. Group cohesion is the term used to refer to the relationship between group members and their abilities to function as a whole within a treatment context rather than between the individual and a treatment provider. Serran, Fernandez, Marshall and Mann (2003) have argued that the level of group cohesion provides an indication of the level of the TA within offending behaviour programs. This makes sense as in group interventions clients will benefit from the input of the therapists as well as from other group members. Conversely, problems in the relationship with either therapists or other group members are also likely to impinge on the alliance. This highlights a level of complexity, however, in the concept of the TA within a group offender rehabilitation program that requires additional considerations to those in mental health dyads.

Factors relevant to the TA in the group treatment context are further outlined by Yalom (2005), whose text on group psychotherapy remains one of the most widely read. He suggests that group cohesiveness can be therapeutic for clients but is also a pre-condition for other therapeutic gains to occur. Although Yalom does not refer to the TA specifically, its relevance to the process of group treatment is implicit in his discussion of the role of the therapist within group treatment. For instance, he describes how the therapist’s posture towards clients should be underpinned by concern, acceptance, genuineness, and empathy,
suggesting the importance of a therapeutic bond with clients. He further suggests that this
stance is more important than any specific technical aspect of treatment. He posits that the
central tasks of therapists are to create and maintain the group, build an appropriate group
culture which encourages honest expression and an orientation to change, and to activate
and illuminate clients’ experiences of the here-and-now to encourage change. Responding
to clients’ in-session behaviours and linking these with out of session behaviours becomes
the central therapeutic task to foster self-awareness and encourage therapeutic change. This
process requires therapists to develop a collaborative and purposive relationship with clients
to engage in a process of sharing their experiences and trying new behaviours.

Despite the development of group technique by Yalom (2005) and others, it has
been suggested that the delivery of offender programs is most likely to adopt psycho-
educational methods in which offenders are ‘taught’, rather than learn from the group
experience (see Day, Kozar & Davey, 2013). In the area of sex offender treatment, Frost,
Ware and Boer (2009) have suggested that this is largely due to the lack of training,
knowledge and expertise about group technique. They suggest the need to balance
educational components of a group with process-oriented work that utilises the group work
concepts, such as those outlined by Yalom. It is the capacity and willingness of the therapist
to foster this process by developing a strong TA and responding to strains in the alliance that
is proposed as potentially critical to achieving positive therapeutic outcomes in offending
behaviour programs.

These suggestions mirror aspects of the Australian Offender Program and
Facilitation Standards (Corrective Services Administrators’ Council, 2013) which articulate
that program documentation should identify and justify the balance of psycho-educational
and group process program delivery strategies. The standards outline eight core areas of
practice in the program facilitator role. These include the use of self-reflection, facilitated
through processes such as debriefing and supervision, as well as maintaining personal
boundaries. A broad range of therapist characteristics and skills are described, such as
engaging and affirming clients, establishing and reinforcing group rules, fostering the
possibility of change, as well as demonstrating warmth, empathy, care and concern. Less
present, however, are those behaviours associated with utilising the therapeutic relationship
as a mechanism of change, particularly in the resolution of ruptures. Thus, although there
are suggestions to manage conflict and that tension should be ‘worked with effectively’,

there is no explicit reference to more process driven methods. This represents a potentially important omission which limits opportunities to develop greater client self-awareness through using the resolution of ruptures as a mechanism of change.

A myriad of issues relating to internal and external treatment readiness factors (being those factors likely to increase client engagement) typically present within the delivery of offending behaviour program will also impact on the development of the alliance and therapists’ capacity to respond productively to ruptures. The complexity of these interactions has been recently highlighted by Ross, Polascheck and Ward (2008), who revised Bordin’s (1994) theory to incorporate aspects of treatment readiness. They suggested that systemic issues can impinge significantly on the TA - the more difficult the client (e.g., complex needs, hostility) and the circumstances (e.g., workload, access to training and supervision), the more compromised therapists will be in their attempts to develop a TA. Therapist and client characteristics, including their personalities, attachment styles and interpersonal schemas, will also influence the interactions that occur within offending behaviour programs, and the quality of the alliance is most likely to be an outcome of complementary transactions rather than separate actions by either party (Constantino, Castonguay & Schut, 2002). Ross, Polascheck and Ward’s model suggests that therapists undertake a wide search when attending to ruptures to examine which aspects of the model (e.g., client, organisational or other contextual factors) may best serve to explain difficulties in relatedness between therapists and clients during treatment.

Just exactly how engagement in treatment is defined, however, is another issue that requires discussion when considering the development of the TA in offender rehabilitation. This is because development of the TA and responding to therapeutic ruptures requires clients actively participate in the process (Bordin, 1994). Holdsworth, Bowen, Brown and Howat (2014a) point to the variability of definitions used in previous research, finding that engagement is often defined more in relation to attendance and completion than active participation in the therapeutic process and the implementation of pro-social out of session behaviours. Holdsworth, Bowen, Brown and Howat (2014b) suggest that while a number of client problems are more likely to be associated with attendance, such as experiencing substance abuse problems, a criminal justice history, lower levels of social support and multiple crises, these do not equate to clients’ capacities to actively engage in treatment. Client factors associated with poor treatment participation included anxiety, avoidance,
hostility, and hopelessness, although research was limited in relation to the number of clinical settings examined. A more consistent finding was that a variety of therapist factors, such as acceptance, understanding, empathy and commitment to client outcomes were positively associated with treatment participation and the development of a therapeutic relationship. Although the available studies relating to these factors are limited, they do provide support for the suggestion that client personality factors exert a powerful influence on willingness to actively attend to program material and involvement in the process of treatment. This is particularly relevant to the delivery of offending behaviour programs due to high levels of antisocial and other dysfunctional personality traits demonstrated by clients in this context, so consideration should be given to how these traits impinge on the TA.

While it might be argued that some form of engagement is required to develop a TA, there are questions relating to how meaningful shifts in behaviour during treatment relate to subsequent re-offending. Consistent with the RNR model, therapists delivering offending behaviour programs target treatment relating to those dynamic risk factors most relevant for each client, such as criminal thinking styles, problems in anger management, negative peer associations and antisocial personality. Woessner and Schwedler (2014) recently explored the relationship between recidivism and pre- and post-measures of dynamic risk factors and the social climate of prisons. They found that pro-social changes in antisocial personality traits, criminal thinking styles, and anxiety/neuroticism were significantly related to better ratings of prison climate in 185 sexual and violent offenders. Change scores on pre- and post-measures were not, however, related to subsequent re-offending. They suggest that changes in skills and cognitions during treatment might, therefore, only marginally relate to long-term recidivism. They further suggest that measurements of not only offender deficits but also protective factors using a broader range of assessment tools might be required to more fully explore those factors that are most predictive of desistance from offending. A capacity to develop a strong TA as well as resolve ruptures within the alliance during treatment episodes may provide a meaningful measure of treatment change to facilitate this process. This particularly relates to the treatment of clients who demonstrate dysfunctional personality traits. These clients are most likely to have difficulty in responding to the demands of treatment, which may elicit responses such as hostility, affect dysregulation, and social withdrawal.
The Therapeutic Alliance and Outcome in Offending Behaviour Programs

Various studies have examined the relationship between the alliance and therapeutic outcomes in forensic populations, although few have examined samples comprised solely of correctional services clients and many have focussed on individual treatment. There is nonetheless a growing body of evidence supporting the contention that the TA plays an important role in offender treatment outcomes. A number of published papers have examined the value of the TA in the treatment of sexual and violent offending. Those that have included outcome measures are summarised in Table 1 (below). A range of studies examining the TA and substance misuse are also included in this table (review papers and commentary are not included in the table). Both empirical and more practice–oriented papers are discussed. When reviewing these papers it is important to note that many of the empirical studies have used the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) to measure the strength of the TA. The WAI is based on Bordin’s (1979) conceptualisation of the TA and comprises three subscales: goals; bond; and tasks. There are twelve items in each of the subscales, with each item rated on a seven-point scale. Given that the measure was not developed for use in a forensic context some degree of caution is appropriate in interpreting the results of those studies that have used this measure (rather than group cohesion measures). However, Tatman and Love (2010) have demonstrated the reliability of a modified short version of the WAI when used with community correctional offenders. This study also considered validity issues by comparing ‘identifiable’ with ‘anonymous’ responses, finding no differences in scores between these two conditions.

Table 1
Research studies on the relationship between the therapeutic alliance, program retention and treatment outcomes in offending behaviour programs.

<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample &amp; Intervention</th>
<th>TA &amp; Treatment Outcomes/Retention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug &amp; Alcohol Dependence Studies</td>
<td></td>
<td>Not CALPAS nor HAq-II predicted</td>
</tr>
<tr>
<td>Study</td>
<td>Participants</td>
<td>interventions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Barber, Luborsky, Gallop, Cristoph, Frank, Weiss, Thase, Connolly, Gladis, Foltz &amp; Siqueland (2001)</td>
<td>308 cocaine dependent clients received up to 52 sessions of SET, CT, or IDC plus group drug counselling</td>
<td>Early strong TA in CT predicted shorter Tx</td>
</tr>
<tr>
<td>Brocato &amp; Wagner (2008)</td>
<td>141 male offenders mandated to a residential program comprising weekly individual and group programs, mean days in treatment = 93.7 days (SD = 39.9)</td>
<td>WAI not associated with retention</td>
</tr>
<tr>
<td>Connors, Carroll, DiClemente, Longabaugh &amp; Donovan (1997)</td>
<td>698 alcohol dependent clients and 498 aftercare clients (following 7+ days of inpatient alcohol Tx) received 12-step, CBT or Motivational Tx for 12 weeks</td>
<td>WAI predicted retention &amp; subsequent alcohol abuse (up to 12 months) for outpatients</td>
</tr>
<tr>
<td>Gerstley, McLellan, Alterman, Woody, Luborsky, &amp; Prout (1989)</td>
<td>48 Antisocial PD clients on methadone maintenance as a subset of 110 clients receiving SET, CBT or IDC for 24 sessions</td>
<td>Therapist HAq predicted client employment</td>
</tr>
<tr>
<td>Joe, Simpson, Dansereau, &amp; Rowan-Szal (2001)</td>
<td>577 methadone-maintained clients receiving long-term outpatient drug counselling</td>
<td>Counselling rapport was significantly associated with subsequent drug use and criminality 12 or 18 months following treatment.</td>
</tr>
</tbody>
</table>

**Sexual Offending Studies**
Beech and Fordham (1997) 76 community-based sexual offenders attending 12 different programs from 36 – 450+ hours GES sub-scales for Cohesion, Leader Support, Independence & Order and Organisation were significantly higher for group members who reportedly made positive treatment gains on post-treatment measures

Beech & Hamilton-Giachristis (2005) 100 men convicted of sexual offences attending 12 different prison treatment programs from 74 - 186 hours GES sub-scale scores for Cohesion and Expressiveness correlated with reductions in pro-offending attitudes

Beyko & Wong (2005) 28 completers and 11 non-completers attending intensive in-patient treatment for high-risk sex offending No difference between WAI scores for completers and non-completers but general criminality/rule breaking & lack of motivation/insight did predict attrition

Harkins and Beech (2008) 73 men convicted of sexual offences attending 10 different prison-based treatment programs from 80 – 106 hours GES sub-scales medium to high but expressiveness was significantly lower for 5 mixed offender groups compared to 5 homogenous offender groups Child-only offender recidivism rates did not differ based on whether they attended a mixed (n=49) or child-abusers only (n=20) group
**Violent Offending Studies**

Beauford, McNiel & Binder (1997)  
322 hospitalised psychiatric inpatients in a locked unit  
Poor TA on a 6-point scale predicted violence in the 1st week. Poor TA was associated with increased hostility

70 partner violent men attended 14 x 2hr CBT groups  
Observer WAI predicted husband abuse at the end of Tx but not Tx retention

Polaschek & Ross (2010)  
50 high risk violent offenders undertaking a 36 week intensive CBT residential program  
Greater changes in WAI-S scores predicted greater increases in VRS scores  
Early ratings of WAI-S did not predict VRS scores

Ross (2008)  
70 high risk violent offenders undertaking a 36 week CBT residential program  
WAI correlated with client motivation, attitude & psychopathy  
WAI predicted change in VRS SOC & program completion but overall change and completion were better accounted for by motivation

Semiatin, Murphy & Elliot (2013)  
82 partner violent men undertaking a 16-session CBT group  
Pro-therapeutic behaviours in Tx were positively correlated with therapist WAI and homework compliance later in treatment  
Pro-therapeutic behaviours in Tx predicted less husband abuse at 6-month follow-up
In the drug and alcohol field, a number of studies have been conducted on the impact of the alliance on treatment outcomes, although there are some inconsistencies in the results of these studies. Meier, Barrowclough and Donmall (2005) in a comprehensive review of studies investigating the alliance and drug treatment outcomes, concluded that early alliance seems to be a good predictor of treatment retention, but a less consistent predictor of treatment outcome. There is more likely to be a significant relationship between outcome and alliance, however, where these factors are measured temporally closer together. A number of these studies are presented to demonstrate the nature of this research and to also highlight some of the literature that has included correctional clients.

Barber et al. (2001) reported that the alliance successfully predicted retention across treatment conditions in a sample of cocaine dependent clients participating in a number of different interventions. Generally, a stronger alliance was associated with higher retention, although surprisingly in the cognitive therapy condition higher alliance was associated with lower retention. Alliance was not correlated with self-reported drug use during the six months of treatment for any treatment condition. Connors, Carroll, DiClemente, Longabaugh and Donovan (1997), however, found a strong alliance in alcoholic community-
based clients was significantly associated with treatment participation as well as drinking behaviour during 12 weeks of treatment and at 12-month follow-up.

Gerstley, McLellan, Alterman, Woody, Luborsky and Prout (1989) reported specifically on treatment outcomes with Antisocial personality disorder (PD) clients with substance use problems. Clients were methadone-maintained and received 24 sessions of supportive expressive therapy, cognitive behavioural therapy, or individual drug counselling. Fifty-three of the original 110 participants received an Antisocial PD diagnosis. Therapists’ ratings on the Helping Alliance Questionnaire (HAq; Luborsky, McLellan, Woody, O’Brien & Auerbach, 1985) were significantly correlated with clients’ employment status at 7-month follow-up, and the clients’ ratings were associated with decreased drug use. They did note, however, that changes with these clients were not as pervasive or as large as the other clients in the original study. This study demonstrates some of the difficulties inherent in treating PD clients who have more complex presentations than other clients, although it emphasises that the TA may nevertheless be associated with measurable shifts in treatment outcome.

This research suggests that the TA is likely to be associated with treatment retention and decreased drug use in some samples, but little research has examined its relationship to criminal behaviour. An exception to this is a study by Joe, Simpson, Dansereau and Rowan-Szal (2001) which found that methadone-maintained clients receiving drug counselling and who had greater counselling rapport, demonstrated less drug use following treatment than those who did not, and also engaged in less criminality. Rapport, although not measured with a TA measure, was operationally defined as the ‘quality of the relationship and the extent of collaboration’, and so is conceptually close to the TA. So it may be that for some clients, a TA within treatment has a number of positive impacts outside of treatment, including involvement in antisocial behaviour.

A critical issue not explored in these studies, however, is the mechanisms at work within therapy that impinge on the development and maintenance of the TA. Issues relating to client motivation, and other aspects of treatment readiness, may provide some utility in exploring how the TA is formed and developed. In their review, Meier, Barrowclough and Donmall (2005) found a moderate but robust relationship between motivation and treatment readiness and the TA. Brocato and Wagner (2008) have also found that alliance
scores (as measured by WAI) for clients participating in an alternative-to-prison residential drug treatment program, where the average stay was about 3 months, were not associated with retention but were associated with motivation to change and treatment readiness. Clients who scored higher on the Bond scale of the WAI, which explores the quality of the relationship within therapy, were also more likely to increase their motivation to change during treatment. This suggests that the alliance both affects and is affected by clients’ attitudes to being in therapy, and their willingness and capacity to positively change.

This review of the literature on the TA and the treatment of drug and alcohol abuse suggests a complex picture in which substance abuse and treatment retention is variably associated with the strength of the alliance, but more often related to treatment motivation. Factors including the length of treatment, how and when the alliance was measured, and the type of treatment offered may significantly impinge on empirical outcomes.

**Sex Offenders**

Based on both clinical experience and a review of the literature, Kear-Colwell and Boer (2000) suggested that sex offenders often have characteristics resembling PD clients and other difficult clients. These groups are typically resistant to change largely due to a history of early childhood traumatic events. They argue that forming a TA with clients is an important process for effective treatment as it assists in the development of healthy attachments and provides a means of moving towards change. In this respect, a TA would seem to be a prerequisite to engaging clients in treatment for their offending behaviour.

Marshall and colleagues (e.g., Marshall & Burton, 2010; Serran & Marshall, 2010) have argued strongly that the TA along with other process factors should be seen as critically important in the delivery of offending behaviour programs. Serran, Fernandez, Marshall and Mann (2003) pointed to the neglect in the literature on issues regarding the development of the TA with sex offenders. Based on their review of the literature on the impact of therapists on therapeutic outcomes, they suggested a number of principles for conducting treatment for this group. Creating a TA and ensuring there is group cohesion is one of the central processes posited. They emphasise that unqualified support is not helpful, but being confrontational is potentially damaging. Their conclusion is that it is important for therapists to be directive, but they must also be supportive. So a similar conclusion is drawn to that of Kear-Colwell and Boer (2000) which is that only following the development of an emotional
bond with a client can work on actual offending behaviour commence. This is perhaps unsurprising given the shame and embarrassment that is often experienced by sexual offenders in the early stages of treatment. More recently, Marshall and colleagues (Marshall & Burton, 2010; Serran & Marshall, 2010) have considered not only the impact of therapist characteristics, but group process issues more generally, regarding these as more critical than any single treatment technique.

There is very little empirical research, however, that has investigated the TA in sex offender treatment programs. In one of the few studies, Beyko and Wong (2005) used discriminant functional analysis to determine predictors of program attrition in sexual offenders participating in intensive in-patient treatment. One of the measures used in this study was the WAI, and no differences were found between completers and non-completers on WAI scores. Beyko and Wong point out that the low number of participants (28 completers and 11 non-completers) might account for this result, however, two other clusters of factors did predict treatment attrition: general criminality/rule breaking behaviour; and a lack of motivation/insight. This highlights the need for therapist responses aimed at developing a TA to be individualised based on specific client treatment experience. The authors suggest that strategies such as behavioural contracting might work for rule breakers, whereas for those who were unmotivated or lacked insight, strategies to enhance the TA or to increase engagement, such as motivational interviewing, might be more useful.

Although no other studies were identified that explicitly measured the TA in sex offender programs, a number of studies have examined the impact of group climate on therapeutic change. Beech and Fordham (1997), Beech and Hamilton-Giachritsis (2005), and Harkins and Beech (2008) for example, have all reported on research using the Group Environment Scale (GES, Moos, 1986) to determine the relationship between group climate and pre- and post-program measures or recidivism. The GES is a ten-scale measure that determines relationships within the group, the personal growth of members, and system maintenance and change. A number of the scales used closely resemble aspects that might be considered important to the development and maintenance of a strong TA. These include group leaders showing help and friendship (Leader Support Scale) and encouraging change (Innovation Scale), as well as leaders encouraging group members to express feelings and take action (Expressiveness and Independence Scales).
Beech and Fordham (1997) administered the GES to group leaders and members of twelve community-based sex offender treatment programs. Programs varied considerably from shorter term programs to longer ‘ongoing’ programs in which clients attended for the duration of their probation period. Significant differences were found between both group leaders and members. Results suggested that group leaders perceived that they had more control, were more supportive and innovative, and able to handle anger and aggression in groups compared to members’ group experiences. Significant differences were also found across treatment programs, and this was largely attributed to anger and aggression being better managed in longer-term groups whereas task orientation (emphasis on practical tasks and decisions), and order and organisation (structure and explicitness of rules) were perceived as better in shorter-term groups. Determinants of treatment effectiveness were derived from pre- and post-treatment measures relating to important treatment factors, such as cognitive distortions and fixation on children, denial, and social inadequacy, the details of which were outlined in previous research by these authors. Twenty-eight of the fifty-two clients attending these programs were assessed as achieving both scores that fell within non-offender limits as well as demonstrating significant differences between their pre- and post-treatment scores. The group that had more clients who had scored better on these measures also had group members that scored the GES as significantly higher on group cohesion, leader support, independence (encouraging independent action and expression) and order and organisation. These results suggest that groups are more therapeutic when their group members perceive that clients can be open and work well together and group leaders are supportive but enforce clear boundaries of behaviour.

Beech and Hamilton-Giachritsis (2005) used a sub-set of these data to examine group leaders and members of twelve sex offender cognitive behavioural treatment programs delivered in prisons, half of which received approximately 80-hours of program and the other half a one-hundred and sixty-hour program. They again found significant differences in scores between leaders and group members, but this time differences were across independence, leader control, and order and organisation. GES scores also significantly varied across different groups suggesting that group climate varies substantially in sex offender treatment. There were particular differences in how groups experienced the quality of their leadership and other group relationships. Treatment outcome, as measured by a number of measures (including the Victim Empathy Distortions Scale, Beckett & Fisher, 1994 as cited in Beech & Hamilton-Giachritsis, 2005; and scales from the Children and Sex
Questionnaire, Beckett 1987, as cited in Beech & Hamilton-Giachritsis, 2005), were positively correlated with group cohesiveness and expressiveness sub-scale scores. These results suggest that leader support (rather than control) has an important influence on group process. Such findings offer limited support for the proposition that therapists should focus on the development of a TA in sex offender treatment programs, not only attending to the group interaction but also helping clients to articulate their experiences within the group.

Harkins and Beech (2008) also reported on GES scores from this data-set for group members of ten prison-based groups receiving between eighty and 106-hours of sex offender cognitive behavioural treatment. Five groups of child-abuse and adult-abuse offenders were matched on treatment length to two groups of adult-abuse only offenders and three groups of child-abuse only offenders. GES scores for these groups ranged between medium and high, suggesting positive group climates, although mixed groups scored significantly lower on expressiveness relative to homogenous groups. It may be, therefore, that clients in groups comprised of the same offence-type feel freer to express themselves. Recidivism data available on the child-abuse offenders suggested, however, there was no difference in re-offence rates based on whether clients attended a mixed versus a homogenous group. These data suggest that regardless of group composition based on offence-type, positive treatment environments can be facilitated, although in mixed groups attention should be paid towards ensuring group members feel comfortable to share information. Group composition may also not impact significantly on recidivism, although Harkins and Beech note the small offender numbers in their analysis (20 in the child-abuse only groups and 49 in the mixed group) preclude generalisations based on their data.

Harkins, Beech and Thornton (2012) explored the relationship between group climate, as measured by the GES, and psychopathy. Although no outcome data were reported, this research is presented to demonstrate some of the complexities evident in the development of group climate for this offender group. They administered the GES to 137 sexual offenders who were detained indefinitely and attended cognitive behavioural programs based on either high or low scores on the Psychopathy Checklist-Revised (Hare, 2003). Length of treatment is based on clients being able to demonstrate consistent self-management skills. GES scores did not differ based on level of risk of re-offending, assessed by the Risk Matrix 2000 (Thornton et al, 2003), comparing very high with all other risk categories. GES scores did differ, however, based on treatment condition with psychopathic
offenders scoring lower on cohesion, leader support, task orientation, self-discovery (although the effect size for this sub-scale was low), order and organisation, and leader control. The psychopathic group scored higher on anger and aggression. Despite these differences, GES sub-scales demonstrated positive treatment climates for both groups, with medium to high ratings for each scale in both treatment conditions except for cohesion, which was low for the psychopathy group. Scores on this sub-scale did increase, however, when comparing clients who were in an early phase of treatment compared to those in later phases of treatment. The authors suggest that this research provides interesting preliminary results that positive treatment climates can be achieved with psychopathic offenders, particularly those who progress to later phases of treatment.

The research summarised above in relation to the TA and sex offender treatment suggests the TA may be associated with a number of significant treatment factors, particularly an ability to express oneself, leader support (rather than control) balanced with the enforcement of boundaries, cohesion, and motivation to participate in the treatment process, although it may not be associated with recidivism. This research, however, is in its infancy and has more often involved the assessment of group climate rather than the TA.

**Violent Offenders**

Similar comments in the literature regarding the treatment of sex offenders have also been made with respect to violent offender treatment. For example, Day, Casey, Ward, Howells and Vess (2010) concluded that characteristics of violent men make them particularly difficult to engage in a rehabilitative process (e.g., high levels of hostility, being legally required to attend treatment), and this can result in high levels of attrition from programs. They suggest that assessing and responding to clients' readiness for treatment is likely critical and that the therapist's ability to engage clients in the therapeutic relationship is likely to provide the foundation for effective practice. In an earlier study validating a measure of treatment readiness, Day, Howells, Casey, Ward, Chambers and Birgden (2009) did show that treatment readiness scores were associated with scores on a measure of program engagement that they had developed in this study (the Treatment Engagement Scale).

There is a lack of published empirical research that has considered violent offender treatment outcomes and the TA. This is somewhat extraordinary given the interpersonal
nature of many violent offences. Most of the existing research has been conducted in treatment programs for spousal abusers. Brown and O’Leary (2000), for example, conducted research on 70 partner violent men who undertook 14 sessions of cognitive behavioural treatment. They found that ratings on the WAI early in treatment were positively associated with treatment outcome. Higher scores on the observer form of the WAI at session one were associated with reduced psychological and physical aggression (as measured by the partners’ ratings on the Modified Conflict Tactics Scale; Pan, Neidig & O’Leary, 1994) for the 14 weeks preceding treatment and then again at the end of treatment. WAI scores were not, however, correlated with treatment completion.

Taft, Murphy, King, Musser and DeDeyn (2003) in their study of 107 partner violent men in a 16 session CBT program also found that the alliance was associated with positive treatment outcomes (but not group attrition). In this study, client and therapist versions of the WAI were administered along with the GES. Collateral partner reports of abuse were determined through administration of the Conflict Tactics Scale (Straus, 1979) and the Multidimensional Measure of Emotional Abuse (Murphy & Hoover, 1999) completed for 6 months pre-treatment and 6 months post-treatment. Group cohesion and alliance scores were significantly correlated with one another, but the formation of an alliance in the early sessions was not associated with attendance. Early clinician WAI ratings did, however, predict both homework compliance and scores on measures of psychological abuse. This perhaps suggests that when therapists’ perceive that a client is working collaboratively on tasks and goals and forging a positive relationship in therapy, he is also engaging in less abusive behaviour outside of treatment.

Using data collected from the same sample, Taft, Murphy, Musser and Remington (2004) found that motivational readiness, as measured by the Safe-at-Home Instrument (Begun et al., 2003) which determines a client’s stage of change, was consistently associated with WAI ratings. Interpersonal problems, psychopathic tendencies, and borderline traits also predicted WAI ratings (although fewer associations were identified with Borderline traits), with motivational readiness mediating the association between psychopathic characteristics and the alliance. This suggests that traits such as hostility, grandiosity, and antisocial features may impinge negatively on the alliance, especially when clients are not oriented towards effecting positive change.
Semiatin, Murphy and Elliot (2013) examined in-session pro-therapeutic behaviour, WAI scores, and homework compliance in 82 clients who attended a sixteen-session cognitive-behavioural program for spousal abusers. Pro-therapeutic behaviour demonstrated during sessions was coded on a five-point scale on three dimensions: acknowledgement versus denial of responsibility for behaviour; interactions with other clients (such as challenging denial, avoidance or minimisation of their behaviour versus attempts at changing clients’ responsibility for their behaviour); positive versus negative attitudes towards treatment, the group, and counselling in general. The Safe at Home Instrument for Assessing Readiness to Change Intimate Partner Violence (Begun et al., 2003) was also administered. Subsequent violence towards partners was assessed through administration of the Physical Assault and Psychological Aggression sub-scales of the Conflict Tactics Scales (Straus, 1979) to partners pre-treatment, post-treatment and at six months follow-up. The three observer-coded dimensions of treatment behaviour were highly correlated so combined in further analysis. These scores were highly correlated with therapist WAI scores and homework compliance later in treatment, but not client-rated WAI. Psychological Aggression and Physical Assault scores for clients rated at the end of treatment were not related to pro-therapeutic behaviours, but were significantly correlated, with small to medium-sized effects, when assessed at the six-month follow-up. The authors suggest that the results support the use of motivational interviewing techniques by therapists to encourage clients who articulate pro-therapeutic behaviours to foster a positive group environment.

In the only identified piece of research involving violent offenders and the TA in a correctional environment, Ross (2008) administered a number of measures to 70 high-risk violent offenders undertaking a 36-week treatment program. The WAI, the Violence Risk Scale (VRS, Wong & Gordon, 2000, cited in Ross, 2008), and the State Trait Anger Scale (STAXI-2, Spielberger, 1999), as well as measures of client criminal and violent attitudes and attachment were administered both pre- and post-treatment. Ross reported that although the WAI was correlated with client motivation, psychopathy, and client attitudes, client motivation was the only significant predictor of treatment outcome. Shifts in the VRS stage of change following treatment were related to the alliance, but changes in aggression or criminal attitude were not. The WAI predicted treatment completion, but motivation was a better predictor. Further analysis suggested that the TA mediates the relationship between
motivation to change and shifts in behaviour and treatment completion. In other words, the alliance may be more facilitative rather than directly related to change.

Polaschek and Ross (2010) subsequently analysed data for 50 men who attended this program in seven treatment cohorts. They found that observer ratings on the short form of the WAI (WAI-S) predicted time in treatment but therapists’ ratings did not (although therapist ratings of pre-program stage of change did). Participants who demonstrated the most change also had the biggest increases in observer ratings of the WAI-S. Initial ratings of the TA, psychopathy, stage of change, and other risk variables did not predict the amount of change made. This perhaps suggests that the perspective from which TA ratings are made and when ratings are made are likely to influence predictions of treatment gains.

The outcomes of the Ross (2008) study are at odds with those reported (see above) in studies of spousal abusers. It is not immediately obvious why this should be the case, however, in the Ross study treatment was longer and conducted in a residential setting. It may be that alliances develop differently in these circumstances. Another possibility is that the findings are a function of the different outcome measures used and the timeframes in which they were employed. There does appear to be relatively consistent evidence, however, that psychopathic traits or hostile and antisocial traits are relevant to how the alliance develops.

In a very different type of study, Beauford, McNeil and Binder (1997) investigated the association between the incidence of violent events in a locked psychiatric in-patient unit and the strength of the TA formed between the admitting doctor and the patient. Of the 328 client records included in this study, 38 incidents of physical attacks, 68 of ‘fear-inducing behaviour’, and 222 of no aggression were recorded. A significant relationship was found between poor alliance (operationalized as scores of 4 – 6 on a 6-point scale) and the two types of violent or aggressive behaviour. Even after controlling for other factors, the TA remained a compelling predictor of violent behaviour. Recent history of violence was correlated most strongly with the TA and also with subsequent violence. Correlations were also significant for a number of other variables, including various scales of the Brief Psychiatric Rating Scale (Overall & Hollister, 1962) such as hostile-suspiciousness, thinking disturbance, and the anxious-depression factor. Hence there may be a significant inter-play between psychological disturbance and ability to form an alliance. This study, therefore,
provides additional evidence that ability to form an alliance is associated with subsequent behaviour, and specifically that patients' attitude towards their hospitalisation and the admitting doctor is a good indicator of how they go on to behave on the ward.

The above review of research on the TA and violent offender treatment suggests the TA may have a direct influence on treatment outcomes, although results are inconsistent perhaps due to when and by who the alliance is measured. Personality factors, such as hostility and psychopathy, may also be important features that impact on the TA. Treatment motivation again appears to be a mediating factor between the alliance and treatment outcomes but research is scant.

Conclusion

The research reviewed on the role that the TA plays in offending behaviour programs is equivocal. While many studies have demonstrated a link between measures on the TA and attrition and/or subsequent scores on post-treatment measures, others have not. Most studies have also not examined subsequent re-offending. Several studies, particularly involving longer-term treatment, have demonstrated an indirect link between the alliance and outcome that is influenced by motivation or treatment readiness and this is particularly the case for longer-term residential treatment settings. The reviewed research, however, demonstrates a range of research design issues, particularly concerning low sample sizes and diverse measures of the TA and outcome that largely rely on self-report rather than more objective methods of measurement. A vast range of factors may be influencing outcomes, such as how, when and by who the TA is being measured. There is also a paucity of offender characteristics considered within the existing research on the TA and offender treatment, particularly relating to characteristics of personality dysfunction. The correlational nature of most of the studies, rather than the use of randomised control studies, also calls into question the veracity of conclusions that can be made (NHMRC, 2011). Outcome measures may also bear little significance to subsequent behaviour outside of treatment, including further offending (Woessner & Schwedler, 2014). A significant question remains in relation to the relevance of the TA and the delivery of offending behaviour programs given the differences between the general psychotherapeutic contexts and
correctional treatment, and these phenomena cannot be adequately investigated through the administration of pre- and post-treatment measures.

Despite the equivocal findings of this review on the relationship between outcome and alliance with different offender groups, there does seem to be some consensus from a practice perspective that at the very least the development of a strong TA will prevent attrition from programs. While the alliance may not have a direct causal influence on the outcome of group treatment for many offenders, it may at least act to moderate treatment outcomes. The development of a bond and engaging in purposive collaborative work with a client is not only likely to represent good practice in offender rehabilitation but also affords clients the respect and dignity that should be demonstrated in any therapeutic context. Nonetheless, it is clear that achieving a strong and functional alliance with some offenders is likely to prove challenging, particularly with those that demonstrate dysfunctional personality traits, and it may be that the ability to work through the problems that arise over the course of treatment lies at the heart of effective rehabilitative practice.

The high prevalence of PD in correctional environments creates specific challenges to the process of developing a therapeutic relationship but this is an area that has lacked empirical attention in the available literature on the TA in offending behaviour programs. A better understanding of the alliance in clients with a PD as well as treatment approaches adopted for this group in the general psychotherapeutic literature may better inform correctional providers in their delivery of treatment. These issues are considered in the next chapter.
CHAPTER FOUR – Personality Disorder and the Therapeutic Alliance

Overview

*This chapter provides an overview of a number of different psychotherapeutic approaches developed to treat personality disorder, including specialist offending behaviour programs. It is suggested that the alliance may be a necessary condition for the successful treatment of clients who demonstrate severe personality dysfunction, but that particular personality traits, client attitudes to treatment, and less collaborative treatment approaches present significant threats to the alliance. An important next step then is to examine the relevance of the therapeutic alliance to treatment provided in the correctional context, given that treatment is often mandated, and delivered though program manuals to many clients who demonstrate personality dysfunction.*

At least some correctional clients with a personality disorder (PD), particularly those who meet the criteria for psychopathy, are at high risk of re-offending in the community (Hart, Kropp, & Hare, 1988) and hence are in most need of treatment but also more likely to drop out prematurely (Olver, Stockdale, & Wormith, 2011). PD can thus be considered a key responsivity factor in the delivery of offending behaviour programs, as therapist failure to consider personality dysfunction in their treatment delivery is likely to result in clients not engaging with program content and possibly dropping out of treatment.

Howells and Day (2007) have suggested that low engagement may be a common factor for clients in both offending behaviour programs as well as those with PD. A defining characteristic across all PDs is significant difficulties in interpersonal relationships (Livesley, 2001), drawing attention to the problems that arise in forming a therapeutic relationship. The interaction between therapists placing these demands on clients with a range of dysfunctional personality traits may inhibit engagement across cognitive (e.g., rigid schemas, problems identifying and accessing internal experiences), affective (e.g., affect dysregulation, alexithymia), and behavioural (e.g., impulsivity, dysfunctional coping) domains of functioning. Particular schemas within the PD population, for example, 'I'm special' or 'I'll change on my terms', create particular challenges for therapists attempting to
effect change. Addressing readiness for treatment, therefore, may require addressing issues specifically associated with clients' PD (e.g., shifting negative beliefs about treatment or behaviours such as impulsivity). Therapist attitudes to this group (e.g., 'Are these clients treatable?') may also be a critical issue. If therapists are apathetic, punitive, wish to befriend their clients, or assume a role as 'treating expert', the development of the TA is threatened. It may be that genuine confrontation that occurs in a respectful manner is required within the therapeutic relationship to create meaningful change.

Langton (2007) has suggested that attending to the therapeutic relationship should be a central focus of the treatment of clients in correctional environments, many of whom will display significant traits of PD. In addition, approaches that are successful in treating PD in mental health settings may better inform correctional providers of the types of therapist skills and strategies required to optimise rehabilitation outcomes. This chapter aims to consider some of these issues. It begins, however, with a discussion of the nature of PD to highlight the varying approaches that have been taken to conceptualising and measuring personality dysfunction.

Categorical and Dimensional Models of Personality Disorder

Livesley (2001) has identified a range of conceptual and taxonomical problems in attempts to adequately define PD, whilst noting that chronic difficulties with interpersonal relationships and problems with self or identity form the central features of all PDs. The way in which these factors have been conceptualised, however, differs markedly. The Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association, 2013), for instance, utilises a categorical system that outlines clusters of traits that impinge on normal functioning. For Livesley, this approach provides only vague criteria that define PD resulting in low diagnostic reliability and an under-emphasis on normal personality functioning. He concludes that the lack of empirical support for the various diagnoses and an inability to sufficiently capture all forms of PD within the diagnostic criteria presents substantial problems for the DSM¹ (and the International Classification of Diseases; World

¹ The publication of the DSM-V (American Psychiatric Association, 2013) represents an initial shift from this categorical approach, at least in principle. Although the PD criteria have been retained from the previous edition of the DSM, the appendix outlines a dimensional approach and suggests this is likely to emerge in future editions due to the vast empirical support for assessing personality in this way.
Health Organisation, 2010). This has resulted in substantial use of the diagnosis ‘Personality Disorder Not Otherwise Specified’ as a ‘waste basket’ to accommodate a plethora of clinical anomalies not otherwise accommodated. He suggests that many of the problems arise as a result of imposing diagnoses on what are continuously distributed behaviours.

Livesley (2001) reviews three alternative conceptualisations to the DSM based on normal personality. First, the interpersonal circumplex organises behaviour on two orthogonal dimensions of dominance-submission and hostility-friendly (Kiesler, 1982). A wide number of labels of interpersonal behaviour are then identified in relation to these dimensions, denoting various personality features. However, Livesley suggests that this approach does not capture a range of important personality pathology, including Borderline and Compulsive PDs.

The second model reviewed is the three-factor model of personality proposed by Eysenck (1987) which comprises extraversion, neuroticism and psychoticism. Similarly to the interpersonal circumplex model, Eysenck’s three factors struggle to accommodate a range of personality pathologies commonly encountered in clinical situations. These particularly include Schizoid, Paranoid, and Avoidant PDs.

The third model to explain personality disorder in terms of normal personality is the five factor model (Costa & McCrae, 1992). The five factors, neuroticism, extraversion, openness to experience, agreeableness and conscientiousness, are made up of six facets each. For example, neuroticism comprises the six facets Angry Hostility; Vulnerability; Impulsivity; Self-Consciousness; Depressiveness; Anxiousness. The extent to which an individual’s personality features demonstrate neurotic traits can then be described as demonstrating high, neutral, or low features of these six personality facets. Although Livesley (2001) points to problems in relation to the reliability of the openness factor, he states that it is possible to adequately translate DSM diagnoses on to these five factors. The five factor model therefore provides a capacity to describe both normal and a broad range of abnormal personality features.

The Treatment of Personality Disorder

Over the past thirty years a number of different treatments have been developed to
assist symptom relief and resolve pathology for a variety of PDs, most notably Borderline PD. These are briefly described below to illustrate their similarities as well as their actual or potential application in the forensic setting. Notably, each of these approaches identify the importance of therapeutic engagement.

Mentalisation-based treatment was originally developed to treat Borderline PD, although more recently it has been applied to comorbid Borderline PD and Antisocial PD (Bateman & Fonagy, 2008). It is based on the idea that the ability to mentalise (i.e., develop an appreciation of what others might be experiencing based on their behaviour) is disrupted in PD clients due to poor attachment experiences. As a result, psychological defences develop leading to an inability to interpret the intentions of others. Treatment focuses on developing greater flexibility in clients’ capacities to mentalise, particularly through their interactions in group and individual sessions. The aim is to assist clients develop the capacity to understand the motives of self and others by actively exploring clinically relevant events (e.g., self-harm, violence), communicating transparently in relation to what happens in sessions, and reducing avoidance. Therapists maintain a stance that balances inquiry with support and validation whilst exploring clients’ issues.

Cognitive analytic therapy also places considerable emphasis on the interpersonal interaction between therapist and client, and integrates aspects of psychodynamic, cognitive, and object relations therapies. Ryle (2001) describes the central task of therapy as identifying patterns of behaviour developed during childhood based on interactions with caregivers (referred to as reciprocal role procedures). For example, abusive parenting might lead to clients experiencing rejection and abuse in adulthood, as well as abusing others. Once these patterns are identified, therapists seek to increase client awareness of ways to enact more functional behaviours. Therapists utilise active empathic listening to initiate an early, collaborative descriptive reformulation of clients’ problems and after four or six sessions, present a letter outlining their understanding of recurrent patterns of problem behaviour being targeted for change. These are reviewed as treatment progresses. Ryle suggests that the development of a therapeutic relationship is central to treatment success, with cognitive analytic therapy used in a range of settings, including forensic.

Muran, Eubanks-Carter and Safran (2010) discuss the development of brief relational therapy, a short-term psychotherapy treatment for clients with a PD. This
treatment is largely based on relational psychoanalysis, but also draws on cognitive and humanistic-experiential methods. Treatment occurs in a dyad and involves collaborative exploration of the therapeutic relationship, particularly experiences of therapeutic ruptures and rupture-repair. Coutinho, Ribeiro, and Safran (2009) outline a number of basic assumptions within this therapeutic perspective, including the paradox a client often experiences in attempting to balance the need to relate to others with the need to be autonomous. They suggest that clients enact efforts to resolve this dilemma in treatment and it is the therapist’s task to identify and develop a client’s self-awareness of their efforts to deny their own experience (withdrawal ruptures) or control and dominate others (confrontation ruptures). Muran et al. argue that therapy increases awareness of ‘self and other’ by developing the capacity for mindfulness and providing new relational experiences. Therapists draw on their own experiences of the therapeutic relationship to assist clients understand core relationship themes (such as denial of their own experiences, subjugation of their own needs, or the need for agency), while maintaining a validating and empathic stance.

This therapeutic approach closely mirrors that of supportive-expressive psychodynamic psychotherapy developed by Luborsky (1984), who based this treatment on the writings of Freud. He suggests that clients’ symptoms are the result of unresolved conflicts or impairments in ego-functioning. The identification of client’s ‘core conflictual relationship theme,’ perpetuated by a client’s desire (e.g., to be close to others) resulting in responses from others (e.g., rejection) that elicit client dysfunction (e.g., social withdrawal), is central to treatment. Diener and Pierson (2013) have more recently identified three categories of technique fundamental to this treatment that facilitates the change process: the identification and expression of emotion in treatment; the exploration of current and past interpersonal patterns of behaviour; and examination of the processes that occur within the therapeutic relationship.

While not originally developed for the treatment of PD, cognitive behavioural therapy has been offered to clients with PD. For example, Wenzel, Chapman, Newman, Beck and Brown (2006) have described the central aspects of this treatment for Borderline PD. Consistent with the standard application of cognitive behavioural treatment, client’s dysfunctional beliefs are assumed to have originated as a consequence of negative childhood experiences. In adulthood these become inflexible and influence information
processing in ways that both confirm the dysfunctional beliefs while discounting information that disconfirms them. A core task for therapists is to identify these dysfunctional beliefs based on observation of client automatic thoughts in treatment and an exploration of relevant childhood events. Therapists spend time educating clients about the cognitive model, clarifying treatment expectations, and developing a collaborative approach to treatment by working on treatment agendas. They also identify relevant treatment and homework tasks, and regularly seek client feedback on their experiences of treatment. Therapists then seek to modify clients’ beliefs through a range of techniques (e.g., cognitive restructuring), assist them to develop skills in managing emotional distress and improving problem-solving, and building hopefulness while validating their emotional experiences.

Cognitive behavioural therapy is the predominant treatment perspective advocated for use in correctional treatment (Andrews & Bonta, 2010), although PD is more often viewed as a treatment responsivity issue rather than the focus of offending behaviour programs.

More recently, a range of cognitive-based therapies that elaborate on cognitive behavioural therapy have been introduced into a range of forensic contexts. Schema-focused therapy is one that has attracted considerable interest. Bernstein, Arntz and de Vos (2012) describe how this treatment was originally developed to treat Borderline PD, but more recently has been applied to forensic populations. It combines cognitive, behavioural, psychodynamic object relations, and existential/humanistic approaches and aims to illuminate early maladaptive schemas, which are patterns of dysfunctional thinking that have developed from adverse childhood experiences. Examples of maladaptive schemas are fear of abandonment, experiences of social isolation, and the belief that others should be punished for their mistakes. Treatment utilises a range of strategies to assist clients moderate or eliminate the maladaptive schema ‘modes’ they experience. These include a ‘child mode’ in which overwhelming emotions are experienced, such as anxiety and anger and a sense that they are being treated unfairly, a ‘detached protector mode’ to escape from painful feelings, or a ‘bully and attack mode’ in which they use threats and aggression to get what they want. Therapists use a range of techniques to assist clients modify maladaptive thoughts, experiential techniques to assist clients express and process emotional experiences, and the use of the therapeutic relationship to provide corrective emotional experiences. Central treatment concepts to this are ‘limited re-parenting’ which aims to provide guidance and support to address unmet development needs, and ‘empathic confrontation’ by first establishing and then challenging maladaptive behaviour using an
empathic and non-confronting stance. Schema focussed therapies can be relatively easily adapted for use in forensic settings, and although originally designed for therapeutic dyads other forms of therapy, including group treatment, are being developed for use with these populations. Beech, Bartels and Dixon (2012), for example, describe a program for sex offenders in the United Kingdom that utilises schema-focussed therapy, suggesting that this approach may be more useful than a standard cognitive behavioural approach. They caution, however, that current research is limited and based on psychometric assessments of schemas which are likely to be inadequate in identifying the schemas relevant to sexual offending. They also suggest a range of other factors are likely to intervene with maladaptive schemas, including treatment process variables (e.g., therapeutic style, therapeutic climate), client motivation, and external elements (e.g., social and cultural environment).

*Dialectical behaviour therapy* (DBT) is a treatment approach originally developed for Borderline PD based on cognitive behavioural therapy integrated with mindfulness practice. Treatment assists clients better understand and respond to problems resulting from affective dysregulation perpetuated by invalidating environments experienced in childhood (Linehan, 1993). It seeks to simultaneously encourage acceptance of clients’ experience while promoting change. Linehan’s original treatment model includes individual treatment, group skills training, and individual crisis telephone support. Therapists use a range of strategies to actively engage the client, particularly validation of experiences, motivational strategies, and focussing on ‘therapy interfering behaviours’. Mindfulness, which requires attending to experience, is taught as a core skill along with emotional regulation, distress tolerance, and interpersonal effectiveness.

Berzins and Trestman (2004) reviewed the application of DBT in six forensic/correctional sites and found a diversity of programs available including for violent and Borderline PD male forensic inpatients, male sex offender outpatients, and both adult and juvenile female offenders. A number of modifications have occurred to the original DBT format to accommodate forensic clients. This includes McCann, Ball and Ivanoff’s (2000) description of treatment for violent offenders with Antisocial PD which focuses on increasing emotional attachment and mindfulness in relation to empathy and consequences to others. Sakdalan and Gupta (2012) also described re-conceptualising the three states of mind postulated by Linehan (reasonable mind, emotional mind and wise mind) to include a fourth, risky mind. This describes the dysregulated state of mind leading up to the time of offending.
and provides clients with the means to explore their criminal acts within a dialectical framework. Sakdalan, Shaw and Collier (2010) also described DBT with sexual offenders who have an intellectual disability.

An important treatment approach frequently applied in the treatment of PD (Bateman & Tyrer, 2012) as well as a range of forensic applications (Shuker, 2010) is that of the democratic therapeutic community. Therapeutic communities offer residential services to clients in which equal attention is paid to participation in psychotherapy and the range of additional activities clients participate in (sociotherapy) so that they complement each other (Norton & Bloom, 2004). Norton and Bloom described how therapeutic communities attempt to ‘flatten’ staff structures while simultaneously increasing client participation in, and responsibility for, their community. This is achieved by participation in collaborative processes to enhance communication between staff and clients, such as involvement in group meetings. The therapeutic mechanism of change posited to occur within therapeutic communities mirrors the development of a strong TA and resolution of ruptures, whereby clients internalise feedback from their community that both validates their strengths as well as challenges their negative behaviour thereby creating new experiences of relatedness.

While numerous prisons have employed the philosophy underpinning therapeutic communities, Shuker has suggested that there is further work required to ensure clarity on the risk factors they can treat and types of offender populations that are best suited to this approach. This is particularly so given the paucity of empirical evidence available in relation to their efficacy.

This overview of PD treatment reveals that all of the identified approaches place significant emphasis on the development of the therapeutic relationship and the use of interactions between therapists and clients as central to the mechanism for change. Most treatments draw on psychodynamic perspectives to inform this process, and most integrate additional theoretical constructs, including cognitive behavioural perspectives, to focus on understanding the function of clients’ dysfunctional behaviour and embed skill development within treatment. It is worth noting that these treatments are either relatively new or represent small but significant shifts to existing approaches. While many PDs were previously viewed as ‘untreatable’, these treatments appear to offer some promise and can be considered in the context of the development of forensic treatments for psychopathy, which are discussed next.
The Treatment of Psychopathy (and Severe Personality Disorder)

The development of a range of treatment approaches for PD clients over the past several decades demonstrates significant development within the general psychotherapeutic field for this group. During this same time period, however, treatment for psychopaths and severe personality disorder in the corrections field has been in a more unsettled position. D'Silva, Duggan and McCarthy (2004) suggest that it was the publication of Rice, Harris and Cormier’s (1992) evaluation of a therapeutic community that significantly influenced correctional policy in relation to the treatment of psychopaths. This research reported an increase in recidivism of the treated group post-release, leading many correctional providers to conclude that treatment for psychopathy is not only ineffectual, but also iatrogenic. D'Silva and colleagues, however, tested this assumption by conducting a systemic review of existing research on psychopaths’ responses to treatment. They identified twenty-four studies that had sufficient quality to include due to at least some consideration of whether outcome measures were included, use of control groups, and randomisation of treatment conditions. They were not able to conduct a meta-analysis, however, due to there being insufficient rigour in the overall design of identified research. Their analyses suggested that there was no evidence that psychopaths have a negative reaction to treatment. Treatment outcomes were inconsistent across studies, with just as many studies demonstrating negative as positive outcomes.

Salekin, Worley and Grimes (2010) have suggested more recently that researchers still hold ‘strong opinions’ in relation to the treatment of psychopathy. Their review of the empirical literature concluded that treatment outcomes ranged from low-moderate to poor for psychopaths. Like D'Silva, Duggan and McCarthy (2004), they identified inconsistent treatment results and concluded that a strong case that psychopathy is untreatable cannot be made on the basis of existing research. They suggest that more needs to be done in relation to how to understand and intervene with psychopathy. This includes factors such as identifying aspects of treatment that psychopathic clients respond to best, and seeking to understand why dynamic and cognitive perspectives appear to have been more successful than therapeutic communities. They make a number of suggestions to inform future treatment practices, including drawing on aspects of current treatments for Antisocial PD and Conduct Disorder that have included behavioural, cognitive behavioural, and interpersonal perspectives. They also suggest that if these approaches do not translate to
effective treatment for psychopaths, other approaches might consider the development of psychopathy in conjunction with general psychotherapeutic theories relating to therapeutic change. From this perspective, the above discussion on the therapeutic alliance and its potential utility in the delivery of efficacious offending behaviour programs, is relevant.

One attempt to develop specific treatment guidelines for psychopaths has been provided by Wong and Hare (2005). They suggest that the aim of treatment should be to reduce violent behaviour rather than to change personality structure, advocating that treatment be delivered in a manner that is congruent with clients’ risks, needs and responsivity. They suggest a particular focus in treatment on responsivity given that psychopaths are likely to demonstrate treatment interfering behaviours. The use of cognitive behavioural methods in the delivery of treatment is recommended, using an information processing approach to assist clients identify a range of social cues before responding to situations, select goals for behaviour that are not self-defeating, and implement strategies after using consequential thinking. While they advocate the development of the task and goal domains of the TA, they suggest that the bond aspect is downplayed. In their view, this can help to prevent the exploitation of staff but they also question the ability of a psychopath to develop a meaningful bond with therapists given their affective deficits (such as a lack of empathy and callousness), and suggest that attempts to develop a bond may be interpreted as signs of weakness or vulnerability. They concluded that the formation of a ‘functional working alliance,’ that reduces the development of the bond but focuses on goals and tasks of treatment, is likely to be most effective while also advocating that therapists remain personable and professional with clients. This approach does suggest, however, that collaborative processes can occur without due attention to a therapeutic bond, which perhaps denies the interpersonal processes required in treatment. It may also mean that therapists using these approaches do not focus on ruptures based on their clients or their own experiences to inform treatment.

While not focussing on the treatment of psychopathy specifically, Livesley (2007) proposes an integrated approach that juxtaposes that suggested by Wong and Hare (2005). Livesley suggests that treatment should focus on both the management and treatment of personality pathology and points to the more recent use of a range of treatment perspectives including psychoanalytic, interpersonal, and cognitive-based treatments as ‘likely’ to be relevant to the treatment of PD clients who are at high risk of re-offending. He
suggests that due to the complexity of pathologies demonstrated in PD, treatment requires an eclectic approach in which intervention strategies are selected on the basis of their efficacy or, when evidence is not available, that are rationally considered. He suggested that the generic component of treatment is the treatment relationship, and this exists in concert with the ‘therapeutic frame’ which outlines the treatment model to which the client is contracted. In this context, the development of an alliance is fundamental to this process both with respect to the therapeutic value of the bond as well as a means of establishing the goals and tasks of treatment. In the process of treatment, the first priority is to reduce client distress. Specific interventions should then be used to assist clients control impulsivity and emotions while reducing violent and self-harm incidents. Only after this level of behavioural control is achieved by clients should strategies that promote adaptive functioning and interpersonal relationships be employed.

In the past twenty years, a small number of services have been developed to treat offenders who are at high risk of re-offending and demonstrate significant personality dysfunction, including psychopathy. Bernstein (2012), for example, has described the use of schema-focussed therapy within the ter beschikkingstelling (TBS) system in Holland. The TBS provides services to personality disordered offenders in prison settings based on therapeutic community principles and a focus on work (Maden, 2007). Bernstein reported the preliminary findings of a randomised clinical trial comparing schema focussed therapy with ‘treatment as usual’ for clients diagnosed with a PD, of which approximately 20% were considered psychopaths. Reductions in assessed risk of re-offending were observed for both groups, although psychopathic individuals appear to have benefitted more from being in the schema focussed therapy condition (as evidenced by their greater access to supervised leave following an episode of treatment, which is required prior to consideration of release).

A significant development in English speaking countries has been the Dangerous and Severe Personality Disorder (DSPD) services in the United Kingdom. These services were developed from 2000 and comprise two prison units and two forensic hospital sites which deliver a range of treatments to clients who pose a high risk of re-offending on the basis of their PD. Maden (2007) described how this service has been based on the Dutch TBS system as well as the Canadian Violence Reduction Program which utilises cognitive behavioural therapy in self-contained prison units. Treatment is eclectic but includes cognitive behavioural offending behaviour programs. Burns et al. (2011), in their overview of
treatment offered at DSPD services, reported that a range of treatments are offered at most sites, including DBT, schema focussed therapy, and cognitive analytic therapy. All sites also offered psycho-educational and psychological skills programs. Although this diversity of treatment options seems impressive, Burns and colleagues suggest that too many different types of treatment are being offered in an inconsistent manner, perhaps reducing efficacy. They propose the services reduce treatment options and work towards more consistent treatment delivery.

These forensic treatments for high risk offenders are indicative of the current application of PD treatments to offender populations. This overview suggests that the development of treatment in this area has perhaps been hampered for a long time by the view that psychopaths are untreatable. Although some progress has been made to date to invigorate the development of services and psychotherapeutic approaches to the treatment of PD offenders, this is in its infancy. It is suggested that exploration of the role of the TA with this population might better illuminate the types of treatment approaches that may be most productive. Langton (2007) has suggested that assessing the TA in PD offenders may provide an important contribution to the examination of treatment efficacy. The characteristics of this group of offenders include having significant difficulties in interpersonal relationships, so it makes sense to examine the extent to which the therapeutic relationship is working. He suggested that although there is limited data in the forensic field on the TA, there is sufficient to suggest that at the very least the TA, if not a causal factor in treatment, may certainly moderate or mediate outcome in certain treatment types. It would seem erroneous, therefore, to not examine the relationship between the TA and treatment outcome, particularly with clients who have interpersonal difficulties. This is despite the fact that there are currently differing views in the field in relation to the importance of the alliance in the treatment of PD clients (e.g., Hare & Wong, 2005; Livesley, 2007). Thus, whilst current treatment approaches to PD in general psychotherapeutic contexts with voluntary clients have universally included specific guidance to therapists around the development of collaborative and validating therapeutic relationships, the application of these methods to clients who are either mandated (e.g., due to court orders) or feel coerced to participate (e.g., to get parole) is less clear. In addition, little is known about the effectiveness of these treatment approaches and the extent to which the TA is an important determinant of outcome in these forensic contexts. As such, the majority of the literature to draw upon comes from non-forensic studies. Before reviewing this literature,
however, it is important to consider the process by which the alliance forms over the course of treatment with PD clients to illuminate the variety of courses it might take when correlated with positive treatment outcomes. Central to this is the notion of ruptures and rupture repairs.

Ruptures to the Therapeutic Alliance in the Treatment of Personality Disorders

There is an expectation that in the course of therapy that difficulties will emerge and negotiation of differences will form a crucial aspect of making treatment gains (Bordin, 1979, 1994; Safran, Muran, Samstag & Stevens, 2002). Enacting appropriate responses to ruptures in the therapeutic relationship is considered key to ensuring a successful therapeutic relationship and maximising clients’ positive behaviour change outside of therapy. There is, however, relatively little empirical work examining the impact of ruptures (and attempts to repair ruptures) on treatment outcomes for PD clients.

Strauss et al. (2006) conducted research on avoidant PD and obsessive-compulsive PD clients, thirty of who were offered up to 52 weeks of cognitive therapy for both depression and symptoms of PD. Clients who achieved an early alliance in treatment, as measured by the California Psychotherapy Alliance Scales (CALPAS; Marmar, Gaston, Gallagher & Thompson, 1989) demonstrated greater clinical improvements. Early alliance was predictive of number of sessions attended and symptom severity. Strauss et al also demonstrated that resolution of ruptures (in which alliance scores decreased at points over the treatment episode and then again increased) assisted in greater therapeutic gain compared to situations where ruptures did not occur or occurred and were not resolved. In addition, clients with very high scores on interpersonal dysfunction also reported lower alliances and were less likely to experience a rupture-repair episode.

Muran, Safran, Gorman, Samstag, Eubanks-Carter and Winston (2009) examined rupture repair in cognitive behavioural therapy, brief relational therapy, and short-term dynamic psychotherapy. Clients with Cluster A or PD diagnoses of ‘Not otherwise specified’ and therapists completed a range of measures, including the 12-item Working Alliance Inventory (WAI-S; Tracey & Kokotovic, 1989) and questions around experiences of ruptures. They noted that therapists and clients often differed in their perspectives on rupture intensity and resolution, which is an important consideration for therapists in their delivery
of treatment. WAI-S scores were the most predictive measure of outcome and higher ratings of the alliance were also correlated with rupture resolution. They concluded that ruptures are important indicators of problems in the therapeutic relationship that offer opportunities for the retention of challenging clients.

Preliminary research suggests, therefore, a potential relationship between client outcomes and the resolution of ruptures within treatment. Coutinho, Ribeiro, Hill and Safran’s (2011) qualitative study on rupture events provides some insight around the experience of ruptures for both clients and therapists. Their research was conducted with eight clients diagnosed with PDs who were treated for up to 30 sessions with eight therapists who were described as primarily trained in cognitive-behavioural therapy. Nine judges observed treatment sessions and rated ruptures using the Rupture Resolution Rating System (Eubanks-Carter, Mitchell, Muran & Safran, 2009, as cited in Coutinho, Ribeiro, Hill & Safran, 2011) which requires observers to rate a lack of collaboration in the alliance on a five-point scale and identify whether a confrontation or withdrawal rupture occurred. Following identification of ruptures (rated at least a 3), clients and their therapists were interviewed independently about the events. Fourteen withdrawal and thirteen confrontation events were identified in the first fifteen sessions of treatment for the eight clients, being 30% of the sessions. Four clients dropped out of treatment prior to the contracted thirty sessions were completed, and all of these clients experienced confrontation ruptures in their final three sessions. Withdrawal ruptures were more spread out across sessions. Core themes extrapolated from participant interviews revealed that ruptures most often occurred when new interventions were attempted or, more so in withdrawal events, clients were recounting difficult past life events or had experienced a relationship difficulty prior to the treatment session. Clients also reported experiences of therapists doing something they did not like or agree with. Therapists and clients also reported experiencing negative emotions during ruptures although therapists more frequently in confrontation events experienced guilt and incompetence. Clients reported feeling sad and helpless as well as ambivalent and confused. They were more likely to experience feeling abandoned and criticised in confrontation ruptures. Therapists reported attempting a range of strategies to resolve ruptures, including attending to clients’ experiences, promoting clients’ understanding of ruptures in relation to relationships outside of treatment, and by providing support and reassurance of the value of treatment. They concluded that therapists were more effective at dealing with withdrawal ruptures and
the development of a stable alliance may be the central task of therapy with PD clients. Due to difficulties in the resolution of ruptures, they suggest therapists need better training and supervision to facilitate this process, particularly with PD clients.

A number of studies have been conducted with clients receiving treatment for a range of PDs employing a task analytic approach (Greenberg, 1984), which requires qualitative examination of specific processes to achieve a particular task, in this case resolution of ruptures. These studies have included examination of a number of treatment perspectives including cognitive analytic therapy (Bennett, Parry and Ryle, 2006), brief relational therapy (Safran, Muran, Samstag & Stevens, 2002), and cognitive behavioural therapy (Cash, Hardy, Kellett & Parry, 2013). Bennett, Parry and Ryle (2006) examined therapist responses to ruptures in cognitive analytic therapy sessions with Borderline PD clients, comparing good and poor client outcomes. Therapists in good outcome cases identified and acknowledged 84% of the ruptures examined in their therapy sessions compared to 34% in poor outcome cases. In addition, therapists in good outcome cases either fully resolved or partially resolved almost all (87%) identified ruptures with their clients, compared to only a third of ruptures identified in poor outcome cases. Their model included a range of stages following identification of ruptures, including acknowledgement of the problem, exploration of the rupture, linking it to a previously established case formulation of the client’s behaviour, negotiation of client’s understanding, and changes to behavioural patterns and aims of treatment.

Safran, Muran, Samstag and Stevens (2002) described the model they have developed employing this research technique in a range of studies to refine processes involved in brief relational therapy. Four stages have been identified to respond to a therapeutic rupture, commencing with attending to the withdrawal or confrontation rupture marker, exploring the rupture experience, exploring any avoidance behaviour, and then a process of encouraging client’s self-assertion to express an underlying wish or desire relating to the rupture (e.g., for more nurturance, expression of a vulnerability). They stated that in comparing resolution and non-resolution sessions, there was a greater emphasis in relation to exploring any avoidance and a pathway from exploring the rupture experience to fostering self-assertion was more evident in resolution sessions. A number of similarities between this model and that of Bennett, Parry and Ryle (2006) are evident, particularly in
relation to acknowledgement and exploration of rupture events and their significance to a client's overall formulation.

Cash, Hardy, Kellett and Parry (2013) reported on using a task analytic approach to verify an existing cognitive behavioural treatment model developed for the treatment of depression to the treatment of Borderline PD. Two good outcome cases comprising forty-one rupture resolution attempts were used to inform modifications to the existing model. Their refined model included a range of processes commencing with acknowledgement of a client’s feeling and/or problem troubling them following a rupture marker, and a change in approach from the therapeutic technique being employed in treatment to taking a reflective and empathic stance to explore the rupture’s significance to the TA (including the therapists own responsibility in the rupture). Subsequent stages to assist rupture resolution include making links with the rupture event and the client’s formulation, and efforts to restore the alliance by re-engaging the client in the therapeutic process. The focus on the processes they revealed, therefore, varied somewhat to brief relational therapy and cognitive analytic therapy processes in that in-session rupture events were not analysed explicitly, but rather therapists responded to the lack of treatment engagement ruptures signified and focussed on client experiences of difficulties outside of treatment. Given the small sample of two, however, the authors suggest that this model is preliminary.

The above research demonstrates the potential correlation between identifying and responding productively to ruptures and treatment outcomes. While acknowledging the rupture in treatment may be useful in the process of collaboration between therapists and clients, it may also not be always necessary. The more critical feature here is that therapists respond to client negative experiences to assist shift the treatment process to one of collaboration. Studies have invariably found a positive association between rupture resolution and treatment outcome, more so than if ruptures are not resolved but also if ruptures do not occur. In the context of offending behaviour programs, it is inevitable that clients will bring to group those characteristics and behaviours that played a part in their offences, and it is the role of the therapist to identify ruptures and intervene at this level during the treatment process. This process is akin to the identification of offence-paralleling behaviour in which clients demonstrate dysfunctional characteristics that mirror aspects of their offending in-session (Jones, 2004) and may have a more profound impact on treatment outcomes than any other technique offered in a therapeutic program. The ability of the
therapist to foster the development of the alliance, anticipate ruptures and repair these throughout the therapeutic process should, therefore, be regarded as a treatment readiness factor but may also be an important change mechanism in and of itself. As the available research examining the relationship between rupture resolution and outcome is limited, however, an overview of research examining the TA, more generally, and outcome for PD clients is provided to examine the types of factors that may be pertinent for correctional treatment providers to attend to in the delivery of offending behaviour programs.

The Therapeutic Alliance and Outcome for Personality Disordered Clients

Research on the relationship between the TA and treatment outcome for PD clients has consistently concluded that the TA plays an important role. Barnicot et al. (2012), for example, reported the findings of a systematic review of treatment outcome studies for Borderline PD. The TA was the only treatment process factor investigated in more than two of the reviewed studies. Of six relevant studies identified, four reported a positive relationship between client-rated TA and treatment outcome, and another found a positive association between observer-rated alliance and treatment outcome. Positive treatment outcomes and alliance ratings have similarly been positively correlated in studies for other PDs, including Antisocial (e.g., Gerstley et. al, 1989), as well as Avoidant and Obsessive Compulsive PDs (Barber, Connolly, Crits-Christoph, Gladis & Siqueland, 2000; Gibbons, Crits-Cristoph, de la Cruz, Barber, Siqueland & Gladis, 2003; Strauss et. al, 2006).

The TA may also be a critical determinant of program attrition with lower early alliance scores being predictive of clients prematurely leaving schema-focussed therapy and transference-focussed psychotherapy for Borderline PD (Spinoven et. al, 2007), cognitive treatment for Avoidant and Obsessive Compulsive PDs (Strauss et. al, 2006), as well as a range of PDs in supportive expressive treatment (Lingiardi, Filippucci & Baiocco, 2005). More recently, the role of the TA and attrition was reported by Wnuk, McMain, Links, Habinski, Muarry and Guimond (2013), who employed a randomised control design to compare 180 Borderline PD clients with co-morbid Axis I diagnoses who received DBT or general psychiatric management (a manualised psychodynamic treatment). Sixty-two percent of clients completed treatment, and lower alliance scores (as measured by the WAI-S; Tracey & Kokotovic, 1989) significantly predicted drop-out along with a higher number of Axis I co-morbid conditions, more previous suicide attempts, and higher levels of anger. A significant
interaction was also found in that those with a higher number of Axis I conditions assigned to psychodynamic treatment were less likely to drop-out whereas this effect did not hold for the DBT condition. Wnuk et al. suggest that this interaction might be explained due to psychiatric symptoms being specifically targeted with medication as part of the general psychiatric management treatment regime. They highlight the importance of attending to a range of factors in treatment to reduce clients prematurely leaving, particularly in relation to the development of the TA but also around client experiences of psychopathology.

Of most relevance to the current discussion is outcome research that has explored Antisocial PD and psychopathy and the TA. Unfortunately very little research has been published in relation to these diagnoses, although two studies have found an association between higher scores on measures of psychopathy and poorer TA (Ross, 2008; Taft, Murphy, Musser & Remington, 2004) and another found positive treatment outcomes for Antisocial PD clients in drug treatment correlated with scores on measures of the TA (Gerstley, McLellan, Alterman, Woody, Luborsky & Prout, 1989; as reviewed in Chapter Three).

Although it would appear that there is an association between the TA and treatment outcomes in relation to PD clients, caution must be applied to the conclusions drawn from these findings. A range of methodological issues in the examination of the TA and outcome studies with PD clients have been identified. Barnicott et al. (2012), for example, pointed to research design problems in the studies they reviewed, including the type of predictor analyses used and variability in relation to when and how the TA was measured. Overall, however, they considered that the TA was a good predictor of treatment outcome and recommended that both therapists and researchers focus on this to improve treatment outcomes for PD clients. Further examination of research on the TA and PD is summarised below, exploring those issues that are likely to be most relevant to delivering treatment in correctional environments. This includes consideration of both client and treatment factors.

Previous research has suggested that the psychopathic traits (at least to some extent) do impact on the TA (Ross, 2008; Taft, Murphy, Musser & Remington, 2004), as well as aspects of the group environment indicative of collaborative relationships, particularly group cohesion (Harkins, Beech & Thornton, 2012). The TA has also been negatively correlated with a hostile-dominant interpersonal style (Beauford, McNeil & Binder, 1997;
This is perhaps unsurprising. The development of a strong TA provides a basis for therapeutic engagement to occur, but this is particularly difficult for clients who have histories of poor attachment, are suspicious of treatment providers or the treatment process, and have difficult interpersonal styles, particularly in relation to hostility. These features are most prevalent for clients who meet the criteria for Antisocial PD, although they are not the only personality features that therapists might find challenging. Lingiardi, Filippucci and Baiocco (2005), in their preliminary investigation of individual supportive expressive therapy with 47 PD clients, found that clients with Cluster A PDs (i.e., Paranoid, Schizoid, and Schizotypal) rated the alliance lower than other PD clusters. This suggests that it may be most difficult for clients experiencing social disconnection, paranoia or unusual perceptual experiences to form meaningful alliances. Interestingly, the therapists of Cluster B PDs (Antisocial, Borderline, Histrionic, and Narcissistic) in this study rated alliance lower than the clients. An important implication of this is that therapists cannot assume that their experience of the TA mirrors those of their clients, and antisocial attitudes or other Cluster B or C PD traits may not be in and of themselves prohibitive to the formation of a strong TA.

An alternative way of assessing the impact of personality dysfunction on the TA is to examine research that has utilised measures of normal personality. Hirsh, Quilty, Bagby and McMain (2012) reported that there is a marked lack of this type of research and described their use of the revised NEO Personality Inventory (Costa & McCrae, 1992) in treatment for Borderline PD. They also administered the WAI-S (Tracey & Kokotovic, 1989) and a range of outcome measures to 87 clients with Borderline PD who randomly received either DBT or general psychiatric management treatment. Individual growth models were used to specifically determine the relationship between ‘agreeableness’ and the TA. Overall, they found significant increases in the TA occurred over the course of treatment and that higher alliance scores were associated with better outcomes. Time in treatment was moderated by agreeableness, suggesting that the alliance improved more significantly for clients higher on this trait. Further analyses suggested this occurred more so for clients in the DBT condition and the effect was not better accounted for by severity of Borderline PD symptoms. This same effect was not evident when other personality factors were entered into the model, suggesting agreeableness is most central to clients’ propensity to develop a TA relative to the demonstration of extraversion, openness, conscientiousness, and neuroticism. It is conceivable that agreeableness, which describes an ability to be cooperative and trusting,
facilitates the development of a therapeutic bond that is arguably fundamental to the process of negotiating tasks and identifying appropriate goals in treatment. This is also consistent with Lingiardi, Filippucci and Baiocco’s (2005) finding that clients who experience social disconnection, paranoia and unusual perceptual experiences are less likely to develop a TA.

The ongoing interactions between therapist and client will not only be impacted by the client’s interpersonal style but also be the client’s attitude to treatment. This was demonstrated by Gibbons, Crits-Christoph, de la Cruz, Barber, Siqueland and Gladis (2003) who examined aggregated data from eight different treatment trials of supportive expressive and cognitive therapy for a number of Axis I disorders as well as Obsessive-Compulsive PD and Avoidant PD. About two thirds of the total 201 clients had at least one Axis II diagnosis. Treatment consisted of weekly one-hour individual sessions and PD clients received up to 52 weeks of treatment. Hostile-dominant interpersonal problems predicted lower CALPAS (Marmar, Gaston, Gallagher & Thompson, 1989) scores at session 10 as did lower client expectations about the outcome of treatment. The authors suggest that a focus on assisting clients with interpersonal problems and exploration of treatment expectations may assist with the alliance.

Therapist personality factors may also be an important consideration for how in-session interactions assist the process of treatment. Spinhoven, Gleson-Bloo, van Dyk, Kooiman and Arntz (2007) found that therapist personality did influence the formation of the alliance in the treatment of clients with Borderline PD, although this was not directly associated with outcome. Clients rated the alliance higher when there was more dissimilarity in personality between therapists and clients. This research points to the importance of matching therapy styles and therapist characteristics to complement client characteristics. It is also noteworthy to emphasise that although personality factors were not associated with outcome, they did impact on the alliance, which subsequently impacted on attrition and outcome. It is perhaps not surprising that with a client group who have difficulty tolerating negative affective experiences and act impulsively, that dropping out of treatment is a likely outcome where there is a lack of collaborative and purposeful therapeutic involvement.

The type of treatment delivered may also impact on the strength of the alliance. Spinhoven, Gleson-Bloo, van Dyk, Kooiman and Arntz (2007) investigated the TA in long-
term individual psychotherapy (up to three years) for 88 clients with Borderline PD using the WAI (Horvath & Greenberg, 1989). They found that lower scores early in treatment were predictive of drop-out and early client alliance ratings were related to clinical improvement and were significantly associated with type of treatment. Both clients and therapists rated the alliance higher in schema-focussed therapy compared to transference-focussed psychotherapy, and although clients’ alliance scores increased in both treatment conditions over the course of treatment, therapist frustration in transference-focussed psychotherapy increased. The authors suggested this might be explained by therapists’ efforts in schema-focussed therapy to develop a collaborative and supportive approach, whereas in transference-focussed psychotherapy there is an emphasis on interpreting in-session transference (ruptures), which may be more likely to perpetuate tension within treatment. Similar findings were reported in Muran, Safran, Gorman, Samstag, Eubanks-Carter and Winston’s (2009) study of the TA and treatment outcomes in cognitive behavioural therapy, brief relational therapy, and short-term dynamic psychotherapy. Fewer ruptures with less intensity were reported in the cognitive behavioural therapy condition compared to the other treatment conditions. Therapists also reported more rupture resolution and a better working alliance in cognitive behavioural therapy than the other treatments. Muran et al. suggest that cognitive behavioural therapists are more likely to approach treatment with the client in a collaborative manner, and therefore focus on aspects of agreement in treatment rather than strains or points of difference. In contrast, the other treatment perspectives, which focus more on ruptures and interpretation of client behaviour, may perpetuate more ruptures. This is consistent with their finding that better outcomes occurred in cognitive behavioural therapy when there was lower rupture intensity, but this was not the case in the other treatment conditions, and a more complex relationship is suggested between outcome and the other treatment conditions.

In their review of previous research, Constantino, Castonguay, and Schut (2002) identified a number of client factors associated with poor alliance formation relevant to the forensic context: low education level, low psychological-mindedness (i.e., a client’s attitude to therapy), high levels of symptoms, avoidance/resistance or defensiveness, difficulties with interpersonal relationships and poor object relations. What appears to make alliance formation as well as ruptures or disturbances in the TA more likely, on the one hand, relates to clients simply not being oriented to the nature and process of therapy, while on the other, certain personality, interpersonal style and mental health issues are more likely to
impinge on capacity and/or willingness for treatment. Taft and Murphy (2007) similarly suggest that although it is difficult to form an alliance with angry and abusive clients, the TA is critical to both motivating clients for treatment as well as achieving therapeutic outcomes. They go on to say that various experiences clients bring to therapy make formation of the alliance difficult, such as previous experiences of victimisation as well as their attachment experiences. These factors may influence both capacity and willingness to develop a strong bond in therapy, and hence may make it less likely for clients to be able to express emotions or reveal their thoughts, and hence actively engage, in therapy.

What is more revealing, however, is the potential interaction of a number of treatment factors on the alliance for PD clients, and how these might impact on client outcomes, particularly interpersonal functioning (Gibbons et al, 2003; Strauss et. al, 2006) and client expectations of treatment (Gibbons et al, 2003). What is of some concern is the lack of treatment outcome studies concerning the TA for a wider variety of PD clients across a number of treatment perspectives. Although different PD symptomology may pose different challenges to the therapeutic task of enhancing the TA in treatment (Lingiardi, Filippucci & Baiocco, 2005), the issue of interpersonal dysfunction and other treatment readiness issues may be a consistent factor, but so far this has not been empirically tested in a forensic setting. There is a strong suggestion, however, that trust, openness and acceptance (Serran, Fernandez, Marshall, & Mann, 2003) are qualities that therapists must develop in treatment to foster a TA in offending behaviour programs, despite the difficulties with which a client may present.

Conclusion

Clients demonstrating PD traits hold specific challenges for correctional therapists in their delivery of offending behaviour programs. Not only do PD clients often demonstrate traits that therapists find difficult to respond to (e.g., defensiveness, hostility) but therapists may also demonstrate characteristics that impede the development of a TA (e.g., unrealistic expectations of clients’ behaviour, questioning whether PD clients are able to change).

More recent treatment approaches developed for PD clients in general psychotherapeutic contexts have often utilised integrative theories in which a number of
theoretical perspectives are drawn on to balance the analysis of here-and-now experiences with skill implementation. At the heart of these processes is the development of a strong therapeutic relationship which is drawn on to facilitate change. A number of these approaches specifically focus on resolving therapeutic ruptures as central to the mechanism of change. Available research examining PD and rupture resolution suggests that a variety of approaches to assisting resolution of difficulties in the TA is likely to improve treatment efficacy, but the evidence in this area is limited. The available literature on the TA and the treatment of PD clients suggests that a relationship exists between personality traits and attitudes towards treatment, the strength of the TA and positive treatment outcomes, but factors such as treatment approach and therapist personality may also be highly influential. It may be that the TA, therefore, represents a highly significant concept in treatment outcomes for both PD clients and those at risk of re-offending, particularly those who demonstrate psychopathic traits. As there is a lack of conceptual consistency with respect to the role of the therapeutic alliance in offending behaviour programs, however, this is an area that requires further analysis.

The following studies seek to explore the nature of the importance of the TA in the delivery of offending behaviour programs and, if found to be a significant issue, to provide guidance for therapists on how to foster the TA within groups in order to maximise therapeutic outcomes.
CHAPTER FIVE – What Correctional Therapists Say about the Therapeutic Alliance

Overview

This chapter reports the findings of the first empirical study, a qualitative investigation of therapist perspectives on the therapeutic alliance in offending behaviour programs using a grounded theory methodology. The analysis reveals significant variability between therapists in how they understand the goals of treatment and, therefore, the specific strategies that they use to develop the alliance. Although some clearly saw their role as providing therapeutic responses to facilitate a process of change, others were more focussed on the delivery of program material. These differences appeared to be related to their training and the type of support that was available from their workplace. All participants identified particular challenges in working with certain types of offender, notably those who presented with traits that are commonly associated with personality disorders. Specific consideration was given to the ways in which they respond to these challenges.

Rationale for Study One

Substantial empirical support now exists for the proposition that the therapeutic alliance is an important determinant of therapeutic change in adult psychotherapy (see Chapter Two). In the context of group-delivered offending behaviour programs, however, the evidence supporting a similar relationship is less consistent. Research in the area is limited by difficulties in conceptualising and measuring the strength of the alliance in treatment that is not only delivered in groups, but is sometimes mandated through court orders or involves a degree of coercion due to parole board expectations. There are also questions about the relevance of the alliance to this type of work, given that the goals and tasks of treatment are largely defined by government agencies who have a mandate to protect the community. It is in this context that the current study was designed. The aims of the study are to first determine the views of correctional therapists in relation to the relevance and value of the therapeutic alliance in group delivered offending behaviour programs, and second to develop a theoretical framework that can inform the development of practice in this area.
Methodology

Grounded theory (Corbin & Strauss, 2008) was identified as an appropriate research methodology to utilise in this study, given the conceptual confusion that exists around the therapeutic alliance (TA) and limited validity of existing quantitative measures\(^2\) in the delivery of offending behaviour programs. This approach used theoretical sampling to explore the underlying mechanisms of current therapeutic practice, to the point of saturation. Saturation occurs when no new meaning is being derived from the data being collected and may require between 20 and 30 participants when a broader range of topics are being explored (Mason, 2010). The Grounded Theory methodology was seen as more appropriate than other methodologies, such as thematic analysis or a case study approach, which do not necessitate theoretical development and hence limit the potential for generalisability (Creswell, Hanson, Clark & Morales, 2007). The research design and approach adhered to domains identified by Tong, Sainsbury and Craig’s (2007) Consolidated Criteria for Reporting Qualitative Studies, derived from existing checklists and guidelines on qualitative research. This included the student researcher (also the writer) identifying to participants her previous experiences in delivering offending behaviour programs during the process of gathering informed consent. Some participants were also known to the researcher due to her previous involvement in program delivery, however none were currently in a position in which an unequal relationship existed (i.e., management or supervisory relationships).

Positioning Statement

In undertaking qualitative research of this type, a range of factors relevant to the researcher, including her profession, will invariably impact on the manner in which the research is conducted (Corbin & Strauss, 2008). Accordingly, it is important for the researcher to provide a positioning statement to offer some context in relation to the framing of the research.

\(^2\) This is largely because existing measures have been developed for dyads in contexts in which clients volunteer for treatment, rather than group members mandated to attend treatment. Existing measures also require clients to have adequate insight into their therapeutic experiences and to respond genuinely without concern about the repercussions of providing negative feedback. See earlier chapter.
After undertaking a Masters in Forensic Psychology, I have delivered a range of offending behaviour programs over approximately seventeen years, commencing as a therapist and then moving to more senior roles. I felt poorly prepared for the first group program I delivered, having never received any training in group facilitation and not being provided any resources to assist in program delivery save for a rudimentary program manual that I was invited to change if I wanted to. Little direction was offered in this first role I had working as a therapist delivering drug and alcohol group programs in prisons as a sole facilitator. I had some difficult experiences, and although I had dealt with hostility and aggression within the context of delivering individual treatment, I was perplexed as to how to respond to clients in groups when they engaged in these types of behaviours. The supervision I received was variable and limited in being able to assist me, at least initially. Over time, largely by discussing experiences with peers, I began to gain a better understanding of group dynamics and developed skills and strategies to deliver group treatment. Eventually a number of different training programs I attended, particularly those that included experiential methods and group facilitation, enhanced the working framework I had to deliver offending behaviour programs. This later allowed me to assist staff under my supervision in their efforts to also engage in this very interesting work. It is within this context that I became curious about what empirically-based research informed our understanding of how we deliver offending behaviour programs, and found that the field had little to offer in this regard. I was interested in the work of a range of academics who commented on the potential utility of the concept of the TA being applied to the delivery of offending behaviour programs and how research applied in the forensic context might provide more substantial assistance to the field.

Procedure

Ethical approval to conduct this study was awarded by the University of South Australia Human Research Ethics Committee (P228/08) and the Department of Justice Human Research Ethics Committee (CF/08/15564) (see Appendix 2).

Participants were invited to attend via e-mails sent by their managers to six different services delivering offending behaviour programs requesting interested potential participants contact the student researcher directly via email or telephone to negotiate a mutually agreeable time to discuss their potential participation. Responses were received
from five of the six services. Once potential participants contacted the researcher, a time and location were negotiated. These generally occurred in the work place, although some participants travelled to nearby locations so groups of 2 or 3 therapists could attend at any one time. Senior therapists were seen in separate focus groups from therapists to reduce the likelihood of therapists’ responses being effected by the presence of staff who held more power. All participants provided their written consent, following discussion of the Plain Language Statement (Appendix 3) and focus groups were conducted in private rooms. All participants who contacted the researcher agreed to participate in the study and all participated voluntarily.

Focus groups were used to allow participants to express their experiences in relation to a broad range of relevant concepts. The interaction between focus group members allows for both points of similarity and difference between approaches and practice to be elucidated to achieve this end (see Belzile & Öberg, 2012). The groups utilised a semi-structured interview schedule, developed to guide initial discussions (see Appendix 4). Questions were asked in relation to their views and experiences of working with clients in offending behaviour programs, particularly in relation to the relevance of the therapeutic alliance, clients they experienced difficulties with in developing an alliance, and strategies they utilised to resolve ruptures in the alliance. The focus groups ran for between an hour and a quarter and an hour and a half and therapist responses were recorded on an electronic recording device. Field notes were taken following the completion of each focus group, and memos developed outlining the central themes discussed and outstanding issues to explore in subsequent focus groups (Appendix 5).

Following the completion of the first six focus groups which utilised the semi-structured interview, the remaining four focus groups focussed on further exploration of issues raised by initial groups. After the tenth focus group saturation was achieved, as no new themes emerged and existing themes were verified; questions raised from previous focus groups had been explored and synthesised within the developing theoretical framework.

The transcripts were coded using NVIVO 10 (QSR International), a statistical package designed to facilitate analysis of qualitative data. Nodes were created initially for each therapist to facilitate the analysis of individual responses. Nodes were then created for the
subject areas discussed with participants. Further analysis then occurred, for which nodes were created, to account for the varying practices described by therapists in their approach to both the development of the TA as well as the way in which they responded to ruptures.

Participants

Ten focus groups were conducted (seven groups of three and three groups of two), involving a total of 27 therapists, four of who were senior therapists. Table 2 outlines the characteristics of those who participated, including their sex, age, professional qualifications, and experience in delivering offending behaviour programs. Most of the participants were female (N=21), and they were aged between 23 and 62 years\(^3\) (X= 35.84, SD=11.93).

Just over two thirds of participants (N=19) were psychologists, including ten with general registration, seven with a post-graduate specialisation in psychology (three with post-graduate degrees in forensic psychology, three with post-graduate degrees in clinical psychology, one with a post-graduate degree in developmental psychology), one who was completing a post-graduate degree in forensic psychology, and one who was provisionally registered as a psychologist. Of the remaining eight participants, four were trained social workers (one held post-graduate qualifications), two were criminal justice degree graduates, and two had diplomas in welfare. Experience in offending behaviour program delivery varied markedly. Seven reported less than one year’s experience, and the majority (18 of the 27) had less than five years’ experience.

Table 2

Overview of participant characteristics from Study One.

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Sex</th>
<th>Age</th>
<th>Qualifications</th>
<th>Experience delivering OBPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>26</td>
<td>Provisional psychologist/Criminal Justice</td>
<td>10 months</td>
</tr>
<tr>
<td>1</td>
<td>Female</td>
<td>23</td>
<td>Welfare worker/AOD Clinician</td>
<td>10 months</td>
</tr>
<tr>
<td>1</td>
<td>Female</td>
<td>36</td>
<td>Welfare worker/AOD Clinician</td>
<td>6.5  months</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>31</td>
<td>Psychologist</td>
<td>4 years</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>32</td>
<td>Social Worker</td>
<td>6 years</td>
</tr>
</tbody>
</table>

\(^3\) Age data were missing for two participants (one failed to provide his age and another declined to provide this information).
<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Age</th>
<th>Profession</th>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Female</td>
<td>24</td>
<td>Criminal Justice</td>
<td>2 programs (in 2 years)</td>
</tr>
<tr>
<td>3</td>
<td>Male</td>
<td>32</td>
<td>Social Worker</td>
<td>2 years</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>52</td>
<td>Social Worker</td>
<td>2.5 years</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>48</td>
<td>Social Worker</td>
<td>4 programs</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>33</td>
<td>Forensic Psychologist</td>
<td>2 years</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>30</td>
<td>Clinical Psychologist</td>
<td>2 years</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>25</td>
<td>Clinical Psychologist</td>
<td>9 months</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>37</td>
<td>Forensic Psychologist</td>
<td>8 years</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>62</td>
<td>Psychologist</td>
<td>7 years</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>55</td>
<td>Psychologist</td>
<td>8 years</td>
</tr>
<tr>
<td>6</td>
<td>Male</td>
<td>53</td>
<td>Psychologist</td>
<td>12 years</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>27</td>
<td>Criminal Justice</td>
<td>9 months</td>
</tr>
<tr>
<td>7</td>
<td>Male</td>
<td>MD</td>
<td>Developmental Psychologist</td>
<td>8 months</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>36</td>
<td>Psychologist</td>
<td>7 years</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>34</td>
<td>Training as a Forensic</td>
<td>7 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Psychologist</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>28</td>
<td>Clinical Psychologist</td>
<td>3 years</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>28</td>
<td>Psychologist</td>
<td>3 years</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>26</td>
<td>Psychologist/ Training</td>
<td>2.5 years</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Criminology</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>61</td>
<td>Psychologist</td>
<td>11 years</td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>50+</td>
<td>Psychologist</td>
<td>6 years</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>27</td>
<td>Forensic Psychologist</td>
<td>5 years</td>
</tr>
<tr>
<td>10</td>
<td>Male</td>
<td>30</td>
<td>Psychologist</td>
<td>6 months</td>
</tr>
</tbody>
</table>

Note: MD = missing data.

Analysis

The analysis was structured around participant responses in relation to the importance of the alliance, the development of the alliance, the nature of ruptures, and broader organisational issues which influence program delivery in the correctional environment. Nodes for each of these subject areas are listed in Table 3 along with the number of references made by participants. The number of references made to a particular theme, although not of direct relevance to the analysis that follows, provides some
indication of which aspects of data collection attracted most attention as well as providing evidence that similar issues were considered across each of the focus groups.

Table 3
Parent and child nodes created for subject areas discussed in Study One and the number of focus groups and references made by participants in relation to each of these.

<table>
<thead>
<tr>
<th>NODE</th>
<th>FOCUS GROUPS</th>
<th>REFERENCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of the TA</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Experiences of developing a TA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals</td>
<td>10</td>
<td>39</td>
</tr>
<tr>
<td>Tasks</td>
<td>10</td>
<td>132</td>
</tr>
<tr>
<td>Bond</td>
<td>10</td>
<td>93</td>
</tr>
<tr>
<td>Positive therapist characteristics</td>
<td>10</td>
<td>94</td>
</tr>
<tr>
<td>Ruptures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negotiating disability and diversity</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td>Dysfunctional personality traits</td>
<td>10</td>
<td>166</td>
</tr>
<tr>
<td>- Anti-social &amp; psychopathic</td>
<td>10</td>
<td>121</td>
</tr>
<tr>
<td>- Avoidant and withdrawn</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>- Narcissistic</td>
<td>7</td>
<td>23</td>
</tr>
<tr>
<td>- Neuroticism</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Rupture repair responses</td>
<td>10</td>
<td>150</td>
</tr>
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<td>- Enforcing boundaries and managing content</td>
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<td>124</td>
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<td>- Engagement strategies</td>
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<td>- Ruptures as opportunities for therapeutic change</td>
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<td>Working in correctional environments</td>
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<td>Negative therapist experiences</td>
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<td>Organisational challenges</td>
<td>10</td>
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Supervision & organisational support

In the analysis that follows, each of these nodes is considered in greater detail. Data are presented first in terms of the broad question that was raised in the focus groups and subsequently in relation to more specific aspects of the responses. A definition and summary of main findings is presented to help guide interpretation.

**Importance of the Therapeutic Alliance**

**Does the concept of the therapeutic alliance have relevance to the delivery of offending behaviour programs?**

**Node Definition**

Comments made by participants on how important they think the therapeutic alliance is to achieving therapeutic outcomes and reducing attrition. This includes discussion around whether it was possible to get good outcomes if only some of the elements (i.e., tasks, goal, bond) were present.

**Main findings**

- Most participants relayed that a strong therapeutic alliance was important to maximising therapeutic outcomes and reducing attrition.
- Participants stated that gains could still be made if not all elements of the alliance were strong, but optimal gains were more likely to occur if all three existed.
- A strong therapeutic alliance was seen as important to attaining therapeutic outcomes, regardless of factors such as personality dysfunction or culture.

Most therapists agreed that all elements of the TA are important to maximising outcomes for clients, and that outcomes could still be achieved if there were problems in any one element of the alliance, but this would likely be at the cost of gaining optimal therapeutic outcomes. This is demonstrated in the following participant quote, which was representative of participants’ comments.
I'm of the firm belief that the therapeutic alliance is the core of everything that we do. If you don't at least have one of those, you're not going to go anywhere. Obviously the more of those that you can get, the better your ability to work with that person is. (Participant 26)

A number of therapists also suggested that if specific clients did not have a bond with at least one of the therapists, this may be compensated if they had a connection with other group members that could assist in their therapeutic process, as demonstrated by the following quote. ‘Like if they relate to the other guys in the group, that sort of makes up for some of the lack of connection between me and that particular client’ (Participant 12).

The complex inter-play between the elements of the alliance and the importance of them working together to attain therapeutic gains if one element was lacking was articulated by a number of participants, and exemplified in the following quote.

You can't ask for a goal or a task if you're not trusted, or if you don't have the therapeutic relationship. If you've got too much of a therapeutic relationship you might be not respected enough to do the tasks or the goals. So without them all being in balance to takes some risks, to have the trust, to give it a go, to weave it. (Participant 9)

Not all participants shared this view, however. A senior therapist suggested that the bond element of the alliance should be downplayed compared to an emphasis on tasks and goals. When the other senior therapist in this focus group was asked if he agreed, he said he thought so but went on to emphasise that change occurred within the relationship, diverging from the other participant who emphasised the importance of a detached relationship with clients.

Despite some variability amongst participants around the relative importance of the different elements of the alliance to achieving positive therapeutic change, participants generally relayed that they believed the concept of the TA was relevant to the delivery of offending behaviour programs. Participants conveyed that program delivery requires a collaborative approach in which pertinent treatment goals are identified, negotiation of tasks occurs with group members, and some level of bond exists to facilitate this process.
The exception to this was participants who pointed to group cohesion between clients, rather than their direct relationship, as a potential means of facilitating the bond required for treatment delivery. This suggests perhaps that these two conceptual frameworks may work together in the delivery of offending behaviour treatment, both serving to enhance any short-comings in the alliance although arguably also exacerbating any difficulties. In general, however, participants viewed the delivery of treatment as a process requiring both their efforts at engaging clients but also client commitment to the treatment process.

**Experiences of Developing the Therapeutic Alliance**

**What are participants’ practices around the central elements of therapeutic alliance in offending behaviour programs? Are these akin to the manner in which the ‘therapeutic alliance’ is described in the individual psychotherapeutic literature?**

**Node Definition**

Identifying therapeutic goals, selecting and negotiating tasks, and attitudes and approaches to developing a bond. Given the link many therapists articulated about the positive therapist characteristics required to assist these processes, a child node was also included here on this topic.

**Main findings**

- Participants largely relayed that goals relating to risk of re-offending are developed with clients while ensuring they are individualised, achievable, relevant and that clients have ownership of them.
- A range of issues impinged on participants’ selection of tasks for treatment, particularly the program manual, responsivity and treatment readiness issues, and group cohesion. Variation around what participants considered the central tasks of treatment was evident. While some focussed on achieving program objectives, others emphasised creating therapeutic change through interpersonal experiences.
- A range of views were offered in focus groups in relation to the nature of the bond aspect of the alliance. While some participants suggested a strong
emotional connection was required to undertake treatment, others suggested a more detached stance was required to maintain a level of objectivity.

- Having knowledge of both offenders and program manual content as well as demonstrating engaging treatment delivery skills were seen as important therapist attributes.
- A number of positive therapist characteristics were discussed as an important vehicle to developing the TA. These largely comprised balancing a range of factors such as conveying empathy or common ground with clients while enforcing appropriate boundaries and clarity around treatment expectations. The development of trust and respect along with fostering relatedness were also seen as central to alliance formation.
- Approaches to assist the therapeutic endeavour included demonstrating acceptance of clients’ situation while also promoting change realistic to their circumstances.

How are goals identified with clients in offending behaviour programs?

The approach to goal formation varied, but overall participants articulated a need for goals to relate to the reduction of risk of re-offending. This being a point of difference compared to other settings was highlighted by a number of participants, such as demonstrated in the following quote.

*The goals here are slightly different, in the sense that they are set to some extent, and we’re made very, very clear of this whenever people come into treatment. These are not goals set by the clients themselves, these are goals told to them that they need to do. (Participant 11)*

Later on in discussion with participants of this focus group, a more complex picture emerged in relation to negotiating goals with clients that was not unique to this focus group. While it was agreed that clients needed to attain goals that would assist them reduce their risk of re-offending, there was also a level of flexibility offered within treatment to address therapeutic goals of personal relevance, as outlined in this quote.

*If we sort of negotiate with them offence-related goals, things that they want to improve or work on, we can usually relate anything to their offending. If you want to*
work on assertiveness, there’s probably some assertiveness is related to their offending anyway, so it’s engaging them that way. We’re going to work on these things but we also need to do these tasks. (Participant 12)

The ‘shared goal’, as one participant put it, is that the client does not come back into the system, even if the therapist and client have different reasons as to why they want that achieved. In this regard, self-interest was invariably seen as the reason clients wanted this goal whereas most therapists were clear that the organisational mandate dictated that their roles focused on community protection. Interestingly, however, most participants viewed these different vantage points as complementary, and articulated that achieving community safety simultaneously benefited the client. Participants accepted that client motivation might be extrinsic to start, particularly given the view that the parole board were more likely to release prisoners if they had completed programs or if clients wanted to fulfil conditions imposed by the courts. Participants commented, however, that many clients subsequently developed intrinsic motivation to achieve program goals and participate in the program process.

Invariably clients will come in and they’ll say “My goal is to complete this eleven week program,” and that will be their goal. If you look at their goals at the end of the program they’ve turned around, and all of a sudden they’ve become personal goals and that’s part of group dynamics and it’s part of the evolution of the person as they go through the program. (Participant 15)

Participants unanimously recognised the importance of goals being individualised, achievable, and for clients to demonstrate a level of ownership and engage in the process, as highlighted in the following quote.

I believe a goal that’s not negotiated is useless, unless you engage with the group and unless they think there’s something in it for them, then they’re unlikely to achieve that goal, whether you set it or not. (Participant 15)

While for many therapists goals related to shifts in client behaviour external to the program room (e.g., relapse prevention strategies) other therapists emphasised the importance of interpersonal changes that could be demonstrated in session, particularly if it
paralleled offending behaviour (e.g., hostility and deceitfulness towards group members) or other interpersonal skills (e.g., expressing views appropriately, taking turns, attending sessions reliably).

Despite organisational mandates about reducing re-offending in the delivery of offending behaviour programs, therapists described a range of strategies to negotiate goals that were relevant to clients and engaged their participation consistent with the notion of the TA. The delivery of offending behaviour programs provides a framework, however, from which therapists frame the goals starting from a client’s ability to attend and participate adequately in group programs but then moving towards individualised therapeutic goals. Clients were not seen as passive recipients within this process. Participants described the importance of capitalising on any form of extrinsic motivation clients might demonstrate in relation to achieving program goals while ensuring a fit with their level of insight and interest in engaging in the therapeutic process.

**What are the central tasks of treatment and to what extent are tasks negotiated with clients?**

Participants emphasised that the first task of treatment is to establish and enforce group rules while maintaining integrity to programs by *ensuring session objectives were achieved*. Therapists articulated a need to remain flexible in delivery to meet both the needs of the group as well as the individual needs of clients. Terms such as ‘responsivity’ and ‘treatment readiness’ were often cited as the means by which therapists determined the nature and timing of tasks delivered. This was particularly to accommodate factors such as intellectual functioning, stage of change, group cohesion, personality characteristics, literacy levels, and learning styles demonstrated by clients. The complexity of factors taken into account when selecting tasks is exemplified by the following participant in response to a question on how tasks are selected in treatment.

*Independent risk factors, and looking at responsivity too. All the individual things that can affect how that client is likely to fit into that group, depending on their own social skills and how the other group members might respond. If there are any issues of toxicity or something in the group. How they’re likely to respond to treatment, and how risky they are, and what the risk levels are. (Participant 10)*
Variability existed in views about the role of case formulation; some seeing it as a critical issue to ensuring the appropriate selection of tasks to target offending behaviour, others seeing it as a useful means of understanding presentations so they were more likely to increase client empathy, and others who articulated that case formulation was not something they undertook. No participants saw their role to conduct diagnostic assessments, although most saw utility in getting information about previous assessments in relation to their clients, despite the fact that the accuracy of these varied. Participants invariably stated that their observations about the client in group were more informative and relevant to informing tasks rather than previous or current diagnoses.

The need to remain flexible in approaching tasks, particularly to balance the delivery of tasks outlined in program manuals compared to those that attempted to strengthen the quality of the bond or group cohesion, was also raised as an issue in a number of focus groups, such as outlined in the following quote.

*Being new, really hard to juggle your desire to want to have good rapport and work with them as opposed to them doing what they’re supposed to be doing, so not giving them too much slack which you’ll regret later on. So, learnt quite a few lessons.*

*(Participant 27)*

The importance of modelling appropriate behaviours and maintaining appropriate boundaries, particularly for clients with personality dysfunction, was a recurring theme within focus groups. So the manner in which tasks were negotiated occurred from this stance but with an emphasis on exercising appropriate flexibility, as demonstrated in the following quote.

*While you can pre-plan as much as you like, it’s also with rolling with whatever happens in the group. You might decide on an exercise, and you sit and explain it, and that’s just not going to work with them, so it’s a matter of also being able to be spontaneous and flexible within the group to determine how they’re feeling, how they’re going to react.* *(Participant 6)*

Participants also conveyed there was therapeutic value in negotiating with clients if they initially responded negatively to a suggested activity but were able to nominate or
agree to other relevant tasks to achieve the same therapeutic benefit. This view of task selection was common although one therapist insisted that if she had set tasks, as what happens in the community, these were non-negotiable and she would work through any ‘barriers’ clients raised to undertaking them. Another suggested that clients were obliged to undertake tasks by virtue of their prisoner status as articulated in the following quote.

*but they know they have to do it, they're in prison. So the tasks are kind of non-negotiable, well they’re only negotiable to an extent, because there’s a manual, and they’re in prison so...* (Participant 1)

Variation existed between a number of therapists on how they approached treatment and, therefore, what they considered the central tasks to treatment. While many therapists focussed on the delivery of activities either in the manual or adapted from the manual as the core task of treatment, others viewed development of the therapeutic relationship, identifying and intervening with offence-paralleling behaviour and creating cognitive dissonance as integral. The following quote demonstrates the latter.

*We actually channel the group so it's actually going to meet their criminogenic needs, because so many of their criminogenic needs are based ultimately in peer relationships and relationships in general, for example, the ability to give feedback. Some we'll probably emphasise that a bit more because it's a key factor in their offending, and poor skills in communication and things like that, so we'll try to utilise the group and give them that experience in addition to the challenging to actually build some skills up.* (Participant 13)

Overall, then, participants described setting and adapting treatment tasks to achieve program objectives with clients based on their fundamental beliefs around how change occurs. This varied from the delivery of program material, challenging current behaviour, and setting in-session treatment tasks to address offence-paralleling behaviour. All participants articulated the importance of being responsive to a range of individual difference characteristics, although particularly to learning styles. While there were instances in which participants described the client’s prisoner status as requiring them to undertake nominated tasks, most articulated that their role was to accommodate objections
raised by clients, and some viewed client objections as a therapeutic opportunity to intervene with clients.

To what extent do therapists believe that a strong emotional bond is necessary for therapeutic outcomes to be achieved?

There was overall agreement on the importance of making an emotional connection with clients, particularly as a means of engaging clients to even have them consider program participation. Almost all participants, however, rejected the need for this to be a ‘strong emotional bond’, but rather used terms such as ‘rapport’ and ‘professional relationship.’ There was a general belief that the better the quality of the bond, the greater the potential outcomes for clients, as this quote shows.

But the more you can establish the bond, not just, you know, with the facilitator but in the whole group, umm, breeds investment in the group, and I think that, yep, the more that they invest in the group and the more they feel comfortable and trust the more they’re going to put in, the more they’re going to get out of it, and I think that’s a huge factor in how much success your group has. (Participant 1)

Other focus group members emphasised the importance of the bond amongst group members and the role of therapists in promoting a level of relatedness with both facilitators and other group members. Some participants pointed to the importance of ‘not pushing the group members too far too quickly’ and another made the following comment.

I think they’re always sussing out the way you enforce rules or boundaries or things, and if you’re doing that fairly and consistently then there’s that respect and they can trust that they can come to you if there’s a problem, that something will be handled in an appropriate way and that it’s always being monitored. And also if there’s no trust in a group, then people aren’t inclined to disclose anything, and then it becomes difficult to form any kind of relationship if they’re not even talking or opening up. (Participant 22)

While the bond was posited as important by most group members, there was variation on how participants viewed the nature of this connection. Some participants stated
that they needed a close relationship in order for the quality of the therapeutic relationship to withstand challenging participants, as shown in the following quote.

*I think it is really essential to have some sort of rapport with the person you are trying to help or to treat. With that said, usually I find that’s one of the easiest things to establish, the rapport with the clients. I guess the difficulty then is to not have that not shaken or stirred by us challenging them or setting clear sort of boundaries and being directive. (Participant 12)*

Other participants, however, said that their emotional connection had to be detached for them to effectively challenge clients. This was seen to facilitate therapist objectivity as well as reducing emotional connections being confused with friendships. The following quote demonstrates this latter notion.

*Bond, I think liked, that you need to be liked by your participants or anything like that, and I think it’s about establishing a respect as opposed to a likeness, because you are going to be challenging. So you want to be able to be consistent and fair in your approach to how you do that. So it’s not about challenging someone and then all of a sudden they’re like “Oh, why am I being challenged?” So it’s challenging across the board, to everybody, and being fair and consistent. (Participant 5)*

This sentiment was shared by the two other participants in this focus group, although ‘rapport’ was still seen as a critical factor to assist achieving positive treatment outcomes by therapists and group members demonstrating mutual respect and developing trust.

An alternative view of the bond developed between therapists and group members was articulated by a male participant who also stated his belief that client change was achieved through the therapeutic relationship but added the following observation.

*To me it’s transparency, the relationship is actually an effort at transparency, “This is what we’re seeing, this is what we’d like you to do” and we’re absolutely crystal clear, the group is a priority, not the individual. (Participant 13)*
A male participant in another focus group echoed similar sentiments in a pragmatic view about the nature of the bond required to achieve the goal of clients leading an offence-free lifestyle.

*It’s in everyone's interests that they don’t come back, even though you might have different motivation from your client as to why you don’t want them back, as to why they don’t want to be back, it’s a shared goal. And then you can quite often say to them “I've got a couple of cute techniques that you can learn that will help you with that. You don’t have to fully embrace my moral code or my values, but how 'bout you try these things and I won’t see you again, and that will be good for both of us.” (Participant 16)*

Other participants offered different qualitative aspects to their view of the bond required to achieve therapeutic outcomes, one in which a greater personal connection was suggested. One of these participants provided this response when asked if it was important to form a strong emotional connection with clients. ‘I actually think it is, because it’s part of your authenticity, you go through a program, you talk about some really deep stuff. And I think that it’s part of your authenticity’ (Participant 8).

Another female participant in this same focus group also raised the therapeutic value of working through differences between therapists and clients within treatment as well as developing a bond with clients who have been deprived of intimate relationships.

*Some people in the group have never had that strong emotional bond, and I still think, and I don’t know if I’m justifying here, that it’s also part of role modelling. “That’s okay, while you’re in here..” being able to say “we can only go so far. We can’t give you a cuddle..” It’s still a professional relationship, but you can still have some warmth and attachment, and say “Well done, fantastic, it’s the first time you’ve done something. Isn’t that great.” So you can still have some of that parental role, but without being the parent. (Participant 9)*

The impact of the bond on achieving therapeutic outcomes was also posed as an important factor in relation to some program content, as demonstrated in the following quote by another female participant in a different focus group.
I think you're missing, you're less likely to do well in certain areas if you don't have that therapeutic relationship. There's core stuff that we're going to get through and maybe satisfy, but the more personal stuff about relationships and self-esteem, and all that stuff, the interpersonal stuff, which is such a big issue for most of our clients, my gut instinct is that they wouldn't work through that as well. (Participant 10)

All participants described their varying views on the bond consistent with the notion of the TA in which it is posited that the bond needs to be strong enough to facilitate the treatment process, although beliefs varied around how strong that connection needed to be. Views articulated by participants varied from those that paralleled aspects of good parenting, and emphasised demonstrating care and respect, developing trust, and consistently enforcing appropriate boundaries, while others conveyed their role as more akin to a teacher who facilitated client learning but remained dispassionate. To some extent, participants who articulated this latter view also conveyed a fear around developing a closeness with clients, and remaining detached served as a form of self-protection. This served to ensure clients would not misconstrue this experience as being 'liked' by the therapist and/or result in the therapist losing objectivity within treatment. The antithesis of this was participants who viewed the bond as being central to change because of the interpersonal interactions that occur within treatment and therefore importance was placed on the therapist allowing an opening for that relationship to develop.

What are the positive therapist characteristics demonstrated that contribute to developing a therapeutic alliance?

Having good knowledge of both program material and the characteristics of clients, an ability to deliver material in a way that is engaging, and demonstrate positive therapist characteristics (e.g., being flexible, transparent, empathetic, authentic, and having an ability to create common ground), were particularly cited by participants as important to the delivery of efficacious treatment. A number of participants also pointed to the importance of being skilled at identifying and responding to ruptures in a non-defensive manner and in a way that encourages positive behaviour change.

Several participants pointed to the utility of having a range of personality factors to


assist in their work role. These particularly included having a good sense of humour, working collaboratively and flexibly, and demonstrating a level of enthusiasm while conveying a commitment to client change. The following quote also highlights the importance of therapists being able to reconcile the dialectic of accepting a client’s value system while also promoting change.

*If you’re going to make a value judgement that someone has said something grouse, and it is a value judgement, what I find offensive and what you find offensive, they’re different things. I don’t have a mortgage on morality, right? My clients come to the group with a value system that they’ve learnt, and in some ways it’s valid, it’s got to come from somewhere. We’re challenging it, we’re working with it, but it’s where they’re at. (Participant 16)*

The importance of being realistic about the amount and type of change therapists should expect from clients was also raised as an issue in a number of focus groups, as revealed in this quote.

*I think you adjust your own expectations when you’re working with offenders to see the small shifts they make are quite significant ones and positive in light of all the challenges of making those changes. (Participant 24)*

Many participants articulated the importance of demonstrating a range of positive therapist characteristics to assist in developing the therapeutic alliance. Trust was invariably viewed as a key factor relating to the success of treatment and flexibility was suggested by most to be important in negotiating tasks. Therapists generally articulated that it was important to develop common ground as well as be transparent, authentic, genuine, and understanding to foster the bond with clients. The role of positive therapist characteristics creating the context for the therapeutic process was a recurring theme amongst participants, as demonstrated in the following quote.

*I think transparency actually in probably any of the issues is incredibly important, showing that I respect the client and their time and their commitment, and that I can see the progress they’re making and really working with them as much as possible. I think it’s something I try to do automatically anyway. It’s also quite good for band aid*
work. You know, then if I’m already doing that, it makes it easier to up the ante if something goes wrong. (Participant 10)

This quote was representative of many participants who emphasised the importance of fostering relatedness such as through the use of appropriate humour and making sure participants feel comfortable to undertake treatment. Demonstrating a commitment to assist clients make therapeutic gains was also a consistent theme amongst participants to develop the alliance. There was some emphasis on the importance of normalising clients’ experiences within treatment and working with clients in a non-judgemental manner.

A number of therapists discussed the role of empathy as critical in undertaking treatment, such as outlined in the following quote.

*Ability to be empathetic with the offenders is huge. Actually I think that’s probably what it entirely comes down to. You have to be able to empathise but at the same time...bear in mind that there are victims of their offences.* (Participant 26)

Demonstrating good boundaries, being consistent and communicating expectations clearly while also being engaging, honest and authentic comprise some of the balance required in demonstrating positive therapist characteristics that foster the alliance, such as outlined in this quote.

*I’ll also come back to that authenticity, if people feel that you’re being authentic in the way you present and that you’re consistent and that you are not something other than you’re presenting, because they’re very good at looking for the inconsistencies or the flaws, you know, the judgements, and if they feel that you’re not judging them but you might be reflecting on what they’re doing, and providing a view on that or reinforcing positive behaviours, but you’re not judging them as being something other, you know, the other.* (Participant 24)

Participants articulated the importance of having adequate knowledge, skills and demonstrating a range of positive therapeutic characteristics to facilitate achieving aspects of the TA. Female participants were more likely to, however, emphasise the importance of empathy whereas male participants were more likely to emphasise a shared commitment to
the therapeutic process. Underlying this for all participants, however, is the assumption that a connection is made with clients to achieve therapeutic outcomes and reduce the likelihood that clients will prematurely leave treatment. The importance of ‘trust’ being developed to facilitate this process implies a level of reciprocity within the therapeutic relationship although this conflicts with some participants also asserting that a level of detachment was required within the therapeutic bond. The manner in which therapists attempt to resolve some of these interpersonal dilemmas is discussed further below in relation to negative therapist characteristics.

Ruptures

What types of ruptures occur in offending behaviour programs and what are the varying approaches taken by therapists to repair difficulties?

Node Definition

Themes discussed on identifying and responding to ruptures, which occur when the strength of the therapeutic alliance is threatened due to either problems in negotiating tasks, misalignment of treatment goals, and/or problems in the therapeutic bond. A number of child nodes were created from this information: ruptures linked to cognitive dysfunction, mental health issues, cultural beliefs and attitudes, and gender issues; dysfunctional personality traits that pose difficulties for the alliance.

Main findings

- Factors specific to clients’ disability, gender, and culture were discussed in terms of potentiating therapeutic ruptures. This was largely due to therapists needing to take different approaches compared to more mainstream clients to ensure individual needs were accommodated.
- Antisocial and psychopathic traits raised particular challenges in groups due to problems in therapists’ ability to create relatedness with clients, the lack of alignment in treatment goals between therapists and clients, and the impact these behaviours might have on both therapists and other participants.
- Challenges raised by clients who present as withdrawn and avoidant included difficulty understanding the reason for the presentation, therapists experiencing
a lack of ability to intervene, and problems associated with clients not being able to verbalise anger or other aspects of their treatment experience.

- Clients who demonstrated narcissistic traits posed particular issues in treatment due to their lack of openness to the treatment process and denial of their own need for change. These clients could also be challenging for younger and less experienced participants, who articulated anxiety in response to accusations by clients of their incompetence.

- Traits of neuroticism posed particular challenges to the alliance due to factors such as clients experiencing high levels of emotional reactivity, hypersensitivity to therapists’ comments, clients getting stuck on their own experiences of victimisation, and interpersonal issues due to poor attachment experiences.

Discussion around ruptures that clinicians had experienced were identified from a number of factors, but clinicians often linked problems in one area as having repercussions on each of the elements of the therapeutic alliance, particularly on the bond. As demonstrated in Table 3, overwhelmingly these latter concerned dysfunctional personality traits, although some references were made in relation to cognitive dysfunction, mental health problems, cultural issues, and gender issues.

To what extent do factors such as a client’s disability or issues relating to diversity impact on the alliance?

A range of issues were raised in relation to disability, culture, and gender as factors that could potentiate ruptures. The most commonly cited issue in this regard was problems with literacy, although other forms of cognitive disability (e.g., ‘low intelligence’ and ‘mild disability’) were mentioned. The challenge of selecting appropriate tasks and potential risk of, for example, prescribing goals for these clients were raised as potentially creating problems in the alliance. One participant also articulated that she had difficulty at times working with ‘the young dick-heads who just think they’re invincible’ (Participant 1).

One participant raised potential issues when treating Aboriginal clients in treatment, and how this might impact on their participation.

When you have a number of them in the group, one’s always considered the elder.
When that person is struggling with a concept or when that person is being resistant, the others feel the need to side with him and follow on, even though it might not be their view. (Participant 26)

A number of comments were also made in relation to working with female clients, and characteristics of this group that could pose challenges to the alliance, such as the competitiveness experienced when working with female therapists, boundary pushing (e.g., asking for personal information), and as demonstrated in the following quote.

A lot more process work, and a lot more victimisation, and colluding together, whereas the men will move forward when things..., they collude, and keep talking about it, and get stuck in it. (Participant 9)

Dealing with symptoms of mental health was also raised by a number of therapists as posing difficulties in the alliance, particularly paranoia and dissociation, but also those with psychotic disorders such as demonstrated in the following quote.

Because there will be people with mental health issues, and if they are stabilised on medication we certainly will accept them into the group, and we do, and I've run groups where we've had people on Community Treatment Orders, and they get their injections of antipsychotic on a fortnightly basis, and often times as not, the week they've got the injection they're absolutely lucid and articulate, and the week that they haven't, it becomes rather challenging. (Participant 14)

The following quote by a participant also demonstrates the impact clients with specific needs can have on group dynamics.

If there's one particular group member who has a specific need, whether it be mental health, depression or suicidality, it's very easy to drift into a situation that borders on a conflict of interest, in that you're showing that person probably more attention, watching them. (Participant 15)
This discussion then outlined how this additional attention afforded to specific group members could impact on other group members negatively due to the ‘special treatment’ afforded them.

Participants demonstrated a level of sensitivity to having to identify and respond constructively to clients who demonstrated disability or diversity by having the appropriate knowledge and skills so that these clients’ particular issues could be accommodated for them to achieve program objectives.

**What are the ways in which personality dysfunction impacts on the alliance?**

Due to the extensive focus of discussion on personality disorder traits in a number of focus groups, this child node was further divided into four nodes. Participants raised issues around personality in responses to questions around the clients with whom they experienced difficulties in developing an alliance, but also in discussion around ruptures and difficult group experiences. These nodes and their definitions follow: antisocial and psychopathic (client characteristics that demonstrate anti-social, anti-authoritarian views, aggression and hostility, pro-offending beliefs, a lack of remorse, high levels of rigidity, and a sense of self-entitlement); avoidant and withdrawn (clients who demonstrate a lack of interest in developing a connection with both therapists and other group members and are withdrawn from the process and avoidant of revealing their own experience or participation in group tasks); narcissistic (clients demonstrating grandiosity, patronising attitudes, who make significant attempts at having others see them in a positive light, dominate group time, and are denigrating of therapist skills/personality/status) and neuroticism (clients who demonstrate high levels of emotional reactivity, dependency on others, complain excessively, and demonstrate an external locus of control. Personality disorders included in this category are Borderline personality disorder (PD), Histrionic PD, and Dependent PD).

**Anti-social and psychopathic traits**

Table 3 demonstrates that the overwhelmingly predominant category of personality dysfunction discussed in focus groups related to anti-social and psychopathic personality traits. This group of clients can have a significant impact on therapists’ ability to undertake treatment. Various examples were raised by a number of participants of clients demonstrating aggressive behaviour, particularly when objecting to undertaking a
nominated treatment task. Numerous participants also raised issues relating to clients not taking responsibility for a range of circumstances, such as the commission of their offending but also their treatment participation, such as poor punctuality. The following quote demonstrates the frustration experienced in relation to an issue with a challenging group. ‘I had to ask them about twenty times, but without getting an answer “Okay, I will do what you suggested, however what can you do to make this group work?”’ (Participant 12).

Another theme that was raised by numerous participants concerned clients lying in treatment in a range of circumstances, from promoting a more positive image of themselves to excusing lateness. More pervasive pro-offending and anti-authoritarian beliefs were also identified as posing a challenge in the following quote made about a client who was eventually moved from a prison due to the disruptive behaviour he engaged in both in and out of treatment.

_We had a Koori⁴ guy who did Exploring Change but he was removed from it. He so strongly identified as a Koori, very young fella and had unfortunately had only been in contact with the more antisocial elements of it, not pro-social people. So he was brought up believing that “All white people have stolen from us, and what I’m doing is just taking it back” so he was completely unsuited to group and spent his time in group drawing Aboriginal flags on chairs... Just stamping his identity, “I don’t need to be here because I haven’t done anything wrong.”_ (Participant 27)

Expression of anger, hostility and aggression, particularly in conjunction with clients articulating that they did not require treatment and/or that there was a good reason for their offending, were commonly raised as a challenge in treatment. The following quote was made by a participant who discussed the difficulty of having clients in group who were not treatment ready in this regard.

_...still at that highly angry resistant stage, and they just want to process their anger and their feelings of injustice, and so on and so forth, about being there. That can then take a long time to repair to get the group working._ (Participant 14)

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⁴ This is a general term used to describe people who identify as from an Aboriginal cultural heritage in this part of Australia.
A range of antisocial behaviours that are difficult to deal with in treatment were articulated by one participant in the following quote.

...just the ones that are so pre-contemplation that they're not even in pre-contemplation, they're just pro-offending. So it’s “f the world and f this group” and I mean, ironically I have a real problem with disrespect, so when participants in groups do things in group that are disrespectful, even something like coming in with their sunglasses on, with their feet up on the chair, it really irks me. I just have to manage that and not over react. (Participant 4)

The difficulty of clients who demonstrate personality disorder traits to adhere to group rules because of their need to feel control was a recurring theme. This notion was also reflected in the following comment by a participant describing clients who commit offences involving domestic violence (DV).

Whether it’s though DV, where they create broken eggshells for people to walk on and “Oh, don’t go there, you’ll upset him,” and when they realise they have a robust facilitator who knows no egg-shells, they find that incredibly difficult and don’t know how to manage the conflict, so continue doing what they’ve always done. (Participant 13)

Several participants also described some highly significant events that signified severe therapeutic ruptures. This included two participants who stated that they had almost been physically assaulted by clients, another two participants who stated that their own clients in group had almost engaged in physical altercations, and yet other participants who described threats that were direct (e.g., being told by a client that he knew where the therapist lived and had her followed) and indirect (e.g., a client asking if anyone had ever hit the therapist in one of her groups).

The significant challenges in treating clients who demonstrate psychopathic traits were evident. One participant described the enjoyment one of her clients seemed to experience in discussing the pain he had inflicted on others and in glorifying his violent offences. Several participants mentioned the challenge of identifying whether you achieve rapport with these clients given they are good at ‘pretending’ and may be agreeable to
therapists due to other gains they think they might achieve for themselves. A range of other challenges posed by these clients was articulated by a participant in the following quote.

He has very limited facial expression and very limited inflection when he speaks, so sometimes he’ll be joking with you and you won’t know it and so you’ll think he’s being serious, so your response is different. Where other times you will joke with him and his response will be nothing and so you’re like “Is there anything going on behind there?” and he’s quite blunt and like snappy. And even if you were to make a joke, like humour, he is sort of the class clown, he’s trying to get everyone on side, so if you try to make a joke to go along with what he’s doing, his response is to try and cut you off and act like you’re not a part of it. So he’s trying to create the “us and them” barrier and get all the offenders on side, but not have us on his side at all. I wouldn’t have a clue if I have therapeutic rapport with him or not, I couldn’t tell you. (Participant 26)

Another participant in another focus group raised similar challenges in dealing with a client who demonstrated psychopathic traits but who was eventually removed from the group due to not only the problems identified by the therapist but also group members who complained about his behaviour.

Both anti-social as well as psychopathic traits could have far reaching effects in group. A significant theme amongst participants concerned the impact that antisocial behaviours had on other participants. This impact was variable, from encouraging collusion of further antisocial behaviours with other group members (e.g., drug use during sessions) to group members being abusive towards other group members such as demonstrated in the following comment by a participant who stated ‘The others will try to contribute but then they get the stare-downs from other participants’ (Participant 19). The impact of these incidents on subsequent treatment was articulated by another participant describing a situation in which a group member had refused to participate in a role-play and her co-facilitator had insisted he participate in it.

...whilst it might be one offender making that threat or enacting violence towards the facilitator, it can cause a rupture in the whole group, all depending on how you react to that, what action you take, how they saw the intention. I mean, that’s just potentially fatal to the whole group, not just the two people involved. (Participant 6)
Comments by participants in relation to responding to antisocial and psychopathic traits suggests these transactions pose difficulties due to a range of reasons. This includes the disconnection between therapists and clients value systems and beliefs around acceptable behaviour, therapists not responding adequately to efforts by clients to create emotional distance in therapeutic encounters, but also due to the physical threat that clients demonstrate. This latter might be viewed as a strong rejection of the therapeutic experience by clients in response to negative treatment experiences.

Avoidant and withdrawn traits

Some of the challenges of working with clients who are withdrawn in group were articulated by a number of participants, particularly in relation to the difficulty of trying to understand a client’s presentation when they do not offer much information about themselves either to therapists or the wider group. Participants gave a variety of suggestions in this regard, such as introversion, resistance, and/or a lack of understanding of what was happening in the group. Another participant added the following in relation to this discussion.

*I find it so frustrating that they don’t do anything and they’ll externalise things. Put the cards out and still nothing, and even after twenty-something sessions, you still get nothing. I find they’re really frustrating. (Participant 9)*

A number of participants also pointed to clients becoming withdrawn in response to other group members’ behaviour, and the challenge of having them repair the difficulty. In addition, other group members may also feel frustrated due to withdrawn clients not contributing to group discussion.

A female participant discussing her experience with female clients raised that clients might be withdrawn due to their concerns about what might be relayed to the parole board. She also articulated the following in relation to how clients who have difficulty verbalising their difficulties or anger may experience a group

*One client said “You know, I was having a bad day” but she was not able to verbalise that she was having a bad day, but she missed the session, but she said she went to*
the medical centre but actually the time didn’t clash with the program time. So when we confronted her with the evidence then she said “Well how come it’s okay for so and so to pack up their special spends, when I genuinely have a bad, you know, hard day, and I couldn’t really go?” so for her it changed the whole perspective of how she perceived the group and how she perceived the facilitator, and I think sometimes if not spoken, it creates a lot of tension in the group, and it’s difficult for the clinician to deal with. (Participant 21)

Withdrawn clients therefore appear to pose particular challenges for therapists as participants described experiencing significant levels of impotence due to problems in understanding and responding to these behaviours more so than any other client presentation described. Clients may equally, however, demonstrate social withdrawal due to difficulties in being able to express themselves adequately in a treatment context or fears that their views will be used against them. This latter may be a particular consequence of the forensic context given program participation is being monitored and reported on by therapists to correctional authorities.

Narcissistic traits

A number of participants particularly raised difficulties in responding to grandiosity demonstrated by some clients, as articulated by a participant who provided the following comment, ‘Ones that think they’re so good, they’re the third facilitator and they’re going to tell you how to run the group’ (Participant 9).

Participants also articulated a number of experiences in which clients would denigrate them on the basis of their lack of expertise or age, and question their suitability to treat them. It was within this context that participants often found it frustrating when these same clients would deny that they had any problems or issues relating to their risk of re-offending. The responses that narcissistic clients might elicit in younger and less experienced therapists due to their approach to treatment and its impact on the bond was articulated by one participant in the following quote.

The one’s I find most difficult to work with are the over confident, I don’t mind confidence, I’m all good for it you know, but over confidence to the point of resistance, and I think maybe that stems from a little bit from my insecurities of my abilities, in
that I feel like I’m not a clinician, or I haven’t had any formal training, so I get a little bit anxious to these really resistant guys who almost do the stand over, so I become conscious about what I say and what I do, am I going to react appropriately, have I done the right thing? So I think my... I get a lot of anxiety to those men. (Participant 6)

This last quote perhaps exemplifies the particular tension posed by narcissistic clients. Clients demonstrating these traits may be responding to a perceived lack of control within the treatment context due to the position of power held by therapists, although younger and less experienced therapists are perhaps more vulnerable to these attempts at asserting power and control due to beliefs about their own inadequacies.

**Neuroticism**

A number of challenges to the alliance were raised by participants in relation to clients’ emotional reactivity to what was happening in treatment and their inability to tolerate these emotions. Another theme in discussing clients demonstrating neurotic personality traits concerned those who excessively complained in treatment and articulated an inability to change so it impinged on all aspects of the alliance. In discussing the difficulty of dealing with clients in the community, one participant pointed out the following issues that impinge on treatment experiences.

*Dysfunctional lives, chaotic lives, lives filled with crises, and also substance abuse issues, so the presentation of a whole group of offenders can change from one session to the other.* (Participant 14)

One participant described a particularly complex client, who demonstrated a range of traits including aggression and grandiosity, but also traits of neuroses.

*He was really hard to listen to, he just kept going around in circles getting to his point, so you just had to spend too much time trying to work out what he was talking about. I also have an issue with needy clients.* (Participant 17)

Another issue raised by a participant concerned the difficulties that could be raised by clients who demonstrate a hypersensitivity to what is discussed in treatment.
One of the group member was saying “Can you just stop please, don’t drown in it” or “don’t rub it in.” I was obviously not knowing what was going on. I thought I was being empathic, so I think sometimes there might be a discrepancy as well. (Participant 21)

A number of participants raised issues in relation to working with clients who demonstrated Borderline PD traits, such as discussed by this female participant who worked with female clients and commented on the interpersonal challenges they posed due to their constantly changing presentations.

Working with personality disordered clients and they’re up and down so much, and I think often testing, and testing you to see how you’ll react, and they want you to react in the way they’ve had people react in the past. (Participant 22)

Therapists described some difficulty in responding to clients who demonstrated problems in regulating emotions, experiencing a lack of empowerment, and demonstrating hypersensitivity to criticism in response to treatment experiences. It may be that therapists had difficulty in this regard due to these behaviours challenging their beliefs around how others should control their emotions. It may also exemplify differences in life experiences between therapists and clients, as these types of responses may have been more commonplace in clients’ families and peer-groups but juxtapose the life experiences of many therapists.

Rupture Repair Responses

Node Definition

Strategies, techniques and stances described to respond to ruptures. These included a wide range of techniques that were implemented to respond to goal misalignment, difficulty negotiating tasks, and strains in the bond.

Main findings

- Participants placed a high level of importance on enforcing boundaries with clients who demonstrated inappropriate behaviour in group regardless of their treatment approach.
A range of strategies were identified to manage difficult behaviours, such as discussing group rules and the consequences of continuing negative behaviour resulting in removal from treatment.

Positive therapist characteristics to respond to ruptures were described, including demonstrating flexibility when clients objected to suggested tasks, patience when responding to problems in the bond, and being transparent when observed group behaviours misaligned with program goals.

A number of other techniques were identified as useful to promote engagement with clients and foster the therapeutic bond, including the use of experiential activities, encouraging the group to assist resolving group problems, motivational interviewing techniques, and validation.

A number of participants described using therapeutic approaches to ruptures, such as promoting corrective emotional experiences, raising self-awareness by processing in-session behaviour, and encouraging pro-social behaviour change.

Enforcing Boundaries and Managing the Delivery of Group Content

An ongoing decision participants talked about in relation to clients demonstrating difficult behaviours was whether (and when) to remove them from groups, and strategies to attempt to resolve the group member’s problematic behaviours early on in their treatment experience to avoid this if possible. These other strategies often included reinforcing the group rules and the consequences of continuing problematic behaviour both within the group and individually outside of group time. The following quote demonstrates this tension.

*I think the most challenging thing in group is always when someone’s not treatment ready, and the impact they have on the other group, like (focus group participant) was saying, the decision to remove them, how much damage are they doing to the group versus how much we want them to get out of it and how much they need this program as well. I think that’s particularly challenging.* (Participant 26)

A number of participants discussed situations in which they were direct with clients about requiring them to manage inappropriate behaviour. The following quotes, which exemplify this, were made by a participant who spoke at some length about the importance
of engaging clients overall, but described boundary setting as her central means of managing difficult behaviours.

That’s when you’d go up to a client and you’d be saying to them “These are the group rules, this is the contract you signed, let’s go back to that because this is what you’ve actually been like. To be involved in the group you need to be doing ya ya ya. Have you got any way that you’re going to be able to do this? What is the problem around that?” And you actually discuss the whole ins and outs with them, and you’re probably touching base with them quite frequently, and letting them know if they’re changing at all, little things if they’re doing well. (Participant 3)

At the end of the day if they don’t want to be there, fuck, there is the door, you know? I’ve just had three guys that I’ve pulled aside individually from one of my groups. I’ve said to them, they’ve been misbehaving or not handing in homework or just the arrogance.. “I don’t need to do this anyway.” I’ve just pulled them aside and it’s like “Okay, I want you to come back in two hours and I want you to think about why you want to do the program. You need to sell it to me. And if you can’t sell it to me, you will no longer be in the program.” (Participant 3)

Participants all pointed to the importance of therapists being responsible for ensuring appropriate boundaries were reinforced regardless of their approach to treatment. The function of enforcing appropriate boundaries with clients was highlighted by a number of participants, including allowing other group members to participate as demonstrated in the following quote.

Both my co-facilitator and I were very consistent with these two people who were the stronger ones, and we didn’t give them too much air time in terms of we could have spent a lot of time challenging them, but it wasn’t going to work for the rest of the group. (Participant 19)

This notion was further exemplified by a participant who discussed the importance of therapists providing leadership in the group when there is a significant crisis involving group relationships, and this is done through creating structure for participants and modelling appropriate behaviour.
We spent weeks trying to repair the relationship and process what was going on and what this facilitator and I resolved right at the end was I think when everything works really well, facilitators can step back a little and let the group run itself, and I think that’s ideal, but when particularly the therapeutic relationship falls down, and there’s difficulty in the group, and it’s sometimes responding to one particular person, what ended up happening to us is we realised we had to take a more structured role in the group...for the group members to feel safe again, we needed to step in and that’s our job...These are people who are very damaged who don’t know how to resolve it. And to model that behaviour and to give them structure whereby they can come back to it. (Participant 11)

A number of participants also pointed to some basic strategies to manage the delivery of set program material within groups, such as setting time limits for specific activities, or developing rules around participation, as articulated in this quote.

...because you always do get the one dominant or one or two that take over, and the few shy guys in the corner. So I just learnt if I asked everyone, then I just get it over and done with, then everyone has to talk. (Participant 2)

Strategies using behavioural methods to assist clients reduce disruptive behaviour were also described by a participant in relation to a problematic group she had experienced.

They’ve got their own group within the group, and they always try and sit together, but we don’t do that, we just number them off or pick names out of hat. They don’t like it but they do it now. They’re always late to group so it’s great for us, we make sure there’s no three seats together. We’ve just had a discussion about punctuality so now they’re on time, but if they’ve been silly or stuff, it’s unfortunate we have to take the teacher role. (Participant 26)

The ubiquitousness of enforcing boundaries articulated by participants suggests that most therapists would consider this a basic foundation for achieving other therapeutic gains. At a minimum, clients are required to adhere to the group rules developed and maintain a level of respect of other group members and demonstrate honesty in their treatment.
experience. These requirements, however, are not seen to be upheld when clients demonstrate the dysfunctional personality traits described above (e.g., hostility, grandiosity, withdrawal, affect dysregulation), although this contrasts with difficulties identified when disability or diversity are demonstrated (e.g., different cultural beliefs, literacy problems, symptoms of mental illness). While the former often represents a challenge to therapists in achieving therapeutic outcomes with clients, the latter is more likely to be viewed as an issue that therapists need to take responsibility for in order for treatment to work.

Engagement Strategies

While participants expressed the importance of enforcing appropriate boundaries in a variety of ways, the use of other positive therapist characteristics, as discussed above, was also suggested as a means of engaging clients when ruptures occurred. The emphasis in this approach was on fostering the therapeutic bond between therapists and clients. The following quote demonstrates the value of being patient, respectful, and flexible with clients, although balancing this approach with more immediate responses to inappropriate behaviour.

And I think at times he might be also testing you to see if you'll react the same way, and some of the people who enact towards his behaviour and I think sometimes it’s about testing the water, and as clinicians sometimes we have to sort of be patient and roll with the resistance and see what's going on and allow a bit of leeway. I think that's where the flexibility comes in place. Obviously if they're being really behavioural and disrespectful, then I think it has to be called on the spot. (Participant 21)

Flexibility in response to objections clients raised about suggested tasks as well as responding to external factors within a program (e.g., changes to program timetables) were commonly suggested by participants who described changing tasks, modifying goals, and/or re-building the bond with clients to adapt to the new circumstances, as expressed in this quote.

So if something's just really not working, looking at their watches, shuffling around, rolling cigarettes, then it's not working and there's no point in pushing on if it's not going to work. Even if I think it's totally worthwhile and they're just not paying
attention, it’s not going to work either way, so just pop it aside and try something else. (Participant 1)

Themes emerged around the need for therapists to be self-reflective and develop empathy as a strategy to improve their relatedness with clients. Other positive therapist characteristics included responding in a transparent manner and clearly articulating program expectations demonstrated in the following quote from a participant who had the experience of a client being advised by a community corrections officer that he had rated the client’s group participation poorly.

As it turned out, it had a useful therapeutic outcome in the end, because the guy said “What the f do I have to do to get a 4 out of 5?” I said “Well, swear a little bit less and answer a direct question when it’s put to you.” “Oh!” Distinct improvement in group participation thereafter. (Participant 16)

A number of specific techniques were also discussed as useful for promoting client engagement. Experiential exercises were suggested as a useful means to assist in developing cohesion when difficulties arose. Putting issues to the group and having the group assist in resolving the problem was also commonly articulated as a strategy to both foster client engagement while also responding to group problems, which the following quote illustrates.

You might just say “All right, we’ve had this incident. That was pretty full on. How do we as a group, because you’re all part of this group, how do we want to resolve that?” (Participant 4)

A range of examples were provided in which motivational interviewing techniques were used to respond to clients demonstrating ambivalence towards treatment. One participant described using humour and avoiding arguments in response to ongoing concerns from group members about what she and her co-facilitator were writing in reports about them.

So now we’ve changed tack and we’re just going with the humorous, and now they laugh (about) it, now they think it’s funny, because, like, “We’re not going to argue with you about this any longer.” (Participant 26)
This participant also described using Socratic questioning in response to clients who used cultural explanations to justify their offending by asking ‘My understanding is not that, can you tell me how it works?’ This same group participant also provided another example with a client she said demonstrated narcissistic traits.

I think quite early on in the group we spent a lot of time doing the team building things and then he left and after group my co-facilitator and I had a conversation with him and he said “No one wants me in there” and we fed back to him, it was just motivational interactions, like he had said in the past that he doesn’t feel like the system has offered him enough support and he would like more of that, so we were saying to him “This is your opportunity to get that support and we understand that it’s difficult, but if you can stay in the room then you’re helping yourself” and he came back, and he did experience difficulty and he was often snide and rude, but the group was really well formed so they were able to challenge him on that, they were happy to do that. (Participant 26)

The importance of not being argumentative with clients was a common theme amongst participants, and this was highlighted in the following comment made by a participant describing her experience of facilitating a group where there were a couple of prison ‘heavies.’

We didn’t set ourselves up as the expert, because one of the tacks that one of these women would take was “Well, what would you know?” “Dunno, what do you guys think?” so always taking it back to the group, so they lost that way of challenging. (Participant 19)

This notion of not promoting therapists as experts was common, and promoted as a means of creating common ground with clients. Using strategies to work alongside clients, particularly those who demonstrated narcissistic traits, was raised in a number of focus groups. One participant said she would suggest to clients who were not engaged in treatment ‘These guys could really benefit from your experience’ (Participant 19) and another participant in another focus group made the following comment.
You can be smart too with someone like that who's monopolising the group, in taking him aside and saying “Hang on fella, you’re carrying this group. You’re actually doing all the work, why don’t you let them do some of the work?” (Participant 15)

Validating clients’ concerns while encouraging change was commonly raised in focus groups, as demonstrated in the following quote.

With the anti-social ones, or maybe with any of the personality disordered people, trying to validate I guess what they’re experiencing where they’re at and what their difficulties are but at the same time balancing that with challenging them to make changes or do things more functionally. (Participant 4)

Similarly, other participants raised the importance of working with psychopaths in a way that illuminated how these clients could have their needs met in pro-social ways, and this could still occur within the context of developing common ground, as this quote illustrates.

I’m certainly thinking of some of the people you would definitely say have really strong psychopathic traits, really, and the emotional connection, whilst it might appear that it’s something, you’d have to question the authenticity of it and realise that that person may be very well trying to hook into you because of what they want to get out of it, so being very careful of how you approach that. And with some people I’d certainly be focussing on the behaviour, and looking at how they can change what they’re doing, what purpose is it serving for them and also whether they can achieve that through another pro-social means rather than trying to create empathy with somebody who’s clearly doesn’t have any, or very limited capacity to empathise, and is really not interested but they want to get you hooked in. So I think you have to be fairly sophisticated when you do that because you may actually just be buying into how they’re presenting and there’s no genuine feel to it, it’s very questionable. (Participant 24)

The participants in this focus group, who were senior clinicians, promoted both the importance of maintaining clear boundaries and a treatment plan when dealing with more extreme personality disorder traits, while also discussing the value in engaging in a
consistent, authentic, and transparent manner.

They're more ready to come and express an opinion and get some feedback so engaging with them in that way. And if they've come back, they've immediately come back and asked “Can I catch up with you, can I see you?” so I think there is an element of trust there, so they maybe feel there is someone they can trust to work with, umm, they value perhaps the feedback. Sometimes they're looking for advice, because they just don't know what to do. (Participant 24)

The manner in which engagement strategies were described perhaps exemplifies the crux of the TA, being to develop purposive and collaborative treatment experiences with clients to assist in achieving therapeutic gains and reduce the likelihood of treatment attrition. These strategies assume that the therapist takes a level of responsibility for developing approaches that will foster treatment engagement to identify treatment goals and undertake treatment tasks while affording clients an appropriate level of acceptance and respect. Demonstrating positive therapist characteristics while also enacting motivational interviewing strategies to respond to client ambivalence assists in developing relatedness to facilitate this process. A consistency exists, therefore, between participants stating that the TA is relevant to delivering offending behaviour programs and many participants’ descriptions of the strategies and techniques they utilise when therapeutic ruptures occur.

Ruptures as Opportunities for Therapeutic Change

The importance of challenging clients’ in-sessions behaviour when it misaligned with program goals to encourage behaviour change was discussed in a number of focus groups. Participants in one focus group discussed that the variable manner in which feedback can be provided to clients, such as providing a direct comment and in-depth exploration of an issue, making a ‘wayward’ comment to highlight a particular issue in a non-confrontational manner, and the use of silence were suggested as some of the options to highlight client behaviour.

Strategies to illuminate and express difficult emotions experienced by clients that might interfere with group performance were raised in a number of focus groups, but
particularly with those who had worked with female clients, as demonstrated in the following quote.

It starts off them declaring their emotions, so it’s good to get an idea of where they’re at, and then asking them to say “What are you going to do about that, how are you going to manage that today?” and I think they find it helpful just to say it. So that’s been helpful, putting it out there and then asking how the group can support this person through that. (Participant 22)

Similarly, the importance of processing group behaviour in order to explore the underlying difficulties clients sometimes sit with that might impact on the bond and group cohesion were raised on numerous occasions, as exemplified in the following quotes from two different focus groups.

I’m quite attuned to how the rest of the group is responding, you notice the body language changes, the rolling of the eyes, and during feedback, how robust the level of feedback is, you know “I choose not to give you any feedback,” which is a snub in of itself of that particular guy. I’m really attuned to that, as well as the individual needs. (Participant 13)

So what’s going on in the room, and then is there anything going on with these guys, particularly in a prison setting, that’s making it unsafe for them to do that? So is there anything I guess happening in the compound that’s being brought into the room? Then I often think back to the previous session, is there anything that happened in the previous session that they’ve brought with them again today that’s got their backs up or they’re just angry about? Are they sitting with a challenge that they’re angry about? I know, I can think of a group, someone.. my co-facilitator had just put something in the way that had offended the guys, and they didn’t say anything at the time, noticed a slight reaction at the time, but they sat with it and they brought it back to the next group. (Participant 19)

This last participant went on to discuss how she responds to anti-social behaviour in an effort to allow other group members to participate more fully.
I’d actually process a lot more on their body language so they’re not attacking the other participants. I’d much rather that come back to the facilitator because it then allows these guys to feel “Okay, I can contribute.” (Participant 19)

A participant in another focus group also commented on the utility of processing in-session behaviour with clients who demonstrate Borderline PD traits in conjunction with clear boundary setting and articulating program expectations.

I find it useful by giving them feedback and providing them with structures, so with more concrete thinking styles, so say “You were behaving quite okay yesterday, so you were nice to me yesterday, but obviously today you’re not okay” I think by itself by providing that feedback, and being reflective of your experience, by saying “when you do that, I wasn’t sure what was going on, it’s kind of confusing” and it gives them the opportunity to be able to be reflective of their behaviour, sometimes they’re not aware so you do it on purpose, so you give them that feedback and being able to be transparent and say “That might be some of the things you like to do, but if you continue to do so, there are certain actions to follow” and I think that gives them the expectations and it communicates your expectation as facilitator about certain behaviour in the group. And maybe sometimes, you can’t just change things in one day. (Participant 21)

Participants often highlighted the value of providing a respectful therapeutic relationship for clients who have not experienced a functional relationship previously, or a corrective emotional experience, which a participant suggested is ‘trying to really shape that attachment’ (Participant 23). Later in this focus group, another participant also pointed out that this approach contributes to the client by demonstrating that not all relationships have to be ‘stuffed’. Another perspective was offered within another focus group on the value of providing feedback within the therapeutic relationship, and responding to ruptures relating to the therapeutic bond to address misogynistic beliefs.

They’ll try out different styles with women, and they’ll try it out with you, and you can normalise that. It can be really pro-social and helpful. Through their offending behaviour they come and they try all their different styles on you. You sort of set them straight. A lot of guys can work through a lot of interpersonal skill problems
with them with a woman facilitator in the group. (Participant 8)

A number of therapists highlighted the importance of using ruptures as a means of exploring offending or other dysfunctional behaviour, and conveyed this as a core task of treatment as described by one participant in this quote.

*Often what’s gone on for them with their offence happens in all sorts of different places. So if you’re able to link what’s happened in the group, with their offence, with their relationships, if you can manage to pull all that together, umm, that can be really compelling.* (Participant 23)

The importance of being self-reflective and then using that information to inform the treatment was mentioned by a few participants, such as exemplified in the following quotes.

*I spend the time trying to figure out what is it about me, what it really gets to me. And trying to see if that something is also triggered off in other people. I’m not saying I don’t ever get annoyed, I just, umm… why am I responding this particular way, and what’s the likelihood that people outside are responding in the same way, and this is something that they do to lots of people.* (Participant 11)

*Even though I could have the best intention in the world, sometimes if it doesn’t work, it just doesn’t work for the client, and I remember we had a really genuine and honest conversation, and I said “Look, you know..” I did apologise to the client, “You know, that wasn’t my intention.” Because I think sometimes we do have a discrepancy too, between how we think we are presenting and how other people perceive us. So I think sometimes it’s about us being able to be honest to ourselves, and accept perhaps it didn’t work, and invite the client to tell you what works for them.* (Participant 21)

Using group interactions to highlight offence-paralleling behaviour and encourage group feedback along with setting behavioural tasks was articulated by a number of participants as a useful means of responding to clients demonstrating dysfunctional behaviours. This quote demonstrates the difficulty some clients experience with discomfort
elicited during treatment but then therapeutically intervening when this does occur.

*The classic one too is Self-Sacrifices, who will deliberately, when a person’s getting barrelled a bit by the group or by the facilitators, they’ll make a joke, make a scene, yawn really loudly, anything to try to distract, or when a guy’s done very little in the group say “Mate, you did a fantastic job today” and rewarding what has clearly not been very effective group participation, and pointing that out to them “Do you notice that you don’t like other people being uncomfortable, which is very noble, but let’s look at your offence. It’s interesting you did that armed robbery because your brother-in-law told you he had no money. Are you seeing any similarities?” (Participant 13)*

Implicit in participants describing processes designed to enhance clients’ self-awareness is that a goal of treatment should be for the client to develop a better understanding of their behaviour. From this vantage point, the basis of change is seen to occur when a greater level of self-awareness is achieved, and this is consistent with a range of therapeutic perspectives, including cognitive behavioural treatments on which correctional programs are largely based. It is perhaps unsurprising, therefore, that participants largely subscribed to this view. An alternative (or additional) position is offered by participants who described using ruptures in the alliance as means of intervening therapeutically compared to descriptions of the alliance as a means of engaging clients to do treatment. This alternative position suggests that the resolution of ruptures is not to facilitate achieving program objectives, but rather that it is the basis of therapeutic change by responding to individual client needs.

**Working within Correctional Environments**

Responses by participants in relation to working within a corrections environment were divided into five child nodes. This parent node was largely focussed on issues relating to therapist difficulties that might be considered in recruitment and when supporting inexperienced therapists, therapist attributes to negotiate working in a correctional environment, organisational challenges, as well as supervision and other forms of organisational support.
Negative Therapist Experiences

What therapist factors make alliance formation and responding to ruptures difficult?

Node Definition

Comments relating to issues around the difficulty therapists described in being able to develop an alliance and/or respond to therapeutic ruptures either because they were inexperienced, untrained, or demonstrated personality factors that are unsuited to the field.

Main findings

- Anxiety was a common theme in relation to difficulties experienced by therapists due to a range of issues such as inexperience, over-personalising client responses, and avoiding conflict with clients.
- Difficulties in the co-facilitation relationship could contribute to therapeutic ruptures, particularly where co-facilitators were not willing to enforce appropriate boundaries or were punitive towards clients.
- Problems emanated when therapists attempted to have some of their own needs met within offending behaviour programs, such as being punitive towards clients, attempting to befriend clients, and/or were rigid in their approach and not open to feedback.
- Less experienced therapists described a lack of confidence in delivering group and attempting to ‘survive’ the experience.

A number of problematic therapist behaviours were identified that related to less experienced staff and/or those who demonstrated personality features that were unhelpful to program delivery within correctional environments. In responding to questions around participants’ experiences of ruptures, Table 3 demonstrates that half of the focus groups raised issues in relation to co-facilitation. A common theme also related to anxiety experienced in response to clients demonstrating difficult behaviours, which therapists might then respond with anger, defensiveness and/or withdrawal in an effort to manage. One newer staff member acknowledged this issue when she stated ‘I get anxious about everything’ (Participant 1). A number of these issues were outlined by a participant in response to a discussion on which people were unsuited to working in a corrections environment.
I think people who personalise it so once they take that on board a bit more, umm, I think another thing is how you view offenders. If you view offenders as people who hurt other people then that's hard to work with them. If you view them as a person who made bad decisions in life, has behaved inappropriately but still has a potential to be a good person then you can connect with them. I think it's about that. You can't have rapport with someone if you're scared of them. (Participant 26)

Anxiety might also be triggered, particularly in less experienced therapists, when working with clients vulnerable to self-harm, which might result in subsequently engaging in non-therapeutic responses such as over-servicing the client and not adhering to agreed treatment plans. A senior therapist made similar observations in relation to the difficulties that could emanate from therapists who experience anxiety around enforcing appropriate boundaries for aggressive clients.

With personality disorder folk, an unskilled facilitator will do something that you said before, will tread on eggshells, because we don't want to upset them, because they're going to disrupt the group, and then what? The group's going to fall over. I've seen a facilitator when they are disruptive, when they do talk over somebody else, actually answering that and reinforcing that, or thinking that “If we just let him say what he wants to say, then we can get on with it” because if we say “Stop! So and so's talking now” then an argument will ensue, so it's avoidance of the conflict, and in a sense its colluding and reinforcing that manipulative power struggle behaviour. (Participant 14)

Within this focus group, another participant pointed out that conversely, an ‘incredibly argumentative therapist that goes in with guns blazing from the start’ (Participant 13) could also be problematic. Similarly, other participants spoke about problems emanating when therapists’ ‘scape-goat’ clients. Other unhelpful responses could occur when therapists were motivated by having the group meet personal needs, such as wanting to be liked and accepted by group members. The following quote by a female participant in relation to a male co-facilitator illustrates this point.

There was a lot of collusion and buddy, buddy and, I guess that was the difference, it was very much “us and them.” I think it had to do with the clinician himself rather than
In situations where co-facilitators had either different views about what was most important to follow-up with a client, had interpersonal difficulties with each other, or had very different styles and priorities within treatment, the impact of these issues were seen as contributing to ruptures within the group. This is demonstrated in the following quote.

_Sometimes I think it can create conflict with facilitators, someone, when you've got someone who doesn't like to challenge and someone who does, and creating that dissonance. Or someone who is quite happy to go off track and have that in the back of their mind, or someone who is sitting there going “We need to get through the content, where are you going?” and how they manage that, 'cause I've seen it sometimes it has caused conflict._ (Participant 19)

Further difficulties that could be created in differences in treatment approach between co-facilitators included ‘good cop/bad cop’ situations raised by a number of participants, which resulted in one of the therapists constantly drawing attention to breaches in group rules or other boundary violations. A number of these issues are outlined in the following quote by a participant who was describing a group experience in which a male co-facilitator did not challenge clients as he was fearful that if he did he would be physically assaulted.

_That was a difficult group, umm, to have to constantly play the bad cop, and try and do the split. Like the guys would try and do the splitting between the facilitators, “You know what I mean mate, women are..” kind of stuff, and because ignoring it in that situation, ignoring it was just as bad._ (Participant 5)

Within these discussions, participants pointed to difficulties that could emerge if something problematic happens in group but, due to the poor co-facilitation relationship, it is not discussed in debriefing or supervision and is not dealt with before the next group session. This was seen as potentially having an impact on how clients view what is acceptable behaviour in group.

_A number of issues were raised in relation to therapists who demonstrate high levels..._
of rigidity, and the challenges this posed organisationally. Therapists having difficulty accepting clients’ presentation and adapting their own expectations about change could also impact on treatment delivery as highlighted in this senior therapist’s comment.

Their approach to somebody in a group when they haven’t seen them either conform to their expectations or behave in a way they thought become colder and withdrawn and not actually really responded to the person, so they’ve had a shift in the way they treat the client. (Participant 24)

Therapists who demonstrated a rigid approach could also pose difficulties in their work with co-facilitators by being unable or unwilling to work together. A lack of openness to feedback within supervision to shift challenging behaviour was also similarly seen as problematic. Problems could occur for therapists who attempt to rigidly adhere to group plans although, as articulated in the following participant quote, so too could staff who lack conscientiousness.

I think over preparing and under preparing before a group is.. can cause ruptures. Umm, obviously under preparing, going “All right we’ll just go in there and wing it and see what happens” and so what happens to the program integrity, are you really achieving the objectives of that session? So you’re kind of slandering. And over preparing, no room for flexibility, if they do something wrong then “Oh my God, what’s going on?” so the facilitators losing control of what they’re supposed to be achieving. (Participant 5)

A range of personality factors were identified by participants that might impede the therapeutic process within offending behaviour programs, particularly around pervasive anxiety which may emanate from wanting to avoid conflict with clients, not knowing how to respond to clients who do not demonstrate expected behaviours, and hypersensitivity to client comments. These factors point to high levels of neuroses in staff as potentially impeding their ability to respond effectively to difficulties in the alliance. Conversely, staff who lack conscientiousness threaten treatment integrity.

A number of participants also described experiences that involved their male co-facilitators befriend ing clients by seeking to align themselves with male clients and
separating themselves from their female co-therapists. Therapist’s pathology, and the subsequent means by which they might seek to have their own needs met within group treatment poses a significant threat to treatment integrity, including directly contributing to ruptures, and was relatively common for participants.

**What particular difficulties do inexperienced therapists have that might impinge on their ability to develop an alliance and respond productively to ruptures?**

The specific challenges posed for inexperienced therapists working within this environment were commonly cited within focus groups, particularly the notion of being anxious about undertaking the role and trying to ‘survive’ the experience. This might result in a focus on needing to get through program content, ignoring clients’ dysfunctional behaviour, as well as issues discussed in the following quote.

*For a long time I was very worried about getting it wrong. And I had the wool pulled over my eyes a couple of times early on particularly, on things that other people thought were very obvious and had huge big flags. And I thought “Shit!” A big part of doing forensic work is developing that bull-shit detector, you know? (Participant 11)*

The following quote by a less experienced therapist also points to a lack of confidence and skills in being able to respond to client behaviour.

*It took me out of my comfort zone, I had to stand in front of a group, umm, and talk and do everything, I’m not one that likes.. people might deny it, but like being the centre of attention. So that’s a huge challenge for me. (Participant 2)*

Less experienced therapists having difficulty in recognising their own limits was also a common theme, and demonstrated in the following quote by a senior therapist.

*In the past when we’ve had someone who was perhaps less experienced get involved into a longer term counselling relationship with someone who was clearly manipulating her and the sessions. I’ve had a couple of occasions where that’s happened. (Participant 24)*
A lack of experience was, therefore, often associated with high levels of anxiety, a lack of confidence, and therapists misjudging their abilities. These experiences point to some of the complexities of working within correctional environments, and perhaps suggest further attention is required by correctional services to ensuring early career therapists are better supported in delivering offending behaviour programs.

Organisational Challenges

What are the factors unique to correctional environments that pose challenges to therapists’ endeavours at delivering treatment?

Node Definition

The broad organisational factors that impact on undertaking therapeutic work within a corrections environment. These revolve around organisational policy and practice as well as implementation issues.

Main findings

- A range of factors specific to the forensic context were seen as contributing to therapeutic ruptures such as the influence of the parole board, changes in facilitators, program logistics, the influence of prisoners outside of program time, and the amount of support demonstrated by staff.
- Challenges working with prison staff were cited by a number of participants, particularly in relation to working with clients who demonstrate Borderline PD traits and psychopathy.
- Organisational pressures posed significant challenges to treatment, particularly for therapists in finding the time to balance the range of tasks to fulfil their job, frustrations in relation to limitations in the type of services available, and for treatment managers to respond to pressure to increase program numbers.

Participants raised a range of organisational factors that posed challenges to program delivery. These included situations that impacted on clients’ treatment experiences and might contribute to ruptures, working with staff who lacked an appreciation of the nature of the client group, the amount of administration required for higher profile offenders, the time taken to prepare for complex clients and communicate with correctional
staff about client difficulties, and limitations in relation to the type of programs and services offered.

A range of issues specific to the forensic context were raised due to their impact on ruptures within treatment. A number of these related to decisions by the parole board to require a client’s participation in group or issues relating to program timetabling to ensure program completion occurred prior to earliest release dates, as exemplified by a participant in this quote.

*If the Parole Board says they’ve got to do it, they go in no matter how good it’s going to be for them or the rest of the group to have them in the room. (Participant 27)*

Other issues included program facilitators leaving, so treatment going ahead even if remaining therapists were unprepared and/or unfamiliar with group members’ half-way through a treatment program. The implementation of Program Support Officers, who are prison officers who sit in treatment sessions, was also problematic for some group members, some of who articulated difficulty with the dual roles this presented.

The impact of organisational factors on treatment in community corrections was also highlighted by one participant in the following quote.

*In locations where the process of programs is not that much supported by community correctional staff, there will be a high level of non-attendances in the first couple of sessions, there will then need to be make up sessions, introducing new members into the group, all of this then kind of disrupts and ruptures the initial very delicate forming cells and membranes of that group. (Participant 14)*

Within prison contexts, a number of potential ruptures were also identified as emanating from ‘the compound’ in which interactions between prisoners outside of group could impact significantly on how a client presented in group. Another issue identified in one prison was having to break for methadone dispensing, although most participants described negotiation with correctional providers to reduce disruptions to treatment on the basis of the delivery of other prison services.
Participants’ identification of the impact of actions by other aspects of the corrections system suggests that tensions do occur on occasions due to different agendas amongst these groups, and therapists would often have to respond to disgruntled clients effected by these actions to either make the best of difficult situations or, in some cases, capitalise on the difficulty by incorporating it into the treatment experience.

Some participants identified a number of challenges in working with prison officers, particularly due to their lack of understanding in relation to personality dysfunction, such as Borderline PD features. This could result in officers being frustrated by client behaviour, or ‘tension’ when prison staff were of the view that therapists should see clients at risk of self-harm whereas therapists’ attempts at creating boundaries and not reinforcing negative behaviours were at odds with this. Another issue raised concerned prison staff lacking an appreciation of psychopathy and the relative danger a client might pose as identified in the following quote.

*For example I have a young person in our area at the moment who fulfils a number of criteria for psychopathy even though he's quite young, but his presentation is so picture perfect and he’s so reasonable and calm, and every time we have an interview about some of the issues the custodial staff will say to me, “Gee, he presents well, doesn’t he?” (Participant 25)*

A range of organisational pressures were also identified as impinging on the quality of treatment provision. This included the amount of time and energy spent on bureaucratic tasks, the time required for preparation and responding to complex clients, and the availability and quality of information available on clients to inform their treatment.

Similarly, a range of limitations in the correctional system’s approach to rehabilitation were also identified as problematic, as identified in the following quotes from different focus groups.

*And whether the group model is good model for some personality disordered clients. I think as an organisation we need to do more work in that. (Participant 14)*

*There’s not a lot of options, particularly as they’re focussed on programs and the menu*
is not that big, and there’s not a lot of room to work with them even individually to get them to a point where they are group ready. (Participant 20)

A number of comments were made on difficulties posed by staff turnover as well as issues relating to models of program delivery that involve single facilitators. Seniors in one focus group commented on the organisational pressure they sometimes experience to run more programs, and the challenge this poses to keeping the work diverse for staff and to avoid ‘burnout’ as outlined in the following quote.

I think we need to look at issues such as vicarious trauma, so people are not constantly being exposed to stories, quite detailed and horrific stories about violence or abuse, so they have the chance to work with someone in a different way or different issues. (Participant 24)

Participants described the organisational environment as posing challenges due to the different agendas of other sectors of corrections who vie for therapists to produce maximum outputs. This may result in exerting pressure on the continuation of programs when staff leave, limiting the amount of time available to accommodate preparation and follow-up in relation to programs, and pressure to increase the number of programs run. Challenges were also posed due to different training and education of prison staff, and their understanding of client behaviour relative to those of therapists.

Supervision and Organisational Support

What types of support structures assist therapists undertake treatment within correctional environments?

Node Definition

Comments about the value of supervision and organisational support, including functional treatment teams, which are useful for treatment delivery.

Main findings

- A range of therapist personality features were identified as useful within correctional environments, including enjoying challenges as well as being collaborative and open to feedback.
• Supervision, both formal and available flexibly, was seen as a valuable process to assist therapists discuss problematic issues in relation to treatment delivery and seek assistance with skill development
• Debriefing after a program as well as informal support from staff also played a crucial role in supporting and advising therapists’ treatment
• It was suggested that ideally, treatment teams should promote a transparent and supportive environment where staff could openly discuss their difficulties

Numerous factors were articulated by participants to assist in the delivery of offending behaviour programs. These varied from the manner in which therapists interact with staff and within their team in correctional environments as well as supervision and debriefing available to discuss their treatment experiences.

A broad range of factors were implicated in assisting therapists negotiate their work within correctional environments. This particularly included being collaborative with correctional staff, being adaptive to accommodate the unpredictability of correctional environments, as well as cope with the range of frustrations that might occur in relation to negotiating program logistics. High levels of resilience and an ability to negotiate the various frustrations in the corrections system along with a commitment to the corrections mandate to protect the community were all factors described by participants to assist their involvement in treatment as well as within the broader corrections system.

Being open to the supervision process and debriefing with co-facilitators was also identified as an important therapist trait to work through issues experienced in treatment. Overall, participants articulated that they placed a lot of value on receiving supervision. Suggestions were made that it should occur in a variety of forums, including formal supervision scheduled into a therapist’s work program but also flexible supervision if issues emerged that would benefit from immediate discussion such as demonstrated in the following quotes.

*But what I found really important, because that went on for some time, that in debriefing and supervision where I was able to come to understand, in doing all of this I had hate.. strongly disliked this man because he was making it so difficult, but the minute that I went ‘Oh!’ so much better, the minute I acknowledged my own response*
to him, I was able to understand it, do you know what I mean? (Participant 23)

Feeling reassured that we all have bad groups, we all have bad days, all groups can be really difficult at times, that it’s not necessarily saying they’re a terrible facilitator, but that reassurance and not only that but also “This is probably what happened” or “How do you want to manage it next time?” so giving them something to manage the group with next time and some confidence, but fairly immediate debriefing is very important. (Participant 25)

Numerous participants raised the value of debriefing with co-facilitators following a group and informal discussion with peers to assist in treatment delivery, as demonstrated in the following quote.

Particularly co-facilitating, you have that opportunity to have a really good debrief with your co-facilitator, and that really links in, and for five minutes if you’re lucky enough to have a Prison Support Officer, they can join in and they can throw things at you and you get a lot of good positive feedback or negative feedback, a different perspective. But ultimately that finishes and then as you’re packing up you’ve got 10 to 15 minutes to debrief with your co-facilitator, which I think’s beneficial and works out really well, it helps to keep that alliance in check and ticking along. (Participant 7)

A number of participants also raised the importance of working within teams that are supportive along with receiving supervision when required, as demonstrated in the following quote by a senior therapist.

I think it’s also about creating a culture in your team or in your environment in which you can allow to admit to mistakes, or indecision, or lack of confidence about that, so people don’t think they have to present as professional to all their team mates and not be human, so it’s about talking it through and allowing that. (Participant 24)

Participants viewed the important role that therapists have in being open to others’ input to assist in their treatment and to work collaboratively with others. Supervision and support from staff teams were seen as allowing therapists to process negative reactions to clients, validate and normalise feelings of incompetence when things go wrong, develop
skills and strategies, and provide opportunities for greater self-awareness of problematic responses to clients. The implication of this, therefore, is that the challenges posed by the delivery of offending behaviour programs will elicit a range of therapist reactions that require therapists to both understand client behaviour as well as their own behaviour, and this should assist informing further treatment delivery.

Summary and Conclusion

Participants described the TA as being important to their practice, although there were differing approaches in relation to how they achieved this, particularly in relation to their attitudes to whether the bond required a detached stance or a high level of relatedness. Participants also invariably described ruptures within the alliance occurring in response to a range of dysfunctional personality traits. These varied from antisocial and psychopathic traits to avoidance, narcissism, and features of neuroticism (e.g., emotion dysregulation, hypersensitivity to criticism). Participant responses to these experiences varied considerably, with some suggesting the enforcement of clear boundaries and group rules was central to their strategies while others focussed on adapting their approach in treatment to accommodate the difficulty. Others emphasised using the therapeutic relationship as a mechanism for change or otherwise utilising ruptures as a therapeutic opportunity. Participants described a range of difficult experiences in their treatment delivery, particularly relating to inexperience, a lack of confidence, but also when organisational support was not available. It can be concluded from these data that the TA is a useful framework in which to deliver offending behaviour programs, however therapists currently engage in a range of diverse practices to foster treatment collaboration. The views of clients in the efficacy of these differing approaches remains unknown and is the focus of the next study.
CHAPTER SIX – What Clients Say

Overview

The second study, described in this chapter, considers the role and importance of the therapeutic alliance from the perspective of offenders who have completed an offending behaviour program. Employing a similar methodology, the analysis identified similar themes to the first study. Participants identified both client (e.g., low motivation and high levels of hostility) and therapist (e.g., lack of experience and being judgemental) characteristics as critical to the rehabilitative process. Offenders highlighted the importance of therapists demonstrating positive characteristics to support and encourage participation, along with valuing opportunities for self-reflection and positive behaviour change.

Rationale for Study Two

Study One found that despite therapists considering the therapeutic alliance (TA) to be important to the delivery of offender rehabilitation, considerable variation existed in how therapists described forming a strong TA and responding to ruptures. While some described implementing strategies to enforce boundaries as a means of managing disruptive behaviour, others talked about using a range of strategies to engage clients when ruptures occurred. An additional, but less common approach in response to responding to personality dysfunction, was to use ruptures as a therapeutic opportunity to explore and intervene with dysfunctional behaviour. The participants who described this often viewed the therapeutic relationship as central to the process of client change. Severe personality dysfunction posed the most significant challenges, particularly for those who were less experienced, poorly trained, personalised client behaviours, experienced anxiety, and/or avoided interpersonal conflict with clients. What could not be derived from this study, however, was the extent to which client experiences of therapist attempts to develop the TA are consistent with therapist accounts, and what clients perceive as the most effectual responses to ruptures in offending behaviour groups. The second study thus aimed to triangulate the notions derived from the literature and Study One.
Methodology

A grounded theory methodology (Corbin & Strauss, 2008) was also employed in this study. This facilitated the continuation of testing a developing theoretical framework on therapist approaches to developing the TA. Theoretical sampling requires that data collection continue until no new information is derived. In this study it was anticipated that a smaller sample size would be required to achieve this as only a sub-set of areas were canvassed and only offenders who had completed a violence program were invited to participate. Violence program participants were selected as it was anticipated that clients in these groups would pose interpersonal issues given that the perpetration of violence is invariably a dysfunctional interpersonal act. Hence in this study a more homogenous sample were interviewed on a narrow set of factors such that saturation was likely to occur more quickly (see Mason, 2010).

Procedure

Ethical approval to conduct this study was awarded by the Deakin University Human Research Ethics Committee (2010-250) and the Department of Justice Human Research Ethics Committee (CF/11/1040) (see Appendix 6).

Therapists involved in the delivery of Violence Intervention Programs (VIPs) in two male medium security prisons were initially briefed in relation to the research. They were provided with an Information Sheet for Program Facilitators (Appendix 7) which outlined the purpose of the research, the role of therapists’ involvement in approaching potential participants from VIPs that they had delivered, and ethical issues considered within the project. This latter included limits around confidentiality, secure storage of research information, and that external counsellors could be accessed if participants experienced adverse effects as a consequence of their participation.

Therapists were requested to approach clients who had either finished or were just about to finish a VIP to ask if they were interested in volunteering to be part of a research project on improving how groups are run. It was not possible to determine, therefore, whether clients came from the same or different groups. If potential participants indicated that they were interested in talking to a researcher about the project, therapists were
requested to give them an information sheet (Appendix 8) and asked to provide their name and location at the bottom portion of the form so it could be passed on to the student researcher. The student researcher periodically contacted therapists interested in being involved in the recruitment process to negotiate times to attend their prison locations after potential participants completed these forms.

Potential participants were interviewed individually in private interview rooms and provided with a Plain Language Statement and Consent Form (Appendix 9) to peruse and discuss with the student researcher. Twelve potential participants were approached of which two declined to participate. Those who consented to participate signed the consent form and were provided with a copy.

A semi-structured interview schedule was developed to guide discussion around clients’ experiences of the TA and ruptures in offending behaviour programs. Questions relating to what therapists did to assist the group achieve its goals as well as potential rupture incidents involving confrontations or not feeling able to express unhappiness within a program were included (Appendix 10). Follow-up discussions were then conducted on whether ruptures were acknowledged, how therapists responded, and whether these responses assisted the client and the group. Interviews ran between twenty and forty-minutes and responses were recorded on an electronic recording device. Brief field notes were completed after each interview and then memos were developed based on each participant’s responses to interview questions outlining the central themes discussed and additional issues to explore in subsequent interviews (Appendix 11).

After the tenth interview, saturation was achieved as a diversity of views on the TA were collected and repetition of themes occurred in relation to rupture experiences. No further questions remained in relation to issues raised in previous interviews and no additional information was contributing to the developing theoretical framework. Early participant responses to questions were not, however, verified in subsequent interviews in an effort to ensure that participant responses remained confidential. This was due to the small sample of potential participants in prison locations available at the time.

Transcripts were coded using NVIVO 10 (QSR International), a statistical package designed to facilitate analysis of qualitative data. Nodes were created that were largely
based on Study One nodes due to the significant overlap of a sub-set of areas of exploration. Some minor modifications occurred due to some variation based on the interview approach taken with clients in which no technical language was introduced and in-depth discussions did not occur in relation to issues such as organisational factors in the offending behaviour programs they attended.

Participants

Ten participants were interviewed on their experiences of program participation. Participants were aged between 26 and 46 (X=35.40, SD=5.91) and the majority, seven of the ten participants, identified as being Australian in nationality. One participant identified as Albanian and another as English. Data on nationality was missing for one participant. Seven participants were interviewed in a medium security programs prison for male offenders, which offered a range of cognitive behavioural programs that were offence-specific and offence-related. The remaining three participants were interviewed in another medium security prison for male offenders. Female offenders were not invited to participate due to the low number of offence-specific programs undertaken at women’s prisons in the jurisdiction.

All participants had completed a VIP and nine of the ten participants reported completing other additional prison programs. Six reported completing programs to address drug and alcohol issues and another two reported completing cognitive skills program. The seven participants interviewed in the programs prison also reported completing brief motivation and skills-based group programs, such as interpersonal skills, as well as individual treatment.

Analysis

Analysis was structured around participants’ responses to questions on the importance of positive therapist characteristics and their views on the TA. Questions on the nature of ruptures that occurred and what was most effectual at responding to these issues are then presented. Table 4 outlines the nodes for each subject area along with the number of interviews and the number of references made by all participants in which data from these nodes were derived. The number of references made for each subject area provides some indication of which topics attracted most attention as well as providing evidence that
similar issues were considered across participants.

Table 4
Parent and child nodes created for subject areas discussed in Study Two.

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Interviews</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic alliance views</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Therapist strategies to build the alliance</td>
<td>8</td>
<td>39</td>
</tr>
<tr>
<td>Ruptures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems in relationships with group members</td>
<td>8</td>
<td>34</td>
</tr>
<tr>
<td>Problems in the relationship with therapists</td>
<td>9</td>
<td>53</td>
</tr>
<tr>
<td>Problems managing disruptive clients</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Problems with activities asked to undertake</td>
<td>8</td>
<td>13</td>
</tr>
<tr>
<td>Rupture resolution strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enforcing boundaries and managing content</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Engagement strategies</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>Ruptures as opportunities for therapeutic change</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Participant responses to each of these nodes is considered below. Overall responses to each topic are considered and then specific participant comments are presented. Node definitions are provided with a summary of main findings. The structure of these responses chiefly follows those presented in Study One to assist compare responses made between the two samples. Direct comparisons were not always possible, however, as the Study Two interview schedule was briefer, more focussed on therapeutic ruptures than Study One, and there were no references to more technical aspects discussed with therapists (e.g., personality disorder, social withdrawal, psychopathy, and neuroticism).
Views on the Therapeutic Alliance

What aspect of the therapeutic alliance do participants believe are most influential to program outcomes?

**Node Definition**

Comments made by participants on what therapists did that most influenced group members to undertake treatment and which aspect of the TA they thought was more important in group treatment (bond, goals or tasks).

**Main findings**

- Participants identified that a number of positive therapist characteristics (e.g., enthusiasm, genuine interest) as well as experiential tasks encouraged group members’ collaboration in the process of treatment.

- While many participants emphasised the importance of the bond in assisting collaborative processes, others identified the goal elements of the alliance as equally (or more) important.

When asked what therapists did to assist the group in treatment, almost all participants identified that it was the demonstration of positive therapist characteristics, such as being enthusiastic, energetic and ‘positive,’ that assisted this process due to the impact it had on developing relatedness between therapists and all group members. Some also acknowledged the function of experiential activities to get the group more comfortable and at ease. The below quotes relate to the importance of group cohesion and a sense of connection.

*Everyone was more agitated about the course and what they did was they tried really hard to get the group to get on with each other and take time out. Everybody had their 15 seconds, you know? (Participant 6)*

*You’ve got to have the bond in the group I think, yeah, otherwise people won’t be honest, people won’t talk, they won’t feel they won’t come out of... because a lot of people don’t like to talk, there’s a lot of people that hide behind their shell or whatever.*
But if the bond was there, once the bond was formed in our group, everybody felt open, they could talk about anything. (Participant 7)

Emphasis was placed by some participants on the importance of pertinent therapeutic goals being developed within the process of treatment, as demonstrated in the following quotes.

And I’ve realised now, just going back on life pathways again, I realise now in life pathways that the path that I was leading got me into trouble again. But whereas before I was just sort of going along the path without sort of worrying about consequences and that, or why things were happening. So I’ve learnt to deal with things different ways and change the way of thinking. (Participant 7)

It was an effort, because I feel uncomfortable in big groups and that, so it was an effort for me to get there every day, but I got there every day. That was one of my goals, to actually get there and be in the group. (Participant 10)

A number of participants demonstrated an appreciation of the inter-play between each of the three elements of the TA, so could not identify any particular aspect as being more important. This is demonstrated in the following quote.

Well I probably say all three are pretty strong things that need to be sorted out. Because the activity part is something that with prisoners they don’t want to pussy-foot around with, because they just want to get into it and then get straight out of the door. The goal thing should be a good thing to focus on because it’ll also help people understand their offending behaviour and be able to understand what they’re meant to work on, and show remorse and understanding why they’re having remorse for their offences. And the facilitator… the relationship with the facilitator should be a trusting and a… something like nourishment between the two, to be able to feed whatever needs to be fed and also, and give and take as well. (Participant 8)

When participants were asked what assisted the process of group treatment, they overwhelmingly discussed a range of positive therapist characteristics, such as being positive, energetic and enthusiastic. It seems, therefore, that clients perceive therapists efforts to encourage participation as the most influential aspect of task negotiation as well
as assisting the process of developing a bond. Participants who were asked about which aspect of the TA they thought was most important varied in their responses. While some believed all aspects worked together, some pointed to the treatment goals as most important. This potentially signifies a lack of bond present in these latter participants’ group treatment experiences, and the value they placed on getting information from their programs regardless of the quality of the therapeutic relationship. There was a sense from these participants, however, that they valued the bond formed in individual treatment relative to their group participation.

**Therapist Strategies to Develop the Therapeutic Alliance**

*What were participants’ experiences of how therapists developed the central elements of the therapeutic alliance in offending behaviour programs?*

**Node Definition**

Identifying ways in which therapists assisted their group identify therapeutic goals, negotiate tasks, and develop a bond. This included demonstration of positive therapist characteristics.

**Main findings**

- A number of participants emphasised the establishment of group rules early in the program as important for setting program goals and expectations of group participation.
- A range of activities were outlined that assisted develop the TA, particularly the therapeutic bond. These including experiential activities and the shared group experience with other clients.
- Positive therapist characteristics assisted the group in a number of ways, particularly around encouraging participation (e.g., enthusiasm), developing trust (e.g., honesty), and progressing the therapeutic process (e.g., articulating a commitment to clients making therapeutic gains).

Several participants mentioned the group rules as serving a number of important functions relating to program goals. These included getting group members’ opinions on
how the group will work, outlining program expectations, to foster trust between group members, to encourage honesty and group cohesion, and to convey that therapists have a shared commitment to clients gaining treatment outcomes.

Most participants identified that therapists included a variety of tasks in programs to encourage participation. In particular this included experiential activities, such as ‘games,’ or the use of behavioural techniques to negotiate participation between group members, such as small group or paired work, as outlined in the following quote.

_We got a few role plays to do and activities, so it started off in the mornings at the start of the class, certain warm up games or something, just to get people active and talking a bit. (Participant 1)_

Many participants identified that undertaking these types of tasks assisted in creating a bond and feeling ‘comfortable’ amongst participants. Several participants also described that having clients check-in and check-out provided an opportunity to articulate any concerns, provide feedback to other group members, express emotional responses to group participants input, or discuss aspects of their group experience. A number of participants also identified that undertaking a life-story module at the commencement of treatment enhanced group cohesion and the development of a therapeutic bond with therapists as this activity requires disclosure of important life events up until the commission of clients’ offences. This was particularly demonstrated in the following quote.

_So I think in doing that at the start helped to create this sort of bond where I knew a lot more about Joe Blow than what anybody else did in the yard, he knew a hell of a lot more about me than what anybody else did in the yard. For me having lack of family contact for a long time, 20 odd years, it was hard for me to open up to strangers about things that I haven’t even opened up to my family about. So for me the support that I got back off the group helped to create that bond for me and find my place within the group. (Participant 2) _

Emphasis was placed by participants on the effort therapists took to build the TA through the demonstration of positive therapist characteristics. These included those factors that encouraged participation in the treatment process, such as being positive, enthusiastic,
explaining things, and demonstrating relatedness (being ‘nice’). Others focussed on building trust within groups, such as by being straightforward about what was happening in treatment, demonstrating a level of openness to what group members suggested, and allowing group members to pace themselves so they were not ‘forced’ to do anything. Other characteristics that assisted the process of therapy included providing honest feedback to participants, and articulating a commitment to assisting group members’ progress. With respect to this latter factor, one participant articulated that therapists ‘gave people a chance’ (Participant 3). Similarly, another stated ‘They listened to what people had to say and worked around it’ (Participant 4). The dynamic process resulting from these efforts was captured in the below quote from another participant, ‘They were trying to get on our level and we were, sort of, trying to get a bit on their level, met them half way. It was good’ (Participant 9).

When asked about which positive therapist characteristics were most important in a group, many participants said that trust was critical. Others, however, articulated that there was an interplay between many of these characteristics. ‘If you don’t have respect then where’s the trust? So they all go hand in hand, so to speak’ (Participant 2).

Participants identified a number of processes that assisted the development of the TA. This included the initial development of group rules to articulate group members’ opinions of how the group should run and what expectations had to be met. A range of specific tasks, such as experiential exercises, ‘check-in’ and ‘check-out’, making personal disclosures, and behaviour management techniques (working in pairs, small group work), were also identified as assisting engagement in treatment. These appeared to assist clients, particularly through developing a therapeutic bond with therapists and fostering group cohesion. Positive therapist characteristics were also identified as an important source to assist the development of the alliance, this particularly included therapists demonstrating openness, transparency, flexibility, patience, commitment, and understanding to orient clients to treatment. These characteristics seemed to achieve a balance between encouraging group members to contribute, developing trust and group cohesion, and allowing clients to participate on their own terms. The outcome of these processes was to provide support and encouragement to assist clients make therapeutic gains by undertaking program activities.
Ruptures

What types of ruptures did participants experience in their offending behaviour program and what, if anything, did therapists do to resolve these?

Node Definition

Clients’ experiences of difficulties that occurred in relation to tasks suggested by therapists, misalignment of treatment goals, and/or problems in the therapeutic bond. A number of child nodes were created from this information: problems relating to relationships with therapists, problems relating to relationships with other group members, problems with tasks clients were asked to undertake, and problems due to disruptive clients.

Main findings

- Objections to group tasks were common, and sometimes resolved through encouragement but could also have a significant impact and effect all elements of the alliance when clients objected consistently.
- Participants described a number of negative emotional responses when tasks were suggested that they did not see the point of, found demeaning, or involved personal disclosures.
- Therapist incompetence, making judgements about group members, or failing to enforce appropriate boundaries were described by participants as impacting on the therapeutic bond.
- Some significant impacts on the therapeutic bond were described in response to frequent changes in facilitation teams, impacting on the quality of the therapeutic bond as well as the program tasks that were undertaken.
- Various issues were raised by participants on concerns they experienced about disclosing their personal information and when confidentiality breaches did occur, therapists either were unable to doing anything about them, disregarding the concerns, or failing to respond appropriately to resolve client vulnerability.
- A number of situations were described by participants in which either they or other group members did not contribute to group discussion.
- Overt difficulties were also described by participants which impacted on the quality of the bond and group cohesion. These included the demonstration of various forms
of aggressive behaviour, not genuinely wanting to make treatment gains, and dominating group discussion.

Participants identified a diversity of circumstances in relation to the experiences of ruptures, which were signified by either problems relating to tasks nominated by therapists, interpersonal difficulties with therapists, or more general problems in being able to participate in the treatment process. As demonstrated in Table 4, problems in the relationship with therapists attracted the most comments from participants, and this included situations in which therapist behaviour directly impacted their program participation but also indirectly impacted their treatment experience due to how therapists responded to other group members.

What experiences did participants have in relation to group members being asked to undertake tasks they objected to during their offending behaviour program?

Disagreements about group activities were common, although differences existed across participants in terms of how easily this was resolved within their program. While a number of participants commented that there were objections to certain tasks over the course of their program, they commented that eventually the group would ‘help each other through’ and that particularly as the group progressed, when you know you have to do it, you just get on with it. Other participants, however, described less conciliatory experiences. One participant commented that ‘things didn’t make sense with me’ and that he kept asking himself ‘what’s the point of this?’ (Participant 10) as the program was progressing. He stated that it was only after the program finished he felt he understood the purpose of a number of the activities. This same group member also objected when an existing agreement about his victim empathy exercise was changed into an experiential activity when his turn came up.

And there was a bit of disagreement about it. “Well why did you say to me that I can do it this way if you don’t let me explain it then act it out? That’s a bit unfair and I’m not doing it. You know, I told you what I felt comfortable with.” There ended up being a big disagreement and I ended up walking out for a few minutes to cool off. (Participant 10)

A number of participants articulated objections to undertaking experiential activities, such as role plays and ‘warm-up’ activities. This was largely because they saw
them as childish and demeaning, as demonstrated in the following comment by another participant. ‘I found them a bit too much playing games, not getting to the point. It was putting me off’ (Participant 1). This participant is later asked whether there were any other activities he did not want to do in the program, and he went on to discuss how he was also uncomfortable with the life-pathways module requirements.

One was life pathways. It was a bit like “open up your whole life story in front of people.” It’s a bit private and personal, and they really try to push you into it. One was warm up games, to make people feel stupid. Like they really trial these games that they try to get you to do and a lot of the other people in the group just thought “no,” just didn’t see no point to it. (Participant 1)

Other participants similarly spoke about their difficulty in making personal disclosures, particularly in front of people they did not know, and one participant stated that he was sure clients left things out due to their narratives occurring in a group context.

While many of the comments made by participants appeared relatively innocuous in relation to their treatment experience, one participant described a significant rupture occurring in his program in relation to group members who continually objected to suggested tasks.

And even with the amount of warnings that some had, you know, just wasn’t sinking in. So what ended up happening is that it upset the establishment of the group and it ended up becoming a point where... where it was more just shits and giggles in there than them learning, you know? Like even when activities were brought up within the group, it was more like, “Oh, do we have to do this?” Or, “Why do we do that?” So it was more the whining kid sort of scenario where eventually the parent just gives up on pushing what the main focus needs to be focused on.. so you end up spending half of the morning, or half of the session, with whining and carrying on. (Participant 8)

Participant responses in relation to disagreements about the nominated tasks in treatment varied from minor ruptures, resolved either due to the encouragement of group members or because clients acquiesced to the requirements of treatment, to more significant rupture events. These more significant events included participants not
understanding the relevance of the task to their treatment goals or concerns in relation to the repercussions of personal disclosures. Quite severe impacts on the other elements of the TA were evident in some of these situations, particularly in relation to the pervasive effects on other group members’ continual objections. This impacted on therapists’ ability to provide appropriate group leadership and enforce boundaries as well as reducing group cohesion.

What types of experiences did participants have in relation to problems in the therapeutic bond with therapists and/or other group members? What types of disruptive behaviours occurred that impacted on elements of the alliance?

A number of participants commented on factors relating to therapist competence, and the impact this had on the bond. One participant articulated that he felt that the therapists in his program were not empathic, did not understand his issues, and were inflexible in relation to how the group was run, ‘It was pretty much their way or the highway’ (Participant 1). He resented what he perceived as being ‘forced to’ undertake specific tasks or he was going to be removed from the program. When asked how this made him feel, he said ‘It pissed me off, being put in that situation.’ Further exploration of this issue revealed that he perceived therapists as both incompetent and not genuine, as evidenced in the following comment.

*I mean the clinicians were all a bit... they haven’t run that many programs and they wouldn’t really know what was going on...it’s like they’re just reading out of a book too. It’s not like they’re being real or something. What they say is just coming out of a book, it’s like they don’t know what they’re saying, they’re just reading it.* (Participant 1)

Another group member also pointed to therapist inexperience, commenting that the therapists were unsure about how to deal with particular group members, and commented that ‘They’re new at this stuff too, you know what I mean?’ (Participant 6). Another participant described another issue relating to therapist competence when he recounted a therapist walking out of a session due to the manner in which the group responded to her. He made the following comment.

*At one stage one of the clinicians walked out ‘cause they got a bit upset about the way*
they were being treated by the group. About something they said. She wanted to do something that she felt she was good at and the group sort of disregarded it. (Participant 3)

Another instance was described in which clients were wary about what therapists were trying to achieve in their program, such as in the following comment which this participant explained related to concerns that clients’ values were being challenged. ‘Sometimes some group members felt the facilitators were trying to make them be something that they don’t want to be’ (Participant 3).

A number of participants commented on therapists being judgemental of group members in their program. The following comment by a participant encompassed this experience in relation to a group member who had misrepresented his crime in treatment.

The facilitators just sat there shaking their heads saying, “Is this really what you want to say?” They let the whole group know that he’s fuckin’ lying right, for one, and then he had to get up and he had to tell the truth and then they just drilled him and pointed him and made him feel like how low you are. (Participant 6)

This participant went on to describe how he provided feedback to therapists on his reaction to this incident and spoke to other group members outside of group, who agreed with him, and ‘That’s one thing they should learn about’ (Participant 6). When asked to elaborate on this point, he stated that the therapists justified their behaviour to elicit information from the client, but the participant conveyed that the therapists had been ‘unprofessional’ in the manner in which this occurred. Another participant similarly stated that sometimes if therapists did not think clients were providing enough information, they might ‘barrel him with questions’ (Participant 2) which had the effect of garnering support for the client from other group members due to the ‘camaraderie amongst prisoners.’

Another participant pointed to a different form of therapist incompetence when he articulated frustration that some treatment goals were not dealt with in sufficient depth, such as victim empathy, and that there was this sense that some group participants seemed content to coast through the group and lacked sincerity in their participation, as demonstrated in the following comment he made.
I think more of the hitting home stuff needs to be focussed on the program instead of just prisoners going through the program... yes that’s confronting to deal with, my emotions this and the victim that... But that’s how it is. It’s just like that type of attitude – it’s like “Yeah, I’ll just get through this.” (Participant 8)

Similarly, this and other participants articulated a level of frustration in relation to therapists not responding adequately to clients’ disruptive behaviour. One participant described a situation in which a group member attended his program sporadically after being granted parole. This participant expressed exasperation for what he perceived as inconsistent therapist behaviour as they demonstrated tolerance for this client attending at whim compared to chastising the participant for being short with this client when he attended a session late. Another participant stated that he believed therapists should have not let a client ‘get away with’ disruptive behaviour for the length of time they had, and another expressed the following.

I sort of got that feeling that they didn’t want to rock the boat because they still want to be the good guy outside... outside of the program hours, and that’s the way I feel about it, like they didn’t want... outside the hours, they didn’t want what happened in group to come outside and the facilitator’s walking down the path and a prisoner goes, “Ahh, you blah blah this, this and this,” because of what happened in program. (Participant 8)

This participant made further comments about problems with boundaries in the program when he described how program start times were changed to accommodate clients who went to get their methadone, but were changed again to allow these clients to get breakfast, and then the program would sometimes start even later than this. This participant also commented on how over the course of the program, check-ins at the start of program ended up being just going through the motion of replying ‘Yeah, good, blah, blah, blah’ (Participant 8) when asked how group members’ day had been. He concurred with the suggestion that contributions lacked depth. Another situation was described by another participant highlighting the impact of therapists not adequately encouraging some clients’ participation.
See that’s one thing I think where they struggled a bit at was like there would be, out of fourteen people, there’d be ten people giving it a good shot, giving it a good go, and there’d be two or three people that just wouldn’t put in. They pushed them but they didn’t push them enough, and it made it hard on other people. (Participant 6)

A couple of participants pointed to the frequent change of therapists as an issue of concern as it created ‘instability.’ One participant specifically noted that his group had seven therapists that ran the program over the course of treatment. He felt it unfair that even though there were group rules established, the original facilitators were more focussed on what was happening outside of group in their lives, which impacted on how the group ran and eventual frequent changes to their facilitation team. Another provided the following comment in relation to the changes in therapists they experienced in their program. “It was mainly the younger people too, again, that were stressing out... “We’re sick of this”, you know? “We’re going through clinicians like underwear,” sort of thing’ (Participant 9). Not only did it effect the relationship with the therapists but it also meant their program got behind on content. This became another source of frustration due to a perception that they rushed through particular topics so missed out on valuable learning opportunities. More serious instances of problems in the therapeutic bond between therapists and clients were discussed as a consequence of frequent changes in therapists and its effect on this participant’s treatment experience.

I end up just saying like “Stick your program, when you sort your stuff out, I’ll sort my stuff out”.... I end up being upset with it myself, you know, so then the days that I did come to program, I just couldn’t be bothered being there. You know, because there was no motivation in what I wanted to strive for it. Which then at the end of it... they usually threaten you. You know, not in a threatening manner but they’ll say things like “Well if you miss a program, you’ll get kicked out of group” sort of thing. You know what I mean? So, but how’s a person meant to go to group when the group is so unstable itself, you know? (Participant 8)

There were many comments about the vulnerability that participants experienced due to concerns about where their personal information was going to end up, and that ‘being in gaol, you’re always on guard’ (Participant 3). One participant described group members preferring to speak individually with therapists due to the ‘humiliation within the
yard between other prisoners’ (Participant 8). When asked to elaborate on this point, this participant stated that he felt not being able to trust other prisoners was ‘the biggest thing’ in relation to clients not wanting to recount their personal details because prisoners tended to ‘gossip’ which can become a form of ‘bullying.’ A number of participants raised issues in relation to breaches of confidentiality in their programs, including an occasion where therapists were limited in what they could do as there was a lack of evidence on who disclosed the information, an instance in which it was raised in one group but ‘it was more or less shoved under the carpet’ (Participant 9) by the therapists, and another participant who described his personal information being given out by another group member to prisoners outside of the group. He explained that he was asked by therapists if this group member should be removed from the group, which annoyed him as he understood that therapists had already stated that any clients who breached confidentiality would be removed from the prison, yet they had asked him to choose rather than taking a stand themselves. He described electing not to have the client removed due to potential repercussions on him by the prisoner wanting to pay him back for impacting on his program opportunity.

Participants also described instances in which they did not contribute to group discussions. One participant stated that there were times when he wanted to say something, but due to other group members being involved in the conversation he felt he did not get the opportunity at the time and then ‘can’t be bothered’ (Participant 3) when a space became available. Another group member commented that he spent some time just listening in the group, taking note of what was going on, before he provided any input. He also commented that he might not say anything for two or three sessions at a time, ‘and that’s fine’ (Participant 5). Other situations were described in which other group members were observed as not participating fully in group tasks, such as one participant who described group members who ‘sat there with their arms crossed and looked down’ (Participant 6) and another who made the following comment.

*There were a couple of them that were not happy that they got held back on the earliest date to do a program. And yeah, they weren’t very happy about participating, most of them were the quietest ones in the group. They were, yeah, didn’t participate much or did the bare minimum that they had to do. (Participant 7)*
Many comments were made in relation to the negative impact of other clients on participants’ treatment experiences. This included not getting along with a number of the other group members leading to minor verbal abuse being exchanged, or clients becoming highly argumentative about what was being asked of them in group. There was also often a perception that many clients were not there to learn but to get parole. Some participants also commented that many clients felt like they already knew what they had to do to avoid further re-offending, that it was an accident they were in gaol or they blamed their drug habit, so constantly communicated that they had no need to attend the program. This was reflected in the following participant’s comments about disruptive behaviour and therapists’ attempts to manage it.

“They’re always like ‘That’s enough!’, and kept warning them, not to kick them out of the room just, you know? I just believe there’s a couple of people there that shouldn’t have been there because they really made it clear, like “I don’t want to do this shit, do I have to get up?” you know? Like “Fuck that, I’m not going to do that.” The whole group would be like “Come on, do it just so we can get it over with, whatever.” They really didn’t want to be there, a lot of them only wanted to be there for parole. …they interrupted the group that really did want to give it a go. (Participant 6)

Another participant described group members dominating discussion with trivialities, and another that a group member would frequently come late and then dominate the session by making it ‘all about him’ and ‘he went on too long with his answers... that was a bit annoying’ (Participant 9) and this led to other group members losing interest. Another participant discussed a group member who behaved in a similar manner.

He was one of these types who’d go off and read psychology books and then come back and try to tell the clinicians about how it was all running, and use ridiculously large words that nobody in the group was going to understand .... So I sort of started to take offence, I took offence that all of a sudden he’s just jumped back in the room and started blurring out all this hokum. (Participant 2)

Another described group members walking out of a session in protest because another group member was ‘telling lies’. A situation was also described by another
participant in which aggressive group members were ‘picking on’ less assertive group members, and how it impacted on other group members’ ability to benefit from treatment.

*It’s frustrating, especially when there’s two or three people in the group that just talked about war stories, about what they did and what they’re going to do or whatever, joking around and wasting a lot of time for the people that did want to try…. there’s two or three people that shouldn’t have been in the group with the attitude, and the way they carried on, and the way they made other people feel uncomfortable, and the way they didn’t put in.* (Participant 6)

Various situations were described in which therapist incompetence impacted on the therapeutic bond with clients. This included perceptions that therapists were inexperienced, lacked understanding of clients’ situations, were inflexible, judgemental, and controlling. Problems were also raised in which therapists either allowed clients to coast through their program or did not enforce appropriate boundaries with disruptive clients. Problems emanated due to breaches of confidentiality, which elicited therapist responses from helplessness to indifference. Whether participants directly felt the effects of this or observed these behaviours in relation to other group members, it appeared to often affect their capacity or willingness to relate to therapists and, therefore, the quality of the bond. The impact of problems in the bond were described as effecting whether group members would contribute to group discussions or some clients overtly expressing their dissatisfaction with the treatment process or dominating discussion with their own agendas. Many behavioural descriptors of clients’ responses to their treatment experience were consistent with antisocial (e.g., aggressiveness, disagreeableness), narcissistic (e.g., use of complex language, dominating discussion), avoidant (e.g., contributing the bare minimum) and neurotic (e.g., hostility, ‘whining’) traits.

What Rupture Repair Responses Occurred?

*When ruptures occurred during group treatment, what were therapists’ responses and how effectual were they?*
Node Definition

The types of therapist behaviours noted by clients in response to goal misalignment, difficulty negotiating tasks, and problems in the bond. Consistent with the nodes developed for Study One, rupture repair responses were coded as one of the following: enforcing appropriate boundaries and managing program content, engagement strategies, and ruptures as opportunities for therapeutic change.

Main findings

- Participants described a range of strategies invoked by therapists to explicitly gain their compliance. The more significant strategy used in this regard was to threaten removal from groups. Participants varied in their attitude to this strategy, with some suggesting it an appropriate approach by therapists while others described it as eliciting negative responses.
- A number of strategies were described by participants that were designed to manage group members’ contributions. These included pointing out that their contributions would be relayed to the parole board, shutting down participants, redirecting participation back to the intended task, and speaking with clients individually out of session about factors impacting on participation.
- Therapists were described as exercising a degree of flexibility in response to participant objections to nominated tasks in a number of situations, and this assisted their participation.
- Positive therapist characteristics designed to encourage participation included demonstration of understanding, support, humour, and enthusiasm.
- A particularly influential strategy to support clients’ participation described by a number of participants was the encouragement of other group members.
- A small number of participants commented on the value of receiving feedback on their participation, and how this enhanced both their self-awareness and encouraged therapeutic change.

Participant responses described varying approaches to the manner in which therapists responded to ruptures in the alliance. As demonstrated in Table 4, comments mainly related to therapists efforts at enforcing boundaries and managing the delivery of group content and the use of engagement strategies. Strategies that used ruptures as opportunities for therapeutic change were rarely described by participants.
Enforcing Boundaries and Managing the Delivery of Group Content

Various participants commented on therapists responding to their, or other group members’, negative treatment reactions by threatening their removal from programs. This strategy was sometimes seen as appropriate, such as in response to clients breaching confidentiality, but also described as having a negative emotional impact on clients, such as demonstrated in the following quote.

It’s like I was forced to do it though, that’s why it will probably give me the shits about it at the moment. Like I was even being approached, “do this or they’re going to kick you out the program and you can’t continue on.” (Participant 1)

Similarly, participants also observed therapists encouraging client participation by pointing out the parole board were waiting for their treatment report to be written and/or a decision to be made. One participant in particular thought that this approach was appropriate for other group members as it was ‘pretty straight forward’ (Participant 9).

Other responses were also described in which therapists managed client input when difficulties arose. This included one participant observing a therapist say to a client ‘It’s not all about you’ (Participant 9) when a group member was dominating a session, and this was effectual ‘for about one session’ after which time therapists avoided him. Another participant noted therapists stating they would come back for group members’ contributions if they were ‘pissed off.’ Another described what happened after he gave therapists some feedback that he was frustrated by other clients telling ‘war stories’ that were irrelevant to the program and that dominated discussion.

Next time it happened I did notice the clinicians say that “we’re taking up time,” and to “stick to the task.” Otherwise, because this course runs for a set time so the more that we talk about other things that aren’t relevant to the situation, they’ll put the course back again. (Participant 7)

A strategy was described by another participant in which therapists sought feedback from other group members to encourage a participant to admit his behaviour had been
inappropriate towards another group member.

So that day when they said, “Oh well, who else agrees to what (participant) said?” after my five minute break, it went around the room and nobody agreed with me. So they all sort of turned on me because they thought they were pleasing the clinician. (Participant 2)

Many participants stated that therapists frequently assisted clients individually, if they ‘had an issue they couldn’t raise with the group’ (Participant 3) and while some reported that these discussions had a positive impact, some stated they did not, and others suggested they might have a brief impact on client behaviour. One participant stated that he had spoken with therapists individually about his concerns in relation to sharing information, and found this helpful. He ultimately did disclose the required personal information to the group after this discussion. Other participants provided the following comments.

If something wasn’t right or they knew I was a bit emotional or didn’t say something, they always had a talk to me after group, and that was the same with everybody. (Participant 5)

Like they’ll take notes during the class of what’s happening and then at the end of the class they might call someone back that needs encouraging, needs help, needs extra time. (Participant 7)

Strategies designed to enforce appropriate boundaries of behaviour, such as encouraging required participation in tasks, included pointing to a range of negative consequences that might occur if compliance was not achieved. These varied from threatening removal from programs, threatening the extension of programs, and reminding participants that their contributions are conveyed to the parole board. A number of behavioural strategies were also described to manage compliance in the treatment process, such as by shutting down and redirecting clients to the intended task if they dominated sessions with irrelevant topics, suggesting they would ask for a response at a later time if they were unable to contribute when asked, and asking for other group members’ feedback on their behaviour. A commonly described strategy to manage group difficulties was to also speak with clients individually outside of group sessions. These strategies were perceived as
being variably successful. While some participants described them as appropriate and having at least some impact on clients’ behaviour, others seemed to perceive them as an abuse of therapists’ power which elicited resentment.

**Engagement Strategies**

A number of clients described therapists exercising a degree of flexibility in their treatment delivery as well as providing a rationale for treatment tasks. One participant described negotiating with therapists in relation to the frequency that experiential activities would occur, and they eventually agreed with the clients and, at first, reduced the number of these activities then stopped asking clients to undertake them. This same participant also described that when he protested about having to make personal disclosures in group during his life-pathways activity, the therapists also modified their approach by allowing him to do this individually with him rather than in the group. Another participant observed that in response to group members being outspoken on particular topics, therapists ‘listened to what people had to say and worked around it.’ Discussion of difficult situations and therapists apologising or making compromises commonly occurred.

A number of participants described the value in therapists conveying a level of understanding, support, and humour to encourage clients to undertake particular tasks when they were having problems. This was demonstrated in the following quotes by one participant.

*If it was something they really didn’t want to talk about they’d just explain it to them that “Look you really don’t have to say things that you don’t want to say.” (Participant 3)*

*Well talking about the offence was one of the main goals of the program and just sort of helped me to get it out there. Come to terms with it a bit. (Participant 3)*

Another participant also made the following comment on other positive therapist characteristics to encourage group participation during experiential activities.

*People didn’t want to do it but once people got into it they sort of, like it was a good way to get everything started. They were enthusiastic and energetic and they tried to*
Many comments were made about group members providing support to each other to encourage participation. This was particularly highlighted in the following quotes.

*And this is where the group’s got to stand up and say, and grabbing him or her and just sort of… and this is like a man’s group… so we’ve got to grab him and just sort of say, “Look, we’ll help you, we’ll walk you through it,” you know? (Participant 5)*

*And then I found that once the other prisoners spoke to them and said “just give it a go it’s got to be done, let’s just give it a go, get it over and done with, don’t drag it out.” They got into it and participated. (Participant 7)*

A number of strategies assisted clients engage in the process of treatment when they were faced with difficulties. This included demonstrating a level of flexibility to compromise on required treatment participation to better suit client concerns. The outcome of some of these therapist responses, however, appears to be an erosion of good clinical practice (i.e., eliminating experiential activities). It may also be that allowing some personal disclosures to occur in an individual setting to reduce client anxiety also has the impact of other group members wondering why different rules apply to some group members and reduces group opportunities to contribute to that client. Other positive therapist characteristics to encourage participation, such as demonstrating understanding, support and enthusiasm, are more likely to both repair therapeutic ruptures but also foster group cohesion. The development of group cohesion in particular then also appears to have the beneficial effect of providing an additional mechanism to assist resolving ruptures, through the encouragement and support of group members when ruptures relating to undertaking nominated tasks occur. These strategies foster collaborative processes as they empower group members in their treatment participation.

Ruptures as Opportunities for Therapeutic Change

A number of participants commented on the feedback they received from therapists when difficulties occurred, and how their observations could be helpful to assisting the process of change. This is reflected in the following comment by a participant who also stated that this helped him develop a greater self-awareness of his behaviour and make
positive changes to his group participation.

They used to say to me “We can see that you’ve sometimes got more to say but don’t say anything”. They did pick up on it a bit ... When they mentioned it, I tried to speak up a bit more. (Participant 3)

This is also reflected in the following comment by another participant.

I guess it’s always good to see your ups and downs with the group sort of there, because it makes you.. if you have any faults or anything like that, I think that’s where the facilitators come in and say, “This is what you could do.” (Participant 5)

Although only reported by a smaller number of participants (six of the ten), considerable value was placed on receiving feedback from therapists. These insights could particularly encourage positive therapeutic change. These experiences highlight the role of utilising both withdrawal and confrontation ruptures as opportunities for therapeutic change.

Summary and Conclusion

Participants in this study conveyed the value of delivering offending behaviour treatment within a TA framework and emphasised the importance of collaborative processes underpinned by trust and respect. Participants in this study also described a range of positive therapist characteristics, such as flexibility, understanding, and encouragement, as integral to assisting clients become involved in the treatment experience. A number of participants experienced ruptures in treatment, such as when they felt therapists were being punitive, when clients withdrew their participation, or by therapists not enforcing appropriate boundaries with other group participants who were disruptive and dominant. A variety of rupture repair strategies were described, although for some participants the enforcement of boundaries evoked negative reactions whereas encouragement, particularly from other group members, was helpful to motivate their involvement in treatment. Few strategies were described that involved interpretation of clients’ behaviour. What might be concluded from this study is that clients experience a diverse range of responses to
therapeutic ruptures in offending behaviour programs, but what is less clear is the frequency that ruptures occur and how efficacious therapist responses are to resolving these.
CHAPTER SEVEN - A Model of the Therapeutic Alliance in Offending Behaviour Programs

Overview

The findings of the qualitative studies are used to inform the development of a model of the therapeutic alliance in offending behaviour programs. This model aims to explain how therapists employ a range of approaches based on their skill, confidence, training, and experience. Three different modes are described which elicit varying responses to clients who demonstrate personality dysfunction: the educative mode focuses on enforcing appropriate boundaries; in the engagement mode therapists adjust program content to accommodate client dysfunction; in the therapeutic mode therapists draw on the therapeutic relationship to intervene in here-and-now experiences of dysfunctional client traits. It is suggested that the therapeutic mode may offer considerable utility as it offers clients insights into problematic behaviours related to their offending.

Summary and Integration of Qualitative Studies

Three main findings were derived from Study One in relation to the therapeutic alliance (TA) in offending behaviour programs: therapist participants viewed the TA as a relevant and useful construct to apply to the delivery of offending behaviour programs; therapist participants described distinct approaches to the way they developed the alliance based on differing notions of how change occurs; clients demonstrating traits of severe personality dysfunction often triggered significant ruptures to the TA, and therapist participants were often limited in their approaches to respond productively to these. These findings provided the context for Study Two, which aimed to consider the developing theoretical model derived from Study One from the perspective of offenders. Comparison and analysis of responses from these two studies in relation to these main findings follows.

Therapist participants in Study One overwhelmingly articulated their view that the TA is both a relevant and important concept that can be applied in the delivery of offending behaviour programs. This notion was supported in Study Two as client participants identified a range of factors relating to the TA that assisted the process of treatment. Positive therapist
characteristics (e.g., enthusiasm, support, understanding, transparency) were particularly described as fostering a bond to facilitate the negotiation of program tasks and achieve relevant therapeutic goals. Participants in both studies varied in relation to which elements of the alliance they believed were most important (tasks, goal or bond) although there was also an acknowledgement by many participants that each element impacted on the others.

Therapists who participated in Study One demonstrated considerable variation in the responses they gave in relation to developing the TA and responding to ruptures. These suggested therapists worked in three distinct modes depending on a range of factors such as the stage of a group (early versus late), characteristics of a client (readiness/responsivity issues), the nature of the program delivered (psycho-educational versus therapeutic) and therapist characteristics (e.g., qualifications, theories of change). The first of these modes emphasises the importance of educating clients by adhering to program manuals and enforcing rules when clients demonstrate behaviours that impinge on this end (e.g., antisocial attitudes, a lack of participation). This emphasises the use of boundaries and setting limits as a means of responding to difficulties encountered. The second focussed on engagement by taking a pragmatic approach to treatment that focussed on adapting to meet the needs of the group and putting concerns back to the group to resolve. This emphasises the use of motivational interviewing skills, particularly around avoiding arguments with clients to respond to levels of resistance. The last mode emphasised the development of a therapeutic relationship as central to clients’ change process and ruptures as opportunities to therapeutically respond to dynamic risk factors. There was also emphasis in the therapeutic mode on identifying and intervening with offence-parallelizing behaviour.

Client participants in Study Two similarly described a variety of experiences in relation to therapists’ development of the TA and responses to ruptures, and were also able to offer their views on the efficacy of these strategies. While the enforcement of boundaries of behaviour, through strategies such as threatening removal from treatment in response to non-compliance with tasks, were sometimes viewed by participants as an appropriate strategy, they could also be experienced as an abuse of therapist power that elicited frustration and resentment. This contrasted with strategies that attempted to engage clients, such as the demonstration of flexibility, understanding, and enthusiasm, to encourage appropriate negotiation of tasks, identification of appropriate treatment goals, and the development of a therapeutic bond. One important factor emphasised in Study Two more so than in Study One concerned the significant impact of clients encouraging each
other in this endeavour. Group cohesion was seen as an important factor in both studies, but the relative importance of this strategy was greater in Study Two with client participants describing it as a compelling factor that assisted their process of treatment. Participants in both studies also discussed therapeutic strategies that involved the provision of feedback that had the dual impact of strengthening the TA as well as assisting the therapeutic process through increasing self-awareness and encouraging pro-social changes to behaviour. Study Two client participants, however, described less variety of circumstances in relation to these experiences. This may have been due to these participants not possessing the range of terminology used to describe these other experiences, such as ‘corrective emotional experiences,’ ‘offence-paralleling behaviour,’ and ‘utilising the therapeutic relationship as a mechanism for change.’ It may also be that client participants actually had fewer of these experiences or lacked the insight to identify them. When client participants did describe therapists interpreting their behaviour to assist them develop new insights and foster opportunities to change behaviour, however, they conveyed a great deal of value in these experiences.

The third significant finding of Study One was the challenges posed to participants in their implementation of efficacious rupture resolution strategies for a range of personality pathology. Both Study One and Study Two participants described a broad range of traits associated with ruptures from a number of different personality disorders (PDs), including antisocial (e.g., aggression, disruptive behaviour), avoidance and withdrawal (e.g., limited social interaction, avoidance of program tasks), narcissistic (e.g., denial of problems, dominating group time) and neurotic traits (e.g., ‘whining’, affect dysregulation). Both studies most commonly described antisocial traits as predominant when describing rupture experiences. Consistent with the notion of there being three distinct modes that therapists use to build the alliance and respond to ruptures, participants in both studies also described experiences relating to the enforcement of boundaries, engaging clients, and responding therapeutically to assist the process of rupture repair. Although therapist participants acknowledged the problematic impact of dysfunctional personality traits impacting on group cohesion, client participants particularly highlighted the detrimental impact of not enforcing boundaries when these occurred with respect to confrontation as well as withdrawal ruptures. Some very significant impacts were described by client participants when these situations arose that impinged on both their own and the broader group’s motivation to engage in the therapeutic process and the subsequent quality of their group participation.
A model of the three modes of the TA, educative, engagement and therapeutic, is outlined below based on the results from the above studies. For each of these modes, the central aspects that define the mode are discussed and a table summarising pertinent factors is included for each. Tables 5, 6, and 7 outline ideal aims for each element of the TA, relevant therapist variables, and how ruptures might be potentiated by clients demonstrating traits of significant personality dysfunction for each mode.

**The Educative Mode**

The educative mode describes the process of delivering program manual content and responding to ruptures in the alliance principally through reinforcing boundaries, encouraging compliance, and the use of behavioural techniques to support this process. The main goal for those working in this mode is to ensure that program information and tasks are delivered as intended within the program manual and problematic behaviours demonstrated by clients are managed to assist this end. In addition to delivering program manual content, the central tasks in this mode include the development and enforcement of group rules as well as promoting appropriate behaviour in session. As outlined in Table 5, the goals of delivery are therefore linked to clients attending closely to the material and interacting with therapists and group participants in ways that facilitate this through treatment compliance. The strength of the bond required for the successful completion of these tasks and goals can be understood in terms of clients’ openness to therapists’ efforts at delivering material and mutual respect for group rules. This table also outlines a range of therapist variables relevant to this mode, which includes that beliefs about change revolve around the need to deliver program manuals to impart skills, and client behaviour that is perceived as difficult should be ‘managed’ to achieve the end of delivering the manual. There was a tendency for therapists in Study One to describe the use of these strategies if they were inexperienced and anxious in relation to program delivery. However, more experienced therapists also described the use of these strategies, particularly at the start of treatment, to establish expectations of behaviour in group.

The delivery of psycho-educational material outlined in program manuals is an important task of this alliance mode. In addition, there are three forms of compliance
management observed in therapists using this mode to respond when clients are not complying with the requirements of the manual. These are: to obtain compliance through the development and enforcement of group rules, to create and enforce structures and boundaries in a group, and to use behavioural techniques to reduce the potential for disruptive behaviour.

Group rules are consistently developed within offending behaviour programs to develop a group culture conducive to therapeutic engagement. Group rules ensure there is clarity around behaviours that are both expected and not tolerated. In addition to developing group rules, boundaries of behaviour are reinforced to ensure the delivery of program material such as by reminding clients where breaches have occurred, re-directing discussion back to intended tasks, and shutting down discussion by clients that are not relevant to therapists’ agendas.

A number of techniques are also used which follow the principles of behavioural theory to reduce the likelihood that clients will be disruptive and to encourage compliance and engagement with a suggested task. These may take the form of behavioural strategies invoked to shift potentially unhelpful dynamics within a group, such as asking clients to swap seats or undertaking a range of experiential tasks to avoid unhelpful alliances between group members and/or to improve engagement with program material. In an effort to encourage more appropriate client behaviour, therapists may positively reinforce client’s behaviour. This may occur by providing praise or encouragement where a positive contribution to the group has been noted or the client's behaviour demonstrates an improvement compared to their previous behaviour in group. Therapists might also suggest clients undertake particular tasks within session (e.g., to make some meaningful contribution to a discussion, ensure everyone has a turn at undertaking an activity, ask clients to write their own or other group members responses on a whiteboard) to both encourage engagement in the task and reduce the possibility of disruptions occurring in group.

There are a range of issues to consider in relation to the use of educative strategies in relation to clients who demonstrate PDs, as outlined in Table 5. These include difficulties that may emanate due to the interaction between therapist requests to adhere to manualised content and clients who demonstrate personality dysfunction (e.g.,
antiauthoritarian attitudes, socially withdrawn clients). Further difficulties are likely if
manualised content does not relate to personality dysfunction demonstrated by clients (e.g.,
impulsivity, emotion dysregulation) as the therapist’s task will necessarily then centre on
obtaining compliance. The quality of the bond may also be superficial as the central task of
the therapist is to deliver the program manual, although abusive relationships may also
develop as there is scant attention to the nature of relationships formed in therapy except
to eliminate those that become too difficult. And finally, clients are able to coast through
treatment provided they are not disruptive due to therapists’ focus on the presentation of
material rather than the quality of client participation.

Table 5
Ideal aims, therapist variables, and factors relevant for personality disordered clients for the
educative mode.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Issues relevant to the Educative Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal aims</td>
<td>Goal is for the client to learn <em>cognitive-behavioural skills</em> from the program manual</td>
</tr>
<tr>
<td></td>
<td>Task is for therapists to competently deliver sessions from the manual and clients participate in activities as required</td>
</tr>
<tr>
<td></td>
<td>Therapist and client develop a bond underpinned by respect for rule compliance through the program experience</td>
</tr>
<tr>
<td>Therapist variables</td>
<td>Belief that change will occur if clients get the program manual delivered as written</td>
</tr>
<tr>
<td></td>
<td>Wants to eliminate ‘difficult’ behaviours in group</td>
</tr>
<tr>
<td></td>
<td>May be anxious about their own ability and/or feel threatened by clients</td>
</tr>
<tr>
<td></td>
<td>Client goals are misaligned because they want control in the session (Antisocial PD, Narcissistic PD), to avoid making a</td>
</tr>
</tbody>
</table>
Potential ruptures with PD clients

contribution (Avoidant PD), or to gain sympathy for their experiences of victimisation (Borderline PD)

The manualised material does not match the PD characteristics of clients (e.g., disruptive, non-compliant, hostile, withdrawn, grandiose, emotionally dysregulated, interpersonal difficulties) so the central task for the therapist becomes to try and achieve client compliance

Bond is superficial (with withdrawn and Borderline PD clients) or the relationship is abusive (with Antisocial PD and Narcissistic PD clients) and no attempts are made to identify and repair ruptures

Does not require significant levels of motivation or a desire to effect change relevant to their offending. Allows client to coast through material which is a particular risk to socially withdrawn clients (e.g., Avoidant PD, Schizoid PD)

The Engagement Mode

The engagement mode emphasises working with clients in a way that is responsive to their individual needs, including the demonstration of dysfunctional personality traits. Therapists are, therefore, sensitive to factors such as levels of defensiveness, anti-authoritarian attitudes, self-entitlement, and interpersonal problems in addition to factors such as literacy, cognitive capacity, and mental health symptoms. As outlined in Table 6, the goals of treatment are to address client dynamic risk factors and the tasks are based on undertaking activities that have been modified from the program manual to achieve this end. A key therapist activity also concerns adopting a therapeutic stance to optimise engagement, so skills such as validation, expression of empathy, the development of common ground, and the use of experiential methods to assist strengthening group cohesion are utilised, particularly to achieve engagement in clients who demonstrate low levels of motivation to be in a group. Table 6 also highlights that there is more emphasis in this mode, compared to the educative mode, in developing a robust bond in which the therapist encourages a trusting relationship underpinned by mutual respect and inspires behavioural change. In addition, therapist variables relevant to this mode include a
commitment to the RNR model, particularly in relation to therapists taking responsibility to adapt material responsively to suit the characteristics of clients.

There are three forms of engaging clients in the treatment process observed in therapists using this mode. These are: fostering the quality of the therapeutic relationship, fostering treatment engagement whereby clients are encouraged to undertake relevant treatment activities, and the use of change strategies to inspire client involvement in session tasks and/or use of skills.

Therapists foster the therapeutic relationship in an effort at building and/or strengthening the quality of the TA with one particular client or more generally with group members. These strategies particularly focus on the connection between therapists and group members and are facilitated by therapists validating clients’ experiences by acknowledging and accepting the difficulty being expressed and conveying an understanding of clients’ responses. This might particularly involve situations in which one or more clients express dissatisfaction with their situation and tasks that need to be undertaken or decisions that have impacted on the group (e.g., changes in program timetable, changes in facilitation arrangements, disclosure of personal information in life story activities). Another strategy includes therapists offering support to clients who demonstrate that they are having difficulty either in the treatment process or outside of group. Support can include conveying a level of emotional support towards clients and/or assisting clients by engaging in problem-solving to assist resolution of the difficulty in session. Support can either be offered directly to clients by therapists or by asking group members to convey their experiences to assist in the client’s situation. Therapists using this mode also encourage clients to participate in the treatment process by asking specific questions about comments made, inviting clients to comment on whether they can relate to a topic of discussion, or by suggesting they provide more information if only a minimal response was made. The context in which this encouragement occurs is by therapists maintaining a level of interest and understanding in what is being said. An additional strategy to foster treatment engagement includes therapists establishing common ground with clients by conveying a shared interest and commitment towards client goals and well-being.

Therapists using this mode will also invoke a range of strategies to foster treatment engagement by responding flexibly when clients raise concerns in treatment. This includes
attending to issues of treatment readiness by modifying activities in the moment or responding to clients in a way that encourages their willingness to undertake tasks. Therapists do this by encouraging group member to assist in resolving group problems, such as problems with the task being nominated by therapists or the quality of relationships between both therapists and clients or between clients. This is achieved by exploring the problem and deciding on a way for the group to be able to continue undertaking treatment in a meaningful manner. This mode also includes a range of other strategies to adapt the therapeutic experience to accommodate clients’ objections to the treatment approach. These include changing goals or tasks to respond to objections around the relevance of tasks or direction of sessions. Alternatively, when group members object to the goals of treatment, therapists might reinforce the purpose and relevance of the intended goal or explain the rationale for a task to foster a more collaborative approach.

The engagement mode also includes therapists’ using a range of change strategies, including motivational interviewing techniques, to encourage engagement in treatment when clients are ambivalent to the process of change. Change strategies have a dual function, which is to encourage the development of skills and shift ambivalence to increase openness to enacting new behaviours. Strategies include therapists encouraging self-reflection, by maintaining a stance of curiosity and engaging in a Socratic style of questioning to encourage clients’ exploration of their own behaviour. If clients become argumentative and disagree with therapists, an engagement strategy would be to roll with this resistance by not engaging in arguments or responding defensively but acknowledging the clients’ difficulties and inviting (rather than imposing) them to view their problem from a different perspective. Therapists might also develop discrepancy for clients by pointing to differences between current behaviour (i.e., issues raised or behaviours demonstrated in group) and goals the client has previously articulated as important to achieving. Therapists in this mode might also promote the possibility of change when they explore clients’ self-efficacy with respect to their ability and confidence to enact required behaviours to effect positive change, as well as encourage practice of new skills. This enables therapists to address views around clients’ ability to change and provides an opportunity to discuss relevant activities and goals to assist their situation.

Table 6 outlines a range of issues relevant to the use of the engagement mode in relation to PD clients. This includes that adapted program material may not address specific
dynamic risk factors for some PD clients and that problems may emanate if therapists’ attempts to engage clients fails or detracts from stated program aims due to therapists’ focus on reducing, for example, client conflict but at the expense of program skills not being delivered.

**Table 6**

Ideal aims, therapist variables, and factors relevant for personality disordered clients for the engagement mode.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Issues relevant to the Engagement Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal aims</td>
<td>Clients achieve the goal of acquiring skills relevant to respond to their dynamic risk factors to avoid re-offending Therapists’ task is to adapt the program manual to respond to client characteristics and encourage behavioural change in response to identified risk factors Therapist and client achieve a close bond in which trust and respect are developed allowing program material to be embraced</td>
</tr>
<tr>
<td>Therapist variables</td>
<td>Knowledge of and commitment to RNR/treatment readiness Takes responsibility for modifying the program manual to accommodate client characteristics Treatment delivery is responsive to client characteristics</td>
</tr>
<tr>
<td>Potential ruptures with PD clients</td>
<td>The central goal revolves around adapting program material to suit client characteristics but PD traits relevant to clients’ risk of re-offending may not be resolved &amp; skills learnt may not be relevant to offending (e.g., attachments problems underlying hostility in psychopaths and Antisocial PD; impulsivity &amp; emotion dysregulation in Borderline PD; avoidance in Avoidant PD; the development of grandiosity in response to problems in self-</td>
</tr>
</tbody>
</table>
concept for Narcissistic PD; experiences of victimisation underpinned by disempowerment and a lack of responsibility-taking in Borderline PD).

Therapists attempts to adapt the manual fail to engage clients demonstrating severe PD traits and/or results in a lack of program integrity as PD clients dominate session time or avoid involvement in activities

The Therapeutic Mode

The therapeutic mode describes therapists’ approach to achieving a TA that aims to achieve therapeutic transformation to reduce risk of re-offending. The central vehicle to eliciting therapeutic change is through the therapeutic relationship, either directly through clients’ experiences of that relationship or the strength of the relationship allowing clients to be sufficiently challenged while maintaining therapeutic engagement. This approach offers considerable utility to clients demonstrating traits of PD as therapists aim to gain an initial understanding of client traits and intervene to address their dysfunction. As outlined in Table 7, the goal of treatment revolves around clients developing insights around their offending, then developing in-session treatment skills to address these which are then generalised outside of treatment. The tasks required to support these goals include the development of a strong professional relationship, interpretation of client behaviour, and the identification of skills to address offence-paralleling behaviour. In addition, therapists need to be highly skilled to achieve this mode. For example, it requires the development of a case formulation of clients’ offending behaviour to enable clients to increase their understanding of the underlying processing of their behaviour, and develop appropriate goals to shift behaviour that responds to dynamic risk. This will include identifying and intervening with offence-paralleling behaviour demonstrated in group sessions as well as encouraging behaviour change to be generalised outside of group session. Therapists will also view the resolution of ruptures as one of the core tasks of treatment. Due to the possibility that clients will feel confronted by such an individualistic and personal approach, therapists are required to develop a strong bond with clients to be effective.
There are three types of strategies observed in therapists using this mode. These are: direct analysis of the quality of the therapeutic relationship, raising awareness in relation to clients’ behaviour to facilitate change, and the promotion of skill building to address dynamic risk as the primary therapeutic goal to be achieved.

Therapists using this mode will focus closely on analysing the strength of the therapeutic relationship to ensure that any ruptures created as a consequence of challenges can be repaired or to facilitate change through offering new relational experiences to clients. Where therapists identify problems in the relational experience with a client, they will acknowledge and explore the difficulty with a view to repairing problems. Another important aspect of examining the therapeutic relationship includes therapists checking-in with clients about their experiences in treatment even if there are no obvious difficulties, although more subtle behaviours suggesting problems may be evident (e.g., being evasive of therapists questions, not completing homework). Therapists might also provide new relational experiences for clients. This may be signified by the therapist linking a client’s appropriate behaviour towards therapists and/or other group members, and contrasting this with dysfunctional responses enacted in previous relationships (e.g., in invalidating or abusive environments).

Therapists will utilise a number of techniques to increase clients’ insight into their own behaviour. The manner in which client behaviour is processed not only raises a client’s awareness of their own behaviours and the link between this and dysfunctional behaviours, but should improve a client’s attitude to enacting behaviour change. The most basic strategy that is invoked to assist this process is by therapists providing feedback to clients with a view to promoting a better understanding of their behaviour or aspects of their behaviour (e.g., motivations, desires, defences, affective experiences). This should provide some impetus for clients to consider how their behaviour has impacted on themselves and/or others, particularly in relation to their offending, as well as more helpful means of behaving to meet their needs. Awareness raising also occurs when therapists challenge clients to create dissonance, revealing a discrepancy between a client’s ideal values and beliefs and current beliefs and/or behaviour. This process should result in the client demonstrating a level of discomfort due to this discrepancy, and some impetus for resolving this occurs. Therapists might also reflect on their own responses to clients’ behaviour to explore their dysfunction, including the likely impact and potential alternatives to their behaviour. Therapists might
also illuminate offence-parallel behaviour by making specific reference to the link between observed behaviour in group and their offending.

Therapists using the therapeutic mode will also focus on fostering client skills by creating situations in treatment where pertinent behaviour change is identified and encouraged to assist the client. This process may occur directly through therapists’ discussion but may also involve discussion with group members and encouragement by the group. This may include identifying in-session dysfunctional behaviour and encouraging the client to enact alternative behaviour in future similar situations. This might involve suggestions the client practice the behaviour during these discussions. Therapists might also promote skill building by creating opportunities for clients to express their difficulties. In these situations, clients are encouraged to identify their own emotional experiences and then express these appropriately. This might occur in-session initially to assist in the development of emotion regulation and interpersonal skills but then be generalised to outside of session. Therapists might also explore pro-social means of achieving the clients’ dysfunctional behaviour by discussing the function of their behaviour and identifying alternative pro-social behaviours that will achieve a similar function.

Table 7 outlines a number of factors relevant to the use of this mode and personality disordered clients. This includes the possibility that techniques may not be effectual if clients are not able to self-reflect or lack openness to feedback.

**Table 7**
Ideal aims, therapist variables, and factors relevant for personality disordered clients for the therapeutic mode.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Issues relevant to the Therapeutic Mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideal aims</td>
<td>The client achieves goals around developing insight into their offending behaviour, demonstrating significant therapeutic change in-session and applying skills to create a pro-social lifestyle</td>
</tr>
<tr>
<td></td>
<td>Therapists’ task is to create opportunities for clients to develop insights into their offending, offer interpretation and feedback on</td>
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previous and current behaviour relevant to offending, and promote behavioural skills and strategies to address dynamic risks

Therapist and client develop a strong professional bond underpinned by trust and respect that on occasion is tested because of the challenging nature of the intervention, but strengthened when these issues are resolved

Therapist variables
Develops case formulation and identifies offence-paralleling behaviour to elicit change
Focuses on ensuring ruptures are resolved
Requires high degree of skill and expertise and an understanding of theoretical orientations that are broader than cognitive behavioural therapy (e.g., psychoanalytic concepts such as transference/counter-transference, group dynamics)

Potential ruptures with PD clients
Attempts at repairing ruptures are not resolved due to clients being unable/unwilling to form a therapeutic relationship. Client requires openness to feedback on behaviours, access to internal experiences, and the capacity for self-reflection which may be challenging for clients demonstrating severe PD traits. Indirect approaches for more severe PD traits require lengthy treatment episodes
CHAPTER EIGHT – Alliance Modes and Rupture Repair in Offending Behaviour Programs

Overview

This chapter reports the findings of the third and final study of the thesis, a quantitative study designed to test the extent to which the model can be operationalised. Segments of videotaped offending behaviour programs were coded to ascertain whether the alliance modes outlined in the model could be reliably identified. This revealed that therapists predominantly used strategies characterised as engagement in their delivery of treatment. While educational strategies were sometimes utilised, therapeutic methods were rarely used. Markers of therapeutic ruptures were then identified and an analysis presented of therapist responses. Both demonstrations of antisocial (confrontation) and social avoidance (withdrawal) ruptures commonly occurred in treatment sessions, although therapists were less likely to respond to client withdrawal.

Rationale for Study Three

The findings of Study One and Study Two informed the development of a new model to describe therapist contributions to the therapeutic alliance (TA) in offending behaviour programs and how they respond to ruptures. Three distinctive modes of practice are identified: the educative mode, which emphasises the delivery of group content and client management; the engagement mode, which focuses on the adaptation of program material; and the therapeutic mode which relies on increasing client self-awareness, particularly of the therapeutic relationship, to achieve program outcomes. As the model was derived solely from therapist and client retrospective accounts of their experiences in offending behaviour programs, a third study was designed to investigate whether these three modes do characterise therapist behaviour in program sessions. In addition, this study aims to document the types of rupture to the alliance that occur and the strategies that therapists use to respond to these. The previous studies both suggested that ruptures would be most likely to occur when therapists are faced with presentations of personality dysfunction. Antisocial and psychopathic traits in particular were cited as most challenging, although other problematic personality traits were identified, including those that are associated with
Narcissistic, Avoidant, Borderline, Histrionic, and Dependent personality disorders (PDs). Some of the therapist participants described their frustration at not knowing how to respond to more severe demonstrations of these traits, with a number describing their reliance on the educative mode (discussing group rules, shutting down antisocial behaviour, threatening removal from group if the behaviour does not change) in these circumstances. Similarly, while some offenders reported the importance of therapists demonstrating positive therapist characteristics in resolving ruptures, others emphasised the need for therapists to enforce boundaries when responding to disruptive behaviour. What has yet to be established, however, is just how frequently ruptures are encountered, which strategies are most commonly implemented to establish the alliance, and which are effective at resolving problems that arise.

In designing this study, consideration was given to those methodologies that have been employed in previous studies investigating ruptures in mental health treatment. Two main approaches have been used: the self-reports of therapists and clients; and observer-based methods (Safran, Muran & Eubanks-Carter, 2011). Studies which have utilised self-report have asked therapists and clients to rate ruptures or document fluctuations in the alliance using measures such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) or the California Psychotherapy Alliance Scales (CALPAS; Marmar, Gaston, Gallagher & Thompson, 1989) at the end of each session and over an episode of treatment. This approach was not identified as suitable for use in the current study, however, as it was expected that clients would be less forthcoming about their treatment experiences because of the potential repercussions of providing feedback that might be perceived as negative (e.g., negative reports to correctional case managers and/or the parole board, breaches of treatment conditions), even when assurances of confidentiality are given. As such, and in light of suggestions that self-report leads to the identification of fewer ruptures (Coutinho, Ribeiro, Sousa & Safran, 2014), an observer-based method was considered more appropriate.

Three different observer-based methods have been reported in the published literature. The first employs coding systems to analyse transcripts of treatment sessions (e.g., Colli & Lingiardi, 2009; Harper 1989; cited in Safran, Muran & Eubanks-Carter, 2011). This was considered not to be practical in correctional environments, given the length of time associated with the analysis of transcripts and concerns about privacy. An alternative is
to use a task analytic approach (e.g., Greenberg, 1984) to develop a model of rupture-repair as has occurred from a number of therapeutic perspectives, including brief relational therapy (Safran, Muran, Samstag & Stevens, 2002), cognitive behavioural therapy (Cash, Hardy, Kellett & Parry, 2013; Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008), and cognitive analytic therapy (Bennett, Parry & Ryle, 2006). This method involves observation of both successful and unsuccessful outcomes within therapeutic dyads. This approach was, however, also not particularly appropriate for the current study as the aim here is more specific - to examine therapists’ use of the three proposed alliance modes in offending behaviour programs and quantify the number and type of ruptures that occur within sessions. Rather, a third observer-based approach involving the Rupture Resolution Rating System (Mitchell, Eubanks-Carter, Muran & Safran, 2011) was used. This is a structured process to identify confrontation and withdrawal ruptures and the range of rupture repair strategies that occur to respond to these. This method was used in this study to answer the following research questions:

- To what extent do therapists demonstrate behaviours consistent with the educative, engagement and therapeutic modes?
- What types of rupture to the alliance occur in offending behaviour programs?
- What modes are used to repair ruptures and how effectual are they?

Method

The Offending Behaviour Treatment Program

Data collected from a community-based sexual offender treatment program were used to determine which alliance modes were utilised by therapists and how they responded to ruptures. The program is typically delivered by two therapists (but sometimes by two therapists and a student) to convicted offenders who have been assessed as posing a moderate to high risk of sexual re-offending. The program utilises cognitive behavioural methods and comprises five core modules: offence disclosure (requiring clients to outline their current offences), life-story (which identifies clients’ core beliefs), offence-process (which identifies offence triggers), victim empathy, and healthy lifestyles (comprising relapse prevention and pro-social goals to address identified risk factors). A range of other modules
are offered (affect regulation, fantasy management, and social competency) when client need is identified.

Two different versions of the program are delivered. For those clients who are assessed as posing a moderate-low risk of re-offending the program consists of 24 weekly three-hour sessions and is run in a closed format with all group participants commencing and completing treatment at the same time (except for those who drop out). The program for moderate-high/high risk offenders is delivered in a rolling format, with group members commencing and completing at different times. Those assessed as posing a moderate-high risk of re-offending attend 30 weekly three-hour sessions, whereas those at high risk of re-offending attend 35 weekly three-hour sessions.

Sessions from three different treatment groups were subject to analysis, equating to 90 hours of therapeutic contact. One group was delivered in a closed format for offenders assessed as posing a moderate-low risk, and two were delivered in a rolling format for those assessed as at moderate-high or high risk of re-offending.

Participants

Participants were 11 therapists and 31 clients who were involved in community-based sexual offender treatment. To be considered eligible for these programs, participants have to be male, not currently demonstrating acute psychiatric symptoms, be of low average or higher cognitive ability, and have been convicted of an offence in which there was a sexual element. These include a broad range of both contact (e.g., rape, indecent assault) and non-contact (e.g., possessing child pornography, indecent exposure) sexual offences.

Across the three programs, at least one primary therapist per program participated in all sessions (except for one session in one program). The moderate-low risk group was delivered by two therapists and a student. For the two ‘open’ programs, seven unique therapist delivery ‘teams’ were involved in the delivery of one program and six were identified in the other (including when students were present). Several therapists also delivered treatment in two of the groups and one student delivered treatment in all three of the observed groups.
Therapist age ranged from 26 to 41 (Mean=33.54, SD=8.90). Eight were female and three were male. Therapists self-reported experience in delivering offending behaviour programs varied from ten weeks (one of the students) to four and a half years, with a mean average of 21.27 months (SD=15.70). Six of the eleven therapist participants had been delivering treatment for two years or less. Eight participants held undergraduate qualifications, of which three held degrees in social work (including one student). The remaining five undergraduates and three post-graduates held qualifications in psychology. Descriptive information about the sessions is provided in Table 8 (see below).

Table 8
Number of sessions, therapists and clients per treatment group included in Study 3.

<table>
<thead>
<tr>
<th>Group</th>
<th>Sessions (3 hrs.)</th>
<th>Therapists</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed One</td>
<td>7</td>
<td>3 (includes 1 student)</td>
<td>9</td>
</tr>
<tr>
<td>Rolling One</td>
<td>13</td>
<td>7 (includes 2 students)</td>
<td>12</td>
</tr>
<tr>
<td>Rolling Two</td>
<td>10</td>
<td>6 (includes 1 student)</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>30</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>(90 hours)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Materials

Alliance Modes in Offending Behaviour Programs: Coding Manual and Checklists

A checklist of items derived from the findings of Studies One and Two (see Appendix 12) was devised to code specific therapist behaviours indicative of the educative, engagement, and therapeutic alliance modes. Items were selected on the basis that they could be scored at any stage of group delivery. For example, the item ‘The formation of group rules’ was omitted as this only applied at the commencement of a closed group or when new members enter a rolling group. Items that relied on inferring therapist intention (e.g., ‘Ensure solid therapeutic relationship to withstand challenges’) were also omitted as they were considered too difficult to reliably rate. Finally, items were not used if it was anticipated that they would occur only infrequently in group sessions (e.g., ‘Create a new group rule for problems identified by the group’). The resulting 31 item checklist consisted of
three sub-scales for each mode, as outlined in Table 9. The educative mode consisted of eight items, the engagement mode thirteen items, and the therapeutic mode ten items.

Table 9
Alliance Modes checklists sub-scales and items.

<table>
<thead>
<tr>
<th>Sub-scales</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educative Mode</strong></td>
<td></td>
</tr>
<tr>
<td>Delivery of program content</td>
<td>Delivery of the program manual</td>
</tr>
<tr>
<td></td>
<td>Practising skills in the program manual</td>
</tr>
<tr>
<td>Group rules and boundaries of behaviour</td>
<td>Re-directs discussion back to the intended task</td>
</tr>
<tr>
<td></td>
<td>References are made to group rules to encourage compliance</td>
</tr>
<tr>
<td></td>
<td>Shuts down client’s contributions if not relevant or dominating a group</td>
</tr>
<tr>
<td>Behavioural techniques</td>
<td>Positively reinforces clients who are doing well</td>
</tr>
<tr>
<td></td>
<td>Manages (potentially) disruptive behaviour by using behavioural techniques</td>
</tr>
<tr>
<td></td>
<td>Negotiates client involvement to reduce the potential for disruption</td>
</tr>
</tbody>
</table>
**Engagement Mode**

- Fosters therapeutic relationship
  - Validates concerns
  - Offers support
  - Encourages involvement
  - Establishes common ground

- Fosters treatment engagement
  - Explains rationale for a task
  - Encourages group to assist in resolving group problems
  - Changes goals to meet clients’ needs
  - Changes tasks if clients do not want to undertake prepared activity
  - Reinforces goals of treatment

- Change strategies
  - Encourages self-reflection
  - Rolls with resistance
  - Develops discrepancy
  - Promotes the possibility of change

**Therapeutic Mode**

- Analyses the therapeutic relationship
  - Explores status of relationship with therapists
  - Acknowledges difficulties in treatment relationship with a client
  - Provides clients with new relational experiences
<table>
<thead>
<tr>
<th>Awareness raising</th>
<th>Provides client feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges clients to create dissonance</td>
<td></td>
</tr>
<tr>
<td>Reflects own responses to client’s behaviour to explore</td>
<td></td>
</tr>
<tr>
<td>their dysfunction</td>
<td></td>
</tr>
<tr>
<td>Illuminates offence-paralleling behaviour</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skill-building</th>
<th>Encourages changes to in-session behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates opportunities for clients to express their difficulties</td>
<td></td>
</tr>
<tr>
<td>Explores pro-social means of achieving the clients’ dysfunctional behaviour</td>
<td></td>
</tr>
</tbody>
</table>

---

**The Group Rupture Rating System (GRRS)**

The Group Rupture Rating System (GRRS; See Appendix 13) is an adaptation of the Rupture Resolution Rating System (3Rs; Mitchell, Eubanks-Carter, Muran & Safran, 2011), which is used to identify ruptures and rupture resolution strategies in clinical settings. Ratings are made based on observations of audio-visual recordings of treatment.

The 3Rs identifies ‘confrontation’, ‘withdrawal’, and ‘mixed’ (comprising elements of both confrontation and withdrawal) ruptures as demonstrated by clients in therapeutic dyads. The clarity of each rupture marker is then rated as either ‘unclear’, a ‘solid example’, or ‘very clear’. An overall rating for each rupture type is also made on a five-point scale from 1 (‘no significance for the alliance’) to 5 (‘very high significance’). The assessor is then required to rate the rupture-repair strategies enacted by therapists in response to an identified rupture. This involves identifying the type of rupture-repair (e.g., Therapist clarifies a misunderstanding, Therapist changes tasks or goals, Therapist links the rupture to larger interpersonal patterns in the patient’s other relationships), which is then rated for clarity and frequency (from 1 - ‘marker did not occur’ to 5 - ‘marker occurred a great deal’). Finally, an overall rating of resolution is made in relation to the extent to which the ruptures were considered to have been resolved in the session.
A number of modifications were made to the original 3Rs measure to accommodate both the context in which offending behaviour programs are delivered (manuallysed cognitive behavioural group treatment), as well as the findings of Studies One and Two. The rupture categories employed in the 3Rs (‘withdrawal’, ‘confrontation’ and ‘mixed’ ruptures), were retained, but supplemented with a rating of the significance of personality dysfunction in perpetuating the rupture (e.g., when clients respond to therapist comments or requests with high levels of grandiosity, anti-social and pro-offending attitudes or make statements in which they degrade therapists or, conversely, withdraw or limit their participation). To do this, each of the behaviours identified in the first two studies as signifying a potential rupture was mapped onto one of the five factors of the five factor model of personality (Costa & McCrae, 1990). This model was selected due to the emphasis on traits that encompass universal personality features, including those that are dysfunctional, in addition to the extensive body of research that supports the validity of dimensional models of personality (see Allik, Realo, & McCrae, 2013). The five factors, plus examples of both a trait facet and client behaviour, include:

- Neuroticism (N; e.g., High Angry Hostility; ‘Raises voice’)
- Extraversion (E; e.g., Low Gregariousness; ‘Provides minimal responses to therapist questions’)
- Openness to experience (O; e.g., Low Feelings; ‘Denies their emotional state’)
- Agreeableness (A; e.g., Low Compliance; ‘Unwilling to undertake nominated task/activity’)
- Conscientiousness (C; e.g., Low Dutilfulness; ‘Minimises the impact of their own behaviour’).

The impact of ruptures on the alliance was rated when it was first identified (initial alliance score) and then when either a deterioration in the alliance or improvements in the alliance occurred (final alliance score). Ruptures were rated on a five-point scale (from 1 = ‘very low/no impact’ to 5 = ‘very high impact’). Only those ruptures considered to have a moderate impact on the alliance, rated a 3 or above, were considered.

A total of ten categories of rupture-repair strategy were identified for inclusion in the GRRS. These are noted in terms of the educative, engagement, and therapeutic modes
(see Table 10). Once a rupture and any rupture-repair strategy have been identified, the client’s subsequent behaviour is noted, signifying either further evidence of the rupture not being resolved (e.g., *being socially withdrawn, continuing to argue*) or resolution of the rupture (e.g., *meaningful participation in treatment activity, apology for difficult behaviour, asserting commitment to treatment goals*).

**Table 10**

Table outlining sub-categories of rupture repair strategies contained in the GRRS.

<table>
<thead>
<tr>
<th>Mode</th>
<th>Sub-category</th>
<th>Examples of Therapist Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educative</td>
<td>Respond to issues by asserting group rules</td>
<td>Consequences of non-compliance with group rules are discussed</td>
</tr>
<tr>
<td></td>
<td>Boundary setting to limit difficult behaviour</td>
<td>Shuts down client’s contributions if not relevant or dominating a group</td>
</tr>
<tr>
<td></td>
<td>Negotiation with participants to compromise on needs</td>
<td>Negotiates client involvement such as the amount of contribution expected</td>
</tr>
<tr>
<td>Engagement</td>
<td>Demonstrate positive therapist characteristics</td>
<td>Demonstrates transparency when discussing a problem</td>
</tr>
<tr>
<td></td>
<td>Develop opportunities for self-reflection to respond to difficulties</td>
<td>Provides opportunities for clients to consider their dissatisfaction</td>
</tr>
<tr>
<td></td>
<td>Respond flexibly/modify approach to respond to client needs</td>
<td>Changes tasks if clients do not want to undertake suggested activity</td>
</tr>
</tbody>
</table>
Use change strategies to shift client
Rolls with resistance

<table>
<thead>
<tr>
<th>Therapeutic</th>
<th>Focus on the quality of the therapeutic bond</th>
<th>Explores status of relationship with therapists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process client experience to inspire change</td>
<td>Reflects on own responses to clients’ behaviour to explore their dysfunction</td>
<td></td>
</tr>
<tr>
<td>Create opportunities in response to dysfunction</td>
<td>Explores pro-social means of achieving client’s dysfunctional behaviour</td>
<td></td>
</tr>
</tbody>
</table>

**Development of the GRRS Checklists and Pilot Testing**

The student researcher initially observed one three-hour session from a moderate-low risk closed group to pilot the alliance mode checklists and the GRRS. During this process a number of therapist behaviours were observed that were identified as indicative of the engagement mode but which were not included in the checklist. Specifically, this was when therapists actively encouraged clients to become more involved. This item was therefore added to the *Fosters Treatment Relationship* subscale of the checklist, which includes a number of other positive therapist characteristics, such as validating client experience and demonstrating emotional support. The *Change Strategies* subscale of the engagement checklist did not contain any items that acknowledged therapist efforts to encourage self-reflection. Given this is potentially important in allowing clients to explore their dysfunction in a non-confrontational manner, this item was also added. No further amendments to the checklists were made.
The administration of the GRRS in its original format required therapists to make extensive notes on the nature of the ruptures as they occur. This process, however, was considered too cumbersome for use in scoring ruptures at the end of each session. To simplify this process, an observation sheet was developed (See Appendix 13) which could be completed as treatment sessions were viewed. This outlines the factors to be recorded (i.e., time, client identification, client behaviour, client personality factor, rupture repair category, therapist behaviour and client subsequent behaviour).

To investigate whether the alliance mode checklists and GRRS could be consistently rated, the student researcher and the principal supervisor then independently viewed a ten minute commercially available audio-visual sex offender assessment interview before completing both the checklist and the GRRS observation sheet. Ratings for these measures were then compared. Both raters identified the therapist as primarily using the Engagement Mode, although there was some minor variation in the specific items endorsed. Both raters identified the same five rupture episodes in the session and identified the same primary personality factor on the GRRS observation sheets. Some minor variations on the rupture-resolution strategies were recorded, although it was concluded that the overall similarity between ratings was high. This suggested that alliance modes, personality factors, and rupture repair strategies could be consistently identified from audio-video tapes of therapeutic sessions.

A full three-hour videotaped session of a moderate-high/high risk rolling program was then viewed by the student researcher and the primary supervisor who independently completed both the alliance mode checklists and the GRRS observation sheet. Both rated the engagement mode as most frequently demonstrated, and there was a reasonable degree of similarity in checklist ratings5 (see Table 11), with both endorsing similar items. This included agreement about therapists’ frequent use of the educative strategy of redirecting discussion back to the intended task, the engagement strategy of providing encouragement, and infrequent use of therapeutic strategies. Differences in raters’ scores

5 Some differences were evident in ratings of the educative mode, due to differences in scoring one item (‘Delivery of Program Manual’). The primary supervisor rated this item more frequently rather than the student rater, who rated the item more globally. For the engagement mode, the student rater endorsed the ‘Encourages self-reflection’ item as occurring more frequently. The primary supervisor endorsed the ‘fosters treatment engagement’ sub-scale in the engagement mode checklist due to differences in interpretation around therapists’ intentions when explaining program information. Both raters endorsed the ‘Provides client feedback’ in the therapeutic mode similarly.
particularly those in the educative mode) were discussed to ensure ambiguities in definitions resulting in discrepancies were clarified for the coding manual (Appendix 12).

Table 11
Frequency ratings of alliance mode checklist items comparing two independent raters at pilot stage.

<table>
<thead>
<tr>
<th>Alliance Mode Checklist</th>
<th>Primary Supervisor Ratings</th>
<th>Student Researcher Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educatve mode</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>Engagement mode</td>
<td>26</td>
<td>33</td>
</tr>
<tr>
<td>Therapeutic mode</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

There was a high degree of similarity in relation to identification of ruptures, with the same three ruptures identified by both the primary supervisor and the student being scored as a having moderate impact on the alliance (score of 3). The student, however, identified an additional rupture, while the supervisor rated this as a rupture but one which had a less serious impact. For two of these four ruptures, the same primary personality factors involved were identified. The other two ruptures were rated as low forms of Agreeableness (Low Compliance, ‘combative and aggressive’) by the student, but as indicative of high levels of neuroticism (one as High Angry Hostility, ‘rageful’, and the other as Low Self-consciousness, ‘glib’) by the supervisor. These trait facets, however, were considered representative of the client presentation by both raters in discussion following the pilot process.

Both of the raters considered that no rupture resolution strategies had been implemented following two of the four ruptures. Some differences were evident in the remaining two ruptures. While the supervisor rated educative strategies as the response to one rupture, the student rated this as engagement, attributing greater emphasis on the part of the therapists to attempting to ‘roll with the client’s resistance’. The remaining rupture was rated as educative by the student (a therapist attempting to redirect the client back to the topic she wanted to discuss), but not identified as a strategy by the supervisor.
In summary, although some differences were evident in relation to how the ratings were made, both raters identified the same client behaviours and therapist strategies impacting on the alliance in this session. It was concluded that the checklists and rating scales were sufficiently robust for use in the study.

Procedure

Ethical approval to conduct this study was awarded by the University of Deakin Human Research Ethics Committee (2013/279) and the Department of Justice Human Research Ethics Committee (CF/13/17675) (see Appendix 14).

Therapist pairs delivering community-based sex offender programs who were eligible to be part of the study were initially identified by senior staff who forwarded an email by the student researcher about the project and advised that they would be contacted about their potential involvement. The student researcher then sent follow-up emails and made telephone calls to negotiate mutually agreeable times for interested therapist pairs. Those who were interested in participating provided their written consent (Appendix 15) and completed a Therapist Demographics Form (Appendix 16) which asked for information relating to age, experience and qualifications following discussion of the Plain Language Statement. Arrangements were then made for the student researcher to meet with clients in groups, without the therapists being present. Those clients who were interested in participating in the research signed a consent form after discussing the Plain Language Statement (Appendix 17). Consent was sought from new participants as they joined the rolling groups. Consent was also sought from students who attended the groups and changes to therapist pairs. All participants signed consent forms and voluntarily participated in the research.

After all therapist and client participants in a particular group had consented to participate, audio-visual recordings of group sessions were viewed and the alliance mode checklist and the GRRS completed by the student researcher. During the viewing of the recording, a system was created to identify each therapist and participant and then notes were made on observation sheets outlining the timing and nature of central activities undertaken (e.g., check-in, warm-up, offence-process, victim empathy exercise) as well as which therapists and clients contributed to discussions. Notes were made on the nature of therapist and client contributions that revealed aspects of alliance formation (e.g.,
agreement to undertake tasks, discussion of risk factors and goals) and ruptures (e.g., disagreements about undertaking tasks, facing away from group members). In the margin, information identifying therapists and items corresponding to their demonstration of the three alliance modes were recorded.

Ruptures that were rated as posing at least a moderate threat to the alliance (a rating of 3 or more on a five-point scale from 1 = ‘no/very low impact to 5 = ‘very high impact’) were noted on the GRRS Observation Sheet. The timing of the rupture and client identification were noted, along with details of the rupture marker, personality factor and trait facet demonstrated by the client during the marker, rating of the rupture, rupture resolution strategy enacted, and client subsequent behaviour. Ruptures were then re-rated and the change score (initial rupture rating minus the re-rated score) noted along with the rupture type (withdrawal, confrontation or mixed). Once the viewing of each session was completed, the checklists for each of the alliance modes were completed by reviewing the observation sheet in conjunction with the coding manual, noting the frequency therapist teams demonstrated the items on the checklists for each mode.

Following the collection of both the GRRS and the alliance modes checklists for 30 treatment sessions, the data were examined for missing values. None were identified. Frequency scores for each alliance mode (educative, engagement, and therapeutic) were noted and the proportion each mode was used within each session was calculated to categorise the modes used in each session.

For each three-hour session, a two-step process occurred to explore therapists’ use of alliance modes. First, an overall categorisation of the mode/s used in the session was undertaken by examining mode frequency scores. If the highest scored mode was at least 10 points higher than the second highest scored mode, the session was considered as predominantly demonstrating this mode. The session was categorised as demonstrating two or more modes where there was less than a ten point difference between scores. Second, an exploration of the modes demonstrated within each session was determined by initially examining which modes met criteria as being ‘present’ within a session. A mode was considered present when its frequency was 4 or more (i.e., a strategy demonstrated more than once every hour). Next, the proportion each mode was demonstrated in relation to the other modes was examined. A mode was considered to have been highly dominant within a
session when its frequency equated to at least two-thirds (67%) of the total scored frequency and a mode was considered to be dominant when frequency scores equated to at least a third (33%) of the total frequency.

Results

This study aimed to examine the extent to which therapists demonstrate behaviours that are consistent with the proposed educative, engagement and therapeutic modes, to describe the types of rupture that occur in offending behaviour programs, and the modes used to repair these ruptures. Each of these questions are addressed, in turn, below.

To What Extent do Therapists Demonstrate Behaviours Consistent with the Educative, Engagement and Therapeutic Modes?

a) What are the predominant modes used by therapists?

The frequency with which each of the alliance modes checklist items were rated over the 90 hours of session time are reported in Table 12. This shows that the engagement mode behaviours were observed more frequently than either the educative or the therapeutic mode behaviours by at least ten in each session. The engagement mode was, therefore, the predominant mode used by all therapist teams across all sessions.

b) What modes were not present and which were dominant within sessions?

Table 12 shows that relatively few therapeutic mode behaviours items were observed, and eight of the thirty sessions (26.7%) did not meet criteria (a score of 4 or higher) for the therapeutic mode to be considered present.

The proportions that each mode was demonstrated in each session are outlined in Table 12 (below). This shows that the engagement mode was highly dominant (i.e., at least 67% of the total frequency scores for the three modes) in nine of the thirty sessions and the educative mode was dominant (i.e., at least 33% of the total frequency scores for the three modes) in an additional seven sessions. In the remaining fourteen sessions, behaviours
indicative of all modes, categorised as 'mixed modes,' were present although overall, engagement and educative behaviours were demonstrated more frequently.

Table 12
Frequency scores for each alliance mode, the proportion (in parentheses) each mode was scored across checklists, and the overall alliance coding for each session.

<table>
<thead>
<tr>
<th>Session</th>
<th>Educatives</th>
<th>Engagement</th>
<th>Therapeutics</th>
<th>Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>20 (33.33)</td>
<td>38 (63.33)</td>
<td>2 (3.33)</td>
<td>ENG-ED</td>
</tr>
<tr>
<td>2</td>
<td>13 (23.64)</td>
<td>38 (69.09)</td>
<td>4 (7.27)</td>
<td>ENG</td>
</tr>
<tr>
<td>3</td>
<td>9 (16.98)</td>
<td>38 (71.70)</td>
<td>6 (11.32)</td>
<td>ENG</td>
</tr>
<tr>
<td>4</td>
<td>18 (34.62)</td>
<td>33 (63.46)</td>
<td>1 (1.92)</td>
<td>ENG-ED</td>
</tr>
<tr>
<td>5</td>
<td>16 (25.00)</td>
<td>45 (70.31)</td>
<td>3 (4.69)</td>
<td>ENG</td>
</tr>
<tr>
<td>6</td>
<td>18 (30.51)</td>
<td>34 (57.63)</td>
<td>7 (11.86)</td>
<td>MIXED</td>
</tr>
<tr>
<td>7</td>
<td>21 (35.00)</td>
<td>31 (51.67)</td>
<td>8 (13.33)</td>
<td>ENG-ED</td>
</tr>
<tr>
<td>8</td>
<td>18 (22.50)</td>
<td>53 (66.25)</td>
<td>9 (11.25)</td>
<td>MIXED</td>
</tr>
<tr>
<td>9</td>
<td>11 (20.75)</td>
<td>41 (77.36)</td>
<td>1 (1.89)</td>
<td>ENG</td>
</tr>
<tr>
<td>10</td>
<td>11 (15.49)</td>
<td>45 (63.38)</td>
<td>15 (21.13)</td>
<td>MIXED</td>
</tr>
<tr>
<td>11</td>
<td>11 (20.00)</td>
<td>34 (61.82)</td>
<td>10 (18.18)</td>
<td>MIXED</td>
</tr>
<tr>
<td>12</td>
<td>14 (26.42)</td>
<td>33 (62.26)</td>
<td>6 (11.32)</td>
<td>MIXED</td>
</tr>
<tr>
<td>13</td>
<td>15 (26.32)</td>
<td>36 (63.16)</td>
<td>6 (10.52)</td>
<td>MIXED</td>
</tr>
<tr>
<td>14</td>
<td>18 (27.69)</td>
<td>41 (63.08)</td>
<td>6 (9.23)</td>
<td>MIXED</td>
</tr>
<tr>
<td>15</td>
<td>10 (24.39)</td>
<td>29 (70.73)</td>
<td>2 (4.88)</td>
<td>ENG</td>
</tr>
<tr>
<td>16</td>
<td>20 (33.90)</td>
<td>37 (62.71)</td>
<td>2 (3.39)</td>
<td>ENG-ED</td>
</tr>
<tr>
<td>17</td>
<td>8 (21.05)</td>
<td>24 (63.16)</td>
<td>6 (15.79)</td>
<td>MIXED</td>
</tr>
<tr>
<td>18</td>
<td>33 (36.67)</td>
<td>46 (51.11)</td>
<td>11 (12.22)</td>
<td>ENG-ED</td>
</tr>
</tbody>
</table>
What Types of Ruptures to the Alliance Occur in Offending Behaviour Programs?

a) How many ruptures were observed?

Over the thirty sessions viewed, 104 interactions were rated as ruptures and their details recorded using the GRRS observation form. Most of these (n=90) were rated as having a ‘moderate’ impact on the alliance (a rating of 3 on a 5 point scale), with a further twelve rated as posing a ‘high’ impact to the alliance (rating of 4). Two were rated as posing a ‘very high’ impact on the alliance (rating of 5). The number of ruptures ranged from one to nine per session, with a mean average of 3.47 (SD=1.89), a median of 3.5, and a mode of 4.

b) What types of ruptures occurred?

Ruptures were classified as either ‘withdrawal’, ‘confrontation’, or ‘mixed’, in accordance with the process described in the 3Rs manual (Mitchell, Eubanks-Carter, Muran & Safran, 2011). Withdrawal ruptures were most common (n=45; 43.7%), although more
than a fifth of the observed ruptures were rated as mixed (n=22; 21.2%) containing elements of both withdrawal and confrontation. Thirty-seven confrontation ruptures (35.6%) were also identified.

c) Which personality traits are associated with ruptures?

The frequency of primary personality factors demonstrated by clients in rupture episodes is outlined in Table 13, below, in conjunction with the associated type of rupture (confrontation, withdrawal, or mixed). This table demonstrates that withdrawal ruptures were typically rated as associated with client low ‘Extraversion’ or low ‘Openness’, whereas confrontation ruptures were associated with low ‘Agreeableness,’ high ‘Neuroticism’ and low ‘Conscientiousness’. Mixed ruptures were often characterised by high ‘Neuroticism’ or low ‘Agreeableness’ as clients demonstrated some form of confrontation towards therapists and then withdrew their participation during these ruptures.

An examination of the trait facets identified within these personality factors revealed that the predominant trait demonstrated for withdrawal ruptures was low ‘Gregariousness’ (socially withdrawn and isolated) within the ‘Extraversion’ factor (n=26; 25%), and low ‘Compliance’ (combative and aggressive) in the ‘Agreeableness’ factor (n=24; 23.1%) for confrontation ruptures. These two trait facets accounted for almost half of the observed ruptures.

Table 13
Frequency of confrontation, withdrawal and mixed ruptures and identified personality factors.

<table>
<thead>
<tr>
<th>Personality Factor</th>
<th>Total</th>
<th>Confrontation</th>
<th>Withdrawal</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Neuroticism</td>
<td>18</td>
<td>8</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>High Extraversion</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Low Extraversion</td>
<td>28</td>
<td>0</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Low Openness</td>
<td>14</td>
<td>3</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Low Agreeableness</td>
<td>33</td>
<td>22</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>
What Modes are Used to Repair Ruptures and How Effectual are They?

\( a) \) What rupture resolution strategies from the GRRS did therapists use in response to ruptures?

Table 14 (below) outlines the initial alliance and final alliance scores for rupture repair strategies across withdrawal, confrontation, and mixed ruptures. This table demonstrates that when therapists responded to ruptures, they were most likely to utilise engagement mode behaviours regardless of the rupture type. Few used therapeutic strategies, although the use of educative strategies was sometimes observed. A high proportion of withdrawal ruptures were classified as having no rupture repair strategy because therapists often did not respond at all to the rupture or asked direct questions in an effort to gain information from clients.

\( b) \) Were rupture repair strategies effective?

Table 14 shows that the ratings of the impact of the rupture at the time it occurred were higher than those made afterwards. This was the case for all ruptures, including for those where no rupture repair strategy was used. These are expressed in Table 14 as change scores, calculated by subtracting the final impact on the alliance rating from the initial impact on the alliance rating.

To examine the number of ruptures that were resolved for each category of rupture repair strategy, Table 15 (below) shows the number of ruptures rated as either a ‘1’ (No/very low impact on the alliance) or ‘2’ (Low impact on the alliance) on the final alliance rating compared to those that were not resolved, which were rated ‘3’ (moderate impact on the alliance), ‘4’ (high impact on the alliance) or ‘5’ (very high impact on the alliance). This reveals that for all but the therapeutic strategies, approximately half of all ruptures were resolved regardless of the strategy used. This table also reveals that when no strategy was directly implemented, the rupture would also resolve itself approximately half the time.

<table>
<thead>
<tr>
<th>Low Conscientiousness</th>
<th>8</th>
<th>2</th>
<th>5</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>104</td>
<td>37</td>
<td>45</td>
<td>22</td>
</tr>
</tbody>
</table>
Analyses of these data using either parametric or non-parametric methods was not possible, principally due to violation of the assumptions of normality and low cell sizes. Tests of homogeneity of variance and normality were undertaken on rupture data for initial alliance ratings and final alliance ratings. These suggested that initial alliance scores were somewhat skewed (Skewness=2.75) with a significant peak (Kurtosis=7.36). This is not surprising given that ruptures were only considered that were ‘moderate’ (a score of three on the five-point scale) or higher, and it would be reasonable to assume that high scoring ruptures would occur less commonly. Final alliance scores were less skewed (Skewness=0.38) with a more even distribution (Kurtosis=0.26). Tests of normality revealed violation of the assumption of normality for both initial alliance scores (Kolmogorov-Smirnov=0.51, p=.000) and final alliance scores (Kolmogorov-Smirnov=0.33, p=.000). Violations of normality remained after transforming these data by calculating the square root for each score both for initial (Kolmogorov-Smirnov=0.51, p=.000) and final alliance scores (Kolmogorov-Smirnov=0.33, p=.000). Analysis of data using parametric statistical procedures on this data was, therefore, considered inappropriate. Analysis of these data using non-parametric statistics was then considered, particularly using the Wilcoxon Signed Rank Test to compare initial and final alliance scores. This form of analysis, however, converts scores to ranks and requires median values to report average scores. Due to the small range in initial alliance and final alliance scores, this approach was also not considered suitable as it failed to sufficiently represent variation in the data. Ruptures were, therefore, categorised as either ‘resolved’ or ‘not-resolved’. However, small cell sizes prevented the use of other methods (e.g., chi-square) to compare the efficacy of different rupture repair strategies across different modes. Presentation of rupture repair strategies was, therefore, restricted to descriptive data.
Table 14

Frequencies, mean initial alliance ratings (standard deviations are in parentheses), mean final alliance ratings (standard deviations are in parentheses), and change scores for rupture repair strategies in response to confrontation, withdrawal, and mixed ruptures (N=104).

<table>
<thead>
<tr>
<th>Rupture Repair Strategy</th>
<th>Confrontation</th>
<th>Withdrawal</th>
<th>Mixed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Initial rating</td>
<td>Final rating</td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>3.00 (0.00)</td>
<td>2.33 (0.58)</td>
</tr>
<tr>
<td>Educative total</td>
<td>7</td>
<td>3.00 (0.00)</td>
<td>2.29 (0.49)</td>
</tr>
<tr>
<td>Engagement total</td>
<td>24</td>
<td>3.17 (0.38)</td>
<td>2.38 (0.65)</td>
</tr>
<tr>
<td>Therapeutic total</td>
<td>3</td>
<td>3.67 (1.16)</td>
<td>2.00 (0.00)</td>
</tr>
</tbody>
</table>
Table 15
The number of resolved and unresolved ruptures when educative, engagement, therapeutic, and no strategies were implemented.

<table>
<thead>
<tr>
<th>Rupture status</th>
<th>None</th>
<th>Educativem</th>
<th>Engagement</th>
<th>Therapeutic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
<td>N (%)</td>
</tr>
<tr>
<td>Resolved</td>
<td>17 (48.6%)</td>
<td>7 (58.3%)</td>
<td>27 (54.0%)</td>
<td>6 (85.7%)</td>
</tr>
<tr>
<td>Unresolved</td>
<td>18 (51.4%)</td>
<td>5 (41.7%)</td>
<td>23 (46.0%)</td>
<td>1 (14.3%)</td>
</tr>
</tbody>
</table>

Discussion

This study shows that therapists draw upon a range of different strategies when they deliver offending behaviour programs. The results provide support for the model developed in the first two studies which proposes three distinctive alliance modes in offending behaviour programs: educative, engagement, and therapeutic. Checklist ratings of specific therapist behaviour, however, revealed a reliance on engagement mode strategies while educative strategies were also used relatively frequently.

A number of ruptures were observed in each session, most typically three or four per session but up to nine. These were mainly classified as withdrawal or confrontation ruptures, although ‘mixed’ ruptures were also observed. A range of dysfunctional personality traits were associated with these ruptures, largely characterised by low levels of agreeableness for confrontation ruptures, and low levels of extraversion in withdrawal ruptures, although high levels of neuroticism and low levels of openness also featured. Therapists often failed to respond to withdrawal ruptures, but generally responded with engagement strategies, and sometimes with educative strategies when they did respond. Of interest was that particularly in withdrawal ruptures, ruptures often resolved without therapists demonstrating any strategies at all. This may be because clients after withdrawing from participating in the program for some time are either required to participate in an activity that has them actively engage in the treatment process or they make an effort to participate to adhere to the group rules or avoid their lack of participation being noted to parole boards and/or correctional case managers. Therapists in this study were most likely to implement strategies that encourage participation, such as explaining the treatment rationale or using motivational
interviewing techniques. These strategies typically resulted in improvements to the strength of the TA although only half of the time. Further exploration of these issues in future research might better examine whether there are qualitative aspects to these strategies that increase the likelihood of resolution and what therapist combinations or sequences assist this process.

One of the most striking findings to emerge from this study was the lack of use of strategies belonging to the therapeutic mode, both in general treatment as well as following a rupture. This perhaps suggests that therapists prioritise delivery of the program manual, albeit in a manner that is responsive to client characteristics, over therapeutic relationship and interpretation of group process. There are a number of possible reasons for this. The first concerns the suitability of using therapeutic strategies, and particularly the use of interpretation, within treatment of this nature. There have been some suggestions, from research conducted in clinical settings, that clients respond defensively when interpretation is used and that less confrontational strategies are more useful (Sarfan, Muran & Eubanks-Carter, 2011). This may also be the case in the forensic context, where sensitivities about confrontation may be high. Therapists in this study, therefore, may have opted to use strategies that they considered ‘safer’, especially in a context in which clients commonly demonstrate a range of antisocial traits. Secondly, therapists may view their primary role in terms of delivering program content as outlined in the treatment manual. Manuals often document a range of activities designed to meet a number of program objectives. They often prescribe content, without attending to process (Day, Kozar, & Davey, 2013; Marshall, 2009). Finally, factors such as a therapists’ training and qualifications, experience and confidence, the type of supervision and organisational support they receive, and their beliefs around where change occurs for clients may all influence their willingness and ability to focus on the use of more therapeutic strategies. The therapists who participated in this study were relatively inexperienced, with half having delivered offending behaviour programs for less than two years. Frequent changes in facilitation teams were also evident which likely impinged on levels of relatedness between therapists and clients and, hence, the appropriateness of implementing therapeutic mode strategies in these situations.

Although a number of clients demonstrated traits that are consistent with Antisocial PD (e.g., low Agreeableness, low Openness) and Borderline PD (e.g., high Neuroticism), these clients were just as likely to demonstrate socially withdrawn behaviour during rupture episodes. It appeared that traits such as avoidance, anxiety, and withdrawal were all likely to impact on clients’ willingness and ability to form an alliance. Therapist responses to withdrawal ruptures were limited, and this may be the result of an over-emphasis on responding to overt problems in compliance and
disruptive behaviour. The danger here is that clients who withdraw may go unnoticed during the treatment process. Alternatively, therapists may have identified withdrawal, but were either unclear about how to respond or chose to use more indirect means of responding, such as the use of experiential activities designed to encourage the involvement of all participants. This may also explain why approximately half of the withdrawal ruptures appeared to be resolved within sessions without the use of direct strategies. Rupture resolution may also have occurred as clients made efforts to involve themselves more; perhaps as a result of their awareness about the potentially negative consequences of receiving a ‘bad report’ from treatment providers.
CHAPTER NINE – Contribution and Implications

Overview

The final chapter of the thesis discusses the implications of this research and how these findings make a contribution to current knowledge. It does this in two ways. First, by considering how mainstream theories of psychological treatment should be used to inform the delivery of offending behaviour programs; and second by discussing the potential advantages and disadvantages of adopting this model of program delivery in terms of the required training and supervision of program facilitators. Finally, a future research agenda is proposed to establish the connection between therapeutic process and rehabilitation outcomes.

Knowledge regarding the most effective way to deliver offending behaviour programs is in its infancy relative to what is known about effective psychotherapeutic practice in individual treatment. Although some progress has been made in identifying those factors that influence treatment outcomes in correctional environments, our understanding of the best ways to deliver treatment remains limited. The therapeutic alliance (TA) is one concept that has been identified as potentially useful in this context (Kear-Colwell & Boer, 2010; Langton, 2007; Livesley, 2007; Marshall & Burton, 2010), although studies that have investigated the relationship between the alliance and offending behaviour program outcomes have produced findings which are neither consistent nor clear. Part of the difficulty lies in the relatively poor methodological quality of the studies that have been conducted to date, with existing studies relying on non-experimental research designs, using different measurement approaches, or examining diverse treatment methods and modalities. As such, there is a need to reconceptualise the area drawing upon the experiences of both therapists and clients, as well as observations of how both actually behave in the program room. This was the aim of this thesis, which also considers how client personality traits (e.g., Beauford, McNiel, & Binder, 1997; Ross, 2008; Skeem, Louden, Poloschek, & Camp, 2007; Taft, Murphy, Musser & Remington, 2004) influence how and when the TA forms. The broad rationale for the thesis is based on developments in the treatment of personality disorder (e.g., Linehan, 1993; Muran, Eubanks-Carter & Safran, 2010; Ryle, 2001) which emphasise the significance of the therapeutic relationship and the need to foster collaboration and attend to the ruptures in the alliance that inevitably occur if optimal outcomes are to be realised.
Three important conclusions were drawn from Study One. First, therapist participants emphasised the importance and relevance of the TA to the delivery of correctional treatment but second, described distinct approaches to the development of the TA. Third, personality disorder (PD) traits were identified as posing significant challenges to resolving ruptures to the TA. The analysis of client perspectives in Study Two was consistent with these conclusions, although clients identified the demonstration of positive therapeutic characteristics to assist in the development of a bond as a particularly important. Clients did not describe strategies to repair ruptures based on the development of the therapeutic relationship or the use of offence-paralleling behaviours in group sessions. Some also described frustration and resentment at some strategies, particularly threatening removal from programs. The final study involved operationalising each alliance mode into a checklist that could be used to document the main strategies used to develop an alliance. An observation sheet was also created to examine the occurrence of ruptures and the resolution strategies used in group treatment. Ratings of thirty group treatment sessions using these tools revealed that therapists predominantly use the engagement mode in their treatment delivery, but also draw on a number of educative strategies. They rarely use therapeutic strategies. Therapists were most likely to use engagement strategies in responding to ruptures, although educative strategies were sometimes used. Again, therapeutic strategies were rarely used. Ruptures were resolved about half the time. These findings are discussed below before considering implications for the delivery of offending behaviour programs.

The Importance of the Therapeutic Alliance to Offending Behaviour Programs

Study One participants placed a high degree of importance on the TA. It was their view that the more elements of the alliance that are present, the less likely it is that clients will leave treatment prematurely and the more likely it is that they will make therapeutic gains. They felt this despite the fundamental differences that exist between the correctional setting and that in which general psychotherapeutic treatment is typically offered (e.g., issues relating to coercion, programs being manualised, delivery in a group format). Client participants also emphasised the importance of therapists demonstrating a range of positive characteristics (such as being encouraging and supportive).

There was general agreement in Study One and Study Two about the value of using the TA framework to assist in program delivery, and in working collaboratively to identify goals, negotiate tasks, and develop a level of relatedness to assist in fulfilling these ends consistent with Bordin’s
(1994) conceptualisation of the alliance. Participants also supported Ross, Polaschek and Ward’s (2008) extension of Bordin’s model which highlights the importance of a broad range of therapist characteristics, client characteristics, and the interactions that occur between them, as well as those contextual factors that impinge on the treatment experience. Factors specific to the correctional context, particularly the influence of correctional and parole board staff, the interaction between prisoners outside of program time, and staffing issues were all identified as impinging on the quality of program delivery.

The therapists who participated in this research identified a need for treatment goals to relate to risk of re-offending, consistent with the Risk Needs Responsivity (RNR) model (Andrews & Bonta, 2010), although they also noted the importance of engaging clients by ensuring that goals are individualised, achievable, and relevant. This also speaks to adoption of elements of the Good Lives Model (Ward & Stewart, 2003) which promotes a strengths-based approach focussing on the fulfilment of client needs. Similarly, although maintaining treatment integrity was regarded as important, so was ensuring that program tasks are responsive to individual differences and the needs of the group. They supported both the responsivity principle (Andrews & Bonta, 2010) and those factors identified as relevant to improving treatment readiness (Ward, Day, Howells & Birgden, 2004). Significantly, a number of therapists also emphasised the need to foster therapeutic change through interpersonal experiences with clients, describing methods that are consistent with a range of current therapeutic approaches used in the treatment of PD (e.g., Bernstein, Arntz & de Vos, 2012; Linehan, 1993; Muran, Eubanks-Carter & Safran, 2010). These same participants made particular reference to the bond aspect of the alliance, arguing that a strong connection enables the therapeutic relationship to withstand challenges. Others, however, suggested that a level of detachment was required to maintain objectivity and be effective in challenging clients.

These positions mirror two opposing views expressed in the rehabilitation literature about the effective treatment of offenders with personality disorder. Hare and Wong (2005) propose that a functional working alliance, which emphasises the task and goal elements of the TA and downplays the bond, is an appropriate approach for treating psychopaths. Livesley (2007) suggests that successful treatment requires close attention to the development of a trusting relationship. It is noteworthy, however, that both Study Two participants and Study Three group treatment observations suggest that Livesley’s approach to alliance formation and rupture repair was less common, and therapists were more likely to rely on strategies that engaged clients or enforced boundaries to resolve ruptures when they occurred. So although it seems as though therapists value
the potential therapeutic contribution that can be made in treatment through the resolution of ruptures in offending behaviour programs, this is an area in which therapists require further support and guidance. The main emphasis in current practice appears to be the delivery of program manuals, and the potential difficulty with this lies in therapists not attending to other psychotherapeutic processes that may facilitate change (Marshall, 2009).

**Personality Disorder Traits as Significant Rupture Triggers**

Overwhelmingly, participants in Study One identified personality dysfunction as triggering challenges to the alliance and expressed uncertainty about how to best respond to these ruptures when they occurred. These were typically linked to antisocial and psychopathic traits and expressed in relation to a lack of alignment in treatment goals, unwillingness to undertake tasks, and/or difficulties in the bond. Therapists provided numerous accounts of clients being hostile, dishonest, and manipulative. Although antisocial and psychopathic traits were described most commonly, narcissistic, avoidance and withdrawal, as well as neuroticism (e.g., affect dysregulation, interpersonal difficulties) were also identified. Study Two client participants similarly described that ruptures were commonly underpinned by clients’ antisocial behaviour, such as denial of responsibility for offending, aggression, and disruptive behaviour. They also identified a range of problematic client behaviours reflective of other PD traits (e.g., dominating discussion, not participating in program tasks, and ‘whining’). Many of the therapists described their attempts to manage these client behaviours rather than to engage clients or respond therapeutically. This reflects what Safran, Muran, Samstag, and Stevens (2002) describe as ‘surface level’ responses, which are likely to limit the capacity of clients to benefit from these experiences.

A range of therapist pathologies were identified as potentially problematic in relation to treatment delivery, and many of these might be considered specific vulnerabilities when interacting with clients who demonstrate PD traits in treatment. Problematic therapist traits identified in Study One included anxiety, over-personalising client responses, wanting to avoid conflict, an unwillingness to enforce appropriate boundaries, being punitive towards clients, attempting to befriend clients, and being rigid and not open to feedback. Less experienced therapists also described a lack of confidence in delivering groups and their attempts to ‘survive’ the experience. Study Two similarly highlighted a variety of therapist incompetence, from what was considered unprofessional and un-empathic responses as well as not enforcing boundaries and allowing clients to coast through programs. They also articulated frustration when therapists proposed tasks that
were childish and irrelevant, or required levels of personal disclosure that might be abused by other prisoners outside of treatment sessions. These observations are important for correctional services to attend to, particularly in light of the association between therapist negative interventions and the frequency of ruptures (e.g., Ackerman & Hilsenroth, 2001; Colli & Liniardi, 2009). For example, interpretations offered at the wrong time in treatment elicit negative client reactions (Marshall & Burton, 2010; Safran, Muran & Eubanks-Carter, 2011). It is also important then, to consider client perspectives on what they find helpful when faced with therapeutic ruptures.

In Study Three, all 104 ruptures were rated as demonstrating high or low levels of one of the five factors from the Five Factor Model (Costa and McCrae, 1992) – Extraversion, Openness, Conscientiousness, Neuroticism, and Agreeableness. Although no formal diagnoses were conducted with respect to PD, this finding supported previous research suggesting that the incidence of PD in offending populations is high (e.g., Blackburn, 2000; Blackburn, Logan, Donnelly & Renwick, 2003) and the suggestion from Study One and Study Two that when ruptures occur they are most commonly triggered by dysfunctional personality traits. Interestingly, observation of treatment sessions revealed that withdrawal ruptures associated with clients demonstrating low levels of openness and low extraversion were common but often not directly attended to by therapists. There may be a number of possible explanations in relation to why numerous clients demonstrated these traits, particularly around clients’ suspicion around how information about them may be used by correctional authorities or being cautious around saying less so as not to say the wrong thing. A number of personality disorders may also be implicated, such as Avoidant PD, which is underpinned by clients limiting social engagement with others, or Schizoid PD, which is characterised by clients not wanting or valuing social connections with others. So although therapists and clients commonly reported the occurrence of antisocial traits, it may be that social withdrawal is as common but not as obviously problematic with respect to ruptures. In contrast, therapists in Study Three were likely to respond to confrontation ruptures which were typically associated with low conscientiousness, low agreeableness, and high neuroticism. These personality traits signify antisocial attitudes in combination with overt demonstrations of affect, and may be indicative of Antisocial PD and Borderline PD. Mixed ruptures, containing elements of both withdrawal and confrontation ruptures, were also associated with low agreeableness and high neuroticism.
The outcomes of both Study One and Study Two were used to inform the development of a new model of the TA in offending behaviour programs. This model is based on three distinct alliance modes that appear to characterise treatment delivery. The **educative mode** focusses on delivering treatment manuals and managing client behaviour to facilitate this end. Strategies include the use of behavioural techniques, such as positively reinforcing appropriate client behaviour, negotiating client involvement in tasks, as well as shutting down negative behaviour. Reminding participants about ‘group rules’ and experiential techniques (e.g., having group members swap seats) are also used to reduce disruption. Therapists are more likely to use the educative mode if they believe that change occurs through the delivery of treatment manuals, and hence any disruption to this by clients is to be managed by implementing strategies to encourage clients to comply or removing them from treatment. The **engagement mode** places emphasis on delivering program material in a manner that is responsive to the characteristics of clients. Therapists do this by validating concerns, offering support, and being encouraging. They assist in resolving problems, changing tasks or goals when clients object to suggestions, and explain the treatment rationale. A range of change strategies are also implemented to facilitate client change, such as encouraging clients to be reflective of their situation, to ‘roll with resistance’, and develop discrepancy between client behaviour and their stated wishes. The **therapeutic mode** is the third alliance mode in the model. This mode focusses on developing the therapeutic relationship to facilitate change. A range of strategies are utilised to assist clients develop self-awareness such as by interpreting in-session behaviour, illuminating offence-paralleling behaviour, creating dissonance, reflecting on their own responses to client behaviour, and providing corrective emotional experiences. Skill development is encouraged in treatment sessions with the support of other group members and clients are encouraged to express their difficulties. Therapists were more likely to describe using strategies from this perspective if they held beliefs around therapeutic change fundamentally occurring through their relationship with clients.

The use of different ‘rupture repair’ strategies was dependent on the nature of the program, the skills of the therapist, characteristics of the clients, and the level of cohesion present in the group. The variety of strategies identified largely mirror those identified by Sarfan, Muran and Eubanks-Carter (2011) in their meta-analysis of studies on ruptures in psychotherapeutic dyads. These include repeating the therapeutic rationale, changing tasks or goals, and explicitly clarifying
misunderstandings if clients have problems with aspects of treatment. In the proposed model, these strategies comprise aspects of the engagement mode. Therapeutic mode responses include exploring relational themes within treatment and linking the rupture to other patterns of relationship experiences, although they emphasise that it is the quality of interpretations offered that is important (there is evidence to suggest that clients experience negative effects when poorly delivered interpretations are offered). They also identify the importance of therapists responding to ruptures in a way that provides a new relational experience for the client. Those correctional therapists who work in this way are potentially embracing theoretical models other than (or in addition to) the cognitive behavioural approach. Some clearly identified their use of Yalom’s (2005) group psychotherapy techniques, whilst others reflected on practices consistent with a relational approach (which proposes that schemas developed in the formative years are reactivated during treatment, so resolution of ruptures can re-shape these through corrective emotional encounters and linking previous and current experiences; see Coutinho, Ribeiro & Safran, 2009). Indeed, a number of participants described processing in-session behaviour and linking this with out-of-session behaviour, particularly when it related to offending. This is akin to attending to what has been termed ‘offence paralleling behaviour’ (Jones, 2004), although behavioural factors (e.g., through intermittent reinforcement) and trauma-induced learning may also be considered in this approach. However, the basic idea that fundamental behaviours linked with offending are invariably demonstrated within treatment settings was endorsed by many therapists. This suggests that a range of approaches are implemented to facilitate positive client outcomes.

The model of the three alliance modes offers a range of approaches to developing and responding to ruptures in the TA, the implementation of which is influenced by therapists’ views about how clients change, their skill and confidence in implementing relevant strategies, the stage and objectives of a program, and the type of dysfunctional personality trait being demonstrated by clients. These factors are outlined in Table 16, below, along with the therapists’ stance toward the alliance, which reflects how the alliance is important for each mode. Costs, benefits, and opportunities each mode offers to the TA in offending behaviour programs are also outlined to signify both when each mode may optimise program delivery as well as the risks associated with each mode.

Before discussing the implications of these findings it is first important to consider the limitations of the research. First, although it appears that three distinctive alliance modes are used by therapists in the delivery of offending behaviour programs, a rigorous process to validate the
nodes in the qualitative study by having third parties also undertake part of the coding did not occur. The scope of the current research was also restricted by the relatively small sample sizes in each study, the small number of ruptures (104), and the limited number of observations (thirty treatment sessions). This resulted in analyses that were either qualitative or descriptive, although the problems associated with collecting data on the alliance that meet the assumptions of parametric analysis are substantial. The approach taken to the qualitative studies, however, did achieve saturation even with the relatively modest number of participants interviewed in Study Two (ten client participants). This is because theoretical sampling occurs by exhausting the range of themes in the areas of exploration, so when a smaller focus of topics is undertaken with a homogenous sample, as occurred in Study Two, small numbers of interviewees are more likely to be required (Mason, 2010). There is nonetheless scope to extend data collection to establish the reliability of the rating tools and the method of categorising sessions overall. It is also important to note that Study Three data were collected from a community-based treatment program for sexual offenders which may not be representative of prison-based treatment programs or programs designed for other offence types. This is particularly salient as the first study involved therapists from a range of forensic services. It may be that different types and numbers of ruptures and resolution strategies are demonstrated in different teams and further research is required to establish this. Finally, while the use of observational methods allows data to be collected on both therapist and client behaviour, it does not provide an in depth understanding of why particular ruptures and rupture resolution events occur. Future research might incorporate both observational methods with post-session feedback from clients and therapists. Data are also required to establish the relationship between the alliance, rupture events, rupture resolution, and subsequent treatment outcomes. In particular, the efficacy of rupture resolution strategies to prevent program attrition for personality disordered clients would be an important area of exploration. This is an issue of particular importance given previous research has suggested that clients who drop-out of treatment are at higher risk of re-offending (McMurran & Theodosi, 2007; Olver, Stockdale & Wormith, 2011). Although previous research suggests that clients benefit more from treatment when ruptures occur and are resolved (e.g., Strauss et al., 2006), this idea has not been empirically tested in the forensic context. This study is, therefore, best viewed as an initial exploration of alliance development and rupture resolution in offending behaviour programs. Further consideration of the mechanisms of change that occur in offending behaviour programs, particularly on the role of the therapeutic relationship, is required. This study does, nonetheless, make some important contributions. It is the first study to consider different therapist styles in offending behaviour programs and to examine the nature of ruptures to the alliance in this context using observational methods that quantify the experience of ruptures and rupture repair. It
has implications for the further development of effective rehabilitation practice and the depth of change that results from completing these programs. It identifies the need, perhaps, to consider that program delivery methods may be just as important to outcome as program content, and highlights the need for therapeutic flexibility to match client characteristics and the therapeutic goals being sought (see Day, Kozar & Davey, 2013).
Table 16
Therapist stance towards the therapeutic alliance, what therapist, program and client (personality disorder trait) factors impact on mode implementation, and costs, benefits and opportunities associated with each alliance mode.

<table>
<thead>
<tr>
<th>Therapist stance towards the TA</th>
<th>Educative mode</th>
<th>Engagement mode</th>
<th>Therapeutic mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>The alliance signifies a commitment to the treatment program and to undertake program activities without disruption</td>
<td>The alliance is predicated on therapists commitment to adapt program material to ensure the individual needs of the client are accommodated in program delivery</td>
<td>Development of the alliance and resolution of ruptures represent significant potential mechanisms of therapeutic change</td>
<td></td>
</tr>
<tr>
<td><strong>Therapist, program and client (PD traits) factors</strong></td>
<td>Implemented when therapists feel clients are violating group rules so they must emphasise appropriate boundaries of behaviour</td>
<td>Implemented by therapists when client characteristics do not allow the delivery of program material as written (e.g., hostility, withdrawn or self-entitled behaviour) so adaption of program material is required</td>
<td>Implemented by therapists who have developed a case formulation of the client and are skilled in intervening in the here-and-now of dynamic risk factors when they feel they are able to have the client accept feedback and/or demonstrate sufficient motivation to address these risk factors in treatment</td>
</tr>
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<td>Implemented when therapists feel clients are violating group rules so they must emphasise appropriate boundaries of behaviour</td>
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therapeutic programs when therapists lack the necessary skills or attitude to respond in a more therapeutic manner. May elicit anger and resentment from clients demonstrating PD traits due to a perception that therapists are over-controlling and lack empathy.

Costs

MANAGEMENT - Therapists attempt to 'manage'/remove clients with 'difficult' traits as they will be seen as trouble makers. Lack of flexibility for clients who are low in motivation or have mental health/cognitive difficulties. Lack of 'real' change/superficial process.

INTERRUPTION - May miss opportunities to utilise client characteristics as potential mechanisms for change. May result in a focus on engagement but at the expense of the development of skills relevant to dynamic risk. Requires at least modest amounts of training/supervision.

THERAPY - May initially elicit significant anxiety/anger in clients, hence risking program attrition. Requires clients to be psychologically minded. May be iatrogenic if attempted by unskilled therapists who identify issues that cannot be addressed in the program structure. Requires significant training/supervision resources and/or experienced therapists.

pose a challenge to the delivery of program material. Should accommodate any type of PD trait that interferes with the delivery of set program tasks to enhance client engagement.

More suited to medium to longer-term treatment programs in which the development of a trusting relationship is possible. Should accommodate any PD trait except when direct methods of intervention with the client are impeded by factors such as high levels of resistance, hypersensitivity to criticism, poor self-concept, and severe attachment problems.
<table>
<thead>
<tr>
<th>Benefits</th>
<th>Opportunities</th>
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<tr>
<td>CLIENT CONTROL - May not be threatening to clients who can pick and choose what aspects of the program they adopt in order to suit their needs Suited to clients looking for 'tools' for change that they can apply on their own terms</td>
<td>SUPPORTIVE - Assists clients' maintenance of appropriate boundaries through the development of mutual group rules and enforcement of these Provides consistency in the maintenance of rules which may provide a level of security Allows clients a degree of autonomy in their learning, to select what information and strategies they choose to take-up</td>
</tr>
<tr>
<td>COLLABORATIVE - Engagement is optimised by focussing on responsivity/treatment readiness in order to enable the delivery of relevant material based on client characteristics</td>
<td>PRAGMATIC - Reduction of conflict in session due to the therapist's flexibility in delivery. Delivery of material in a way that is responsive to client individual characteristics. Session content focuses on responding to dynamic risks</td>
</tr>
<tr>
<td>CHALLENGING - Aim is to effect real therapeutic change for the person in conjunction with behavioural shifts to reduce risk of re-offending</td>
<td>DEEP-LEARNING - The experience of an authentic therapeutic relationship which may assist in repairing previous problems in interpersonal functioning/attachment. Elicits emotional responses relevant to personal dysfunction but with the opportunity for feedback and support to resolve these</td>
</tr>
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Implications for Practice

These studies have a number of potential implications for the development of effective practice in the delivery of offending behaviour programs. Such implications relate to the development of practice in the delivery of offending behaviour programs that may signify important shifts to existing processes. Recommendations include the development of therapeutic skill, as well as processes for the selection, training, supervision, and support of correctional therapists. The provision of appropriate training and supervisory support is paramount in circumstances in which less qualified and experienced staff are often expected to undertake this challenging work. In addition to the recruitment, training, and support of therapists, it is important to ensure that therapists are provided with adequate time to focus on the therapeutic interactions experienced in group sessions, and with co-therapists in debriefing and planning. Finally, investment in a research and evaluation program to test the efficacy of implementing shifts in practice, congruent with the alliance modes model, is an important consideration.

Selecting and Supporting Therapists

This thesis highlights the importance of correctional providers developing strategies to both select and retain appropriately trained staff so that an experienced pool of therapists who are skilled in alliance development, the identification of ruptures, and implementation of rupture resolution strategies are available to deliver programs. This includes ensuring sufficient resourcing occurs to provide high level training and supervision to upskill and support therapists in their treatment delivery. The first study suggests that therapists who are change oriented, flexible, and can take on feedback in a non-defensive manner are most likely to respond productively to challenging behaviours demonstrated by clients. This is consistent with Ross et al.’s (2008) suggestion that it is detrimental for therapists to have overly high or low expectations of a client. In these circumstances therapists may feel frustrated if expectations are not met on the one hand, or not offer appropriate opportunities to foster change should they believe the client will not succeed on the other. Taft and Murphy (2007) also suggest that level of education impinges on how therapists develop the alliance, with less educated therapists more likely to adopt a more confrontational style.
Therapists who deliver offending behaviour programs come from a range of professional backgrounds, including psychology, social work, and alcohol and drug counselling. Their qualifications include both undergraduate training as well as a range of post-graduate degrees, and experience levels vary considerably. It seems likely, therefore, that exposure to research about the alliance as well as opportunities for skill development to assist alliance formation and rupture resolution in offending behaviour programs will vary. Information on the alliance modes used within the delivery of correctional treatment provides therapists with a framework that they can use to develop a TA and respond to ruptures when delivering treatment. Skills practice to gain expertise and confidence in the implementation of strategies from all modes, and particularly the therapeutic mode, may also promote greater therapeutic flexibility. Advanced process training for clinicians would therefore seem critical to enable the acquisition of skills in both direct and indirect means of responding to therapeutic ruptures.

The specific skills required to identify and respond to ruptures have hitherto not been systematically outlined for the delivery of correctional treatment. Within the context of delivering individual treatment to clients with Cluster C PDs using brief relational therapy, however, Eubanks-Carter, Muran and Safran (2014) outline a number of important therapist skills. Their training is designed to equip therapists to respond helpfully to ruptures. It might also be useful in the delivery of offending behaviour programs to reduce the likelihood that therapists will responding defensively and personalise comments made by clients demonstrating dysfunctional personality traits, as identified in the first study. Skills include developing better self-awareness to stay attuned to client treatment experiences (a skill they suggest is important due to therapists often not noticing ruptures), being able to regulate emotional experiences in response to ruptures (to avoid hostility or avoidance), and practising interpersonal sensitivity when communicating with clients about their ruptures (which involves promoting ‘accurate empathy’ in conjunction with developing client awareness of their rupture experiences without exacerbating the situation). Eubanks-Carter and colleagues stress the importance of meta-communication of rupture experiences by therapists, a set of skills designed to enhance awareness and communication.

Safran and Kraus (2014) have outlined a number of training principles to enhance meta-communication with clients in relation to rupture experiences. These include
therapists taking on a collaborative stance in which ruptures are shared experiences to be resolved together, and to non-defensively accept responsibility for client experiences of their role in rupture events. Emphasis is placed on therapists drawing on their subjective experiences and being concrete and specific about what is observed. This assists the client in better understanding ruptures as they occur in-the-moment. Although Safran and Kraus suggest that the relational meaning of client responses to the therapeutic intervention should be reflected on, they caution against abruptly assuming parallels between rupture experiences and other relationships outside of treatment. They also opined that rupture resolution strategies may lead to more ruptures and it is to be expected that ruptures will be re-experienced over the course of the intervention. They conclude that the art of resolving ruptures requires meta-communication of these experiences as well as a practising responses in role-plays to encourage client participation, rather than eliciting experiences of intrusiveness or criticism.

**Therapeutic Skill**

The current emphasis by correctional services on ensuring clients at risk of re-offending attend a program has arguably been at the expense of focussing on therapeutic practice likely to result in ‘deep’ change. The lack of appreciation for the qualitative aspects of program delivery, rather than throughput, may be due to the current paucity of outcome studies on program efficacy in Australian corrections. Strategies and structures to support such a shift are required, such as the provision of training, supervision and program manuals that emphasise the value of focussing on the TA, and the development of therapeutic relationships with clients based on current literature. This should particularly include the use of manuals that allow flexibility to develop the TA, which should consider community safety but be primarily focussed on goals that benefit the client (provided they reduce the harm toward others). In this context, Livesley’s (2007) integrated approach is of particular interest. Livesley promotes a generic approach grounded in the development of the TA along with therapeutic techniques delivered in a staged manner, moving from containment to skill development and then more substantial therapeutic shifts. This suggests a number of treatment perspectives can be integrated based on client need, and many current treatment perspectives for PD that can be used as an adjunct to cognitive behavioural therapy may enhance current approaches. It is encouraging that a number of offending behaviour programs are already utilising integrative treatment perspectives, particularly the use of
schema-focussed therapy (e.g., Beech, Bartels, & Dixon, 2012; Bernstein, 2012) and dialectical behaviour therapy (e.g., Biggs & Kozar, 2013; McCann, Ball, & Ivanoff, 2000; Sakdalan, Shaw, & Collier, 2010). Livesley also places emphasis on the ‘here-and-now’ of experience which seems like the most relevant and practical approach to respond to not only PD clients but also offending populations more broadly.

This thesis points to the importance of therapists not only focussing on a range of strategies that develop the alliance, but also being attuned to the range of ruptures that occur in offending behaviour treatment programs. Recognising and responding to both clients demonstrating socially withdrawn behaviour as well as those demonstrating overt difficulties, is likely to play an important role in effective therapeutic practice. All three elements of the alliance, alignment of goals, negotiation of tasks, and the bond to facilitate these processes, should be a focus of therapeutic practice. There is no evidence from these studies that any single category of response to ruptures is superior (although it was not possible to ascertain the utility of therapeutic rupture repair responses given the small number of times they were implemented). Therapists might consider the range of strategies that can be implemented to match client characteristics, therapeutic goals being achieved, and therapist skill and confidence to best fit the rupture event. Most importantly, given that about half of all ruptures were not resolved in the sessions that were rated, therapists should evaluate the utility of implementing rupture repair strategies and consider follow-up strategies. It is worth noting, however, that taking a punitive approach to difficulties that arise in session will not endear therapists to clients. Taking an interest in why clients are unhappy with the treatment process and seeking amicable means of shifting negative behaviour in group will likely enhance the possibility of resolving a rupture.

Serran at al. (2003) note that offenders may minimise their offending in an effort to protect themselves, and this will be demonstrated in a number of ways during the treatment process. They see it as the responsibility of the therapist to create a safe and comfortable environment and build self-esteem to work with these defences. Therapist warmth and empathy can assist in reducing resistance, rather than attacking clients when difficulties arise. Treatment providers, therefore, must promote program practices that seek to resolve difficulties through the use of collaboration and encouragement to ultimately assist in group cohesion and alliance formation. Conversely, Taft and Murphy (2007) argue that if a client views relationships as being based on power and control, then a confrontational approach
by therapists may affirm this schema and result in clients feeling angered if they perceive they are being belittled. Clients may respond aggressively in an effort to feel empowered within this type of interaction. Taft and Murphy suggest that motivational and other therapeutic strategies conceived to challenge client minimisations and justifications are likely to be more effective at enhancing engagement and making treatment gains. It is also encouraging that the Good Lives Model (Ward & Stewart, 2003), which promotes the perspective that clients have human needs that can be achieved in pro-social ways using a strengths-based approach, is now more frequently being incorporated into correctional services practices. This approach values clients as humans who require autonomy and respect, rather than offenders with problems that must be eradicated in therapy.

A number of different therapeutic responses to ruptures have been described in the clinical literature, and various commonalities are central to these. Identification and acknowledgement are the first two critical tasks, followed by allowing the client to reflect on the nature of the rupture (Bennett, Parry & Ryle, 2006; Safran, Muran, Samstag & Stevens, 2002). Constantino, Castonguay and Schut (2002) also urge clinicians to ‘avoid avoiding.’ So, if a client is angry, it is best to allow a freedom to express that anger or it is likely to remain present and interfere with treatment. Bennett et al. (2006) then suggest invoking processes around negotiating and explaining the threat to the alliance and linking it to the dysfunctional patterns of response previously identified in the client’s case formulation. This strategy should ultimately lead to a revised understanding of the rupture and new ways of relating. By contrast, Safran et al.’s (2002) approach focuses more on examining core relational themes derived within the therapeutic process, rather than early formulations of the client’s problem. They also emphasise the importance of having clients express their feelings and identify underlying wishes and needs demonstrated by the ruptures. Alternatively, Cash, Hardy, Kellett and Parry (2013) suggest that although it might be important for therapists to internally identify and reflect on ruptures, what might be more critical to resolution are client responses to ruptures and acknowledgement of client experiences. The afore mentioned approaches signal that ruptures can be addressed both directly and indirectly, though in correctional settings where previous assessment of the function of offending and underlying mechanisms are elucidated, Bennett et al.’s (2006) model may have greatest utility. This model is commensurate with the notion of exploring offence-paralleling behaviours at appropriate junctures within group treatment (Jones, 2004). The relative merits of encouraging self-expression and self-exploration of wants and
needs, however, should not be discounted as part of this process. Indirect strategies may be best implemented for certain PD traits, however, such as high levels of defensiveness, hypersensitivity to criticism, and emotion dysregulation. Clients demonstrating these characteristics may have difficulty responding productively to direct analysis of ruptures, at least in the early stages of treatment.

The importance of timing the use of specific techniques should again be emphasised within the context of rupture repair processes. Safran et al. (2002) suggest allying with resistance, to ensure clients can use their defences, may at times be appropriate. Similarly, Bennett et al. (2006) found that therapists who were involved in good outcome cases were also more likely to collude knowingly with a client at times in order to maintain the relationship when difficulties arose, but they did this with an understanding of what was occurring. This level of insight while concurring with client dysfunction during critical stages of relationship formation, contrasted with therapists in poor outcome cases, who colluded without knowing that the therapy may be compromised. Safran et al. (2002) also discuss the possibility of dealing with ruptures at times indirectly, such as by shifting tasks or goals, or directly, say by providing an explanation for the use of particular activities, responding to complaints, or reframing the meaning of tasks or goals in a manner that the client can relate to, and clarifying misunderstandings.

Because ruptures may be demonstrated in very subtle ways, it is important to carefully monitor clients’ experiences of the TA. Therapists may assume they are being received very differently from what they understand, whether positively or negatively (Constantino, Castonguay, & Schut, 2002). Asking frequently for feedback from clients is essential, and having a structured efficient process to implement this ensures therapists’ and clients’ collaboration within the treatment process. In seeking feedback from clients in relation to their therapeutic experiences, a wide variety of alliance measures exist to facilitate this process (See Appendix 1) however their utility at gaining appropriate information from clients in offending behaviour programs is questionable given these measures were designed for voluntary clients attending dyadic treatment. These measures equally focus on aspects of the alliance but a focus on therapeutic ruptures that commonly occur in offending behaviour programs might provide more valuable feedback for therapists. No known measures have been developed to facilitate this process, but an example of what this measure might look like is provided in Appendix 18. Study Two client participants were
asked to complete this measure, which asks questions regarding clients’ experience of the strength of the alliance, ruptures, and rupture resolution strategies. This draft measure, the Therapeutic Experiences in Offending Behaviour Programs, was viewed by participants as a viable means of providing therapists with feedback about their program experiences and might be utilised more widely and routinely. The measure is succinct, so does not impinge significantly on treatment sessions, and implementation after the commencement of treatment might provide important information to therapists about their clients’ treatment experiences. Further research on the development of a reliable and valid measure to assist this process is warranted.

Duncan et al. (2003) devised a brief measure of the TA, the Session Rating Scale (SRS), for use as a clinical tool that might be more appropriate for regular implementation in treatment settings rather than standard alliance measures. This measure was based largely on Bordin’s (1979) concept of the TA as well as Gaston’s (1990) notion of the importance of the therapist and client having common beliefs around how people change. The SRS requires that the client rate four visual analogue scales: the therapeutic relationship, goals and topics, approach or method, and an overall rating of the session. This measure has demonstrated good test-retest reliability and adequate construct validity, and is moderately and significantly correlated with the Outcome Rating Scale (ORS). The ORS (Miller, Duncan, Brown, Sparks & Claud, 2003) consists of four analogue scales requiring the client to identify their experience over the previous week. Ratings are made overall, individually, interpersonally, and socially. These measures provide immediate feedback to therapists regarding both the quality of the experience that clients had during their session, as well as the outcomes they are achieving outside of treatment. These measures can also become important clinical tools for discussing discrepancies in therapist’s perception of a client’s group experience and progress, and how the client rates these experiences. Whilst the use of these tools is likely to assist in both the identification of ruptures and ensure progress is being made outside of therapy, ongoing research is needed to validate their use in the forensic context.

Co-working Strategies

An important process that can be implemented in correctional contexts to facilitate the delivery of offending behaviour programs concerns the fostering of functional working
relationships between co-facilitators. Just as working alliances can be developed between therapists and clients, so too can alliances be drawn between therapists co-facilitating treatment programs in relation to negotiation of tasks, identification of program goals, and a bond to facilitate the process. Therapists in Study One reported numerous situations in which difficulties arose resulting in ruptures because of difficulties in their relationship with their co-facilitators due to factors such as befriending clients, undermining therapist authority, or ignoring problematic behaviours. It would seem important to therefore develop strategies for therapists to set-up and develop functional working relationships with their co-workers to both optimise the therapeutic intervention and model appropriate negotiation within the co-facilitation relationship. Baim’s (2014) book on mindful co-working, which he described as conscious and collaborative work undertaken to achieve a common goal, suggests that co-working relationships that are most productive demonstrate strong partnerships underpinned by respect. Conversely, poor co-working relationships lead to ‘highly regressive and infantile behaviour’ and can negatively impact on staff performance and contribute to burnout. Baim outlined a broad number of skills required in co-working, including allowing therapists taking the lead on specific activities while also bringing in their co-worker to contribute. He suggested that co-workers develop common ground before commencing co-facilitation by exploring topics such as their attitude to their work and co-working, respecting boundaries (e.g., amount of personal disclosure), and anticipating problems and how they might be resolved. He suggested too that attention be paid to ensuring co-workers spend adequate time preparing and that tasks are divided and delegated. He also emphasised the importance of debriefing to reflect on the content, process and outcomes of the work undertaken in addition to issues relating to skill development and how to improve co-working relationships. Baim pointed out that if things go badly, there can be a lot of value in repairing the relationship. The parallels between this process and therapeutic interventions delivered to clients to illuminate their interpersonal experiences and repair therapeutic ruptures are obvious. To facilitate these processes, Baim provides a range of worksheets on setting up the co-working relationship as well as planning and debriefing agreements. Therapists delivering offending behaviour programs may find that completion of these documents assists in creating and repairing their co-working relationships.
Supervision Practices

In a new book on forensic supervision, Davies (in press) suggests that the function of supervision is to explore therapeutic experiences, develop ideas and skills, provide an opportunity to reflect, and plan on what actions will be taken to progress therapist practice. Davies reviews research suggesting that there is a link between client outcomes and supervision, including improved therapeutic alliances, reduced client drop-out, reduced staff burnout, and improvements in therapist confidence. Although more research is needed in the forensic field to investigate factors such as different supervisor styles and matching these with supervisee characteristics, he concludes that there is sufficient evidence to suggest that the provision of quality supervision assists both therapist and client outcomes. Davies also suggests that there is potential utility in identifying parallel processes occurring in the supervisory relationship that duplicate therapeutic relationships. The manner in which this is explored with therapists, however, needs to consider their stage of development in order to reduce the likelihood that therapists will respond defensively and with resistance. The development of supervision agreements, that include relevant goals for practice, is another important aspect of the supervision arrangement and he draws on Bordin’s (1994) model of the alliance, suggesting utility in viewing the supervisory relationship as comprising these elements, including how strains and ruptures in the supervisory experience will be managed.

An important function of supervision is to manage risk, particularly in relation to a client’s behaviour to themselves, therapists, and others in the community. Davies (in press) suggests that a major factor is to explore and intervene with any boundary crossing or boundary violations that might occur. A continuum exists from boundary crossing (e.g., sharing personal information with a client, failing to confront a client over their behaviour, enacting punitive responses towards clients) to boundary violations (e.g., gift giving) and dual relationships (e.g., sexual or business relationships with clients). He suggests that the role of supervision should be to prevent or manage breaches or potential breaches. This notion is particularly poignant in relation to the current research, given the extent to which clients may duplicate dysfunctional relationships in treatment that parallel their offending or, as suggested by Davies, that clients may also unwittingly attempt to recreate more familiar roles (e.g., to be a friend) thus limiting the impact of the therapeutic endeavour. These factors highlight the importance of quality supervision being provided to therapists and the importance of correctional services providing adequately trained and resourced
supervisors to do this. He identifies a number of issues that contribute to boundary problems, including a lack of availability of quality supervision, as there may be large numbers of staff with limited education who are exposed to complex clients, and that some forensic environments may also promote unstructured activities in which staff socialise with clients. So in addition to funding and training, examination of organisational processes that may unintentionally communicate boundary crossing should be undertaken to ensure a consistent approach to role definition and maintenance of professional relationships. Davies outlines a number of measures that are available for use in supervisory relationships to determine the strength of the supervisory alliance, and these would seem to offer opportunities to explore and examine the effectiveness of supervisory relationships in correctional environments.

This thesis suggests that direct observation and feedback are essential to optimising supervision outcomes. The use of the Alliance Modes Checklists and the Group Rupture Rating System are recommended to assist this process, although these measures might be stream-lined for use in correctional services to ensure they are not overly cumbersome for supervisors to utilise. The implementation of supervisory tools are essential, however, given that therapists in Study One spoke about implementing a range of therapeutic strategies that were not experienced by clients in Study Two or demonstrated in the actual sessions in Study Three. Although these studies used different samples, the results signal the possibility that what therapists think they should do and what they actually do in practice can differ. When therapists engage in deliberate practice (Ericsson, 2008) by getting feedback and coaching on their actual performance, the development of expertise is more likely. This may particularly be the case in identifying and responding to withdrawal ruptures, which appeared to be largely overlooked. Having supervisors complete the checklists developed in this thesis may also provide a rich source of feedback on skills in identifying and implementing both indirect and direct strategies to assist strengthening and resolving problems in the therapeutic alliance in offending behaviour programs. It is encouraging that corrective services in Victoria, Australia, have indicated an interest in this occurring for their jurisdiction in order to initiate the measurement of process issues in offending behaviour programs to enhance treatment integrity.

Eubanks-Carter, Muran and Safran (2014) have outlined a number of specific supervisory skills they develop in their alliance-focussed training to assist trainee therapists
to directly respond to ruptures. The first supervisory task is to conduct video analysis of
challenging moments in therapy. They ask trainees to nominate situations in which they
have felt stuck, anxious, frustrated or confused to enhance their awareness of what was
happening for them during the event. The aim of this process is to develop therapist skills to
intervene in a genuine and empathic manner with clients. Eubanks-Carter and colleagues
suggest that this process is assisted by exploring therapists’ own experiences and getting
feedback from supervisors and other trainees to illuminate and validate their in-session
experiences. This process is considered to have important implications for therapists
delivering offending behaviour programs. However, given that the current research suggests
that therapists may be missing a number of withdrawal ruptures in treatment groups, it is
suggested that both situations in which clients experience negative emotional responses and
other situations are discussed. Awareness-oriented role-plays are the second set of
supervisory skills in which therapists are trained, and involve experimenting with different
interventions in the roles of therapist and client. These are designed to practice meta-
communication skills by enhancing therapists’ understanding of their own experience in
treatment while also assisting resolution of their own internal processes to shape genuine
communication with clients. If practiced in supervision groups on the delivery of offending
behaviour programs, awareness oriented role-plays would provide therapists with
opportunities to explore group experiences in addition to developing an enhanced
understanding of therapeutic experiences, and opportunities to practice new skills to
implement in offending behaviour programs. Eubanks-Carter et al. state that mindfulness
training should be encouraged between sessions, as well as practiced within supervision
sessions, to enhance therapists’ ability to engage in meta-communication about client
ruptures in a non-judgemental and open manner. This skill would also apply in the delivery
of offending behaviour programs. Finally, Eubanks-Carter and colleagues suggest that
supervisors should also attend to alliances with their trainees, including the development a
sensitivities to their internal experiences, so exploration of ruptures which may otherwise go
unnoticed can occur. This also highlights the importance of supervisors being adequately
trained in both the variety of skills required of supervisees as well as having an ability to
coach and support them implement these skills judiciously.
Conclusion

Strategies that enhance the TA engage clients in the process of treatment, instil confidence in clients that group is a safe place to share personal information and that they can trust therapists to negotiate group tasks. During the course of treatment, it is inevitable that a number of clients will demonstrate significant PD traits due to the maladaptive responses they demonstrate to the demands of treatment. Therapists are responsible for first, identifying therapeutic ruptures, and then developing a range of strategies that should be implemented flexibly to provide opportunities for clients to engage with program material, develop personal insight, and practice the skills that are required to lead an offence-free lifestyle. The alliance modes model developed in this thesis provides a framework for therapists to gain a better understanding of the variety of skills and strategies that can be utilised in offending behaviour programs. It provides three distinct approaches to the development of the TA that can be used, each of which has therapeutic value. The educative mode emphasises creating and enforcing boundaries that facilitate a safe treatment environment. The engagement mode invites the use of more indirect methods to develop the TA by responding flexibly to client characteristics. Techniques from the therapeutic mode draw on the quality of the interaction between therapists and group members, and their parallels with offending behaviour, to facilitate deep learning about client dysfunction. This model elaborates on existing models of the therapeutic alliance in the literature, which identify that different depths of processing can occur in relation to the TA, but given the context of treatment delivery using manuals within a corrections setting (which offers a range of unique treatment conditions) the current model offers greater elucidation in relation to the extent these varying approaches can occur. The results also importantly highlight that although therapists aspire to implement a range of therapeutic interventions in offending behaviour programs, they are, however, more likely to be focussed on responsively delivering treatment manuals. Such a focus is likely to limit the identification of clients who demonstrate socially withdrawn behaviour in offending behaviour groups. The implementation of a broader range of strategies, particularly those that intervene in here-and-now demonstrations of offence-paralleling behaviour, may substantially assist the process of treatment.
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Appendix 1 – Summary of Therapeutic Alliance Measures

Measuring the Alliance

Commensurate with the different theoretical perspectives on the alliance has been the development of a range of assessment tools for observers, therapists, and clients to measure their relative experiences of the alliance. Martin, Garske and Davis (2000) provide a summary of the significant schools of thought in relation to the TA and outline the measures that have been developed within these. These are outlined in Table 17 below to demonstrate the range of theoretical conceptualisations that have evolved in relation to the TA as well as the breadth of means in measuring these.

Table 17
Summary of the major scales developed to measure aspects of the therapeutic alliance.

| The Pennsylvania Scales – These scales are based on Luborsky’s (1984) concept of the TA as comprising two types of alliance. Type 1 signs are evident when clients experience the therapist as helpful, and Type 2 signs are when clients experience the treatment process as beneficial and work towards agreed goals with the therapist. A number of scales have evolved to measure these aspects of the alliance, the most recent of these is the Helping Alliance Questionnaire Method (HAq; Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985) comprising 8 items describing Type 1 signs and 3 Type 2 signs. The client rates each of these on a 6-point scale from -3 (‘No, I strongly feel that it is not true’) to 3 (Yes, I strongly feel that it is true). A therapist version of this measure was also developed (Gerstely et al, 1989). |
| The Vanderbilt Scales – These scales were developed by Strupp and colleagues (e.g., Strupp & Binder, 1984) and are based on their conceptualisation of the alliance as well as those of Bordin (1979), Greenson (1965) and Luborsky (1976). The more recent and preferred of the scales they developed is the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), an observer rating scale that can be based on a segment of a therapeutic session and requires the completion of 44 items on a 6-point scale from 0 (none at all) to 5 (a great deal) on dimensions relating to the client, the therapist and the client-therapist interaction. |
The Toronto Scales – Marziali, Marmar and colleagues have developed these scales based on classic psychodynamic conceptualisations of the alliance as well as Bordin’s (1979) integrative model, to form the Therapeutic Alliance Rating Scale (TARS; Marziali, Marmar, & Krupnick, 1981). This scale is designed for observers to rate affective aspects of the alliance on 42 items from 0 (not present) to 5 (intensely present), half of these items relate to the client and half the therapist. Marziali (1984) later developed client and therapist-rated versions of this measure, which were found to be better predictors of client outcome than the observer-rated version.

Working Alliance Inventory – Horvath and colleagues (Horvath & Greenberg, 1986, 1989) created the Working Alliance Inventory to measure Bordin’s (1979) conceptualisation of the TA. Three scales were developed to measure the therapeutic bond, agreement on tasks, and agreement on goals based on 36 items. Versions were developed for observers, therapists and clients to rate on a 7-point scale from 1 (never) to 7 (always). A shortened version of this measure has also been developed (Tracey & Kokotovic, 1989).

The California Scales – These have been based on the TARS. Marmar, Gaston, Gallagher, and Thompson (1989) developed the California Psychotherapy Alliance Scales (CALPAS) which comprises 24 items assessing Gaston’s (1990) conceptualisation of the TA so includes the Patient Working Capacity scale, the Patient Commitment scale, the Therapist Understanding and Involvement scale and the Working Strategy Consensus scale. Items are rated on a 7-point scale from 1 (not at all) to 7 (very much so) and versions were created for clients, therapists and observers.

Therapeutic Bond Scales – Saunders and colleagues developed the Therapeutic Bond Scales (Saunders et al., 1989) based on Orlinsky and Howard’s (1986) generic model of psychotherapy. This measure is 50 items: 15 comprise the Working Alliance scale, 17 the Empathic Resonance scale, and 18 the Mutual Affirmation scale. The sum of these scales deduces a Global Bond Scale. Clients rate these on a 21-point scale from 0 (no experience) to 20 (a lot of experience).
Appendix 2 – Study One Human Research Ethics Committee Approval

Dear Ms Kozar,

The Department of Justice Research Ethics Committee considered your response in relation to the project *Treating personality disordered clients in offending behaviour programs: A qualitative study on the role of the therapeutic alliance* and granted full approval for the duration of the investigation. The Department of Justice reference number for this project is CF/08/15564. Please note that the Committee requests that you provide a copy of the Professional Indemnity Certificate.

You must ensure that the Committee is notified immediately of any matter which arises that may affect the conduct or continuation of the approved project. To enable the Committee to fulfil its reporting obligations, you are asked to provide an Annual Report every 12 months and to report on the completion of your project. Annual Report and Completion of Research forms are available on the Justice Research Ethics website which is located at [www.justice.vic.gov.au](http://www.justice.vic.gov.au) About Us > Our Values > Ethics.
The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses or conferences presentations that result from this research.

All future correspondence regarding this project must be sent electronically to ethics@justice.vic.gov.au and include the Department of Justice reference number as well as the project title. Hard copies of signed documents or original correspondence should be sent to The Secretary, Human Research Ethics Committee at the following address: Level 21, 121 Exhibition St, Melbourne, VIC 3000.

Please sign the Undertaking attached and return within ten business days. If you have any queries regarding this application you are welcome to contact me at any time on (03) 8684 1514 or email: ethics@justice.vic.gov.au.

Yours sincerely,

Carolyn Theodore
Secretary, Human Research Ethics Committee
From: Melissa Alagich on behalf of Vicki Allen  
Sent: Wed 03-Sep-08 4:17 PM  
To: Kozar, Christina Julie - kozcj001  
Cc: Andrew Day  
Subject: Ethics protocol P228/08 “Treating personality disordered clients in offending behaviour programs: A qualitative study on the role of the therapeutic alliance”

Dear Christina

Re: Ethics protocol P228/08 “Treating personality disordered clients in offending behaviour programs: A qualitative study on the role of the therapeutic alliance”

Thank you for submitting your ethics protocol for consideration. Your protocol has been considered by the Chairperson of the University’s Human Research Ethics Committee on behalf of the Committee.

I am pleased to advise that your protocol has been approved subject to you:

1. Obtaining written approval from Department of Justice, Victoria, for the research to take place within the organisation

2. Asking participants to contact the researcher directly if they wish to take part, instead of being required to report their willingness to participate or not to the Senior therapist. This is to reduce the sense of obligation among potential participants and to preserve participant confidentiality (3.6 and 3.7)

3. Acknowledging that confidentiality cannot be guaranteed during data collection given the nature of focus groups (3.7) and including this information in the Information Sheet and in the eighth point of the Consent Form

4. Including in the invitation letter to services that the research has been approved by the UniSA Human Research Ethics Committee

Please note that the Chairperson's decision will be reported to the next meeting of the Human Research Ethics Committee for endorsement.

Please regard this email as formal notification of assessment.

Under the national guidelines, you must not begin your research before receiving final approval. Once you have submitted the necessary amendments, and they have been accepted, your approval will be finalised and you may commence your research.
Ethics approval is always made on the basis of a number of conditions detailed in the attachment; it is important that you are familiar with, and abide by, these conditions. It is also essential that you conduct all research according to UniSA guidelines, which can be found at http://www.unisa.edu.au/res/ethics/human.asp. These guidelines should assist you with the formulation of necessary papers such as the information sheet and the consent form.

We look forward to receiving your amendments in the near future. In the meantime, please contact me if you have any questions.

Regards, Vicki

Vicki Allen
Ethics and Compliance Officer & Executive Officer,
Uni SA Human Research Ethics Committee
University of South Australia
Research and Innovation Services
Mawson Lakes Campus
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CRIS Provider No. #00121B

Please consider the environment before printing this email
Appendix 3 – Study One Plain Language Statement and Informed Consent Form

University of South Australia

Division of Education, Arts and Social Sciences

SCHOOL OF PSYCHOLOGY

Treating personality disordered clients in offending behaviour programs: a qualitative study on the role of the therapeutic alliance

Chris Kozar of the University of South Australia is conducting this research project as the first study of a PhD. This research will involve focus groups of 3 – 5 therapists who currently deliver offending behaviour group programs (ie. programs of 10 hours or more designed to reduce participants’ risk of re-offending). We would like to invite you to participate if you have delivered at least two offending behaviour group programs.

Group discussions will be audio-taped while central responses to a semi-structured interview schedule will be recorded on a flip-chart by the student researcher. The process should last no more than 1.5 hours. Participants will be asked questions on delivering group programs: how tasks and goals are negotiated, aspects of the therapeutic relationship formed with clients, difficulties encountered in previous group experiences, and strategies used to assist in making therapeutic gains for clients.

Participation in this project is voluntary. You may decline to participate or withdraw at any time without consequence. Should you elect to withdraw after commencing the focus group, you may elect for the student researcher to remove information you provided once audiotapes have been transcribed.

Participants may experience a negative emotional response to aspects of the focus group, such as when describing the difficulties previously encountered in groups. If you elect to participate and this occurs, resulting in concerns about your own well-being, you are urged
to contact the researchers for assistance on the phone numbers below. Assistance will be made available to you by the researchers. In addition, should the student researcher identify that you or someone else is at risk of harm as a result of your participation in this project, this information is required to be reported under the Australian Psychological Society’s Code of Ethics.

As the method of the research involves focus groups, it is important that the information disclosed by group members remains confidential except, as mentioned above, regarding issues of harm to self or others. The researchers, however, cannot guarantee confidentiality by other group members. Consequently, there are also risks involved in participating in this research relating to your information being disclosed by others, and subsequent potential damage to your reputation.

There are also risks involved relating to privacy. These concern potential disclosure of your identity in this project, or those of your clients or colleagues that you discuss. To minimise this risk, we ask that you maintain confidentiality of the group and take care in revealing information in focus group discussions (such as not mentioning names, not providing specific details of offences, and not talking about exact times and locations in which you’ve delivered programs).

All audio-tapes and documentation generated as a consequence of this project will be stored under secure conditions by the researcher by storing transcripts, memory sticks, and flip-charts in a filing cabinet that is locked with a key that is secreted by the student researcher and not accessible to anyone else. Memory sticks used to store research information will be pass-word protected. Following analysis, all research information will be stored under secure conditions in the School of Psychology, University of South Australia, for seven years beyond the completion of the project. As per university protocol, they will be destroyed after this time.

Publications made on the outcomes of this research will not contain personally identifying information, but indicate the type of service in which you work. As there might be a possibility that you will be recognised as a participant in this project in publications, the student researcher will provide copies of reports and articles generated by the research for peer reviewed journals prior to their publication to your General Manager/Chief Executive Officer for distribution to staff. Should you have any concerns that this information will potentially reveal your identity, the researchers will modify the content to protect your identity. Your General Manager/Chief Executive Officer will also receive a copy of final publications based on this research for distribution to staff.

Should you have any queries regarding this project they can be directed to: the student researcher, Chris Kozar, on 0433 022 093; the Principal Researcher, Andrew Day, on (08) 8302 1008; the Secretary to the Department of Justice Human Research Ethics Committee, on 8684 1514; or the Executive Officer of the University of South Australia Human Research Ethics Committee, Vicki Allen, on (08) 8302 3118.
Participant Consent Form

I __________________________________ agree to participate in a research project

(name of participant)

entitled ‘Treating personality disordered clients in offending behaviour programs: a
qualitative study on the role of the therapeutic alliance’ conducted by the University of South
Australia.

Christina Kozar, the student researcher, has discussed this research with me. I have had the
opportunity to ask questions about this research and I have received answers that are
satisfactory to me. I have read and kept a copy of the Participant Information Sheet and
understand the general purposes, risks and methods of this research.

I agree to take part because:

1. I know what I am expected to do and what this involves.
2. The risks, inconvenience and discomfort of participating in the study have been
   explained to me.
3. All my questions have been answered to my satisfaction.
4. I understand that the project may not be of direct benefit to me.
5. I can withdraw from the study at any time.
6. I am satisfied with the explanation given in relation to the project as it affects me and
   my consent is freely given.
7. I can obtain a summary of the results of the study when it is completed.
8. I understand that my personal information will be kept private, but that there can be no
   guarantee of confidentiality from other group members.
9. I agree to the publication of results from this study provided details that might identify
   me are removed.

Signed by the participant: _______________________________ Date: __________

Signed by an independent witness: _______________________________ Date: __________

(Print name in full – independent witness) ____________________________________________

Address of independent witness (Professional or Home): ________________________________

__________________________

Signed by the researcher: ________________________________ Date: __________
Appendix 4 – Study One Semi-structured Interview Schedule

Study One: Treating Personality Disordered clients in offending behaviour programs – A qualitative study on the role of the therapeutic alliance

Interview Schedule

1. Introductions – include some of my experience in delivering offending behaviour programs, difficulties I’ve encountered, and why my interest in the project.

2. Project overview and PI&C forms. Note that to retain their privacy, Ps should not give their surname or any info that would make clients they discuss identifiable.

3. Have Ps introduce themselves. Write-up the following for discussion:
   - age
   - training (formal and ongoing PD)
   - experience in delivering offending behaviour group programs
   - current role

4. What do you enjoy most about your role? What about least? How difficult from 1 - 10, one being least difficult and 10 being most difficult, do you find delivering group programs?

5. How do you determine what tasks need to be undertaken in a group? Do you deviate from program manuals at all? When? Why? How do you negotiate your time in a group? Who do you attend to most? What about the least?

6. Do you use case formulation? What about formal diagnoses of clients in groups? Are these important?

7. What tasks are undertaken to build group cohesion (i.e. to assist the group work together)?

8. How do you work out specific goals for clients? What are some examples of client goals that you have adopted in the last couple of groups you’ve delivered? So do you approach it from a ‘community safety’ or ‘client’s individual needs’ perspective?

10. How much do you attend to the therapeutic relationship with clients? Is it important to form a strong emotional bond with clients? How do you go about developing a bond with a client?

11. Have you heard of the therapeutic alliance (TA)? It concerns the tasks and goal of therapy, your ability to negotiate these, and how this impacts on the bond with a client. What do you think about the TA and its bearing on therapeutic outcomes, especially client’s ability to adopt pro-social behaviours/desist from offending? Does the TA impact on whether clients stay in group? How do you know if you’ve got a strong alliance with a client?

12. Describe a time when you experienced an ideal group. What about when you were most pleased with what happened in a group? How about a group situation that became a real turning point for your clinical practice?

13. When problems occur in the TA this is known as a ‘rupture’, and it can occur in any of the elements of the TA (tasks, goal, bond). What types of consequences occur within groups when ruptures occur with clients? What do you do in these situations? Who do you turn to? What’s most helpful? Why? What’s least helpful? Why? Is supervision helpful? How about your training?

14. Describe the worst thing that’s happened in a group. What other difficult situations have presented in groups? How do you respond to difficulties with your clients? What about difficulties with the treatment context? What about difficulties with your own practice?

15. What types of things are present in the TA that lead to therapists making mistakes in group? What are some examples of therapeutic blunders you’ve made in groups? How did this impact on the TA with the client? Did you try and fix it? Then what happened?

16. Delivering groups in a forensic setting has some very unique factors (eg. the nature of the institutions, mandated treatment, the role of the APB). What’s been your experience of negotiating clinical work within this context? To what extent does it impact on the TA? Can you describe a situation that demonstrates the complexities created in either building a TA or repairing a rupture with a client because of the forensic setting?

17. Which clients do you like the most? Why? What about the least? Why? Which clients are the most challenging to build a TA with in group? Describe a time where you felt it was difficult to build a TA with a client. How did you manage the situation?

18. It sounds like in situation X, this particular client was demonstrating characteristics of [borderline, antisocial, schizoid, avoidant, dependent, histrionic, narcissistic, compulsive, schizotypal, paranoid, passive-aggressive – based on Millon’s taxonomy;
psychopathy – based on Hare’s conceptualisation]. How useful is this label? What about other PD labels (especially APB, BPD, psychopathy)? Do you find any particular classification system (eg. DSM, Hare’s psychopathy) useful? How? What are some of the difficulties with these systems?

19. In general, what’s been your experience of treating clients with characteristics of PD in your groups? How do you find treating these clients? What’s most difficult? What’s least difficult? Do you have special strategies for fostering a TA with these clients? What about repairing ruptures?

20. That concludes the questions, is there anything else Ps want to say? How have they found the process?
Appendix 5 – Study One Focus Group Memos

Focus Group One - Memo

Three female Counsellors who delivered cognitive skills and alcohol and other drug (AOD) programs in a medium security prison were interviewed. They were a 26 year-old provisional psychologist, a 23 year-old welfare worker, and a 36 year-old female welfare worker. Both welfare workers had also trained as AOD clinicians. The 23 year-old welfare worker had worked at the prison longest, being ten months.

The relevance and importance of the therapeutic alliance in offending behaviour programs

All participants viewed the therapeutic alliance (TA) as an important component of clients getting the most out of programs. They suggested that clients could still benefit if not all elements were present but ideally these would all work together. Despite this assertion, however, during numerous examples these participants conveyed an ‘us’ and ‘them’ approach in their program delivery. This was always within the context of describing difficult clients who seemed to be demonstrating anti-social attitudes (ie. not completing homework, not wanting to participate in activities, demonstrating crude and/or aggressive behaviour). There was a suggestion that they felt personally affronted when clients were overtly hostile or rude.

They used the term 'classes' to describe sessions, implying a teaching role. Although they explicitly mentioned during one part of the focus group that 'everyone' was there to learn and that they did not want to create an impression of division between themselves and clients, there was a consistent theme of needing to stay on top of difficult clients. It seems, therefore, that only when they felt personally attacked or detected subterfuge within their program that they responded more defensively, utilising the 'power' that they had by virtue of their role as facilitator. One member also acknowledged her lack of experience and confidence, and that this made managing group dynamics difficult at times. The others did not specifically articulate these as issues although difficulties in their skill and knowledge to manage more difficult group situation was implied through a number of limitations in their responsiveness to those situations (see below section on rupture repair).

Participants appeared to mainly utilise developing group norms and using 'ice-breakers' to assist in the formation of the TA alliance with clients in groups. There was also discussion on the importance of developing a therapeutic bond where possible, and two of the participants described utilising self-disclosure as a means of relating with clients. One spoke about discussing previous drug and alcohol use to her group while the other said she would refer to being a parent and the difficulties of that role. There might be a question around whether these participants may have engaged in these behaviours in order to befriend clients as it suggests less focus on clients’ issues and greater on strategies to enhance rapport. Arguably these behaviours model poor professional boundaries.

There was a suggestion that in general they perceived their work as client-centred. For example, the eldest stated in response to a question on the development of goals that it was
'all' the clients. Implicit in this was that these goals were pro-social, but they did not explicitly state that not re-offending was a given organisational goal. They talked about some level of flexibility in relation to negotiating tasks within sessions, but the welfare workers also discussed that for certain activities they required all participants to be involved. There was mention, however, that if clients had literacy difficulties that they would not elicit shamed by making them write or read in 'class', and the provisional psychologist mentioned that if an activity was 'not working', then there seemed little point in continuing to force clients to undertake it. The eldest participant mentioned that if she was met with resistance to a task she would often ask the group about this and use that as a point to explore their discomfort.

Overall, these participants pointed to a lack of organisational support. Regular formalised supervision did not occur for the welfare workers but was provided externally to the provisional psychologist. They also pointed to a paucity of relevant training being provided to them. It might be inferred that some of the difficulties posed within programs for which they described limitations in their approach may have been responded to differently and more adaptively should they have received greater support. Although they anticipated their supervision and training situation improving in the near future through recent management commitments, they saw their greatest source of support as each other and cited examples in which they sought advice and to debrief about their program experiences. They also stated that they did not use case formulation or diagnostic systems in their roles, and perhaps this contributed to limits in their responses to difficulties.

The types of ruptures that occur

Many instances were noted as sources of ruptures, particularly including logistical problems -methadone being issued during session times, session times being erratic due to staff departures and then pressure in having to have a particular group finish to coincide with client release dates.

Various sources relating to the clinicians themselves were provided including a lack of knowledge of programs being delivered, lack of support from co-facilitators (who either left or were otherwise absent from sessions they were meant to co-facilitate), limitations in skills and confidence as well as questioning whether their personal dislike of particular clients was responsible for problems encountered in group.

Various problematic client behaviours were also discussed, including aggressive behaviour, non-compliance, withdrawn/shy clients, and clients who spoke little English. One situation described by a participant sounded particularly difficult, and she talked about speaking with then peers initially about getting a client out of her group as he was consistently aggressive, controlling, produced 'vulgar' homework, and was non-compliant. Although the initial organisational response was that clients weren’t taken out of group, eventually this client was and the participant declared that she shouldn’t be expected to work under those conditions. She described difficulty in the process of having him removed, including an emotional reaction and frequent questioning of herself around whether removal had been the right thing to do.
Strategies to repair ruptures

The central theme to rupture repair in this interview involved 'managing' difficult situations. When problems occurred that seemed at the less significant end of difficulty, participants described reminding clients of the 'rules' that had been derived at the start of the program. One participant talked about this issue in terms of not letting participants 'get one over you', suggesting that it was the facilitator's role to re-gain control should it be perceived that others were attempting to usurp it. There was some difference between participants in their preferences to managing these problems either in treatment sessions or outside of group. One participant resolutely stated that she preferred to take problems out of the group, as difficult clients often wanted to try and exercise their control in the company of their peers. In some situations, clients were asked to think about their behaviour and provide reasons for them to remain in the program, and to not just say that was because they wanted to get parole. Several instances were discussed by one participant in which she had got her manager to sit in on these types of discussions, commenting that clients acted differently when there was 'someone else in the room'. I suggested in this discussion that it sounded like clients were being asked to take responsibility for their place in the group, to which participants agreed. These techniques, however, were also designed to force clients into behaving well without examining the etiology of the difficulties demonstrated or using it as a therapeutic opportunity. There were a number of discussions in relation to removing clients from group should they be unable to behave appropriately following attempts to have them re-dress difficulties.

Issues relating to Personality Disorder clients

Throughout the focus group, participants described interactions with clients who demonstrated significant personality disorder traits. These included psychopathic traits as well as those relating to anti-social, narcissistic, and borderline personality disorder (PD). These participants had no specific diagnostic classification systems, particular knowledge of PDs, or specific strategies to deal with these clients. There was some level of enthusiasm by the two younger participants to have more knowledge of these so that instead of simply finding participants annoying or difficult, they could have a framework to understand and better work with these clients.

Analysis and discussion

It appears that these participants' valued the development and maintenance of the TA with clients in their group, however when difficulties emerged they demonstrated limits in their response to the problems. They therefore reverted to surviving the experience by attempting to regain control by virtue of their status as facilitator. This was largely couched around the consequence of removing clients from groups should they not become compliant. Overall, poor supervision and training may have largely contributed to this approach. It may also be that the welfare background of two of the participants meant they were less interested in diagnosis and case formulation which may have also limited strategies to respond to difficult behaviour. The provisional psychologist made many references to wanting greater knowledge, skills and experience to assist her in her work. This situation was not assisted through the lack of current organisational support. Future focus groups will explore different approaches taken to the development of the TA and rupture repair.
Focus Group Two - Memo

Three participants comprised the second focus group, a 31 year old psychologist with four years of program experience, a 32 year old social worker with six years of program experience and a 24 year old Bachelor of criminal justice graduate who had delivered two programs. They demonstrated some quite different attitudes and practices relative to participants in the first focus group. They had more formal qualifications and experience overall although when asked to make ratings of how difficult they found delivering group programs, they rated them as more difficult than the first focus group.

The relevance and importance of the therapeutic alliance in offending behaviour programs

Consistent with the first focus group, all participants viewed the therapeutic alliance (TA) as an important component of clients getting the most out of programs. This particularly related to achieving client engagement, otherwise clients’ participation would be ‘pretty void, meaningless’. The TA was described as the ‘vehicle’ to achieving real gains. As with the first focus group, however, certain situations were described in which difficulties in delivering programs were described, and then other priorities than developing and preserving the TA, such as self-preservation and removing difficult clients, were evident.

The central factor described in relation to the development of the TA with clients seemed to relate to responsively delivering program content, so that if clients were in pre-contemplation or literacy issues were evident, efforts would be made to modify material to accommodate these issues while balancing this with the need to maintain the integrity of the program. Specific activities discussed to assist in developing the TA included those management strategies discussed in focus group one, such as developing group rules, but also included additional engagement strategies, such as experiential activities, adapting materials to learning styles, and using humour. The importance of building trust and going at the clients’ level of comfort was also emphasised, particularly in relation to the need for clients to take ownership of goals. There was also a distinction made between broader goals and small ‘step goals’, such as getting to group on time, and that goal formation was a process that evolved. These participants stated that tasks are negotiable to some extent, but that this was more problematic if a pattern of resistance emerges (ie. clients not wanting to participate repeatedly in activities). In discussion about the bond aspect of the TA, participants reacted quite strongly to this term and preferred the term ‘rapport’, arguing that bond sounded ‘too personal’ and that sufficient challenging couldn’t occur if a more personal relationship developed. They suggested that clients’ expectations would be that you would not challenge them if a bond developed. The sense here is that a degree of detachment is used to protect from blurring the boundaries between clinician and friend, although rapport was still suggested as a requirement to promote changes in behaviour. They stated that rapport building is based on developing trust and a mutual respect, partly by demonstrating honesty and fairness. All agreed the TA was an important vehicle for achieving individual outcomes, saying it informed facilitator and client responsibilities. There was also a suggestion that clients also have a high degree of responsibility to ensure treatment goals are developed and achieved.
The types of ruptures that occur

Similar to the first focus group, a variety of instances were cited as possible sources of ruptures in these participants' experiences although a significant theme concerned situations in which co-facilitators' contributions impinged significantly on the TA. One example was where a client outright refused to undertake role plays, and the co-facilitator insisted he should participate. Another where a co-facilitator continuously challenged two particular group members, although she did use debriefing to discuss the situation and develop strategies to reduce this tendency. Other examples included when less experienced clinicians did not challenge or respond appropriately to negative comments made by clients and attempted to befriend clients. These latter situations were seen as creating a 'good cop/bad cop' dynamic in groups. In one of these situations, a co-facilitator described not being able to challenge group members fearing that he would be 'attacked', another co-facilitator seemed to lack the insight that befriending was not appropriate, yet another appeared to be inexperienced at being able to challenge or maintain appropriate boundaries effectively. One participant also admitted to 'siding' with participants against her co-facilitator due to problems in the co-facilitation relationship. She stated that it was her 'fault', not being able to 'put those differences aside', but at times her frustration was so strong. She explained this was particularly because her concerns with the co-facilitator's behaviour had been brought up in supervision but no changes in behaviour were evident following this. Being placed in the 'bad-cop' role posed numerous dilemmas, particularly in not being able to challenge clients in the period of time a group would normally be established due to splitting. Comment was made of clients being able to pick 'facilitators' anxieties', or noticing then exploiting difficulties in facilitation relationships. So difficulties within the co-facilitation relationship potentially exacerbated problems within a group significantly.

An additional theme in this discussion concerned how behaviours viewed as problematic, such as overt acts of aggression or co-facilitators befriending clients, impact on the whole group; that in responding to ruptures, therapists needed to be mindful that how they responded to these behaviours would be observed by the group and serve as an indication of how therapists would respond to similar future problems. This was discussed in terms of groups learning what they could 'get away' with.

Sources of ruptures included problems with either client or therapist punctuality, therapists under-preparing (not being able to respond to issues within the group effectively or being inadequately informed about topics), or over-preparing for a group session (having particular expectations of how clients will respond to group material and not coping if the plan is not followed by clients). There were also various descriptions of aggressive behaviour being enacted towards participants. One participant in particular described a client being overtly threatening to her and she feared for her safety. She described his eventual removal from the group due to this behaviour and that he was subsequently referred to a domestic violence program which she believed was probably better suited to him. Other significant problematic behaviour included clients using drugs. These situations present interesting dilemmas for therapists. At what point does a therapist over-ride a client's clinical and/or programmatic needs? In other words, to what extent should therapists work therapeutically with clients, particularly if they are demonstrating offending behaviours? This requires consideration of a range of factors: staff safety, the safety of other clients, and the impact of problematic behaviours on other group members' therapeutic progress. These factors need
to be balanced against the potential benefits for both individual group members and the group as a whole in working through significant ruptures.

**Strategies to repair ruptures**

Several discussions in relation to repairing ruptures concerned the need to develop an awareness of 'traps' that therapists can fall into, which described responding in an unhelpful manner to clients. Participants talked about needing to be careful to not attend too much or too little to either 'positive' or 'negative' clients in this regard. When specifically asked what strategies assist in rupture repair, these participants stated that a good relationship with co-facilitators involving open communication in briefing and debriefing meetings was critical. If this doesn't occur, they discussed that when significant ruptures with clients' occur, these may not be discussed or resolved with either the group or the co-facilitator and have significant impact on future sessions. If there are problems in this relationship, supervision was seen as the next best option to assist in developing strategies to resolve ruptures. Participants also noted that going back to the group with the problematic issue can also be advantageous, hence making it part of the group experience and having the group take ownership of the issue. They commented that being transparent and open in the process is essential. What's not helpful is ignoring issues, not being receptive to feedback, and assuming a role as expert.

**Issues relating to Personality Disorder clients**

When asked what specific clients these participants had difficulty forming an alliance with, one stated that she found very 'needy' clients difficult, particularly when coupled with them not taking responsibility. If placed in a group situation with a client like this, the participant stated she would 'lean' on her co-facilitator to assist the intervention. Another participant mentioned she found difficulty in developing a TA with ones who are in 'pre-contemplation' and 'pro-offending' and has to 'manage' herself when she perceived these clients being disrespectful (e.g., wearing sunglasses or putting their feet on seats in group). The youngest, less experienced therapist stated that she found working with 'over confident' clients most difficult, and offered that this stemmed somewhat from her own 'insecurities' of her abilities and her age. When it was suggested that each of these types of clients resembled different personality disorders (PDs), they were asked if they used any particular frameworks to deal with these clients. The social worker stated that she was more inclined to focus on the here-and-now of clients' behaviours and the less experienced therapist stated that she had not been introduced to any such frameworks. The psychologist, however, imparted that her knowledge of PDs was in the Diagnostic and Statistical Manual of Mental Disorders, some familiarity of working with Borderline PD clients based on Linehan's work, and Hare's work on psychopaths.

When asked whether participants used any particular strategies to deal with PD clients, the youngest clinician stated she would seek additional support through her co-facilitator or supervisor to assist with these clients. The psychologist stated that, perhaps not with psychopathic clients but with other clients who had PD traits, she would use validation but balance this with challenging them to make more functional changes. She contrasted this by stating that with psychopaths she would work towards collaboratively finding a way for these clients to have their needs met but without harming others or engaging in other antisocial behaviours, and that this is hard to do. The social worker emphasised being aware
of what was happening in the group and what impact PD clients might be having on others, but wasn’t sure if she would do anything differently. The psychologist also suggested that some individual sessions with clients demonstrating PD traits might be useful to explore some of their specific issues if these were impacting on group participation. This then led on to a discussion about whether ‘fully fledged psychopaths’ should even be in your group, particularly if it made the group ‘unmanageable’.

**Analysis and outstanding issues**

This group of participants demonstrated a broader range of strategies to develop and respond to problems in the TA than Focus Group One. They also demonstrated an understanding of the nature of PD clients although questioned whether these clients should be in offending behaviour programs they had delivered. Although they demonstrated a greater depth of knowledge of offender characteristics than Focus Group One participants, they stated that due to the nature of programs that they had delivered previously (relatively short programs) and organisational expectations in relation to their practice (ie. what they were ‘meant’ to be doing’), they did not develop full case formulations for clients but the psychologist and social-worker were familiar with the process of undertaking them. This may point in part to how the process of approaching delivery depends on the purpose and nature of the programs being delivered and organisational expectations relating to task (ie. to undertake specific processes in relation to accountability versus focussing on developing clinical practice that has depth). Overall, there appeared to be a divergence of attitudes present; one reflecting some level of sophistication in relation to approaching groups that recognised therapist’s adaptability to engage a range of client presentations and the use of co-facilitators to support the process, and the other in which an attitude was conveyed that if clients did not ‘fit in’, they should be removed or not included in group. A range of factors may be at play to explain this dialectic - one concerns beliefs around how clients’ change, and when they can’t change, the other is around their own self-efficacy as a therapist and when they perceive they are unable to contribute to a client’s therapeutic change. Various factors appear to contribute to these two factors, some of which were raised in Focus Group One, such as a therapist’s experience, confidence, qualifications, theoretical orientations, and organisational support. These participants in particular pointed to differences in approach based on professional differences, particularly in relation to issues to do with PD clients. The psychologist had received additional training and was better equipped to deal with these issues. Client factors seem to concern the severity of symptoms as well as their willingness to participate in programs and take responsibility for their behaviour. Further exploration should occur on the confluence of these factors on the development of the TA. These participants also provided some concrete examples of how to respond to ruptures but, except for the psychologist, little detail was provided save for seeking support and feedback. It is not clear whether the other participants did not feel like they had functional strategies or did not have the insight around what strategies they used. More information in relation to specific actions taken in group is required to build on those discussed by the psychologist.

**Focus Group Three - Memo**

Three participants comprised the third focus group and they were all social workers who were delivering offending behaviour programs in a medium security prison. There were
some commonalities in approach although, unlike the first two focus groups, a number of differences in clinical practice were also revealed. They all recognised group delivery, however, as both challenging but satisfying. One male who was thirty-two years of age and two females who were fifty-two and forty-eight years of age participated.

The relevance and importance of the therapeutic alliance in offending behaviour programs

As in the previous two focus groups, these participants also stated that it was their belief that clients would likely get much better outcomes if all three aspects of the therapeutic alliance (TA) were working together in balance. There was some suggestion by one participant, however, that if there was no alliance with the therapist, that a client may still get benefits if there was someone else in the group with whom they could relate to and gain support.

Similar to the second focus group, a significant theme in relation to developing and maintaining a TA with clients concerned responsively delivering material, with one participant particularly talking about re-writing a manual, while maintaining program integrity, to accommodate a client’s narcissistic traits. The development of goals was also seen to occur based on a client’s level of functioning as well as their attitude and insight into their own issues. These might vary from fostering client’s attendance and participation, such as getting clients who articulated that they have literacy issues to stand up and spell, to more high level therapeutic gains. Goal formation seemed to sometimes be driven more by the therapist, particularly when a client might not know what benefits they could gain from a group apart from release on parole.

Two participants seemed to have a similar approach to the negotiation of tasks to the previous focus group, in that they would exercise a degree of flexibility based on client characteristics and their degree of comfort with the task. The other therapist, however, took a divergent view. She held that it was her role to create dissonance in clients and when discomfort occurred due to their resistance to a task, she would continue to negotiate their completion of it, arguing that elsewhere in the community people were expected to undertake tasks that they did not necessarily want to do. This difference in approach permeated the focus group discussion, although points of commonality were also evident. These included the importance of being responsive to client characteristics and the value of the therapeutic relationship in helping to achieve client outcomes. One participant also pointed out that while it was important to create discomfort in clients as a means of eliciting change, the timing in which this occurred needed to be considered. In session two or three, for example, ‘you might not push the button’ due to the group not being properly formed.

One interesting point, which has not been highlighted in previous focus groups, was the therapeutic value in working through differences that might exist between therapists and clients. This was particularly highlighted later when discussing the value of dealing with gender issues, and that male clients would often relate to female therapists in the dysfunctional manner in which they have related to women in their lives, and that these problematic styles could be worked through in programs. Consistent with other focus groups, mention was also made of needing to have an awareness of ‘triggers’ that therapists might have in relation to client characteristics. Participants were then asked to what extent
they thought they needed to have a bond with a client. This inspired one participant to discuss a ‘protective streak’ she had with a client once who had an acquired brain injury because she had wanted to ensure that other group members did not treat him badly, but this tendency stopped once she felt he was able to manage himself in the group. Another participant in responding to the question about bond reflected that she had felt a ‘sense of loss and grief’ when completing a group program recently due to the strength of the relationships that were formed. The other female also talked about the importance of developing an attachment with clients to model appropriate human relationships, although a sense of nurturance was also evident. In discussing this issue the male participant, however, stated that he did not feel there was an ‘emotional attachment’ with group members but spoke about it in terms of making connections with clients, such as through the acknowledgement of progress made.

In discussing the relationship between the TA and therapeutic outcomes, one participant stated the extent of its importance depended on whether you were doing ‘education’ or what else you were trying to achieve. The central features for this participant around the TA were to ensure there was a balance between all aspects and trust was an essential to achieve this. She also added, however, that it was important ‘to take some risks’ to achieve therapeutic outcomes. There was then a discussion in relation to the importance of the bond aspect of the alliance, and agreement that this was particularly due to clients in offending behaviour programs being coerced to participate, may have low literacy or be otherwise less engaged. One participant particularly described the therapist’s role as creating dissonance, and an emotional bond was essential for that to occur. For the male participant, it was important to establish boundaries and a relationship, but later in the program you would expect that clients have some ‘self-motivation’ in relation to their participation and the kinds of gains they seek to make.

The importance of the bond aspect of the TA in this focus group diverges significantly from those of the last focus group, in which participants articulated that they purposefully maintained a level of detachment to ensure that they could challenge participants. These differences aren’t easily explained simply through differences in qualifications, as one participant was a social worker in the last focus group, but may be accounted by differences in supervision and work experiences.

**The types of ruptures that occur**

Further examples were provided in which external factors influenced ruptures. Interestingly, most initial responses to this discussion focussed on situations in which participants were required to finish programs earlier than initially intended, and the impact of this on the alliance. Participants commented on how these circumstances required goals to be changed, tasks re-organised, and they inevitably impacted on the relationship with clients.

One participant shared her experiences of delivering programs to women compared to men. She said that women tend to elicit a lot more victimisation and were more likely to be ‘colluding together’ after getting stuck on particular problems that occurred in the group, whereas men would ‘move forward’ from group problems quicker.
Instances were also raised in which participants had particular responses to clients' dysfunctional and aggressive behaviour in group. One participant described a situation in which she highlighted the inevitability of a client’s re-incarceration after he made an insensitive comment to another group member. Another participant described a narcissistic client who responded to her processing his behaviour by stating that he knew where she lived, had people following her, and knew all about her. She described being able to challenge the client while in group but later felt disturbed by the behaviour. The last participant mentioned an instance in which a client had casually grabbed a lanyard that was around his neck and at the time he responded with humour but he kept his lanyard in his pocket after that.

**Strategies to repair ruptures**

One participant discussed using clients' responses within programs, such as frustration elicited due to changes to program timetables, as therapeutic leverage. She provided examples of responding to these ruptures by processing participants’ responses, and sometimes incorporating these into aspects of the program she was delivering. This same participant also commented that there was a group who did not want to undertake the 'exercises' in a program she was running, and the manner in which she dealt with this was to get them to elicit what tasks they could undertake to achieve the same outcomes. So a range of in-depth discussions and other activities were undertaken to achieve this. As described above, a different participant commented that if clients did not want to undertake the exercises as set, she would explain the rationale of the activity and it was part of their learning to work through levels of discomfort in relation to these. She also described that her main response to problems within group revolved around processing difficulties and 'calling' clients on their dysfunctional behaviours.

In situations where problems escalated, so perhaps more serious threats were made, participants discussed the importance of holding themselves together and not revealing the extent to which they were, say, fearful. This might also involve directing challenging the veracity of the threat or making a joke out of it. One participant talked about the importance of ‘assessing’ a situation when problems in the relationship emerged, and your response would depend on the rapport you might have already developed.

Participants described the value of working out how to respond to a rupture in debriefing with facilitators and supervision with team leaders, and to ensure that this was done in a timely manner. There was some discussion also on issues relating to solo facilitation, and one participant stated he didn’t agree with it and another saying it was okay as long as you put measures around it, such as regular debriefing with a team leader or other senior staff member.

**Issues relating to Personality Disorder clients**

Participants described a range of clients for which it might be difficult to build a TA. These included narcissistic clients for one participant. The other two agreed with this but also brought up clients that 'don't give you a lot' and are quiet, and might sit in groups, session after session, not saying anything. Similarly, clients who have a 'closed mind' were also raised as difficult to develop an alliance with, as they present as having worked out their
own situation, and are not prepared to examine their issues any further. When asked to reflect on the strategies that they used to respond to clients with personality disorder (PD) traits, a consistent focus was to speak with other staff familiar with these clients to determine what their experiences were and whether any particular strategies could be gleaned through this. For one participant, this also allowed opportunities to reflect to clients how others perceive them and 'Even if it blows it up' that it's an 'edge way in' to discussing their behaviour.

One participant recounted two experiences of dealing with psychopaths. When asked if it was important to create a bond with these clients, she stated 'To try to.' She provided one example where she had attempted to create a connection one of these clients but he had 'destroyed' these attempts and was eventually removed from the group as he could not relate to others, 'he couldn't attach to anything' in the group and other group members complained about his behaviour. He consistently articulated that he did not want to attend group and embellished his own offending experiences in group. He was called up several times out of group to discuss his participation but this did not assist the situation. Her experience of another psychopath was quite different, as he did not make as many comments about his offending, although he was also not able to 'engage in attachment stuff' with the group. Her strategy was to therefore focus on his 'needs' and 'not fuelling' problematic aspects of his behaviour both to benefit the client and the rest of the group. The importance of choosing group members who will 'contain', relate to, or otherwise balance clients demonstrating significant PD traits was also discussed.

The use of formal classification systems were not used by this group as they stated it was a social work 'tradition' to focus more on specific behaviours. They did comment, however, that looking at psychometrics and 'schemas' assisted in developing appropriate responses to these client traits. Despite the challenges posed by PD clients, and the time required to explore their behaviours and develop hypotheses and strategies, participants stated that there was real professional satisfaction when positive changes were elicited.

**Analysis and outstanding issues**

This focus group outlined an array of therapist approaches, client presentations, and in-group strategies to respond to ruptures. The differences in practice were highlighted in both theoretical approaches (how therapists perceive clients making change) as well as gender differences. This latter was evident in differences in approach to the bond aspect of the TA, with the male participant stating he did not strive to develop an attachment but did strive for a connection. It is unclear what qualitative difference this would make to a client’s process of therapeutic change. Other gender issues were also highlighted through descriptions of therapeutic engagement with female clients compared to male clients, and that females were more likely to require more processing as they ‘get stuck’ on group issues and focus on their own victimisation. This has highlighted the need to examine gender issues further.

The first three focus groups have revealed a diversity of strategies being used by therapists. Focus Group One participants described managing difficult behaviours, Focus Group Two emphasised responsively delivering group material, and Focus Group Three described a
range of responses but tended to be more committed to therapeutic engagement with clients who demonstrated PD traits. Further focus groups might seek to develop a more comprehensive range of strategies therapists invoke to develop the TA and respond to ruptures.

**Focus Group Four - Memo**

Three female participants comprised the fourth focus group, all of who had post graduate degrees in psychology (two in clinical and one in the forensic area). They were aged twenty-five, thirty and thirty-three. They all delivered sex offender treatment programs and articulated a variety of strategies they invoked to create optimal group experiences that facilitate therapeutic change. The diverse range of strategies described may have been reflective of participant qualifications or because these therapists all delivered treatment programs (rather than psycho-educational programs), but may also be indicative of focus group questions being more specific on techniques to develop the therapeutic alliance (TA) and rupture repair.

The relevance and importance of the therapeutic alliance in offending behaviour programs

These participants, consistent with all other focus groups at this time, stated that they believed that to get good outcomes, a TA was very important. Also consistent with the previous focus group, the exception to this was the suggestion that clients may still get good outcomes if a client lacked a connection with therapists but did have good connections with others in the group. Particular mention was also made of the frequent difficulties within this client group in relation to interpersonal difficulties, and that this made the development of the TA more critical in relation to therapeutic outcomes and attrition. The nexus between the TA and group cohesion was also discussed within this context, with participants acknowledging that it was the therapist’s role to get the group to a point where they could challenge each other, but there had to at least be some kind of connection between therapists and group members, particularly around trust, for this to occur in the first place. The importance of clients feeling 'validated and safe' before they are able to engage in treatment was also emphasised.

When asked how they determine what tasks need to be undertaken in a group, like in most recent focus groups, participants initially talked about independent risk factors and issues relating to responsivity. This latter was to ensure clients can benefit from the material, and may mean for some clients discussions of particular issues is effective whereas for others experiential exercises may be important. They also mentioned that how well participants fit into groups, such as their social skills, as well as how other group members respond to participants as important considerations. Matching course material in modules to participant need was also discussed, whereby more time would be spent when specific group members risk issues were most relevant to particular areas in the manual. When asked to what extent they might deviate from the manual, participants stated they would still ensure the central elements of each module were covered, partly to ensure that should the client need to return to court, their report would be able to articulate that they had completed all aspects required of the program. The importance of using case formulation to inform the specific tasks was also discussed, and viewed as more important than in previous
focus groups. Participants mentioned, however, that they wished they had more time to create formalised case formulations, such as the four Ps, and provided examples of where a failure to do so resulted in therapists taking different directions in an offence process. The use of diagnosis was also mentioned as a potential means of developing case formulations, which then inform the delivery of the intervention. Narcissism, in particular, was mentioned as a specific diagnosis where a particular style of working was required to be able to work collaboratively. In this way, the case formulation also places a structure around therapy and assists in developing treatment goals. Participants were very clear that the goals of treatment have to ultimately address clients’ risk of re-offending, although they discussed that sometimes to engage the client offence related goals, such as self-esteem or assertiveness skills, might also be addressed. The importance of engaging the client in goal development was also discussed as a process of 'instilling hope' that change is possible, and only from that position could work on dynamic risks occur.

In discussing issues relating to the bond aspect of the TA, these participants were keenly aware of the importance of relationship factors within their treatment. One clinical psychologist also discussed research supporting this notion. The other stated that she wished she focussed on process issues more, as she saw them as more important than content. Like other focus groups, the importance of developing trust was emphasised to assist this process although these participants also acknowledged that therapists were likely to be seen as part of the establishment that punishes clients, so the development of a good therapeutic relationship in this context is always going to be a challenge. An ongoing theme in this focus group was that given this work occurs in a correctional environment, participants stated they were constantly surprised by the type of therapeutic work clients do undertake. This was particularly given the humiliation they might experience in having to talk about their offences in front of a group of men. These participants also talked about needing a strong therapeutic relationship to enable challenging and setting clear boundaries. The forensic psychologist likened it to good parenting in that challenging and creating structure is not necessarily a bad thing if accompanied with a strong relationship. This notion is at odds with the positon participants took in the second focus group, in which they articulated that they did not want to develop too strong a relationship with clients in order to enable challenging. As with other focus groups, the term 'strong emotional bond' felt a bit too intimate for these participants in their description of the bond aspect of the TA, but they specifically discussed the importance of needing to have empathy for the client and a level of emotional connectedness while emphasising the professional nature of the relationship. For those clients who 'press my buttons', there was an expectation that at the very least a working relationship was required based on trust. They also conveyed within their practice a level of care, concern and respect for their clients.

The types of ruptures that occur

Ruptures were identified as potentially occurring in all areas of the TA. This discussion emphasised both the role that therapists might play as well as those focussing on client behaviour. In relation to therapists’ behaviour, participants described a rupture as potentially occurring simply because 'we've lost sight of where we’re going,' possibly due to running out of time or because of 'bad treatment,' so therapeutic goals had not been achieved. In discussing issues around the therapeutic relationship, participants all demonstrated that they engaged in a high level of self-reflection on the motives of their own practice. The forensic psychologist, for example, described her tendency to want her clients
to like her on the one hand, while also being aware that at times she wanted to 'win' and not have clients feel like they had been able to dupe her. It was also participants' view that clients leave treatment prematurely if they feel judged by therapists or other group members and/or they do not feel safe within treatment. Therapists changing groups was also cited as potentially contributing to ruptures, and a specific example was discussed by a participant in which a 'high profile' group had been treated by so-called 'experts', and group members did not respond well when seemingly less experienced therapists took over the group. Equally, when this participant returned from three weeks of leave, the work that had been undertaken to get the group functioning had been undone on her return. This latter example perhaps demonstrates the potential fragility of the TA, and that for complex clients seemingly minor changes in delivery has the potential for ruptures to re-emerge.

Numerous examples of ruptures were provided within this focus group involving difficulties emanating from clients. In this latter example, this group was described as also having problems prior to the change of therapists due to group members not responding well or trusting another group member. Then there was 'almost' a fight in the group and the participant questioned whether she and her co-facilitator should have dealt with it differently by removing those involved. Later, another group member made a 'very very hurtful comment' to a suicidal client, who then responded by stating he or the other group member had to leave. A lot of work then occurred with this latter participant to re-engage him in treatment. In open groups, new group members were also described as being potential sources of ruptures. A particular example of this was provided by a participant in which she described a new client 'turned the group to feeling really unsafe,' so additional work was required at re-establishing the functioning of the group. Group members continually complaining about their conditions and the system was also discussed as a potential means of derailing their treatment. Clients who compulsively lie were also cited as creating ruptures, and an example provided where a low-functioning client consistently stated he was late due to his bus-driver getting lost. Similarly, accepting what clients say on face value, to later find out that they had misrepresented their circumstances, could also create problems in the TA. Clients who are 'angel faces' and have been 'over-therapistised,' so have perfect responses to all issues, were also mentioned as potentially creating ruptures as it was easy to like these clients. Overall, participants recognised that ruptures were often indicative of clients' own particular problematic histories, especially as these were likely to impact on attachment.

**Strategies to repair ruptures**

An ongoing theme that emerged in relation to strategies to repair ruptures was the importance of maintaining a level of transparency with clients. This included demonstrating respect for clients' commitment to treatment and acknowledging their progress, so that if things did go wrong that impacted on any element of the TA, the relationship could be relied upon to get things back on track. If a strong relationship exists, then validating difficulties, reflecting on what is happening in a group, providing options for what might occur, as well as offering support for the choices they make, were processes described that could assist the situation. This needed to occur in tandem, however, with working diligently with co-facilitators to get things back on track. An example was also discussed in which a participant made a conscious decision with her co-facilitator to create structure in a group once difficulties had occurred, as there was an acknowledgement that given the nature of difficulties that clients experience, there cannot be an expectation that they will always be
able to work out the difficulties themselves. This participant commented that she and her co-facilitator had spent 'weeks in the wilderness' trying to get the group to resolve the ruptures, but realised in the end it was their responsibility to model means of moving forward and to allow clients to step back into the process from there, with an emphasis on clients needing to 'feel safe' again before they re-engaged with the group.

There was broad agreement that when groups have difficulty in functioning, 'bonding' activities can be conducted to get the 'group's esteem up'. Raising the issues of contention to discuss with group members was also important, and group members might be provided with an undertaking by therapists that they are committed to particular courses of action to assist the group, but this needed to occur alongside urging group members to also demonstrate a level of responsibility that they were willing to also work at re-creating a therapeutic environment. Another example was also discussed in which a participant suggested to a client that re-engaging in treatment after they had lost trust would be a way to demonstrate that he had made treatment gains. This was particularly as this client's dynamic risks involved problems with trust and dealing with rejection. Another course of action discussed as a means of responding to ruptures involved therapists' reflecting on their own reactions to clients, describing these responses to clients, and then exploring whether clients also get these response from others. There was much discussion on how feedback like this to clients might be particularly therapeutic, as they may not be aware at all of the impact they are having on others. Allowing the group to do some of this work was also described as useful, particularly when wanting to have clients reflect on discrepancies in their presentation (ie. I thought you said this last time, but what do you other guys recall?). So avoiding confrontation but allowing for group exploration of the issue under discussion was seen as paramount in this context, particularly in relation to issues relating to offending.

Supervision was seen as a crucial process to enable working through 'personal issues' elicited within treatment. Mention was also made that when therapists are newer, they should be told that they can make mistakes as the fear elicited from wanting to try and constantly get treatment right could create problems. Relying on co-facilitators in situations where it is difficult to deal with a particular client was seen as a potential means of assisting situations and, overall, supportive colleagues was also cited as an important mechanism to assist in rupture repair.

**Issues relating to Personality Disorder clients**

A number of examples were described in working with personality disorder (PD). This included one participant stating that she found it difficult to work with narcissistic clients, and compared this with her experience of working with borderline clients where she felt that she could at least empathise with them as they’ve usually had difficult histories. Similarly, 'patronising' and 'entitled' clients were also cited by another participant as difficult to deal with in a group, as were clients with an extreme external locus of control, who excessively complain about their situation. The last participant, however, stated that she previously had difficulties working with narcissists also, but was now having an experience where she felt like she was able to work with one in her current group, and it was an extremely professionally rewarding experience. She described being able to do this by attending to the connection she had with this client.
When participants were asked about their use of classification systems in working with PD clients, two of the three participants described using the Diagnostic and Statistical Manual of Mental Disorders and having an understanding of Robert Hare's notion of psychopathy. They stressed, however, that they had them in the 'back of their heads' when working with PD clients, rather than formally acknowledging these classification systems in their work. One of the clinical psychologists stated that she resisted working with formal classification systems, as she did not accept that these clients were 'unchangable' and preferred to focus on client behaviour experienced in group, rather than label it with a diagnosis.

**Analysis and outstanding issues**

This focus group clearly valued the TA as part of a framework to work therapeutically within a correctional environment. This was evident in their commitment to developing strong therapeutic relationships with clients to ensure sufficient challenging and boundary setting could occur within a treatment episode. They elicited some very specific examples of client/therapist interactions relating to ruptures and rupture repair that were diverse. Further work might occur in subsequent focus groups to continue to build on these examples, particularly with specific reference to other PDs.

This group found working with challenging clients, including PDs, could be particularly rewarding, although difficult work. Not only did it require developing particular skills but managing the impact the PD client is having on other group members also needed to be considered. In conclusion, they discussed the notion that that 'witnessing change is a privilege' and the most rewarding aspect of their job. These changes might be small, such as clients apologising for difficult behaviour they demonstrated in group, or when clients described more significant changes they made in their lives.

**Focus Group Five - Memo**

A 37-year old male with post-graduate qualifications and a 62-year old female with graduate qualifications participated in the fifth focus group. They were both senior psychologists who delivered and supervised staff in their delivery of offending behaviour programs. The male practiced in a prison and the female in community corrections. Although there was some agreement between these participants in their approach to both issues relating to the TA and the resolution of ruptures, there were also some marked differences. The male, for example, emphasised processing group issues as a means of addressing criminogenic risk more so than the female. This may have been a consequence of the higher qualifications, as he made numerous references to the guidance he received during his Masters. Both participants were clear that their role was to ensure ongoing community safety.

**The relevance and importance of the therapeutic alliance in offending behaviour programs**

In discussions on the aspects of the therapeutic alliance (TA), these participants stated that they believed they were integral to therapeutic change, although the female participant stated that she believed that the task and goal elements were more important than the bond. The male participant stated that he believed this in part, that what clients need is 'mental skills coaches', but that it was through the relationship that clients develop skills, so forming a bond was 'the responsivity side' of it. This particularly occurred through processing
offence-paralleling behaviours in group.

In relation to the determination of tasks in a group, both participants concurred with previous focus groups that the contents of the manual needs to be adapted responsively to the characteristics of clients (e.g. low levels of literacy, mild intellectual disability, symptoms of major mental illness) and the functioning of the group to ensure clients could relate to it. The female also commented that to not do so felt like you were 'putting them down or lecturing to them.' Both participants stated that there was a level of importance around the use of case formulation, with the female suggesting that this was to inform an individual's specific treatment pathway within the group. The male, on the other hand, saw it specifically as a means of framing the particular interpersonal challenges that facilitators channel within the group to respond to criminogenic needs. As in the most recent focus group, the male participant specifically pointed to interpersonal difficulties, particularly in relation to violent offenders, as central to their offence processes, and the most significant goal of treatment was to reveal and intervene at this level. The female participant's responses were more indicative of attempts to manage interpersonal difficulties that emanated within the group and a detached approach to the bond. She suggested that the development of the therapeutic relationship commences at the assessment process, and functions to reduce client resistance to undertaking the program. This contrasted with the male participant who stated that the development of the therapeutic relationship was critical to achieve therapeutic change, and that despite potential elements of coercion to participate, 'you can find more common ground than uncommon ground with the clients'. This was described as providing the backbone to treatment, by being honest, clear on expectations and following through on undertakings given. This participant also commented that it also permeates to providing the basis of a good treatment culture in a prison. It was his view that his team had a reputation for being fair, honest, transparent, and supportive, but also demand the client will undertake therapeutic work. When asked if they thought a strong emotional bond with clients is important, both said no. The female in particular stated that 'the antithesis of that is important', and went on to talk about the importance of clinicians being objective and that the 'therapeutic holding' was about 'supportive containment'.

The types of ruptures that occur

The male participant spoke at length in relation to the types of client presentations in groups that were reflective of aspects of their offending, and that this would be challenged in group so might potentiate a rupture. Clients might demonstrate overt aggressive or demeaning behaviour although behaviour might also be more subtle, such as with 'Self Sacrifices' who might not tolerate others' discomfort in group, so yawn or otherwise distract the group, or tell a group member that they had done well in group when they had not. A number of situations were also described where client behaviour might otherwise disrupt group processes, such as when a client would constantly make jokes in the group when the mood of the group lowered, as detailed below. Both participants also agreed that caution had to be exercised within groups to ensure that where clients had been diagnosed with major mental illness, that they didn't 'escape into those categorisations' when things got difficult in group. The female discussed issues relating to resistance, and clients' 'anger and feeling of injustice' that can impinge on the working of a group. She also mentioned in locations where programs are not fully supported that a high level of non-attendances might occur, and this would result in clients going into the group late which could create difficulties. Equally, where 'personality disordered folk' or psychopaths might enter a group, they will 'often
enter into a power struggle about who's going to lead this group and where.' Both the skill of the therapist and responses of the other group members were seen as dependent on 'the efficacy of that group'. One type of rupture discussed that can particularly occur in the bond aspect of the TA concerned situations where clients further offend while being in treatment. An example was given by the female where a client stated that they had 'let down' the therapist, and the therapist subsequently stating in supervision that they had felt they had let the client down. The male stated this was 'classic counter-transference' and 'a real rookie error'. This inspired a discussion around the need for clients to take personal responsibility for their behaviour, and the male stating that he tends to 'become extraordinarily punitive' where clients articulate that they won't offend if 'you would just..', and he turns this into a process issue.

Within the context of talking about clients with a personality disorder (PD), an example was raised where a client with narcissistic traits had initially boasted that he had bribed another participant to say in group he had been sick when he hadn't, then bribed another one to say that he had made a great apology about this. He failed to return to group when advised he would need to make an apology. When he returned to a different group, he was 'the best performer' as he had 'found some boundaries'. Another example concerned a client with psychopathic traits who was 'so antisocial', he ran the risk of getting 'belted' by other group members. He had made a comment in the group about some children who had died, while other men in the group were 'grieving' the loss of children through protective services. His lack of insight into the insensitivity of the comment was problematic and he was ultimately moved to another prison to try another program. Further examples were provided, such as domestic violence clients who 'create broken eggshells for people to walk on', and this may become particularly difficult for a group when they have 'a robust facilitator who knows no eggshells'. Later in the session, the female participant recognised that what can create further problems is when therapists don’t want to upset clients who demonstrate these tendencies, so will avoid reflecting their behaviours and disrupting the group or, even worse, when the client is talking over somebody else in group 'actually answering that and reinforcing that'. These responses were seen to be 'colluding and reinforcing that manipulative power struggle behaviour'. Conversely, the male participant also pointed to problems created with extremely argumentative clinicians, 'who go in with guns blazing from the start' and don't appreciate the level of subtlety that challenges can take.

A critical issue raised in relation to running groups, discussed within the context of PD clients, concerned group cohesion. The male participant in particular spoke about attending to how group members relate to each other and observing behaviour, such as rolling eyes or clients not giving feedback to certain group members, as indicators of problems in group relationships which risk the integrity of the group.

**Strategies to repair ruptures**

For the male participant, the significant theme for responding to potential ruptures, and means of achieving therapeutic gains for clients, was extensive processing of interpersonal interactions. This might be in the form of simple feedback, done by either therapists, such as by stating '(I) actually don't like what you said, I find that quite offensive', or by inviting the group to do this. This was also achieved by specifying links between their group behaviour (e.g., clients complimenting what is otherwise bad behaviour in other group members to
avoid the latter’s discomfort) and their offending (e.g., committing an armed robbery because a family member said they had no money), so ‘using macro and micro, and switching between the two’. As with another member of focus group three, there was an emphasis on the need to create circumstances within groups to elicit emotional responses, including humiliation, in order to highlight the client’s interpersonal characteristics relevant to their offending. This participant stated ‘they’re invited in, but you’re inviting them onto a rug to pull it out’ and then promoting change within the group as a means of addressing these issues. The male participant also spoke about the importance of therapists combining training and ‘personality’ to assist them demonstrate a level of confidence, humour, and enable flexible responses to clients' dysfunctional behaviour. As indicated above, this might include very subtle challenging, such as using an ‘invitation question’ to ask the client ‘I wonder why you’re…’, and that a good therapist will notice subtle changes in body language in response to these questions, to ‘abject humiliation’ in order to find a way for client’s to enhance their awareness of problematic behaviours. These situations may potentiate a rupture, in that client responses to therapists’ challenges may directly impact on the bond aspect of the TA, however, this participant argued that the therapist is required to reflect dysfunction while also supporting clients develop alternative responses in a contained and respectful way. The key here is for therapists to persist in the intervention and ‘be fairly clear on what are the goals of this session’.

The female participant commented that, particularly in relation to responding to PD clients, that if the clinician is skilled enough to provide adequate feedback to the client for the first three or four sessions, and other group members develop ‘faith in the strength and the ability of the facilitator’, group members will then assist with the containment process by also providing robust feedback about the PD client’s dysfunctional behaviour and its impact on the group. The male participant then went on to describe a situation in which a PD group member constantly made jokes, particularly if the ‘mood started to dip’ in the group. The clinician’s then started counting every time he made a joke, and ‘the group ends up getting in on it’. Subsequent feedback from group members that he did this rather excessively provided greater impetus for the therapists to frame the behaviour as a ‘coping mechanism’ that he was then invited to address.

**Issues relating to Personality Disorder (PD) clients**

Numerous examples, as detailed above, were provided in which PD traits can result in ruptures within a group. These were largely actions in which clients demonstrate differing levels of confrontation both towards therapists and other group members, whose subsequent responses might contribute to aspects of the rupture. When asked about how therapists might effectively deal with situations where psychopaths engage in a ‘power struggle’ within groups, the female participant stated that her strategy is to have a number of parallel individual sessions where staff are ‘trying to form a contained relationship’. The male commented that, as he worked in a prison where numerous programs ran, that he had ‘booted’ a number out of group after a few ‘quiet chats’ about the difficulties of their presentation, and ‘it’s the best thing we could have done’ as they had done better in subsequent groups. They both went on to discuss the importance of outlining to individuals with PD traits the requirements for appropriate behaviour, and that anything less will not be tolerated. This strategy speaks to a group of strategies commonly articulated by focus group participants that focuses on managing problematic behaviours. The female participant went further, saying that with PD clients, the relationship ‘really does need to be a detached one'
and containment was the objective to be achieved, particularly to manage acting out, the 'devaluing and denigrating...putting down of the facilitator, trying to find the trigger where you’re going to blow your top at them and you don’t, and they escalate'. When asked to comment on what it is that PDs find difficult about being in a group, the male participant offered that they are used to feeling like they are in control, and consistently applying group rules means that they are 'Not getting their way, and they're used to it'. The female concluded that 'as an organisation' more work needed to be done to examine whether PD clients are best dealt with in a group.

When asked which PD presentations participants found most difficult to developing a TA, the female participant offered that with those who demonstrated high levels of psychopathy, ‘there's a way of out manoeuvring them’ to which the male participant responded 'self-interest'. She then stated that 'whereas the personality disordered ones', presumably comprising a range of antisocial, borderline and histrionic traits that had been described in the focus group, were a challenge as ‘they will escalate in order to cause that disruption and shock’. By contrast, the male participant stated that it is 'the absolute disinterested client' he found difficult, but had no difficulties in responding to PDs and anger because he 'can channel it' or, when there might be two clients demonstrating confrontational behaviours he could 'bounce them into each other'. When asked how he responds to disinterested clients, he raised again the importance of finding common ground. He then discussed that difficulties really emanate in groups 'when I've got a couple of vulnerable guys and a couple of sharks that can smell blood in the water', and that a 'big mistake' some people make is deciding on group mix based on offences, as 'some of the most devastating psychopathic-style people are white collars, and they will get the ruthless armed robber and absolutely demolish him in group, because he's articulate and able to read body language'. When asked if they liked working with PDs, the male participant said he did. There was then a discussion in relation to how approaches taken to this work, with the female participant saying she was frustrated with the limits the system put on the treatment of PDs, and that she wished some more basic behavioural modification groups could be delivered, whereas the male stated that he was clear that the function of interventions was to reduce risk of re-offending. He commented that PDs likely lead quite lonely existences, but it was his role to tap into the 'portion of their behaviour...where they've injured people'.

Similarly to other focus group participants, both participants in this focus group described a familiarity with classification systems for PD clients, particularly Robert Hare’s PCL-R, but talked about using it to try and understand a client’s behaviour rather than to formalise diagnoses.

**Analysis and outstanding issues**

This focus group, although providing some support for the TA as a useful framework in delivering offending behaviour programs, had a slightly different take on it's conceptualisation than other focus groups. The female stated clearly she thought the emphasis should be on the goals and tasks, and for PD clients in particular, that a detached stance was required to undertake the work. The male, on the other hand, emphasised the importance of developing a therapeutic relationship based on honesty and understanding and this provided the context on providing challenges to clients to achieve the process of
change. As with the previous focus group who also comprised psychologists with postgraduate degrees, he discussed the importance of interpersonal aspects of behaviour as these invariably related to clients’ offending. This focus group, particularly the male participant, provided a whole array of examples of ruptures (e.g., distracting from potential discomfort in others, making jokes, denigrating behaviour) and rupture repair techniques, from very subtle to very overt responses. They also went further in providing other insights into therapist responses to these behaviours that could be problematic, and this also varied from avoiding confrontation to being overly confrontational. Conversely, therapist behaviours to promote therapeutic change were also described, such as by flexibly challenging that aspect of the client’s behaviour that was impeding their ability to achieve therapeutic goals. Further development in future focus groups might involve additional exploration of issues relating to the TA, as there continues to be a level of divergence in the role of the bond in offending behaviour programs.

Focus Group Six - Memo

The sixth focus group comprised two males and a female. The males were psychologists, one was fifty-five years old with eight years of experience and the other was fifty-three years old with twelve years of experience in running offending behaviour programs. The female was twenty-seven years old and had a degree in criminal justice and had delivered programs for nine months. They were all currently delivering offending behaviour programs within community correctional services. The focus group functioned to verify a range of findings from previous focus groups, particularly around the importance of the therapeutic alliance (TA) in achieving good therapeutic outcomes and the types of ruptures that can impinge on the alliance. There was also a specific focus on issues relating to the therapeutic relationship.

The relevance and importance of the therapeutic alliance in offending behaviour programs

The focus group was told that invariably participants in other focus groups believed that the TA was a useful framework within offending behaviour programs, and that good gains could be achieved if there was agreement on goals, negotiation of tasks and the development of a bond. In addition, clients could make gains if there was a breakdown in any of the aspects of the TA, however therapeutic gains were maximised if all three elements worked together. There was agreement on these notions, and which led on to discussion of some of the aspects of negotiating the therapeutic relationship with clients within this context. This discussion involved the younger male pointing to an ‘element of concealment’ that occurs with clients, that you might reveal more specific information to case managers on client group behaviour than you would clients because, unlike private clients, ‘someone else is paying the bill, so to speak’. This highlights an important aspect of a fundamental factor in offending behaviour programs around obligations to correctional administrators, and how this impinges on the TA by virtue of there being other parties involved, each who are interested in the ongoing status of clients’ risk of re-offending.

Factors were described from previous groups in relation to the determination of tasks undertaken in offending behaviour programs including: participant characteristics, program manuals (chiefly in relation to program objectives), issues specific to the day (such as group and clinicians' mood) and logistical issues (such as time remaining within a program/session,
clients arriving late due to timing of medication). Participants agreed on these but then also suggested that a category might be added acknowledging the group dynamics. In discussion around the negotiation of goals with clients, there was agreement with other focus group participants that goals have to be around reducing risk of re-offending, however a high level of engagement needs to occur with clients so goals have relevance, are achievable for a client, and that clients are invested in. Similar to other focus group members, there was also mention of putting to the group that ‘these are the goals set out in the program, this is what we have to achieve, how are we going to do that?’ The process of goals changing over time was also discussed, particularly that they may move from extrinsic (ie. getting through the program or getting parole) to more personal goals, and ‘that’s really a measure of the success of the program’. The bond aspect of the TA was then discussed, in which it was suggested that an emotional connection was required with clients that included trust, being genuine, and empathic. There was agreement with these and the younger male then commented that ‘You’ve got to have a working relationship. It’s very much about a shared goal’ and it’s ‘in everyone’s interests that they don’t come back’. When the notion of transparency was also introduced, a discussion occurred in which it was acknowledged that while a high degree of engagement with clients has to occur, there is a limit to the honesty within the relationship. Other focus group members have not raised this notion in particular, but it does point to an aspect of the bond around the power and authority of the therapist, and their obligations to case managers and, ultimately, the community.

An interesting comment was also made in relation to the development of the TA. There was an expectation that clients will demonstrate varying levels of pro-criminal attitudes, and side against the ‘square-head straight’ therapists at the start of the group but once ‘the stereotypes disappear’, this changes and clients are more likely to start to challenge each other.

**The types of ruptures that occur**

A range of scenarios likely to impinge on the TA were presented to focus group participants. This included logistical issues, such as having to finish the program quicker than expected or changes in facilitators, problems in the co-facilitation relationship, and also problems in relating to specific clients. Focus group participants then also added that there might be difficulties between clients that can create ruptures. ‘Personality conflicts’ within groups that can be ‘quite serious and quite hard to control’ were described, and in attempting to respond to it ‘do you alienate half of the group, by taking a direction with the other half of the group. Or alienate one or two participants to pacify another?’ Implicit in this comment is the notion that communicating some form of alliance, approval or support, with particular participants, can suggest a lack of alliance and/or disapproval of other participants. Various interpersonal difficulties were described that were quite serious, such as when the younger male participant stated he had two group members ‘come that close to punching each other out’ in a group. Another situation was raised in which a client confronted a therapist. A case manager had revealed to a client the specific negative feedback the participant had provided her. This resulted in the client being angry and confronting the therapist about the feedback, although his response resulted in a therapeutic outcome for the client, as detailed below.

In discussion of what other things could go wrong in the therapeutic relationship, the female offered that ‘sometimes you just really don’t get along with someone...and sometimes you can have a favourite’. In further discussion it was acknowledged that difficulties might occur
if clients remind you of previous clients or other people, say from previous relationships, that you have not liked. With respect to difficulties that might occur when clients are 'liked', the female participant stated that there is a risk that the client develops an awareness that they are favoured in some way, and feels 'a bit puffed up'. Further examples of this kind were described by the older male in which he stated that other group members might also detect differences between how therapists relate to different clients when, say, suicidality or other mental health problems, are evident in one client and the therapist has contact with them in addition to group time. He then went on to give an example of a client who had sleep apnoea, so would fall asleep during parts of the session. He described negotiating an agreement with the group that this client could attend make-up sessions for the sections he missed.

Other examples were discussed in which ruptures were likely to emerge due to therapists’ poor insights and skills. When asked how to manage emerging rifts between participants in groups, the older male frequently stated that 'invariably I put it back to them'. One example he provided, however, seemed to involve the group resigning themselves to tolerate the situation, saying they only had a few weeks of the program left so were best to just keep going. Another situation was raised (and further discussed below) in which this participant commented in relation to a group in which offensive language and pro-offending attitudes were being demonstrated, but 'I was sitting there listening and working out who my friends were in the group' although he described his supervisor, who was observing the group, articulating that was it was inappropriate to not respond at this juncture to clients demonstrating antisocial behaviours.

**Strategies to repair ruptures**

A range of examples of rupture repair strategies in response to clients' participation in group were described. The younger male participant stated that where a client had been given feedback about his poor group performance by his case manager, and then angrily confronted him, he took the opportunity to provide specific feedback to the client. This included swearing less and to answer questions put to him and resulted in improvements in his participation. He then went on to describe that by providing positive feedback to group members doing well, and not providing feedback to other group members who are not doing as well, 'you let the rest of the group know that maybe they could lift their game'. Later in the focus group session, this participant also discussed other means of negotiating behaviour change within a group when discussing clients who are resistant and withdrawn. He suggested being specific about the type of input expected from these clients, such as suggesting that they must contribute at least six times per group, for at least five minutes each time. Again, the notion of being upfront about the consequences of this was mentioned. 'You want a good report for the parole board, okay, I can write you one, but only under the following circumstances, because I will not lie for you. Here's what you do and here's what I do'. These strategies appear to be attempts at engaging the client, but doing this in a way where clear limits, boundaries, and expectations are set out.

As in other focus groups, there was mention that if particular difficulties occur in the bond with a client, the therapist should acknowledge the problem to themselves, and then potentially rely on their co-facilitator who might better respond to the client. Naming difficulties with clients might also assist in resolving ruptures, and when clients are having
problems within a group, therapists might put it back to the group to work out a better way of working together. A situation in which group members almost came to blows was also described as ending up as 'a reasonable sort of group' when one group member was removed 'for their own safety', and then the difficulties that had emerged between the two splits in the group were discussed with the group, so naming it 'cleared the air' and then the group was able to re-form. Another strategy to respond to clients was also discussed in terms of the framing of a group issue. For clients who are dominating a group, the older male described taking these clients aside and telling them 'You're actually doing all the work, why don't you let them do some..' to encourage others’ participation. The younger male also suggested that they be provided with opportunities to take a lead in the group, and 'they either do an appalling job, and they realise how badly they've done, so pull their head in, or they do a fairly good job and you just have to put the finishing touches to it'. This inspired a discussion around the importance of encouraging clients to take on responsibility for the content of their group. A specific strategy raised by one participant was to attend to the group dynamics, and work out 'who's going to speak up, who's going to be the nay-sayer, ...so you're actually picking up who are the guys who are with you.. who are the ring-leaders in this, who are actually leading it, who are the followers'. There was also a discussion later on in the focus group around some simple behavioural strategies that can be implemented to shift the dynamics of a group, such as changing the logistics, such as by getting participants to change seats, or using experiential activities.

A discussion occurred on the difficulties created in situations where both therapists report on having difficulties in relating to a client. In this situation, it was suggested that therapists determine who likes the client most, and in this way at least one facilitator would be designated to take a lead role in supporting and challenging the client. The younger male participant also pointed out, however, that if you're struggling with a client, 'you might actually be in the best position to issue the really pointed challenge that needs to come, whereas if you like a client, there's always the danger that you will fail to challenge..someone at some point has to issue the challenge'. With respect to issuing challenges, discussion then occurred on means of communicating these: a very pointed comment can be made in relation to the behaviour, it can be more a 'wayward comment' such as 'I think it was an inappropriate comment for this reason, what do the rest of you guys think', or a more subtle response like posing a rhetorical question. The use of silence was also described as possibly taking two forms. Either 'the pointed pregnant pause' where you might have a 'look of complete bemusement', or you just ignore it in the 'hope you'll extinguish the behaviour'. Where a series of difficulties have emerged, however, it was acknowledged that a more assertive response is required.

**Issues relating to Personality Disorder clients**

A discussion around the clients that participants found difficult to develop a TA with commenced with the female participant elaborating on a situation she had briefly described early in the focus group. She talked about a client who she and her co-facilitator had both experienced difficulties with, and who seemed to have demonstrated significant personality disorder (PD) traits. 'He just seemed to want to take over the group, seemed to know it all, but didn't know it all. Would get, in a way, almost aggressive toward the facilitators and also to the rest of the group...he just kept going around in circles getting to his point...I also have a bit of a problem with needy clients'. So a diversity of areas of difficulty are evident in this description for which a range of responses occurred. This included 'diverting him back to the
group' instead of her co-facilitator. They then negotiated to sit in different chairs during sessions to reduce this tendency, sometimes waiting for group members to seat themselves before sitting down, to shift this dynamic. The situation culminated in the group challenging this client, however the facilitators only learnt that a physical fight had almost occurred outside of the group after it was resolved. The participant then saw him in a make-up session and provided him with specific feedback about the difficulties that were being observed both by group members and facilitators. She stated that his participation improved for some time after this but then declined, so another discussion occurred with him further into the program. The other participants then described a number of other strategies they used to respond to clients who dominate a group, particularly those with narcissistic traits, such as suggesting they allow other group members to do some of the work or providing opportunities for them to contribute to group content. As mentioned above, this might have the effect of either revealing the inadequacies of the client or allowing them to take greater responsibility for meaningful contributions.

The older male then described that he found it difficult to respond to clients who are resistant and withdrawn, and he described as passive-aggressive. Similar to other focus group participants, he stated that if someone's being a 'know it all' or talking in circles, he felt equipped to do something with that. It was when they refused to participate and pulled their chairs out of the group circle that he said he struggled. This inspired another discussion of some environmental strategies that might be used, such as pushing all the chairs to the back of the room, or a range of experiential activities that 'can bring them out'. Exercises which move people to different seats were also mentioned as a useful strategy for those who attempt to distance themselves from the group.

In the final section of the focus group, participants were asked about their experiences of working with psychopaths and the importance of developing an alliance with them. The female stated that she hadn't had any experience in this. The older male participant described one group he facilitated in which he had a 'diagnosed' psychopath in a group who he believed he and his co-facilitator had developed an alliance with but who 'dressed down' a Department of Justice official who came to congratulate participants on completing their program. The participant stated that 'he had come a long way, but he still had that propensity' then later added 'the problem is they'll get to point where they say "No, I wanted that, and if I wanted that then I have a right to" and you can't go past that, because they're not bound by the moral strictures that perhaps the rest of us are necessarily'. The younger male stated that he hadn't ever had psychopaths in a group, but in individual work it was about finding something that the client could invest in, such as maintaining their liberty. When asked specifically about the importance of an emotional connection within this context, he stated 'Have we got any common ground here?' So similar to the male senior psychologist in the last focus group, emphasis was on exploring connection through similarity and conveying an understanding of the client.

**Analysis and outstanding issues**

A number of interesting issues were raised by group members in relation to the role of therapists. This particularly related to instances in which a participant negotiated with a group member to 'make-up' sessions he missed due to sleep apnoea. This suggests that the role of the therapist is to 'teach' the client what is in the manual, so catching up on parts
missed is acceptable. This is at odds with the suggestion by some focus group members that it is the group experience that is therapeutic. This issue also relates to whether the focus of offending behaviour programs is on psycho-education or therapy.

Another potential implication of an example from this participant relates to his supervisor suggesting that he should challenge antisocial behaviours in his group. While, on the one hand, he may have been analysing the roles assumed by clients in the group, on the other he may have been avoiding conflict or unaware of how to productively challenge this behaviour. This also possibly highlights attempts at befriending clients (or at least avoiding conflict), and perhaps a lack of openness to feedback. As pointed out in Focus Group Four, clients who present in offending behaviour programs may experience a multitude of dysfunctions, including those relating to attachment and interpersonal relationships. It might be that some groups cannot satisfactorily self-initiate psychotherapeutic changes required within this context, so reliance on this as a central strategy is not likely to always be appropriate.

This focus group did go on to describe a range of very specific strategies that can be implemented in groups, to both assist in the development of the TA as well as respond to ruptures. Further examples of client behaviour that can contribute to ruptures included clients who articulate highly antisocial attitudes to being resistant and withdrawn from the group. Strategies ranged from logistical strategies on the room set-up, utilising experiential activities, processing difficulties and challenging dysfunctional behaviour, negotiation of changes in group behaviour, implementing strategies based on group dynamics, and supporting the group to initiate problem-solving strategies. Despite the length of experience of the males in delivering offending behaviour programs, their did not include analysing client's behaviour in terms of a case formulation of their offences, and supporting the implementation of strategies to directly challenge offence-paralleling behaviours. This may have been due to differences in training, as both males in the current focus group did not have post-graduate training. Despite this, a wide array of responses to a range of client presentations and ruptures that might emerge were discussed. Some of the discussion also highlighted that therapists may be unaware of their own contributions to ruptures, particularly when they might genuinely perceive that they are being helpful to the client and are implementing the best strategies that they know.

Focus Group Seven - Memo

The seventh focus group comprised three psychologists, a male and two females. There was one female aged thirty-six years old with graduate qualifications and the other was thirty-four years old and partway through her post-graduate qualifications. Both had delivered offending behaviour programs for about seven years. The male had post-graduate qualifications in developmental psychology and had been delivering offending behaviour programs for eight months. He did not give his age. They were all currently delivering offending behaviour programs in a prison-setting. This focus group continued to verify findings from previous focus groups, particularly around the therapeutic alliance (TA) in offending behaviour programs, participants’ experiences of specific ruptures and issues relating to gender.
The relevance and importance of the therapeutic alliance in offending behaviour programs

Participants were provided with an overview of what previous focus groups had described in relation to decisions on what tasks should be undertaken in group. This included utilising the assessment process to deduce dynamic risk factors, individual difference characteristics and learning style. The manual would then be consulted to guide session content, ensure that learning objectives were being translated into appropriate group activities, and that responsivity issues were accommodated. In running sessions, group dynamics need to be accounted for to respond to how clients are interacting and clients might also raise issues based on their current experiences. Therapist factors also determine what tasks are run, such as skill-level, confidence, whether they have a co-facilitator and the nature of the relationship with them. The final therapist factor presented was a therapist’s beliefs around how change occurs in clients, and this has varied in previous focus groups from those who are committed to creating dissonance and effecting therapeutic change through relationships in treatment, to those who focus on presenting program material. Therapists who adopt the latter may also challenge clients, but building good rapport might be prioritised over this. Participants agreed that these factors seemed relevant in relation to determining the tasks that occur in a group session, and the younger female suggested that part of what drives your approach is also the nature of the program and the time you have available to achieve outcomes. A discussion then occurred around when it was important to challenge clients and when it was not. The male stated that it would depend on your level of rapport with a group member and the older female added that it would also depend on the importance of the issue, whether moving on from it would mean group member still ‘get’ the rest of the program or you would likely get increasing resistance without any substantial treatment benefit. In discussing challenging, there was agreement that timing was important, and things need not be dealt with always as they arose but may be re-visited at a later time and perhaps individually.

Supportive factors were then raised, which comprised the type of supervision experiences people have but also debriefing and preparation with a co-facilitator around who does what in a session, the types of difficulties that might be experienced and strategies to assist with these in the following sessions. Organisational supports were also presented as a consideration to program delivery, including whether staff are supportive, logistical issues (such as room availability), competing demands (such as methadone dispensing times), as well as the policy and resource contexts. This latter included treatment options, which the younger female raised a number of times, particularly her frustration in relation to the limited number of treatment programs that were available and that often there was not capacity to, say, work individually with someone to get them treatment ready. Discussion with peers was also presented as a potentially important factor, particularly for those therapists whose supervision arrangements are not adequate or if there are problems in the co-facilitation relationship so debriefs are not adequate. These supportive factors were presented as key to the development of strategies to deliver subsequent group sessions. The older female suggested that of these factors, informal debrief was key, and there was discussion around problems with either single facilitation models or if co-facilitators articulate difficulties in their working relationship that do not get resolved or refuse to debrief after sessions. The younger female then raised that a consequence of experiencing difficult groups when unsupported is that you can internalise the experience and think ‘I’m the worst psychologist’. When asked about the importance of supportive factors, the older female added that the quality of preparation time was critical and the younger female added
that enthusiasm was also important in program delivery.

Issues around the development of goals was then presented based on previous focus groups who had determined that goals are driven by dynamic risk factors but they can also be driven by client needs or issues. They also need to be owned by clients, so be relevant and achievable. They may also change over time from participation in group to more intrinsically motivated issues. There was agreement around these assertions in the current focus group and then a discussion around the importance of having treatment readiness issues as goals too, particularly motivation, and that programs might at least shift clients along the stage of change.

Issues relating to the therapeutic bond were then presented. In previous focus groups participants would often talk about the need to have a strong emotional connection with the client but it needs to be a working relationship. Empathy, finding common ground, being transparent, being genuine, demonstrating understanding have all been raised as important positive therapist characteristics, although trust has often been identified as a key issue. Current focus group participants also agreed with these notions. They were then told that a point of difference between previous focus group participants has been on issues relating to the strength of the bond described, with some stating that they need a level of detachment because if they are not emotionally involved or invested, then they are better able to challenge the client. Whereas other focus group members have commented that they need a really solid relationship to be able to challenge clients. The older female commented that she thought she could be both, that ‘I still feel myself as detached, as the observer, as that person. But I still see that in terms of having that empathy, and that trust, and that transparency, it’s being able to actually, umm, have the client feel some connection with you’ and the reason this latter was important was due to clients often having ‘many issues with trust’. As in various other focus groups, this pointed to the importance of interpersonal relationships within treatment, particularly due to clients having often experienced negative relationship histories. The male then suggested that a level of detachment might be helpful in challenging clients, but you could not challenge clients without a level of empathy. There was further discussion that to do so would be disrespectful. The younger female then commented that either extreme, of being detached or empathic, was probably not going to work. When it was suggested that those stating they needed to be detached did so in order to remain professional, she commented that she saw this rather as ‘having good boundaries or a strong sense of what you’re there for’ and not having therapists’ own needs being met within group. She then added that all of the positive therapists characteristics raised in relation to the emotional bond aspect of the TA were required to challenge appropriately in addition to having an appreciation of the level of self-disclosure you are comfortable with as a therapist. The older female stated that for her trust and respect were key, as without these any challenge would appear meaningless to clients.

The types of ruptures that occur

A range of difficult situations that can potentiate ruptures in relation to co-facilitators’ behaviours were discussed throughout the focus group session. The older female commented that where two facilitators have different ideas about program delivery, this can create conflict. While one is happy to go ‘off track’ and challenge clients, the other might be more content driven and believe it’s important to cover all the material required. She went
on to say that this can confuse the clients, who might have one facilitator who encourages open discussion and elaboration, and the other who wants clients to ‘stick to the topic’. She later pointed out that differences between co-facilitators in their level of disclosure could also create difficulties in the co-facilitation relationship. Problems in program delivery when co-facilitators deliver material in a monotone and uninterested way was also raised by the younger female. She mentioned a group in which clients had said in relation to her co-facilitator that ‘I cannot sit through her voice anymore!’

'External factors', client and therapist factors were all presented as sources that might create difficulties in the TA. A range of specific examples were raised by current focus group participants. These included things said by therapists that might offend clients, things that might have occurred within prison units between clients that are then brought into group, and 'stronger personalities' dominating a group. These highlighted the importance of creating a level of safety in group programs and the problems that can be created if clients sense that what they say will not be treated respectfully or that it might even put them in physical danger from other group members. Difficulties experienced with inexperienced therapists were then discussed. The older female noted that in her early experience of group delivery 'I didn't challenge much, and the group just went to south, and there was a couple of dominant people that just got away with it'. Comment was then made that previous participants in focus groups who were less experienced seemed to be trying to survive the experience. The male then concurred with this notion, and talked about the importance of group mix to assist the situation, as his first group experience was difficult as it was dominated by unmotivated clients. Difficulties with single facilitation models were also raised, and the younger female commented that you do not know what all group members are doing at any one time in those situations, which can be problematic.

A particularly difficult group experience in which multiple ruptures occurred within the program was described by the younger female. She explained that 'Very strong personality disordered people (were) in the group, very resistant, very not motivated', and her original co-facilitator was absent much of the time due to personal problems. She therefore had a number of people assist in co-facilitating, and in one of these sessions her senior came to sit in the group. At one stage a group member made a move to 'gang up on someone' but she told them it was not appropriate and to sit back in his original seat. In response to the dissatisfaction he expressed, the senior said 'Oh how old are you?' which the client took as 'a massive sign of disrespect' and left the room. The group then 'had a sit-in' to support this client saying the senior should apologise, which she refused to do, saying rather that the client was the one who should apologise. At lunchtime, the participant approached the client who had stormed out and when asked if he would apologise initially stated 'well I'm not doing that, it's her fault, she showed me up'. Eventually he agreed to come back and apologised to the group, but another group member said he was not happy with him having to make this apology. At this point she called the group off for the day after a small debrief. She stated of this situation that 'when it's your senior who has done this and caused massive chaos within the group, but who still thinks they've done the right thing' and blamed the participant for not challenging the group enough, this made the situation even worse. It had already been a difficult group and 'It was very uncomfortable and I kind of felt stuck'. This exemplifies problems not only in the co-facilitation relationship, particularly when there are challenging clients with highly antisocial tendencies, but also issues relating to staff ranking.
The older female also described a very difficult group experience she had delivering her first group program to women. She was unaware at the time that two ‘prison heavies’ were in her group of twelve, which eventually reduced to three (two of which were the ‘heavies’) due to their intimidation of other group members. She said that as she was still relatively new, ‘clingling’ to the material, and ‘made the mistake’ of referring to her manual during a session. When she asked one of these ‘heavies’ a question ‘she’s just gone “You just think you can read from a text book, rah rah rah” and basically got up and was about to punch me’ at which time she terminated the session. When asked why she thought the client had such a strong reaction, the participant stated that she had challenged her on a number of things and asked a difficult question. There was then a discussion around experiences of working with women in general, and there was agreement that there is a tendency for some women to be direct in their criticisms within groups, and while men generally follow a prison ‘code' of not attacking female therapists, female clients may not share this. In further discussion, the older female stated that the times she has felt unsafe in prisons have been in women’s prisons, and she described an exchange she had with a woman in an orientation program she was running on prison drug programs, ‘she was just sitting there staring, and you got that feeling in the back of your neck, and she's just looked at me and said 'Has anyone ever hit you in one of these groups before?’ And it was like “No, but if you're thinking about it, maybe you should leave.”’ Further comments relating to female clients were that they have a greater tendency to push boundaries, such as asking for personal information from therapists, and that when faced with female therapists there is an element of ‘competitiveness’ that potentially has them respond in some of these particular ways. These situations highlight some of the extreme aggressive responses clients might demonstrate and interpersonal difficulties as a significant source of ruptures. The male said he wasn’t able to really provide comment on gender and group facilitation at this time, as there was nothing evident in the groups he had run that he could speak to on these matters.

**Strategies to repair ruptures**

Similar to the last focus group in discussing how to respond to clients that are not motivated, the older female stated that if they articulate that they just want their certificate, she sometimes 'makes them the expert' and poses to them that 'These guys can definitely learn from your experience' so ‘it's bringing them into it'. She also commented that she would probably do more processing in these situations, commenting on body language, particularly so these clients to not ‘attack’ other clients and allow those who are motivated to feel it is okay to contribute. In relation to shifting motivation, an interesting example was brought up by the older female who stated she had co-facilitated a program in which there were two ‘stronger personalities’ who were attempting to create difficulties in a group she delivered with female prisoners. Actions she and her co-facilitator as well as other group members took appeared to be responsible for making significant shifts in this group. She stated that she and her co-facilitator were consistent with the ‘stronger’ females and although acknowledging the inappropriateness of comments made, they ‘didn't give them too much air time’. As one of them repeatedly attempted to discredit the therapists by saying 'what would you know', they would respond that they didn't know and put issues back to the group. The group members themselves also had time before these women arrived late each session to provide the direction of the group. One group member also noticed that one of the ‘stronger’ women chose a seat in front of one of the therapists, a ‘power seat’, so elected to sit in that seat herself. In the end, the ‘stronger’ women’s negative comments went ignored, and eventually they too wanted to join in discussion with the rest of the group.
Current focus group members were asked specifically what they do when they encounter difficulties within a group, and the source of this might be external factors (such as having to fast-track a program), characteristics of clients (due to 'personality' or other specific problematic behaviours) or it may be a therapist characteristic. They were told previous participants have talked about examining whether it is something about how they're reacting to the client or is it something within the client themselves. The older female then provided a range of strategies she applies when difficulties emerge: asking what's going on in the room, what might be going on for the clients (such as in the prison compound), are they sitting with a challenge that they're angry about, and thinking about whether anything happened in the previous session. In relation to this latter, she provided an example in which her co-facilitator in a program session had said something that had only got a slight reaction during the program, but which the clients took offence to and in the subsequent session they were unwilling to engage in the session. The other female stated that she too had experienced this situation. The older female then gave another example of 'unit stuff' impinging on a program session in which some of the clients were 'trying to send a clear message' to another client who had reported someone to staff. She commented that they were unable to proceed with program material in these situations until they had processed these issues.

**Issues relating to Personality Disorder (PD) clients**

The female participants provided a range of examples relating to clients with significant PD traits. These have been signified particularly by descriptors such as 'strong personalities', 'prison heavies', and 'very strong personality disordered people' described above, most of which seem to describe traits of antisocial personality disorder. It seems that a range of professional practices described within these situations assisted in the therapeutic engagement of these clients: providing consistency in approach, not assuming the role of 'expert', ensuring motivated clients are able to make contributions by creating safety in sessions (ie. that they will not be attacked), but particularly by engaging in a lot of processing to illuminate clients' dysfunctional behaviours. Not ignoring dysfunctional behaviour and working closely with co-facilitators also appeared to be important in treating these clients.

**Analysis and outstanding issues**

The focus group participants supported much of the information presented from previous focus groups and the more experienced clinicians particularly extended previous discussions on the use of rupture repair strategies. This particularly includes behavioural strategies, such as not providing too much attention to those who make inappropriate comments as well as strongly supporting those who are motivated to attend programs. Greater detail was also provided in relation to considering that difficulties might arise from previous sessions or within prison compounds. Issues relating to the bond aspect of the TA were illuminating, particularly the suggestion that therapists who maintain a stance in which they are either too detached or too empathic were probably not going to develop good therapeutic relationships and may indicate therapists are having their own needs met within groups. Of interest was the suggestion that in programs run by women for women, an element of 'competitiveness' might be evident in this dynamic that may need attention to forge a therapeutic bond.
Focus Group Eight - Memo

Three female psychologists, two aged twenty-eight and one aged twenty-six, participated in the eighth focus group. One had post-graduate qualifications in clinical psychology, one had obtained registration as a graduate, and the other was a Masters student in Criminology and provisionally registered. All had been delivering offending behaviour programs in prisons for three years, and two were currently delivering these in a women's prison and the other in a male prison. Further verification of previous focus group findings occurred in this focus group and then there was a particular focus on issues relating to personality disordered clients. This focus group’s discussion particularly emphasised issues around processing and the use of psychoanalytic concepts, such as transference/counter-transference, to inform their practice.

The relevance and importance of the therapeutic alliance in offending behaviour programs

An overview of issues relating to the therapeutic alliance (TA) provided by previous focus group participants was presented. This commenced with a discussion around deciding what tasks to undertake, which starts with utilising the assessment process to deduce dynamic risk factors, individual difference characteristics (including issues relating to personality) and learning style. This information is then used in conjunction with the program manual, issues around responsivity and the length and purpose of each session to guide session content. During session delivery, therapists need to respond to group dynamics, which will be dependent on more pervasive client characteristics (e.g., introversion, level of aggression) as well as situational variables (e.g., clients receiving bad news). Focus group participants were in agreement about these factors. Therapist factors were then presented, including skill-level, confidence, and relationship with co-facilitators. Therapists’ beliefs about change were also suggested as an important factor determining the tasks therapists will bring to a group, and that these were likely based on training and supervision experiences, and for some therapists this centres on delivering the program material and for others it focuses on developing a therapeutic relationship then creating cognitive dissonance by processing client behaviours. Participants agreed that these issues shaped the tasks that occur in a group and it led on to a discussion about the impact of gender on program delivery, with the post-graduate commenting that when she was delivering the same type of program in a female-setting, this aspect had to be considered in how the program was run. In further discussion around the impact of male and female co-facilitation pairs the provisional psychologist then commented that she had worked with two male co-facilitators at different times, and one modelled good prosocial relationships between males and females in that relationship, and one did not as he appeared to want to befriend clients. This latter experience was contrasted with one in which she had delivered a seven-month intensive therapeutic program with another female co-facilitator with whom she said she was very comfortable discussing her own reactions to the program experience.

This discussion then turned more generally to supportive factors, such as debrief and preparation with co-facilitators, supervision, and support from colleagues, and how these also assist in shaping the range of tasks undertaken in group through feedback on clients’ responses as well as dealing with clinicians’ reactions to these. Organisational factors, including logistics (e.g., room access, methadone dispensing) as well as policy and resources might also impinge on what tasks are run in group. A discussion then occurred on how
therapists negotiate program times around canteens, musters and methadone, can have a positive or negative impact on the therapeutic alliance. Specifically, if therapists are seen to be understanding and flexible, as opposed to rigid, in their outlook then this can assist the therapeutic relationship. The post-graduate in particular commented that ‘if the clinician’s understanding, in terms of trying to accommodate and compromise, it can go positively to promote change, but whereas if there are absolutely no alternatives and one can be rigid in terms of what they need to do, it can really create anger or perhaps conflicts within the relationship’. This then led onto a discussion about the difficulties clients can have in verbalising difficult interpersonal responses they have within groups, and so strategies to avoid creating these difficulties, such as pre-group negotiation to have clients’ needs met, can be useful to avoid some of this potential resentment. The provisional psychologist then commented that it was her belief that there were opportunities, even in psycho-educational programs, to undertake process work in order to promote client therapeutic change, although it was only through increasing experience and confidence that she had come to this realisation.

There was brief mention that the goals of offending behaviour programs clearly centre on dynamic risk factors and then issues relating to the therapeutic bond were presented. Trust was described as underpinning the relationship, particularly as without trust clients would not engage in the group, and demonstrating empathy assists in the development of trust. In situations where a therapist finds it difficult to be empathic towards a client, previous participants have commented that they would hope their co-facilitator could achieve this. The need to develop common ground with clients was also seen as an important aspect in developing a bond with clients, and this is partly done by being transparent and genuine. Demonstrating understanding and respect for the client has also been critical to developing a strong connection, and the better the connection, the more likely tasks, goal and bond will work together to lead to better outcomes. There was agreement amongst current participants around these suggestions and the youngest participant stated that ‘I think trust is it all, if I haven’t got that or some commonality for being there, then what are you doing there?’ The post-graduate further stated that being transparent is very important, particularly in a correctional setting where information about program participation will be passed on to the parole board. Ensuring clients have a clear understanding of what information will be passed on and that there are limits to confidentiality, particularly in relation to therapists’ obligations to maintain the good order and security of a prison, were then discussed as an important issue to relay to clients in an open manner. The youngest participant also commented that clients’ trust is also developed by them observing how issues are managed in a group, and whether they feel difficulties are managed in a fair and consistent manner. Managing clients’ anxiety was also raised as an important issue, with the provisional psychologist commenting that it can be important to forewarn clients that personal issues will be raised, articulating the emotional responses they may experience to these, and flagging strategies that might assist them manage their responses.

The types of ruptures that occur

Within the context of discussing how some clients have difficulty articulating their anger, and that this can lead to unexpressed resentment within the group, the post-graduate brought up an example of a rupture. She described that a client had a ‘bad’ day during one of the session times, so told the facilitators she was going to the medical centre. When the therapists confronted her later that she would not have missed the session to attend a
medical appointment, she retorted that it didn't seem fair that she was taken to task on this when she was having a genuinely difficult time, given that another group participant was regularly allowed to pack up her 'special spends' during group time. She said 'so for her it changed the whole perspective of how she perceived the group and how she perceived the facilitator, and I think sometimes if not spoken, it creates a lot of tension in the group, and it's difficult for the clinician to deal with'. The provisional psychologist added that non-verbalised anger might also be demonstrated as 'sarcasm or trying to spoil what's been done, it's expressed in all sorts of ways'. Comment was also made that clients' not trusting what information clinicians will be passed on to the parole board might result in them withholding personal information and thus limiting the therapeutic gains to be made.

The youngest focus group member commented on a number of therapist factors that might contribute to ruptures. Confidence about delivering particular group tasks and having to deliver the required content within the given timeframe, particularly for a pilot program she was running, were factors she had to deal with. She stated that 'You've got a certain objective to meet and you've got to deliver the content, but if you don't process it, it can compromise the content, and you haven't got enough time. It can be difficult to balance the two'. There was then a discussion that a therapist's emphasis on processing might come down to their confidence in undertaking the task, which may be related to their personality, training, and supervision experiences. Co-facilitators attempting to get this balance was seen as a critical issue, as this participant commented she had also been in situations in which you 'do too much of the process, and losing the content'. Alternatively, the provisional psychologist suggested that 'if you’re talking about interpersonal role taking', it's sometimes perhaps therapists' avoiding the discomfort of process work that has them not want to undertake it.

In describing a negative co-facilitation experience, the provisional psychologist said that her co-facilitator colluded and befriended clients, by being 'buddy buddy' with them, so an 'us and them' division between her and the male co-facilitator/clients evolved. This type of splitting in a group can be detrimental to all aspects of the TA, as it suggests a lack of cooperation and respect between the therapist, her co-facilitator and the clients.

Strategies to repair ruptures

The central strategy discussed within this focus group to repair ruptures revolved around processing issues while being honest, transparent and inviting the client to change their behaviour. A range of specific situations were described within the context of talking about personality disordered clients, and are outlined below.

Issues relating to Personality Disorder clients

When participants were asked to discuss developing a TA and responding to clients with personality disorder (PD) traits, the youngest participant stated that she was working with a lot of Borderline PD clients in her current female group, and this could be challenging at times because of their frequently changing presentation. Some days they could present in a 'foul mood' because of 'external factors, so something's happened in the compound' and they may not want to talk in group. These same clients may be supportive and contribute well in group at other times. When asked what’s useful to respond to this, she said that in
her current group they commence by each participant 'declaring their emotions', which assists in determining 'where they're at' and an opportunity to ask 'what are you going to do about that, how are you going to manage that today?' and how the group can support them. This participant went on to say that 'I think they find it helpful just to say it'. In other groups, if there have been ongoing issues, talking to them individually to see how their difficulty can be managed collaboratively but posing 'this is coming up, what's going on for you, how can we solve this together, and how it's impacting on us.' This participant stated that this has usually assisted the situation although less so with more anti-social clients, as 'it depends on whether they care that they're effecting the group'. She commented that they have removed people from group if their behaviour is not rectified and it's impacting on the group in a negative way. Further discussion around processing client difficulties occurred when the provisional psychologist was asked how she responded to problems. She commented that 'I always try to slow it down, so I have time to think about it and try and understand what's going on, and that can be really difficult if you're in the thick of it'. She went on to discuss a client who responded negatively to her in her intensive therapeutic program. She stated that she vividly recalls 'sitting in the room and having him berate me, just berate me, and my heart pounding in my chest, and just being able to sit there and tolerate that.' She described mainly resisting the urge at 'snapping back', and suggested he was maybe feeling 'discomfort' and wanted to make her feel 'bad' to distract from this. She described how after 'persevering' with processing their interactions, his behaviour improved, and in a post-group follow-up session he apologised for his poor behaviour towards her. In discussing some of the difficulties in responding to this situation, she said his offending involved stabbing, and this is how she experienced him in group, like 'he was constantly jabbing me, needling me, trying to get me to bite back. And there were times I'm sure I wanted to go like this, and I probably did it at different times'. The post-graduate then suggested that sometimes clients' behaviour is about 'testing the water' to see how therapists will respond, but it's the therapists' roll to 'be patient and roll with the resistance and see what's going on and allow a bit of leeway. I think that's where the flexibility comes in place. Obviously if they're being really behavioural and disrespectful then I think it has to be called on the spot'. This participant when on to discuss that in responding to Borderline PD clients whose presentations continually change, its useful to provide feedback and structure, particularly with responding to more concrete thinking styles. She stated that 'I think by itself by providing that feedback, and being reflective of your experience, by saying “when you do that, I wasn't sure what was going on, it's kind of confusing...” and it gives them the opportunity to be able to be reflective of their behaviour, sometimes they're not aware'. She articulated that pointing to the likely consequences of their continuing behaviour is also an important aspect of this as 'it communicates your expectation as facilitator about certain behaviour in the group' but shifts in their behaviour may take time. She then described a situation in which she had apologised to a client for some processing she had undertaken in which she was attempting to be empathic but the client had responded defensively and that 'sometimes we do have a discrepancy too, between how we think we are presenting and how other people perceive us. So I think sometimes it's about us being able to be honest to ourselves, and accept perhaps it didn't work, and invite the client to tell you what works for them'. She further commented that apologising might be perceived by some as creating a power-imbalance, in which the therapist loses power, however it also provides an opportunity to address ruptures and model resolution of difficulties with authority figures. The youngest participant then commented that when working with PD clients, they are 'up and down' and often 'testing' the relationship and seeking previous responses to their behaviour, but trust can be developed by being consistent and providing feedback. These new relationship experiences then provide clients the capacity to develop more functional relationships outside of treatment. This led on to a discussion about the importance of
attachment experiences, and the provisional psychologist commented that corrective emotional experiences provided during program sessions do try to re-shape these poor attachment experiences. In further discussion about a Borderline PD client who was in her intensive therapeutic program, she commented that this client would mock her in sessions, but when in debriefing and supervision she came to the realisation that she strongly disliked this client for making her program experience so difficult, this improved her ability to be able to respond to him. She then talked about the importance of acknowledging difficulties with clients, and identifying their early relationship re-enactments and 'if you’re able to link what’s happened in the group, with their offence, with their relationships, if you can manage to pull all that together, umm, that can be really compelling.'

When asked about how they find working with PD clients, focus group participants commented that it could be difficult, because of the changing presentations and attempting to develop good case formulations with complex clients, but very rewarding when you developed an understanding of their behaviour and could assist in promoting therapeutic change. When asked about what was most difficult in dealing with these clients, focus group participants discussed understanding and responding to transference and counter-transference. The importance of debriefing, supervision and organisational support was also raised within this context, and the post-graduate commented that it was also incumbent on therapists to be open and honest not just in treatment but also within their teams in order to promote good work environments. In further discussion she commented on being able to actually capitalise on differences in therapists' experiences, perspectives and ways of working, and that 'the differences actually make it great'. Some discussion then occurred on how analysis of transference and countertransference can provide rewarding experiences not just to facilitate client change, but also therapist change, for example 'If you’re really rigid, you learn to be flexible'. The provisional psychologist then commented how clients sometimes demand levels of self-disclosure from therapists, particularly in light of the level of self-disclosure they are required to engage in. She commented that some therapists do this in a superficial manner, but in her intensive group she modelled being reflective of her own experience. There was then a general conversation about how it was unavoidable to not reveal aspects of yourself as a therapist within a group, but the post-graduate also observed that one had to also be insightful about why they self-disclose.

Participants were then asked about the utility of the TA concept in working with PD clients in offending behaviour programs. The provisional psychologist said she preferred to conceptualise it as 'group process' due to the complexity of relationships within a program although the other focus group participants commented that they did think it was useful. This was particularly the case for the post-graduate who commented on the parallels between the TA and empirical evidence relating to the common factors of psychotherapy.

**Analysis and outstanding issues**

Focus group participants were in agreement with a range of findings presented from previous focus groups, including tasks being derived from the manual, client dynamic risk factors and individual difference characteristics as well as therapists' beliefs on how clients change, which may either emphasise delivery of group content or on creating dissonance through process work. The importance of the co-facilitation relationship was again emphasised. The post-graduate also suggested that differences in co-facilitation technique
and style could actually enhance the therapeutic relationship. This final point is an important one and poses a question around the extent to which clients might benefit from a variety of therapist skills and techniques, and whether different client characteristics respond better to different therapist characteristics.

The current focus group articulated a strong reliance on engaging in process work to both develop the TA and respond to clients with traits of PD. This was particularly evident in their emphasis on analysing transference and counter-transference as a means of responding to ruptures. The older graduate in particular embraced psychoanalytic technique in her description of observing and responding to relationship and offence re-enactments. This is an interesting finding given the emphasis in the literature on cognitive behavioural techniques being most effective in offending behaviour programs but invites the possibility that psychoanalytic techniques may be useful in conjunction with these programs. Consistent with other focus groups, there was also an emphasis on the types of therapist characteristics that promoted the development of the bond as well as assisting in repairing ruptures, such as being honest, genuine and respectful in order to develop trust within this process work.

A large part of the discussion revolved around how to respond to PD traits in group. This conversation was similar to other focus group discussions on responding to ruptures in general, which suggests that good practice in responding to difficulties in the TA may be transferable between both situational difficulties with clients as well as those more pervasive difficulties that might occur in clients with a PD. Further exploration of this notion, however, is required.

Focus Group Nine - Memo

Two female senior psychologists participated in the ninth focus group. One was aged sixty and had nineteen years of experience delivering both offending behaviour programs as well drug and alcohol services. She was currently overseeing offending behaviour programs in a maximum security prison. The other was ‘in my fifties’ with seven years of experience in corrections as well as several years of experience prior to that also in drug and alcohol services. She was a senior clinician in a medium security prison. Participants in this focus group, as in the past few focus groups, were asked to verify a range of findings, although a number of related topics were introduced around the therapeutic alliance. This included discussion on the types of motivation staff might have for undertaking this work as well as working with cultural diversity. Similar themes were derived from participants to previous focus groups although there was some emphasis on the need for therapists to be realistic in relation to expected changes within clients and the importance of being genuine and authentic within therapeutic relationships. This latter was described particularly when working with personality disordered (PD) clients, who may attempt to manipulate therapists.

The relevance and importance of the therapeutic alliance in offending behaviour programs

Participants were advised that previous focus groups have emphasised the importance of realising program manual objectives by attending to responsivity issues in order to shape
decisions around the types of tasks that will be undertaken, this includes issues around literacy, stage of change and intellectual functioning. The importance of a therapists beliefs on the mechanisms of change, with some emphasising the importance of delivering program material whereas others have focussed on the importance of creating cognitive dissonance and effecting change through the therapeutic relationship, was also presented. When asked about their views on this, the senior from the medium security prison stated that she thought there was a need when delivering violence programs for cognitive dissonance, but 'I think it's quite an art and a professional skill to make judgements about how much dissonance to create and when to pursue the challenges'. In this context she articulated that therapists should be discerning in relation to when they create dissonance based on both the stage of a group, so not issuing challenges early in a program before clients are engaged in the therapeutic process, as well as taking into account individual differences of group members' levels of engagement. The other participant concurred with this, also adding that at her location where clients are not necessarily 'treatment ready', that creating cognitive dissonance is also important but that the focus may be initially on the development of a therapeutic alliance (TA). She commented that 'it takes a lot of knowing and knowledge of that individual client' to do this skilfully. Both focus group participants commented that individual work with a client can play an important role in developing a client's confidence and trust in being able to attend a group, plus the culture of a prison was important. Interestingly, when the medium security prison senior discussed this, she mentioned clients doing homework on tables within the prison unit, carrying books around, and a belief within her unit that programs are 'okay to do', as evidence of a positive culture, but this suggests an educational aspect to the culture. The senior from the maximum security prison stated that due to the nature of her location, in which clients might be early in their sentence and not treatment ready, the focus was on developing positive relationships with clients even informally prior to their being invited to attend a group. This then led onto a discussion about the importance of therapists being seen within prison units and interacting more informally with prisoners, to not be seen as 'experts', and the view that this also assisted in the development of the alliance. Comments were also made within the focus group that the development of the alliance was always critical within any therapeutic relationship, and may come about by eliciting small changes within clients that signify increasing engagement, such as a smile, eye-contact, or brief conversations. Part of the rewards of working within a correctional environment were these small changes, which might lead to circumstances in which confrontation about clients' dysfunctional behaviour was possible.

As in other focus groups, a range of organisational responses were raised to assist therapists. The use of supervision was discussed at length, as well as co-facilitators assisting to 'balance' out a group, particularly when a therapist might dislike a client. When asked what assists younger therapists when they've had difficulties in their groups, the senior from the medium security prison stated that as soon as possible, and hopefully immediately, they should debrief about difficult situations so they are allowed to express their emotions about the situation, have their experiences normalised and validated, be provided with a level of analysis in relation to what had occurred and reflect on 'How do you want to manage it next time?' This should provide them with some confidence and practical means of responding to similar situations in the future. The other senior then also pointed to the importance of 'creating a culture in your team or in your environment in which you can allow to admit to mistakes, or indecision, or lack of confidence about that', and then there was some emphasis on the utility of peers also assisting with supporting staff by sharing their own experiences.
When asked what might assist staff to become more adept at responding to difficulties in group programs, the importance of offering professional development activities that might provide other theoretical perspectives that can enhance practice was discussed. In further discussion around strategies to keep clinicians 'keen', the senior from the medium security prison suggested that swapping around co-facilitation pairs could be valuable in developing skills, particularly to 'bring out your strengths or offer you an opportunity to take a lead'. A range of other broad strategies to ensure staff are not burnt out or impacted by vicarious trauma were discussed, including having staff undertake a range of tasks, ensuring that caseloads contain a variety of presentations (and not just difficult clients), and promoting self-care.

**The types of ruptures that occur**

In relation to being asked why therapists choose to work in correctional environments, a range of examples were provided in which potential ruptures were implicit. Although there was general agreement, based also on observations from previous focus groups, that therapists are essentially trying to 'do good' in the delivery of programs, the senior from the medium security prison stated staff need to be realistic about what 'doing good' means in correctional programs. This is particularly in relation to their expectations around change that clients might elicit, and presumably frustration that occurs when unrealistic expectations are not met. The senior psychologist from the maximum security prison described a situation which exemplified this, saying that she had observed a couple of therapists 'become colder and withdrawn and not actually really responded to the person, so they've had a shift in the way they treat the client' when clients had not conformed or behaved in a way therapists had wanted. The senior from the maximum security prison stated that sometimes people wanted to work with 'dangerous people from the other side', or to 'save people from themselves' which she found concerning. Similarly, she expressed a problem also with staff who feel responsible for shifts in clients' behaviour, emphasising that therapists might assist in the link to facilitate change, but they themselves were not responsible for either 'clients successes or failures'. These examples perhaps suggest that therapists in these circumstances are seeking something from the therapeutic relationship to meet their own personal needs, which threatens their ability to work effectively with the client.

When presented with some of the difficulties commonly experienced by younger less experienced therapists that have been discussed in previous focus groups, particularly when they are attempting to learn the material and trying to 'survive' the experience, participant concurred that this could be a problematic time for staff. The senior from the maximum security prison noted that this was particularly the case because they often set out to present the material, and attached to this is some 'anxiety' around ensuring this occurs as planned. When things then do not go to plan she had observed some therapists 'get angry and really take their anger out by being punitive in how they respond to questions or behaviour they believe is not appropriate' within their group. She went on to say that this response might have been 'a little bit about their personality and perhaps not being more self-aware and willing to perhaps look at their own triggers'. Additional comments were also made in cases where therapists do not get on with particular clients in groups, as 'it can really rail-road a group if the group then sees someone being scapegoated or overly criticised'. Two additional points were made in relation to this issue: firstly, the impact of therapists having negative interactions with clients is that this information 'ripples' out into
'the community' and may then have prospective clients not wanting to attend treatment with particular therapists. Secondly, the importance of therapists being open to feedback was discussed, and the senior from the maximum prison stated 'That's probably the most important thing, if they're not willing to take on feedback or reflect on their own behaviour or own attitudes, if they're closed off to that, that can be really difficult'.

A range of additional ruptures are outlined below in relation to clients with a personality disorder (PD). These include clients misrepresenting themselves or making unreasonable requests of therapists, as well as therapists feeling 'special' within a therapeutic relationship, wanting to be liked by clients, feeling that they are responsible for clients' behaviour, or responding due to concerns relating to their duty of care.

**Strategies to repair ruptures**

Specific strategies to repair ruptures with PD clients are outlined below and include: clinicians being wary of clients' motivations for their behaviour, exploring clients dysfunctional behaviour and how they might achieve the function of this in more prosocial ways, demonstrating commitment and developing common ground, being genuine and transparent within the relationship, being clear on the limits of the relationship, communicating with staff and within teams about treatment, modelling appropriate behaviour, utilising basic behavioural strategies to promote target behaviours by using positive reinforcement and not reinforcing unwanted behaviours, being honest and assertive with clients (not agreeing to provide what cannot be provided), promoting self-reflection, assisting in the resolution of long-standing problems, the development of trust, improving relatedness, providing 'advice' and assisting in problem-solving practical problems.

**Issues relating to Personality Disorder clients**

Discussion around PD clients commenced by exploring staff interventions with clients demonstrating psychopathic traits. Comments elicited by some participants in previous focus groups were presented, which included that although difficult to do attempts should be made to develop an emotional connection with these clients. Current focus group members cautioned against this, commenting that staff needed to be wary about whether any emotional connection developed within this context was genuine and not being used to take advantage of the therapist. The senior from the maximum prison stated 'I think you have to be fairly sophisticated when you do that because you may actually just be buying into how they're presenting and there's no genuine feel to it, it's very questionable'. She also commented that focussing on the behaviour of these clients, and particularly assisting them develop prosocial means of achieving the functions of more dysfunctional behaviour, was more appropriate than focusing on, say, empathy when they clearly demonstrate difficulties in this area. The other focus group participant also commented that all therapeutic relationships require a degree of rapport building and therapeutic alliance, however within this context it requires 'a border', to which the other participant added that therapists needed to be aware of 'all the different layers that's going on there.' This was particularly demonstrated by their observations that psychopaths tend to present well in a custodial environment, and may impress a range of staff. This led on to a discussion around how therapists’ may have difficulty in identifying the problematic and manipulative aspects of these clients’ behaviours, particularly if they perceive that they have a special relationship with the client and/or want to be liked by them. The senior from the maximum security
prison commented that a couple of her younger staff have been involved in experiences such as this. In further discussion, however, there was agreement that it was a common experience for therapists in correctional settings to have a lack of awareness of the reality of a clients' situation due to the manner in which they portrayed themselves, and that focus group members also at times in their career had been 'hooked' into situations or felt they'd been 'played'. Focus group members concurred that to be effective when working with clients who have psychopathic traits, therapists should be wary of the difficulties these clients may demonstrate, but develop a commitment to assisting them therapeutically as well as being genuine and transparent about the nature of the relationship and expectations of behaviour.

The challenges for therapists working with Borderline PD traits were discussed. The senior from the medium security prison commented that in her environment, where staff are able to see clients individually, dealing with the 'neediness' and ensuring some boundaries are placed on the amount and frequency of contact could be particularly challenging for early career staff. She stated that staff could sometimes feel responsible for clients' problematic behaviours and also might be concerned due to issues relating to their duty of care. The other senior then commented that these clients could elicit a lot of anxiety in staff but basic behavioural strategies should be applied to assist, so when Borderline PD clients are engaging in antisocial or self-destructive behaviour, less supports should be provided and when they are engaging in appropriate strategies, more support should be provided. Further conversation included the importance of developing a time-limited treatment plan, having role clarity on the nature of engagement with the client, and providing clear communication to the therapist's team and custodial staff around this. It also requires the development of an authentic relationship in which therapists need to be transparent and honest, 'but very clear about what you're doing in terms of the context of that contact, whether it be through group or individual'. The importance of modelling appropriate behaviour, and developing therapists' confidence in being able to say 'no' to clients and not respond to unreasonable requests was also discussed within this context. When asked if they could describe examples of client gains in their experience, the senior from the medium security prison stated that one client in particular, who had psychopathic traits, had more recently done a lot of work in exploring difficult areas in his life and making subsequent changes in his behaviour. She then went on to discuss how many clients who had developed an 'impulsive disagreeing response' were assisted by the development of a TA and capacity to have ongoing engagement so they could better reflect on their behaviour and build trust so that long-standing issues of trauma could be addressed. The other senior reflected that it was different at her location, but the changes she had noted in a number of her clients involved them reducing their involvement in institutional violence or other problematic behaviours. Over time she had noted that 'they're more ready to come and express an opinion and get some feedback'. The development of trust was seen as critical to this work but also that the clients valued the feedback as well as being able to seek advice on a range of issues. She also commented on the importance of 'being authentic in the way you present and that you're consistent and that you are not something other than you're presenting, because they're very good at looking for the inconsistencies or the flaws, you know, the judgements, and if they feel that you're not judging them but you might be reflecting on what they're doing, and providing a view on that or reinforcing positive behaviours, but you're not judging them as being something other, you know, the other'. The importance of generalising skills from group treatment, into the prison, and then into
the wider community was emphasised, particularly as an important issue for PD clients. This might include encouraging appropriate relationships with people in authority. An additional point was made in relation to clients sometimes seeking advice, and that particularly PD clients may simply have lacked exposure to prosocial means of responding to difficulties. Helping them in different practical ways, such as encouraging them to write letters to the parole board to describe their current situation, might assist them.

Focus group participants were then asked to contrast whether the way therapists approached PD clients was the same way they might approach someone from diverse cultural backgrounds. Participants then went on to describe a number of experiences they had with this latter group. The use of experiential techniques, such as art and movement, was mentioned in conjunction with being adaptive in program delivery. This was particularly highlighted in a situation in which the senior from the medium security prison stated that a Vietnamese prisoner, who spoke English but did not write it well, was allowed to take a dictionary into sessions to assist in his participation. The importance of being culturally aware and attempting to make a connection with this group, even if they have limited English, was also raised. Some discussion then occurred around the importance of not making assumptions about the needs of different cultural groups. Some Koori prisoners, it was suggested, relate just as well to non-Koori prisoners. There was also discussion around the value of having culturally diverse groups to assist clients accept difference. There was also a suggestion that clinicians might be given detailed notes, so that at particular junctures in a program they are aware of culturally specific issues as well as how they might respond to these.

**Analysis and outstanding issues**

These senior clinicians both concurred with a range of previous focus group findings, particularly around broad support for the importance of the therapeutic alliance. They suggested that the development of cognitive dissonance was important to effect client change, but this could only be done once an appropriate level of engagement and TA had been formed. Focus group members also pointed to a range of potential ruptures such as therapists' expecting unrealistic gains from clients, their anxiety around program delivery, and an unwillingness to take on feedback about their own behaviour.

Many issues relating to PD clients were discussed, particularly around psychopathy and Borderline PD. In these discussion various behavioural strategies were suggested to assist clients, but the importance of being genuine within these relationships, communicating well with custodial staff and team members, and generalising therapeutic gains was emphasised. Some interventions also appeared more informal, and might involve giving practical advice.

It was difficult to gauge within this focus group whether there might be a qualitatively different approach taken to PD clients compared to, say, culturally diverse groups. Consistent themes emerged in discussions within these group such as needing to approach clients in a genuine way and taking a practical approach to assisting in their treatment. There is also a suggestion that PD clients require 'management' whereas CALD groups require 'understanding'. These notions, however, require further investigation.
Focus Group Ten - Memo

One male and one female psychologist, both who delivered offending behaviour programs in a prison, participated in the tenth focus group. The female was aged twenty-seven and had five years’ experience delivering offending behaviour programs. The male was aged thirty and had previously worked in another area of psychology but had delivered offending behaviour programs over the past six months. Participants in this focus group were also asked to verify a range of findings from previous focus groups and, similarly to the Focus Group Nine, were invited to discuss the types of motivation staff might have for undertaking this work and issues relating to culturally diverse groups. Focus group members confirmed a range of views from previous focus groups, particularly that the therapeutic alliance (TA) bares great importance in helping clients achieve therapeutic outcomes, and that a range of difficulties in client presentation around treatment readiness (e.g., low insight, lack of alignment with program goals, paranoia, offence attitudes) may be assisted by having a strong co-facilitation relationship, fostering group cohesion and processing difficulties with clients.

The relevance and importance of the therapeutic alliance in offending behaviour programs

In relation to the TA in offending behaviour programs, participants were told that previous focus groups have described using the responsivity principle to deliver program manuals to ensure tasks accommodate client characteristics. They have also suggested that goals centre on reducing a client’s risk of re-offending, although on occasion some goals may relate to enhancing engagement. The female responded to this by suggesting that she agreed with these contentions in the main, although preferred to couch client need in terms of treatment readiness rather than responsivity. The male then pointed to difficulties in implementing treatment readiness strategies when external factors might influence decisions around who enters programs. This specifically related to the parole board requesting clients who were not treatment ready to be included in programs, and the difficulty that this has sometimes created. This then led onto a discussion on difficult group experiences and how they are managed (as outlined below). Part of this discussion also included the male commenting on the difficulty of negotiating tasks and, as previous participants have also reflected, that particularly early in a therapist’s career, there is sometimes a tension between when to insist clients undertake a task compared to exercising flexibility and fostering rapport by accommodating clients' wishes. This appeared to reflect on the importance of ensuring an appropriate level of client engagement, and 'not giving them too much slack which you'll regret later on' when attempting to negotiate additional tasks throughout the program.

Issues relating to therapists’ approaches to their role were discussed, and these reflected comments made in previous focus groups. The female stated that there are not many rewards in delivering offending behaviour programs, but that when they come they are very satisfying and potentially have a significant impact. Focus group members then commented that an ability to empathise with clients is critical in being able to work effectively, then the female added you need to also 'bear in mind that there are victims of their offences. You can’t pussy foot around, you can’t be nice to them, it’s not about that. You need them to respect you for doing your job well and not like you'. This provides an interesting insight into the position a therapist might take in their role, and is reminiscent of previous focus group
members’ comments on developing a bond with clients. It reflects a need to balance making an emotional connection while ensuring clients are engaged and accountable for their behaviour. She added that people who like a challenge and have ‘unrelenting standards’ are suited to this role. The male participant also commented that it was important to have an understanding of the population you are working with, that this assists in not personalising attacks from clients. Further discussion reflected that effective TA development and responding to ruptures is assisted through the use of case formulation. When asked if the TA is a useful framework to use in the delivery of offending behaviour programs, focus group participants agreed also commenting that the more elements of the TA that you have, the better the outcomes. The utility of having a co-facilitator to assist if, say, you do not have a bond with a client was also reiterated from previous groups’ comments.

The types of ruptures that occur

Discussion around ruptures largely focussed on difficulties created due to clients not being treatment ready, with some emphasis on the impact of personality disorder (PD) traits on this. The female participant stated that in a group she was currently running, clients were highly suspicious of what reports or profiles she and her co-facilitators might be producing on them. She then also relayed the difficulties created in a group where a client with narcissistic traits was both passive aggressive at times during group, and ultimately said that he wanted to leave the group as he believed no one wanted him there. He appeared to feel persecuted by group members at times, and became defensive when they attempted to have him understand their perspective and ask that he listened to them. This situation is elaborated on below. One group also ‘kicked up the biggest stink’ in relation to the requirement that they do ‘hassle logs’ as part of their violence program. When asked if the participant believed that potentially this was because they perceived doing the program as punishment she did not agree, however she stated that it was a clear requirement to get parole. The other participant did believe that some clients have this view as they have stated about their program involvement ‘You’re further punished.’ In other discussion on this, an additional client attitude identified that could also contribute to a rupture was when clients believe they have already made the required changes to live offence-free and therefore would not benefit from group participation. In discussion around PD clients, one client was discussed who demonstrated a range of psychopathic traits that challenged the TA (discussed further below). He glorified violent acts and conveyed enjoyment in making others feel pain. He also tried to create a split between the therapists and the group members, by joking with the latter and being dismissive of attempts by the therapists to join in with this. The participant described being perplexed by his behaviour, and finding it difficult to identify when he was being serious and when he was joking, so interactions with him appeared to elicit confusion and tension within the participant.

A range of cultural issues were broached that impinge on the TA. More broadly, participants described clients using culture as an ‘excuse’ for their violent behaviour. One client described as demonstrating psychopathic traits was also described as having culturally-based attitudes that shaped his willingness to challenge his own views, and consequently to form a TA. The female participant explained that ‘he comes from one of those cultures where protection is expected from males’, and hence attempts at fostering the notion that his behaviour was underpinned by a value-system, rather than a ‘truth’, seemed to be intolerable for this client. The female participant also described potential difficulties around dealing with a number of Aboriginal clients in group as a consequence of their collective
culture. As a mark of respect, Aboriginal clients will always follow the lead of their elder so in situations where an elder is 'struggling with a concept or when that person is being resistant, the others feel the need to side with him and follow on, even though it might not be their view'. She described a group she had delivered in which there were three Koori men who attempted to split themselves from the rest of the group and would act like 'grown children' by doing things like drawing on each other and poking each other. A number of strategies were implemented (as described below) to assist this situation. Another difficult situation concerned a young Aboriginal client who had a belief around White people having stolen from his race, so he was justified in his offending. The male participant described that he kept drawing Aboriginal flags everywhere, 'stamping his identity', and did not believe he had done anything wrong. He was eventually removed from the group and the prison for his 'behavioural' issues. Further discussion on this suggested that his goals were not aligned with the program's goals, so continued involvement at that time was unviable. Conversely, the male participant described a situation in which a male elder in a group who was committed to his own change was also a highly positive influence on group members. Not only did it seem that another Koori client in this group was encouraged by this elder to participate more fully in this group, but he also took on other non-Aboriginal group members as 'quasi Kooris', and this was considered to benefit these clients.

A range of situations external to treatment were described that were perceived as contributing to ruptures. This included issues relating to the implementation of Program Support Officers (PSOs), prison officer-held positions involved in group delivery. These positions were recently implemented and in one group run by the female, they unexpectedly had a PSO attend the first session. Group members became angry due to perceived role conflict (that prison officers lock them up and strip-search their family). Clients being directed to attend programs due to parole board requirements was presented as another factor that might then contribute to a rupture. The male commented 'If the Parole Board says they've got to do it, they go in no matter how good it's going to be for them or the rest of the group.' This led to a discussion around how clients placed in programs in these situations were sometimes very disruptive and unwilling to engage in the program content or connect with the group members. The male focus group member described one such client who was disruptive at times and then refused to talk for a number of sessions before he was removed from the program, and the difficulty of taking this decision given that both he and his co-facilitator were new to group program delivery. He described how ‘We had to get a lot of advice from all the people sitting around us, knowing whether we're doing the right thing, and whether it's us or it's him’. This comment has been reflected in other focus groups and emphasises the constant need for therapists to explore the possibility of both the clients and their own actions contributing to a rupture. The female participant also described a situation in which she is finding it difficult to respond helpfully to a client and could not work out why he is so argumentative and will challenge her even after asking for assistance with something. She was also astounded that in reviewing group rules, he commented that 'Can we not get stuck on topics too long, and when there's two different opinions, can we just let it go?', behaviours she perceived he engaged in. She stated that she tried to remain patient with this client, but felt quite drained and frustrated by him. Further discussion of this topic included comment by the female that she believed some therapists found this role difficult if they had the wrong 'personality' and were not 'thick-skinned', so would personalise clients' behaviour. She then commented that 'if you view offenders as people who hurt other people then that's hard to work with them, if you view them as a person who made bad decisions in life, has behaved inappropriately but still has a potential to be a good person, then you can connect with them. I think it's about that. You can't have
Strategies to respond to ruptures were described that incorporated those described over previous focus groups. These involved the use of humour, motivational interviewing techniques, a range of management techniques which outlined expectations and consequences of non-compliance, promoting acceptance, validating concerns, allowing opportunities for clients to explain and be heard, respectfully challenging beliefs and utilising group members to assist client difficulties. The use of humour in particular was described by the female participant in response to group members articulating their suspiciousness around her and her co-facilitator writing reports and producing profiles on them. She stated that she and her co-facilitator realised there were only so many times they could attempt to refute their suspicions, so humorously stating that they were indeed writing reports appeared to reduce some of the group members' focus on this. In further discussion, she agreed that this was partly rolling with resistance, and that continuing to argue with them was futile, and now they were able to laugh about the situation although their suspiciousness did not disappear completely.

A range of strategies to assist in the resolution of ruptures was described in relation to a client who demonstrated narcissistic traits (further elaborated on below). These largely involved using the group members to challenge but also encourage his participation, and utilising motivational interviewing strategies to shift the client's ambivalence in relation to his participation. In response to a client that had psychopathic traits in this same group, the female participant described her and her co-facilitator making very clear at the outset that there was an expectation that participation was required, or he would be removed from the group. She believed that this ultimately encouraged his involvement. What seemed to be most helpful in these situations, however, was the cohesiveness of the group and willingness of individual members to assist in other group participants' involvement.

A range of strategies were implemented to assist the situation described above in which PSOs were introduced into a group, including specifically addressing expectations around the PSO in group rules, suggesting that they needed to work out a way to accept their involvement, and validating their concerns while remaining supportive of the PSO. The senior clinician also came into the group to reiterate that the decision to have the PSOs in the program was a prison decision and not the facilitators. She further commented that she felt the group was then willing to move on with the situation, despite occasional re-emergences of their difficulties with the decision. This was because they felt that they had been heard and realised that programs staff were unable to change the decision.

In a range of situations with clients from diverse cultures, a mix of culturally specific and generic strategies were described to respond to potential ruptures. In order to respond to potential problems created by clients suggesting that their violence was due to their cultural beliefs, both participants described having detailed discussions with clients in which they would explore and challenge these issues. The female participant in particular described the need for 'probing a bit further' and 'playing dumb', in which she would ask participants to describe in full how their culture explains their violent behaviour. She stated that inevitably
in these situations, clients would not be able to do this convincingly. A range of responses were described to respond to perceived problems in the TA with Aboriginal clients. When these clients have rationalised that their violence was acceptable to protect their families, they were challenged by therapists querying whether they were either protecting their families in relation to current offences or indeed now in a position to protect their families from prison. A number of strategies were used to respond to a group of Kooris who were perceived as demonstrating negative behaviour in a group, similar to those previously described by participants to respond to these same issues in non-Aboriginal clients. This included arranging seating so that they were not physically sitting together and discussing the importance of punctuality. In situations in which Aboriginal clients do not overtly disagree with an elder who might be articulating negative views or demonstrating some level of resistance, focus group members described it appropriate to challenge the elder in this situation, rather than other clients who are respecting their elder.

Two organisationally based strategies to assist therapists resolve ruptures were discussed. This included the importance of utilising co-facilitators strengths to take advantage of client characteristics, such as allowing quiet co-facilitators to more subtly encourage quiet clients. The use of peers and supervision to assist in resolving ruptures was also discussed, particularly having both structured supervision as well as the flexibility to have ad hoc sessions should difficulties arise that would benefit from more immediate discussion. They also suggested that there was great utility in having group supervision to provide a forum in which shared knowledge and input from multiple perspectives occurs to assist with problems. The female commented that there is also value in viewing a parallel TA with team members in these supervision contexts.

**Issues relating to Personality Disorder clients**

A range of situations were described in which clients who demonstrated Narcissistic, psychopathic and Borderline PD traits were described. In discussion about the utility of case formulation to assist with working effectively with clients, the female participant commented that this was particularly in the case of working with clients who demonstrate traits of Borderline PD. 'They’re so so difficult to work with, but when you know they’re being needy because they’re insecure as opposed to they’re just frustrating the hell out of you, you can bare it a bit more.’ A client who demonstrated narcissistic traits was described by the female. She was delivering an interpersonal skills module which involved participants learning about and providing feedback on each other’s communication skills. The group was quite well formed but this particular participant was ‘passive aggressive’ and became aggressive when negative feedback was provided to him. He eventually believed participants did not want him there and asked to leave the group. At this point she described using motivational interviewing techniques to encourage further participation with her co-facilitator, reminding him that he had said that he had not been given sufficient assistance by the system, so that this was his chance to receive it. She described a range of other factors as contributing to his ability to stay in the program: the group was prepared to challenge this client but also encourage his participation, the program was only ten sessions and they had a consistent warm-up activity in which group members had to share personal experiences. She described his ambivalence at times, and in response to his perception that he was being persecuted ‘he wanted to leave because he was quite angry and wanted it to be his way, but at the same time he wanted to maintain his positive persona’ so did not remove himself from the group. She commented though that it was not seen as ‘feasible' to
put him into a long-term therapeutic program following the completion of this group.

In discussion around psychopathic clients, the female participant discussed one client who had revealed to the group that he didn't 'feel' and he openly discussed his enjoyment in other people's pain and glorified violent acts. Both participants stated in discussion around this situation that they believed that it was important to try and achieve a TA with these clients, however it was questionable about whether you could get it, as attempting to gauge the authenticity of psychopathic clients was not easily done. This particular client also worked at dividing the therapists from him and other group members by using humour with the group and disregarding therapists’ attempts to join in on these experiences. The participant also commented that he demonstrated few facial expressions making it difficult to gauge his reactions in group and at times it was difficult to realise if he was joking. She then commented that she did not know if she had any therapeutic rapport with this client, but surmised that part of the TA must be intact as he had answered some quite personal questions and involved himself in the group activities. She commented that other clients she had with similar traits she felt she had a better TA, although sometimes they had articulated that they were interested in learning from her as she was a psychologist, to which she articulated some concern. The male participant then mentioned that the group member who was removed from his group (described above) appeared to have emerging psychopathic traits as he was emotionally cold and described the murders in which he was involved in a very matter of fact manner, 'as though he was cooking a barbeque'. Although he stated that he felt 'bad' about his offence when asked, 'he couldn't fake the emotion.' This participant believed that this client was much better off doing individual work rather than a group program. Interestingly, the female participant had this same group member in her interpersonal skills module, and stated that at this time he was a more willing participant after she and her co-facilitator provided clear expectations around participation. Focus group participants surmised that when this client commenced a violence program, he had no connection with the group. They also believed he had decided that as he had received the minimum sentence for his offences, which reinforced a belief that he had done nothing wrong, he was not interested in further group participation which required him to be accountable for his behaviour. He eventually refused to say anything in group sessions. The female participant concluded that him being removed from his violence group was going to be 'immensely helpful', as the likely consequences would be that he would not get paroled at his earliest release date, and hence there would be consequences for his refusal to engage in the therapeutic process. This latter statement suggests there should be a link between program non-attendance and being punished.

**Analysis and outstanding issues**

Current focus group members reiterated the range of ruptures, rupture repair strategies and issues relating to PD clients that have been described in previous focus groups, even though a broader approach was taken to discussing the TA and problems they had previously encountered. This included the position that the TA is a useful framework in which to view the delivery of offending behaviour programs and some focus on how client behaviour and therapist behaviour may contribute to ruptures. A range of rupture repair strategies were described to assist in the resolution of ruptures that ranged from management techniques (such as client seating and the use of 'group rules') to those focussed on engaging the client. The use of case formulation to assist in inform this was also reiterated although this group did not focus in detail on eliciting strong therapeutic change through the process of rupture
resolution as some other focus groups have.

In contrast to the previous focus group who relayed a level of sympathy in relation to discussing culturally diverse groups, these therapists described using both similar approaches to those used with other clients but also incorporating their knowledge of cultural groups to adapt their practice where required. In this way both a level of appreciation for the potential impact of cultural beliefs was demonstrated but a degree of wariness was also conveyed in relation to how clients might rationalise their behaviour giving cultural reasons that actually have no direct basis in explaining violence.
Appendix 6 – Study Two Human Research Ethics Committee Approval

Department of Justice

Human Research Ethics Committee

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18 March 2011

Reference: CF/11/1040

Professor Andrew Day
C/o Ms Christina Kozar
Deakin University

Re: Clients' perceptions of therapeutic ruptures in offending behaviour programs

Dear Ms Christina Kozar,

I am happy to inform you that the Department of Justice Human Research Ethics Committee (JHREC) considered your response to the issues raised in relation to the project Clients' perceptions of therapeutic ruptures in offending behaviour programs and granted full approval for the duration of the investigation. The Department of Justice reference number for this project is CF/11/1040. Please note the following requirements:

- To confirm JHREC approval sign the Undertaking form attached and provide both an electronic and hardcopy version within ten business days.
- The JHREC is to be notified immediately of any matter that arises that may affect the conduct or continuation of the approved project.
- You are required to provide an Annual Report every 12 months (if applicable) and to provide a completion report at the end of the project (see the Department of Justice Website for the forms).
- Note that for long term/ongoing projects approval is only granted for three years, after which time a completion report is to be submitted and the project renewed with a new application.

- The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses, conferences presentations or audiovisual materials that result from this research.

- All future correspondence regarding this project must be sent electronically to ethics@justice.vic.gov.au and include the reference number and the project title. Hard copies of signed documents or original correspondence are to be sent to The Secretary, JHREC, Level 21, 121 Exhibition St, Melbourne, VIC 3000.

If you have any queries regarding this application you are welcome to contact me on (03) 8684 1514 or email: ethics@justice.vic.gov.au.

Yours sincerely,

Dr Yasmine Fauzee

Secretary,

Department of Justice Human Research Ethics Committee
UNDERTAKING

Project Title: Clients’ perceptions of therapeutic ruptures in offending behaviour programs

Reference No. CF/11/1040

I acknowledge that I have read the conditions outlined in the current guidelines of the Department of Justice Human Research Ethics Committee (JHREC), and undertake to abide by them.

Reporting requirements:

- **RE: Amendments:** I will ensure that an Amendment Request Form is submitted to the JHREC if amendments to the project are required (e.g. staff changes, extension of completion date and adjustments to aims/methodology).

- **RE: Amendments:** If my JHREC application included a Department of Justice (DOJ) letter of support, I will advise the DOJ contact officer of proposed amendments before an amendment request is submitted to the JHREC.

- **RE: Annual Reports:** I will ensure that annual reports are provided if my project extends 12 months in duration.

- **RE: Completion Reports:** I will ensure that a completion report is provided at the conclusion of the research.

- **RE: Long term/ Ongoing Projects:** I acknowledge that if my project is an ongoing/long-term project I need to provide a completion report at the end of every three-year period and renew by submitting a new JHREC application.

Name of Principal Researcher:

Signed (Principal Researcher):

Date:
Memorandum

To: Prof Andrew Day
   School of Psychology

F

cc: Ms Christina Kozar

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 13 December, 2010

Subject: 2010-250

Clients' perceptions of therapeutic ruptures in offending behaviour programs

Please quote this project number in all future communications

The application for this project was considered at the DU-HREC meeting held on 06/12/2010.

Approval has been given for Ms Christina Kozar, under the supervision of Prof Andrew Day, School of Psychology, to undertake this project from 13/12/2010 to 13/12/2014.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
Modifications are requested by other HRECs.

In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
Information Sheet for Program Facilitators

Research project on clients’ perceptions of therapeutic ruptures in offending behaviour programs

Thank you for agreeing to approach some of your clients to see if they are interested in participating in this research project. The aim of this research is to explore the nature of therapeutic ruptures that occur within offending behaviour programs and to identify how therapists might best respond, particularly when working with difficult to treat clients. Ruptures occur in therapeutic relationships when clients either confront or withdraw from their therapist.

Project Overview

There are two parts to this research project.

The first part involves asking participants to complete, and then give feedback on, a 20-item questionnaire. These questions have been developed to help therapists work out when clients are having problems. Responses are made on a 5-point Likert-type scale and items include both positive (e.g., ‘The program facilitators and I worked well together to be clear about the program goals’) and negative (e.g., ‘I often disagreed with the program facilitators’) group experiences.

The second part is a small qualitative research study in which participants will be asked questions relating to the types of rupture experiences they have had in programs. Responses will be electronically recorded. To complete both parts should take between 20 – 30 minutes.

Program Facilitators’ Role

We are asking that you ask clients in your groups to consider being involved in this project and give them a recruitment flyer. This will include clients who are completing (or have completed) a Violence Intervention Program or Making Choices Program. These flyers should be made available to you but if you have not received them, please contact Chris Kozar on 0433 022 093 to arrange this.

To invite participants to be a part of this research project, you might want to say something like ‘Deakin University is doing some research on trying to improve how groups are run. They would like volunteers to talk with them about their group. If you’re interested in talking to a researcher about this, you need to fill in the bottom of the sheet and give it to me to pass on to the researcher. She will be in contact with you after your group finishes’ Should clients ask questions that you cannot respond to or you think are better addressed by the researcher, please suggest that they sign the form on the bottom of the flyer and the researcher will make time to speak with them about their queries. Chris will then be in contact with you about obtaining signed forms.
Ethical Issues

Ethical approval for this project has been obtained for this research to be undertaken. Should potential participants agree for the researcher to get in contact with them when they finish their program, a Plain Language Statement and Consent Form will be provided to them which outlines a range of ethical issues and information about the project including:

- **Privacy** – all information will be treated as strictly confidential except where risk of self-harm or harm to others, detailed disclosure of criminal activity that have not previously been disclosed, or security breaches are discussed.
- **Storage of information** – all information from the project will be stored in locked filing cabinets
- **Risks** – if participants experience negative emotional reactions from the research project, external counsellors can be arranged.

Further Queries

Please contact Chris Kozar on 0433 022 093 if you have any questions in relation to this project.

We very much appreciate your support in this project and look forward to working with you to progress it.

Complaints

Concerns relating to the ethical conduct of this research should be directed to:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125, Telephone: 9251 7129, Facsimile: 9244 6581; research-ethics@deakin.edu.au

Please quote project number EC 2010-250.

Or the Secretary to the Department of Justice Human Research Ethics Committee, 21/121 Exhibition St., Melbourne, 3000, Telephone 8684 1514; ethics@justice.vic.gov.au
DEAKIN UNIVERSITY

INVITATION TO BE PART OF A RESEARCH PROJECT ON OFFENDING BEHAVIOUR PROGRAMS

Would you like to talk about how things went in your offending behaviour program?

Chris Kozar is doing some research for her PhD university degree on clients' experiences of being in offending behaviour programs. She is interested in speaking with you about how you found the program.

There are two parts to this project. The first part involves asking you about a 20-item questionnaire being developed to help program facilitators work out when clients are having problems in their program. The second part involves a discussion of how you found being in your offending behaviour program, including the types of problems you might have come across and what program facilitators did to help. This information will then be used to help train future program facilitators.

If you would like to talk to the researcher about being in this study, please complete the bottom part of this form and give it to your program facilitator. Chris will then be in contact with you after you have finished your program.

If you have any questions about this project, please contact your program facilitator. If you have any concerns about the project, you can contact the The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125. Please quote project number EC 2010-250. Or contact the Secretary to the Department of Justice Human Research Ethics Committee, 21/121 Exhibition St., Melbourne, 3000 (or call on (03) 8684 1514). You may also want the help of an official prison visitor to get in touch with agencies involved with this research if you have any concerns about it.

Kind Regards,

[Signature Redacted by Library]

Associate Professor Andrew Day
School of Psychology, Faculty of Health, Medicine, Nursing & Behavioural Sciences
I am happy for the student researcher, Chris Kozar, to contact me at my prison or community corrections location after I finish my Clinical Services offending behaviour program to talk about being involved in her research project.

Name: __________________________    Signed: __________________________

Date: __________________________

Location: __________________________
DEAKIN UNIVERSITY
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO:  Men who have completed a Clinical Services offending behaviour program

Plain Language Statement

Date: March 9, 2011

Full Project Title: A research project on offending behaviour programs

Principal Researcher: Professor Andrew Day

Student Researcher: Ms Chris Kozar

Associate Researcher(s): Dr Jim Vess

This Plain Language Statement and Consent Form is 4 pages long. Please make sure you have all the pages.

1. Your Consent

You are invited to take part in this research project. This form tells you about the project so that you can make a decision about whether you want to take part. Please read this carefully and feel free to ask questions. Once you understand what the project is about and if you want to take part in it, you will be asked to sign the Consent Form.

2. Purpose and Background

Problems sometimes happen in offending behaviour programs. Some research shows us that the way a program facilitator reacts to these problems can make a difference to how successful the program is. You are invited to participate in this research project because you have completed an offending behaviour program. We are interested in how you found the program and to hear about any problems you might have had in your group.

The results of this research may be used to help facilitators deliver better programs and the student researcher, Chris Kozar, to obtain a PhD degree. Chris Kozar used to work at Clinical Services. If you were a client of hers, you cannot take part in this research.

About twelve (12) people will be doing this project.
3. Procedures

If you decide to take part in this project you will be interviewed by the student researcher. The interview should take between 20 and 30 minutes depending on how much you say. We will meet in the prison or community corrections office that you attend.

You will be asked to complete a 20-item questionnaire and tell the researcher what you think about it. This should take about 10 minutes. You will then be asked to talk about some of the things that happened in your group such as any good things that you noticed and what helped you in the program, any of the problems you had, as well as what happened after these problems. This should take between 10 and 20 minutes.

The interviews will be recorded electronically but only the researchers will have access to the recordings. They will not be made available to anyone else, including corrections staff, court staff, or the Adult Parole Board.

4. Possible Benefits

This project will try to improve how facilitators deliver offending behaviour programs. Having the chance to talk about your group may give you a better picture of what happened. This might help you see how well you really did or get you to try something else. You may not, however, get any direct benefits from this project.

5. Possible Risks

You might feel bad, disappointed or stressed out about how things went in the offending behaviour program if things didn’t go well. If you have any bad feelings or anything happens that you’re not happy with from talking about this in this project, then you should contact a program facilitator or Clinical Services staff member. They will get the researchers to get you free counselling or other professional help if needed.

If you find that you do not want to continue with the project after you start for any reason at all, including if you get stressed, you are free to stop the interview at any time.

6. Privacy, Confidentiality and Disclosure of Information

*It is important to us that your information stays only with the researchers and that your privacy is protected. The only time your information will not be kept private is if the researcher believes you are at risk of harm to yourself or someone else, you talk about security breaches (like drug dealing) in prison or you give details of crimes you have not been convicted of. The researcher will need to contact Corrections Victoria staff if you talk about these things.*

To reduce the chance of giving other peoples details in the research, it is important not to give names or details about any crimes. It is better just to use general words like ‘this guy’, ‘he’, ‘my facilitator’ or ‘someone else’ when talking about people in your group and ‘violence’, ‘theft’, and ‘assault’ if you talk about crimes. If you do start to give this information during the project, the interview will be stopped and you will be asked to not provide those kinds of details.

*None of the information we work on today will have your full name or criminal records number on it. Only your first name needs to be used. The questionnaire that you fill in along with the researcher’s notes will then be stored in a locked filing cabinet. Once the interviews have been*
recorded, the researcher will type them – all electronic information will be password protected and all paper records will be placed in locked filing cabinets. Only the researchers will be able to look at this information.

Once the researcher’s degree has been completed, all information is stored by Deakin University for at least five years. After that, the university destroys the information.

Information from this project will remain confidential. Names, prison locations and community correctional services offices will not be mentioned in any papers produced about this study. Corrections Victoria managers will not see your information but they will check articles we write about this study before they are published to make sure you or your prison/community corrections office cannot be identified.

7. Results of Project
The researchers are happy to make a summary of the results of this project. Please write to the student researcher, Chris Kozar, at School of Psychology, Faculty of Health, Medicine, Nursing & Behavioural Sciences, Geelong Waterfront Campus, 1 Gheringhap St., Geelong 3217 and she will send one to you.

8. Participation is Voluntary
Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to stop the interview at any time. If this happens, you can also ask that no information that you provided be used and it will be destroyed. Whether you decide to take part or not to take part, or to take part and then withdraw, will not affect your relationship with Corrections Victoria, the Adult Parole Board, courts, those treating you or your relationship with Deakin University.

Before you make your decision, a member of the research team will answer any questions you have about the research project. You can ask for any information you want. Sign the Consent Form only after you have had all your questions answered.

9. Complaints
If you have any complaints about this project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Office of Research Integrity, Deakin University, 221 Burwood Highway, Burwood Victoria 3125. Please quote project number EC 2010-250. Or contact the Secretary to the Department of Justice Human Research Ethics Committee, 21/121 Exhibition St., Melbourne, 3000.

10. Further Information, Queries or Any Problems
If you want any more information, wish to withdraw from the project or if you have any problems with it (for example, feeling stressed), you can contact the researchers:

Principal Researcher: Professor Andrew Day
Student Researcher: Ms Chris Kozar
Associate Researcher: Dr Jim Vess
School of Psychology
Faculty of Health, Medicine, Nursing & Behavioural Sciences
Geelong Waterfront Campus, 1 Gheringhap St., Geelong 3217

Phone - (Business Hours) 03 5227 8715  fax 03 5227 8621 (After Hours) Andrew Day - 0403 064 239
**DEAKIN UNIVERSITY**  
**PLAIN LANGUAGE STATEMENT AND CONSENT FORM**

**TO:** Men who have completed a Clinical Services offending behaviour program

<table>
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<th>Consent Form</th>
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<tr>
<td><strong>Date:</strong> November 1, 2010</td>
</tr>
<tr>
<td><strong>Full Project Title:</strong> A research project on offending behaviour programs</td>
</tr>
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I have read and I understand the attached Plain Language Statement.

I freely agree to participate in this project according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant’s Name (printed) ……………………………………………………………………

Signature ……………………………………………………… Date ……………………………

Witness’ Name (printed) …………………………………………………………………………

Signature ……………………………………………………… Date ……………………………
Appendix 10 – Study Two Semi-structured Interview Schedule

Study 2

Semi-structured Interview Schedule on Therapeutic Ruptures

I’m interested in finding out about how the group you attended went, and in particular how difficulties in your group were sorted out. Every group is likely to have its ups and downs, and I’d like to ask you some questions about the kinds of problems the group faced, what happened after these problems occurred, and how this left you and your group. There are no right or wrong answers to these questions - just think about your own experience of being in offending behaviour programs. These answers will help with training future program facilitators on the things they can do that are helpful when they deliver programs.

Could we start by you giving me your age, whether you are Aboriginal or Torres Strait Islander or any nationality other than Australian, and what kind of offending behaviour program/s you have attended.

We will now begin to discuss your group experience, but just a reminder to not mention other group members by their first name or to give lots of details of crimes. Using general words like ‘he’, ‘this guy’, ‘the facilitators’, or ‘someone else’ for others in your group and ‘theft’, ‘violence’ or ‘assault’ is the way to go.

1. a) What types of things did the program facilitators do to help everyone in the group get on with the program activities (discussions, warm-ups and role-plays?). How well did they work?

What did they do to help everyone work together? How well did this work?

What was important to you about the ways in which the facilitators approached the program?

b) So it sounds like __________ (e.g., trust, honesty, transparency, flexibility, understanding, empathy, respect) was important for the group to be able to get on with tasks and work with each other. Is that right?
What else is important for a group to be able to work well together?

What about ___________ (e.g., trust, honesty, transparency, flexibility, understanding, empathy, respect)?

Which one of these is most important?

Do you think that any of these were missing from your group? If so, what effect did that have on you and the group?

2. a) A lot of different problems can arise for people when they are in a program. They can either be fairly small, such as feeling a bit annoyed at what you’re asked to do, or pretty big, such as feeling really angry and fighting with facilitators. What were some of the problems that you experienced when you were in your offending behaviour program?

b) (For each problem identified) What happened with this problem? How big a problem was it for you from 1 = only a small problem to 5 = a big problem? Did the facilitators notice?

Then what did they do?

[Prompt] Did they ask you or other group members to talk about the problem?

What did the facilitators do next?

So how did you feel after this? And what about the rest of the group?

[Prompt] Did you gain anything from how these problems were handled? Did you learn more about yourself? Were the group able to work better together afterwards?
3. Some group members find being in a program really difficult, and will constantly fight or just not get along with the facilitators and other group members. Did you notice this in your group?

[If yes] What do you think is going on for these group members?

What do you think is most helpful for getting these group members to get something from the program?

4. Some facilitators think that there are bound to be problems that happen in a program because everyone comes with different wants and needs. They also think that to get real benefits from a program, you have to reveal and work through these problems. What do you think?
Appendix 11 – Study Two Interview Memos

Study Two - Interview One - Memo

Study Two was developed to pursue a number of important findings from Study One, particularly issues relating to the importance of therapist characteristics in the development of the therapeutic alliance (TA), the difficulties that often arise in programs that contribute to ruptures within the alliance, and the importance of being able to work flexibly to repair ruptures while also making a therapeutic contribution to the client. Study Two was specifically designed to determine whether clients' experiences in offending behaviour programs differed from the perspectives shared by therapists from Study One by asking a range of questions about clients' program experiences. A twenty-nine year old Albanian man who had just finished a moderate intensity violence program in prison, but also reported having completed approximately five other offending behaviour programs at other times, participated in this first interview.

Forming a therapeutic alliance and demonstration of positive therapist characteristics

The participant commented that he thought therapists worked very hard to get people involved in group activities, by being 'nice', demonstrating a positive mood, and 'just talking to them, try and get them active like get them talking about something...'. The importance of therapists genuinely wanting to assist clients both in and out of program time was also identified as key to garnering cooperation from clients. When asked about the use of experiential activities within groups, this client said that at the start of the 'class' these often occurred, but he did not find them always useful as he 'found them a bit too much playing games, not getting to the point. It was putting me off' suggesting the occurrence of a rupture in relation to his participation around these. We discussed that his comments mainly sounded like respect and understanding were important in the group, but honesty and trust were also important. Trust, he commented, was built in a group by being truthful. When asked which of these therapist characteristics was the most important for him in a group, he said it was honesty. Comments were also made on the importance of therapists responding to clients' needs, and not sticking rigidly to their own program agenda.

The types of ruptures that occur and strategies to repair them

This client's dislike of some group activities was then discussed. He said that it was 'their way or the highway', and eventually group members had stated that they were unhappy with having to undertake experiential activities, and his frustration around therapists insisting that they just had to do them even though he felt they were 'demeaning'. This participant then stated that he did not think group facilitators had any 'empathy' towards him or understood his situation. He believed the therapists should have made more of an effort to 'understand what's going on and do the right thing.' The participant then discussed that the therapists were trying to 'push' him into providing information he felt was too personal and private when undertaking the 'life pathways' aspect of the program. He rated both of these group problems a three out of five in terms of their seriousness. He commented that he felt that the rupture relating to the need to do 'warm-ups' was resolved when the group negotiated for them to occur less frequently, to which the therapists agreed and eventually did not undertake them. With respect to his difficulty in the 'life-pathways' aspect of the program, he believed that the therapists
both saw he was struggling with the task and he also relayed this to them. He reported that the therapists gave him reasons as to why he should do it, but the participant conveyed a level of ambivalence in relation to this activity, saying both that he could see why they wanted him to do it as well as him not seeing the point in doing it. The fact he felt 'forced' into doing it seemed to be a central difficulty for the client, that not participating risked being removed from the program. Eventually this participant negotiated to do his life-pathways in a one-on-one session. When asked about how happy he was with being able to negotiate these arrangements with the therapists, he stated that he thought they could have responded quicker to both of these difficulties.

**Issues relating to 'difficult' (personality disordered) clients**

When asked why this participant believed clients might become verbally abusive to therapists in a program, he stated that he thought it was because clients are being 'forced' into doing programs and so 'they're a bit upset'. When asked what therapists might do to assist these clients get something out of a program, this client said that he was not sure what they could do, and pointed to therapists' inexperience and 'they wouldn't really know what was going on'. He concurred that, therefore, it would be helpful if therapists were more experienced, knew the material really well, and knew what they were talking about. He then pointed to his own frustration of when he felt like therapists were simply 'reading out of a book' and 'It's not like they're being real or something'. This was then related back to his own experience in the program of feeling misunderstood.

**Analysis and outstanding issues**

This participant pointed to a range of issues that assisted both the formation of an alliance, particularly around the importance of honesty to develop trust within a group, as well as difficulties that arose when he did not want to undertake either 'warm-up' activities due to him feeling these were demeaning, or his life-pathways activity as he did not want to share personal information with the group. In both of these circumstances he discussed these issues with therapists and changes occurred within the group to accommodate the problems. Overall, however, there was a sense that this participant was not happy with the program when discussing the difficulties he experienced. This revolved around his experience of being coerced to participate and believing therapists were inexperienced and had a lack of understanding of his situation. These finds parallel information collected in Study One, in which therapists also identified a lack of experience and knowledge as problems that could contribute to ruptures. Re-asserting group rules around participation, repeating the rationale of activities, and negotiation of tasks have also previously been identified as a means of resolving ruptures. Further exploration is warranted in other interviews around the range of other means of resolving ruptures, as Study One revealed that ruptures could be resolved utilising more therapeutic approaches, and these have not been cited in this interview.

**Study Two - Interview Two - Memo**

A thirty-eight year old Australian man who had completed a moderate intensity Violence Intervention Program (VIP), an Exploring Change Program, a seven week drug and alcohol program, and approximately twelve months of individual treatment in a prison participated in the second interview.
Forming a therapeutic alliance and demonstration of positive therapist characteristics

This participant stated that having completed a lot of individual treatment, and working through some of the difficulties he experienced with his therapist in this context (particularly around the experience of being coerced into disclosing personal information and the time taken to work through issues), prepared him for participation in the VIP. He commented that his group developed a close bond and he attributed this to them all disclosing personal information early on in the treatment in the Life Pathways module. He also commented that ‘the support that I got back off the group helped to create that bond for me and find my place within the group’.

This participant spoke at some length about how an alliance developed with his therapist during individual treatment, and once the therapist had explained how the process would work, they developed trust and he realised that other prisoners had disliked this therapist because he was a ‘hard task master’. This participant appeared to place more value on his individual treatment compared to his group treatment, even though he believed his therapist had a times ‘pushed’ him too far on particular topics. Two other mechanisms were identified that assisted the group develop an alliance. These included clients ‘camaraderie’, which resulted in them aligning together against therapists who were seen to be giving other clients a hard time as well as when therapists and clients aligned together against a client who was not so ‘forthcoming’ in the group. The point of difference between these situations seemed to rest on whether it was perceived that the therapist was being reasonable or not.

When asked about the types of positive therapist characteristics required to assist a group work together, such as trust, honesty, understanding, respect and flexibility, this participant suggested that all of those factors had to be working together for a group to move forward. He stressed that this was because of the manner in which these traits were intermingled so that if, for example, there was no respect in the group then trust was lost. He also stated that these things, amongst others, were all placed in their group agreement.

The types of ruptures that occur and strategies to repair them

When asked whether there were any problems in the violence program in relation to clients not wanting to undertake particular tasks, this client said that when this did happen, group members supported each other in getting through the material. The participant also expressed frustration at a client who, after being granted parole, would turn up for group then leave for periods of time. He described one situation in relation to this when the client turned up at the end of a lengthy discussion in which a lot of the group members contributed, and he ‘ignored’ the client by talking to another prisoner but was spoken to by a therapist who said he was being ‘rude’. Although the participant stated that he expressed dissatisfaction with the situation within the group, there was no resolution to the situation and he initially rated the situation a 3 out of 5 in relation to how big a problem he saw it as, but it escalated higher at its culmination. The participant was called in to individually discuss the situation with the therapists then the therapists asked the group members if they agreed with the participant, but most of the other clients ‘turned’ on him. The participant believed this occurred due to the clients wanting align with the therapists because during breaks they had also expressed frustration about the situation. The client
continued to be allowed to attend parts of the remaining group sessions.

**Issues relating to 'difficult' (personality disordered) clients**

The participant expressed an appreciation for different clients being at different stages, and that not everyone is at the point where they are doing a program for themselves but may be doing it for parole. He saw that these differences in attitude then played out in groups in different ways, such as amount and quality of participation.

**Analysis and outstanding issues**

Of interest in this interview was the participant’s perspective in relation to group treatment, which he referred to as a course which had a ‘curriculum’ suggesting an educative experience. This contrasted with his individual treatment which he described in therapeutic terms. One of participant’s ruptures concerned a situation in which therapists failed to enforce boundaries (ie. a client who was allowed to come and go from treatment sessions) which he described remained unresolved when he was the one chastised for responding with frustration. This situation was exacerbated when clients ‘turned’ on him seemingly to align themselves with the therapists. Despite these difficulties, the participant described group members as developing a good bond due to both the ‘camaraderie’ demonstrated amongst prisoners as well as the trust and respect developed in the group after all members disclosed highly personal information and supported each other through activities. Group success seemed to be attributed to the individual clients in the group as opposed to therapist skill. Strategies applied by the therapists (group agreements, individual discussions with clients, getting group members to comment on other group members’ participation) appear to have focused more on the management of behaviours rather than therapeutic strategies. Further analysis to explore other strategies and rupture experiences is required.

**Study Two - Interview Three - Memo**

A forty year old Australian man who had completed a high intensity Violence Intervention Program (VIP), an Exploring Change Program, a communication and a drug and alcohol program participated in the third interview.

**Forming a therapeutic alliance and demonstration of positive therapist characteristics**

When asked what the participant thought the therapists had done to help the group work together, he suggested that the ‘games’ and other group activities, including small group work, had assisted them ‘bond’ even though some of the other clients thought some of these were ‘childish’. When asked whether he thought the therapists were straightforward with the clients, he agreed mentioning the development of group rules as well as the frank and open discussions they had with group members to assist this process.
When asked what characteristics were most important to have in a group, such as trust, respect, flexibility, and honesty, he said he thought they were all pretty important. When asked if he thought that possibly this was because these traits were intermingled, he agreed saying that if you don’t think you can trust others you are not going to be honest.

The types of ruptures that occur and strategies to repair them

When asked how the therapists dealt with clients who did not want to undertake tasks within the group, this participant stated that when clients had problems that they did not want to raise in group, the therapists would speak with the clients outside of group time to deal with the issue. He also described a situation in which a therapist walked out of a treatment session due to the manner in which clients were being verbally disrespectful to her. He stated that this was resolved by the remaining two therapists discussing the situation with group members, some of who eventually apologised to the therapist in the next session.

When asked if anything was missing from his program, he said that a bit of trust was due to ‘the environment’. He stated that it is not just about the trust of therapists and clients but ‘being in jail, you’re always on guard’. The participant went on to clarify that there may be a reluctance to talk about things in the group because some clients might take it ‘further’ in ‘the yard’ and that some clients were also concerned about what might get back to the parole board. The participant went on to describe that he had experienced difficulty in wanting to disclose personal information, but that the therapists ‘took me away and had a word with me about it’, reassuring him that the information wouldn’t go further and this helped him eventually make more disclosures.

The participant discussed how at times he had things he wanted to say in group, but due to other clients’ contributions he felt unable to do this at an appropriate time. When asked whether the therapists noticed this, he said that they did and reflected this to him. He said he was glad they had noticed and he reported it did make him try and contribute more. In further discussion about the value of being challenged, the participant likened it to exercise, stating that there was no point if it was too easy.

Issues relating to ‘difficult’ (personality disordered) clients

When discussing the types of problems encountered in a group, the participant raised that some clients were particularly argumentative, and the therapists and group members found it difficult to deal with them. While on the one hand they didn’t want to ‘upset’ the person who had a ‘legitimate reason for getting upset about not wanting to do something, but at the same time they just wanted to get on with the group.’ When asked why he thought these people were argumentative, the participant stated that they ‘put up walls’ due to being in a prison environment as well as reacting towards therapists who were ‘trying to make them be something that they don’t want to be’ such as by having them disclose details of their offence which might be ‘dobbing’ someone in. As with other ruptures, when this occurred the participant stated that the therapists would either speak with people out of group, talk in the group about the issue, and at times suggest to the client that they didn’t have to talk about certain things if they didn’t want to.
Analysis and outstanding issues

While this client raised similar management strategies to the previous participants to assist alliance formation as well respond to ruptures, such as through the development of group rules and taking people outside of session to discuss issues. He also described a considerable number of engagement strategies to assist difficult situations, including rolling with resistance as well as processing clients’ experiences. Further exploration of additional strategies will occur in subsequent interviews.

Study Two - Interview Four - Memo

A thirty year old Australian man who had completed a Violence Intervention Program (VIP) participated in the fourth interview. He stated that he had not attended any other program.

Forming a therapeutic alliance and demonstration of positive therapist characteristics

When asked what the therapists did to help the group do its work, the participant stated that they first got people to get to know each other by doing ‘exercises’ so everyone was ‘comfortable.’ Group rules also assisted group members to express their opinions and expectations about what they thought was important to have in the group. When a range of positive therapist characteristics were discussed, such as trust, honesty, and flexibility, the participant described honesty as the most important trait, and discussed a situation (described below) in which the group rebelled against a client who was lying.

The types of ruptures that occur and strategies to repair them

In discussing his group experience, the participant articulated that there were a lot of ‘outspoken’ people in the group he attended and the therapists responded to concerns about group activities by listening to what they had to say and ‘working around’ issues.

The participant also raised a situation in which all group members walked out of a session when a client was lying about his offence. He explained that this client ultimately told the truth in the next session even though it was difficult for him. In further discussion of this situation, the participant stated that the therapists had pulled the client aside and said they had the truth ‘in black and white’ and that the client would be removed from the group if he was not honest. The participant stated that this client did not really have a choice in relation to this situation.

Issues relating to ‘difficult’ (personality disordered) clients

The participant expressed that people might find it difficult to be in a group if they did not feel comfortable with the people that they were doing the group with, but did not identify any other particular issues relating to difficult clients.
Analysis and outstanding issues

This participant continued to describe a range of management strategies to resolve ruptures (e.g., discussing issues with clients outside of group time, threatening removal from treatment), but also emphasised the role of the therapists to develop group cohesion and respond to breaches in the group rules. This participant gave the impression that following this process, it was the group members who assisted the treatment process mediated by the therapists. The role of therapists, therefore, to assist in developing greater insights and utilising the therapeutic relationship within this process is not particularly evident. Further exploration of the range of clients’ experiences in this regard is warranted.

Study Two - Interview Five - Memo

A thirty-six year old Australian man who had completed a Violence Intervention Program (VIP) along with three months of ‘goal setting courses’ participated in the fifth interview.

Forming a therapeutic alliance and demonstration of positive therapist characteristics

The participant discussed the formation of the therapeutic alliance was achieved by therapists developing a relationship with clients to enable discussion of personal issues, and trust was required for this to happen. This participant identified that he was ‘shy’, so trust was the most important thing for him to develop in the group. Group rules were also identified as a useful process to identify expectations as well as the therapists being transparent about staff changes so the group was clear about who was facilitating the group and when. He also described the importance of both the leadership and the supportive function of therapists, saying that he would often wonder if he had said that right thing, so would discuss his concerns with the therapists for five minutes after the group finished to allay his fears and avoid perseverating on it. Activities were also balanced between those that were ‘emotional’ as well as ‘games’ that were ‘fun’ so that it wasn’t always tense and serious.

The types of ruptures that occur and strategies to repair them

Therapists mentioned to clients that they were there to support them if they experienced any difficulties, and the participant described the therapists being attuned to how group members were during the program, and would catch up with him (and others) after the group when he was ‘a bit emotional or didn’t say something.’ The process of checking in and checking out also provided opportunities to express frustrations within the group, such as if it was thought particular clients were not ‘putting in’.

The participant described being given feedback about his tendency to be ‘shy’ in a review meeting with his therapists, at which time they encouraged him to ‘step up’. He described that this feedback inspired him to contribute more to group discussions.
Issues relating to 'difficult' (personality disordered) clients

The participant described some clients being ‘smart arses’ and other clients, like himself, who did not want to talk during sessions. On occasion, however, those who could not cope with being in a group would often find a way to get out of it, such as by doing something wrong to get sent to a different location ‘because they don’t want to handle what there is going to be in front of them.’ Further discussion occurred in relation to these clients having difficulties coping, lacking adaptability to respond to the anticipated difficulties that might emerge in a group, and they just really did not want to attend.

Analysis and outstanding issues

This participant continued to develop other participants’ concepts of the importance of the group developing a high level of cohesion although with the therapists providing high levels of support and leadership. He also described therapists providing him with feedback and an in-session task to change his behaviour, which he described responding to positively. A continuing theme, however, is the contact that therapists have outside of group session rather than as part of the group process. Of interest was the observation that those who are not able to cope with a group contrive to be removed from the location which speaks to the importance of organisational supports required to respond productively to clients who are not treatment ready. Further exploration of the factors contributing to alliance formation and rupture repair will occur in subsequent sessions.

Study Two - Interview Six - Memo

A thirty-six year old Australian man who had completed a Violence Intervention Program (VIP) and a cognitive skills program participated in the sixth interview.

Forming a therapeutic alliance and demonstration of positive therapist characteristics

In response to questions around alliance formation, the participant stated that some clients were agitated but the therapists ‘tried really hard to get the group to get on with each other’. When asked about the kind of activities that helped this process, the participant stated that there were ‘little games to warm up the group.’ He also suggested that overall the therapists made an effort to be respectful, empathic and flexible within the group to facilitate group members working together on the activities. His sense was that their efforts were mainly positive, although a number of situations (discussed below) frustrated him.

The types of ruptures that occur and strategies to repair them

If clients became agitated, the participant reported that the therapists encouraged relatedness, would come back to group members if they had difficulty responding, would see them individually outside of group time to discuss their participation, as well as allow ‘time out’ during sessions. In speaking about warm-up activities, the participant mentioned that some people did not want to do it but the therapists were ‘enthusiastic and energetic and they tried to pick people up’ to encourage participation. In further
discussion about whether they challenged clients who did not participate, the participant stated that they ‘pushed them but they didn’t push them enough and it made it hard on other people.’ This was because other participants wanted to get on with group content rather than the disruptive behaviour enacted by these clients who told ‘war stories’ and would express that the group was ‘shit.’

In response to some of the disruptive behaviour that occurred within the group, the participant described how the therapists would warn these clients that they would be removed from the group, ‘joke around and try and brush off’ the comments made, and signal to these clients that their behaviour would likely lead to their re-imprisonment. It was the participant’s view, however, that these strategies did not assist the situation. He expected that this occurred because the therapists ‘were new at this stuff.’ The possible impact of these clients’ then limiting how honest and upfront other clients might be was discussed, although the participant stated this may have occurred for others in the group but not him as he was ‘confident’.

The participant felt that group members and therapists ‘used to pick on this one guy’ who had lied about his crime in group. They eventually encouraged him to tell the truth but ‘just drilled him and pointed him and made him fell like how low you are.’ He mentioned expressing his dissatisfaction about this situation to the therapists, but otherwise believed the therapists made an effort for the group to work together.

**Issues relating to ‘difficult’ (personality disordered) clients**

In discussing the participant’s frustration towards the small number of clients who were not participating fully in his group, he articulated that these people weren’t there to change, and they ‘just talked about war stories.. joking around and wasting a lot of time for the people that did want to try.’ When asked what should have been done in this situation, he suggested that they should have got three warnings and then be removed. In further discussion about these clients, the participant recognised that they were young, had been in prison previously, and felt that they knew what they had to do to change and could do it. He commented that his experience from that age was that it was not that easy. The participant also expressed frustration at the intimidation experienced by one of the group members towards another group member outside of group time. The negative impact this might have on group participation was discussed.

**Analysis and outstanding issues**

This participant raised a myriad of issues in relation to some of the difficult dynamics that can be created in group programs, particularly around clients who are both not treatment ready but enact highly anti-social acts both in and out of group sessions. As in Study One, clients being made a scapegoat and not enforcing appropriate boundaries was described as significantly impacting on the whole group. Limitations remain, however, in relation to the breadth of strategies enacted by therapists described by participants. Current strategies seem to chiefly revolve around management (e.g., threatening removal from group) and engagement (e.g., demonstrating enthusiasm, use of humour, pointing to the likely consequences of behaviour).
Although the interview provided accounts of different ruptures experienced by the client, it was not clear which aspects of the alliance were actually working for the client. Further interviews will, therefore, explore more specific elements of the participant’s experiences of the three elements of the alliance.

**Study Two - Interview Seven - Memo**

A thirty-nine year old Australian man who had completed a Violence Intervention Program (VIP) as well as drug and alcohol programs, Exploring Change, and a ‘prisoner listener’ program participated in the seventh interview.

**Forming a therapeutic alliance and demonstration of positive therapist characteristics**

When asked what the therapists did to help the group members do activities and work together, the participant mentioned ‘playing games’ and encouraging discussion. He particularly mentioned that everyone in the group would check in at sessions and discuss their emotional state, and this ‘broke the barriers and everybody was comfortable and we trusted each other.’ When asked whether there was anything specific that assisted the process, he identified undertaking the ‘life pathways module’ which enabled him to think differently about his situation. He also commented that after other group members also did it ‘you sort of got a bigger picture of every person that was in the group and made them more comfortable for everybody.’

When asked about this participant’s experience of identifying the goals of treatment, he stated that he initially undertook the group because he was told to, but eventually the gains he made were around developing a better understanding through the life pathways module of how his ‘path’ got him into trouble. This then allowed him to focus on learning how to deal with things in different ways. The participant identified the bond aspect of the alliance as the most important, and commented that this went well in his VIP as all twelve group members finished the program. He described that this was due to the trust that developed and ‘they could talk about anything, so I think the bond was pretty strong.’

**The types of ruptures that occur and strategies to repair them**

In relation to negotiation of tasks, this participant identified that at the start of the program some clients said the activities they were asked to do were ‘childish’ but the therapists and other clients would respond to this by being encouraging. He also mentioned for himself that he did not really want to bring up his issues from the past, but as everyone else contributed, it got easier over time. He added later that when he understood the relevance of the information, this also assisted the process and the therapists assisted him by fostering a greater awareness about how his past had influenced his offending. Additionally, the participant identified that a couple of clients were unhappy as to finish the program meant they were going over their earliest release dates, and they ‘were the quietest ones in the group.’ He explained that most clients had a long time on their sentence, so bonded very well and encouraged
these other clients to get on with the tasks. When asked if the therapists did anything to help the situation, he said that they mentioned to these clients that it was up to them if they wanted to participate and that the parole board was waiting on their program report, so they were quite direct to the clients about their choices. The participant also stated that he told the therapists in an individual session that he thought some clients were taking up too much time talking about ‘war stories’ and other events that were irrelevant to the course. He observed subsequently that the therapists did provide feedback in the group when this happened which had a positive impact. If clients struggled with participation, the participant stated that they were also provided with individual time with therapists to work on their issues.

**Issues relating to ‘difficult’ (personality disordered) clients**

Although this client identified that there was a strong bond in his group, a range of difficult client traits were also described, as outlined above. This included clients engaging in disruptive behaviour as well as avoiding program content by dominating group time with their own agenda or withdrawing participation.

**Analysis and outstanding issues**

As had been identified by therapist participants in Study One, this participant described an interesting process of shifting goals for program attendance as he participated within the treatment process. He identified various processes that assisted this, including therapist feedback and understanding the treatment rationale. These assisted in resolving ruptures created by being asked to make personal disclosures, particularly as he did not initially understand the reason for needing to discuss this information. Additional therapist strategies continued to include management (e.g., advising clients the parole board were waiting for their treatment report) as well as engagement (e.g., by being encouraging) although it seems that a more therapeutic approach (e.g., providing feedback to increase client awareness) was an important experience for this participant. Further analysis of how the alliance is formed and ruptures are responded to will be undertaken in subsequent interviews.

**Study Two - Interview Eight - Memo**

A thirty-four year old man who had completed a high intensity Violence Intervention Program (VIP) as well as a RUSH program and individual treatment participated in the eighth interview.

**Forming a therapeutic alliance and demonstration of positive therapist characteristics**

When asked which of the three elements of the therapeutic alliance were most important, the participant stated ‘all three are pretty strong things that need to be sorted out,’ explaining that ‘the activity part is something that with prisoners they don’t want to pussy-foot around with, because they just want to get into it and then get straight out of the door’ but it was also good to focus on goals. He mentioned that the bond with therapists ‘should be a trusting and a... something like nourishment between the two’ with ‘give and take’.
The types of ruptures that occur and strategies to repair them

The participant discussed that clients would more often than not talk to therapists in individual sessions when they had difficulties ‘because then they don’t feel that… that sense of humiliation with the yard between other prisoners’ due to concerns that information they disclosed would be used against them by clients outside of treatment. Later in the interview the participant disclosed that there had been a breach of confidentiality in the group he attended, and in response to this the therapists had given the prisoners ‘a spray about confidentiality in groups’ in their area at a ‘community meeting.’ The participant stated that he did not think this had been particularly effectual and if he had his way he would have threatened them with removal from the program if there were any more issues. He added that the therapists had expressed that they were ‘displeased’ with the situation in the group but there was little they could do given that the client involved had denied disclosing information outside of the group so it was only ‘speculation.’

The participant also stated that in response to clients being disruptive in group, such as by questioning why they were doing particular activities, or ‘skylarking,’ the therapists attempted to assert boundaries but likened it to when ‘the parent just gives up on pushing what the main focus needs to be focussed on, so you end up spending half of the morning, or half of the session, with whining and carrying on.’

Difficulties in the group were further exacerbated due to the high turnover of staff, and the participant stated that seven different individuals facilitated his group. He believed that the therapists ‘need to be a bit firmer’ within the group but he was under the impression that they ‘didn’t want to rock the boat because they still want to be the good guy’.

The participant identified that due to these disruptions, he wasn’t able to deal with a range of issues that he wanted to and ‘ended up being upset with it myself, you know, so then the days that I did come to program, I just couldn’t be bothered being there.’ He also expressed feeling confused due to things he was raised to believe (e.g., to hit a punching bag when you were angry with someone) were challenged by the therapists. He suggested that although they had noticed that he was ‘unhappy with it’ they did not appear to believe this strategy worked for him. He then added that the therapists were ‘always right and I’m wrong’ and agreed that it might have been better if they were a bit more open to what he was conveying.

Issues relating to ‘difficult’ (personality disordered) clients

This participant raised a range of antisocial behaviours demonstrated in group treatment, including clients who would disclose other clients offence details ‘out into the yard where it’s meant to be confidential’ due to there being clients who have committed different offence types, and ‘one will frown upon the other type of group and then just start gossip in the yard which can put prisoners on edge.’ He added that these clients were also often at a program ‘for just getting the parole papers signed off so they can go home. Not learning actually.’ He went on to describe a number of clients who were persistently disruptive and would constantly question the therapists and create their own distractions to avoid participating in group activities. When asked why some clients might breach confidentiality, the participant on reflection commented that it might be to make themselves feel important, because ‘it’s
like bullying pretty much.’

**Analysis and outstanding issues**

This participant’s experiences demonstrate the range of difficulties that can emerge when there is a significant rupture in a group, such as a breach of confidentiality, as well as persistent disruptive behaviour. Of interest was the difficulty he articulated experiencing due to the impact this, along with regular changes in therapists, had on his own participation to the point where he could not be bothered contributing in group. As with other participants, when asked what responses they thought would ideally be invoked in these situation, he cited the use of management strategies (ie. removal from the group). It does highlight, therefore, the balance that needs to be struck within groups between wanting to encourage clients to participate in group compared to the need to enforce boundaries, which various participants in Study One also emphasised. The participant did, however, express value in treatment being framed in relation to the elements of the therapeutic alliance and further exploration of this is warranted.

**Study Two - Interview Nine - Memo**

A forty-six year old English man who had completed a high intensity Violence Intervention Program (VIP) as well as drug and alcohol and Exploring Change programs participated in the ninth interview.

**Forming a therapeutic alliance and demonstration of positive therapist characteristics**

When asked which of the elements of the therapeutic alliance were most important, this participant suggested that it was the bond. He expressed that he thought this was the case as ‘before you can talk in front of other people you need to trust them’ and this was particularly to develop relatedness with the group members (rather than the therapists). When asked what assisted his therapeutic process, he described the therapists providing feedback about participation and undertaking a range of program activities in relation to empathy and ‘thinking.’ He suggested that these had allowed him greater insight into others’ behaviour so he now communicated better with people. He commented that the therapists assisted this process by ‘trying to get on our level and we were, sort of, trying to get a bit on their level, met them half way. It was good’. He also commented that a range of activities in which there was some ‘competitiveness’ and got people out of their seats with everyone involved were valuable.

**The types of ruptures that occur and strategies to repair them**

The participant discussed how there had been a breach of confidentiality in the group he had attended, and the therapists responded by speaking to the group about the importance of confidentiality and that if it occurred again, the client responsible would be removed. He stated that he believed they had handled the situation appropriately. In response to a client that arrived late and dominated the group, the participant stated that the therapists did give him feedback about his behaviour, and then they would ‘avoid him a fair bit.’ He also believed that therapists would have raised it with him in an individual session too, and believed this was an appropriate way to respond to the situation although
they might have dealt with the situation quicker. The participant also identified that for group members, including himself, he had difficulty with approaching the Life Pathways module requiring disclosure of personal information, ‘I guess people would have decided to leave certain things out, because it was going to get told in a group. It was a bit difficult.’ He put this down to it being ‘embarrassing’ to have to describe highly personal and sensitive information about his past but could not think of any additional strategies the therapists might have used to assist the situation. In further discussion around how disruptive behaviour should be dealt with, the participant expressed that he thought it should be discussed in an individual session so as to not ‘embarrass’ the clients involved or during check-in without ‘naming and shaming’ the clients involved.

Having several changes in therapists in his group was also raised as a difficulty that had occurred which ‘stressed out’ group members, until about a third of the way into the program when they got therapists who ‘gave their word that they were going to stick it out to the end.’ This appeared to resolve the situation as the therapists took the comments seriously and expressed a level of empathy in relation to the group members’ experiences.

**Issues relating to ‘difficult’ (personality disordered) clients**

The participant described a client who was disruptive in the group, saying he always arrived late after getting methadone then would dominate the group – ‘did a lot of talking, chatting and answering most of the questions, and I think people got sick of that.’ He added further that ‘he made it all about him.’ When asked whether there were clients in his group that found it difficult to be in a group, the participant stated that there were a couple, and these were mainly ‘the younger people’ who were disruptive at times.

**Analysis and outstanding issues**

This participant expressed a high level of sensitivity to embarrassment and shame in relation to disclosure of information within sessions when considering both his own and others’ situations. This was despite the value he placed on aspects of the program on assisting his own communication, as well as efforts by the therapists to develop relatedness and use experiential technique to encourage participation from all group members. A continuing theme revolved around the importance of therapists enforcing boundaries promptly as well as the value in receiving feedback to develop greater insights. These factors continue to support the results of Study One.

**Study Two - Interview Ten - Memo**

A twenty-six year old Australian man who had completed a high intensity Violence Intervention Program (VIP) as well as an interpersonal relationships, a drug and alcohol program and individual treatment participated in the tenth interview.
Forming a therapeutic alliance and demonstration of positive therapist characteristics

When discussing the elements of the therapeutic alliance, the participant stated that he believed the goal aspect was most important, and this was because he felt ‘uncomfortable in big groups’ and it had been an effort to get to the program every day but he had achieved this. In discussing what the participant believed had made the biggest impact on him, he stated that it was the ‘information’ that he was given that had assisted him change his behaviour. He said that he also benefitted from hearing the other group members discuss their experiences and being encouraged by the therapists to think about his previous behaviour. In discussing the importance of the bond, the participant stated that he did not feel like he had a bond with the therapists facilitating the group, but did with the therapist in which he had individual sessions, but really wanted to give the group a go so persisted with it despite a number of set-backs (as described below).

The types of ruptures that occur and strategies to repair them

The participant explained that due to having difficulties in being in big groups, he was anxious about engaging in a victim empathy exercise, and that the therapists had asked him how he would like to do it. He had said he wanted to just sit down and explain it but when therapists later set-up the activity they presented him with a role-play. He said this had ended up in a disagreement, and he told the therapists what he felt comfortable doing, it was unfair they have changed it, and he was not going to do it. This resulted in him walking out of the session for a few minutes ‘to cool off.’ He explained that after returning to the group, the therapist had apologised and told him he could talk about it instead. Additionally, he said that another group member had also aligned himself with the participant by stating ‘you just pretty much made him feel this big in front of everyone.’ In further discussion on how the group progressed, the participant stated that he did not get along with some of the clients in the group and there were changes in therapists which ‘really tossed things up with everyone.’ When asked what activities occurred to re-stabilise the group, he stated that the group had been aware that the changes were going to occur but he did not think any particular activities were enacted to try and get the group back on track because they were ‘behind the eight-ball’ in terms of getting all the program elements completed. He also stated that some groups just don’t get along as well as others, and this had been the case for him, and he had often sat in group and the activities ‘really didn’t make sense with me.’ He explained, however, that after completing the program he noticed his behaviour had changed positively. He also commented that the therapists ‘made me sit and think about how I went wrong like with my life pathway, victim empathy’ to help him understand.

The participant disclosed that another group member had breached confidentiality in group around information to do with his wife and it ‘made me feel real bad, real crap.’ He stated that in response to this, the ‘head clinician’ had discussed the situation with him individually asking what he wanted to do, and he had said that he didn’t want the client ‘kicked out of the goal’ and resigned himself to accepting ‘if it makes him feel better about talking about other people, so be it.’ He further discussed that the therapists had stated at the outset that they would remove clients who breached confidentiality and they should ‘keep to your word’, and did not like the decision to rest with him. In discussing how to deal with clients who were unmotivated to get anything out of a program except parole, he suggested that they should be encouraged to give it a go.
Issues relating to ‘difficult’ (personality disordered) clients

The participant identified that there were clients in the group that did not want to change. He suggested that these people were not in the right ‘headspace’ and only wanted to do the program to ‘go home.’

Analysis and outstanding issues

This participant described experiencing a range of ruptures but that being motivated to give the program a go and achieve that goal had assisted him remain committed to the program. It suggests that despite experiencing a range of ruptures, outcomes can still be made even when these are only partially resolved. It may be, however, that the support of this participant’s individual therapist had assisted him through this process. It does speak to, however, the impact of different personality traits, such as persistence, that can assist making therapeutic gains and that for some clients the bond aspect of the alliance is perceived as less important than therapeutic techniques taught in sessions. This suggests that different clients value different aspects of the alliance and the importance of therapists individualising their approach to respond to varying needs.
Appendix 12 – Study Three Alliance Modes in Offending Behaviour Programs: Coding Manual and Checklists

Alliance Modes in Offending Behaviour Programs

Coding Manual and Checklists

Rationale
The therapeutic alliance concerns the development of a collaborative relationship between the therapist and the client that enables the negotiation of tasks to be undertaken in treatment, the identification and agreement on goals to be achieved, and the development of a bond to allow these processes to occur (Bordin, 1994). Within a group context, therapists form similar alliances with group members, although the relationship is influenced by a range of issues relating to group climate. These include factors such as the leadership demonstrated by therapists, and the level of cohesion that exists between group members in supporting and contributing to each other’s treatment. Thus there is a need to consider the impact of an individual alliance on other group members. Similarly, ruptures that emerge in the alliance will also be influenced by other clients and impact on factors such as the quality of the bond, a client’s willingness and attitude towards undertaking therapeutic tasks and/or agreement on the goals of treatment. The manner in which a therapist responds to clients, both as a group as well as the individuals within that group, may have variable impacts from assisting in the process of alliance formation, contributing to ruptures in the alliance, as well as rupture repair.

Qualitative research conducted on the delivery of offending behaviour programs has identified that therapists work in three distinct modes when attending to both the development of the therapeutic alliance and repairing ruptures in the alliance (Kozar, 2013). Although there was variability in the offence-types and nature of programs described (particularly in relation to their emphasis on psycho-education versus therapeutic intervention), therapists described the need to consider factors relating to the therapeutic alliance in conjunction with the delivery of material outlined in program manuals, responsively meeting the individual difference characteristics of clients, and effecting therapeutic change. These alliance modes are respectively called the educative mode, the engagement mode, and the therapeutic mode. Therapists choice to work in one of more of these modes depends on factors such as level of experience and knowledge, qualifications, training and supervision, the type of program being delivered, timing in group (early or late stages, levels of group cohesion), the types of ruptures that occurred, and the nature of the co-facilitation relationship.

To assist in providing feedback to therapists about their delivery style, this manual describes these alliance modes and provides a method by which they can be assessed using checklists and coding rules based on observations of any group session. For each item in the checklists, therapists are rated on the frequency with which they demonstrate each behaviour. When observing an offending behaviour program, completion of these alliance checklists are likely to assist therapists identify whether any particular mode is being utilised predominantly over another, and to discuss in supervision strategies to shift into preferred modes based on the needs of their group. The checklists can be completed at any session in the delivery of an offending behaviour program. As such, checklist items are generic and not reliant on any specific stage of group development. Items for each mode are divided into a number of categories and include the central tasks, approach to goals, strategies to develop a therapeutic bond,
Rating Procedure

Raters should be familiar with each checklist and coding instructions prior to viewing the group. As the group is being viewed, the observer should first develop a coding system to identify individual therapists and clients present in the group on the Session Running Sheet. After this has been created, raters should then note the group activities undertaken (e.g., check-in, victim-empathy exercise, group discussion) in addition to observations of clinical importance. These might include specific therapist and client behaviours, comments made, and affective responses observed throughout the duration of the group representative of educative, engagement and therapeutic mode indicators. Notations identifying each therapist and different group members to assist in determining the number of clients involved in behaviours indicative of alliance development and ruptures to the alliance as well as the contribution of each therapist to these behaviours. During the group observation, interpretations of group behaviour that aligns with alliance mode items can commence by the rater noting potential alliance mode items in the right-hand margin of the running sheet.

Once the group has been observed, recorded observations should then be reviewed with the coding procedures outlined below for each alliance mode, and further notes made in the right-hand margin aligning other observations with items from each of the alliance modes. Once this process has occurred, the checklist can then be completed by summing the scores for each item. Total scores for each mode are then determined by summing the scores for each item.

To determine the predominant mode or modes demonstrated in the session, mode frequency scores are first compared. If the highest scored mode is at least 10 points higher than the second highest scored mode, the session is considered as predominantly demonstrating this mode. The session is categorised as demonstrating two or more modes if there is less than a ten point difference between scores. An exploration of the modes demonstrated within each session is then determined by initially examining which modes meet criteria as being ‘present’ within a session. A mode is considered present when its frequency is 4 or more (i.e., a strategy demonstrated more than once every hour). Next, the proportion each mode is demonstrated in relation to the other modes is examined. A mode is considered as highly dominant within a session when its frequency equates to at least two-thirds (67%) of the total scored frequency and a mode is considered to be dominant when frequency scores equate to at least a third (33%) of the total frequency.
Session Running Sheet

Date: ____________ Program: ___________________________________________

Therapists: ______________________________       _____________________________

Client & therapist coding system: ___________________________________________________

<table>
<thead>
<tr>
<th>Clinical observations</th>
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Page # _____
The Educative Mode

The educative mode describes the process of delivering program manual content and responding to ruptures in the alliance principally through reinforcing boundaries, encouraging compliance, and the use of behavioural techniques to support this process. The main goal for those working in this mode is to ensure that program information and tasks are delivered as intended within the program manual and problematic behaviours demonstrated by clients are managed to assist this end. In addition to delivering program manual content, the central tasks in this mode include the development and enforcement of group rules as well as the promotion of appropriate behaviour in session. Goals are therefore linked to clients attending closely to the material and interacting with therapists and group participants in ways that facilitate this. The strength of the bond required for the successful completion of these tasks and goals can be understood in terms of clients’ openness to therapists’ efforts at delivering material and mutual respect for group rules.

Coding

The delivery of psycho-educational material outlined in program manuals is an important task of this alliance mode. In addition, there are three forms of compliance management observed in therapists using this mode. These are: to obtain compliance through the development and enforcement of group rules, to create and enforce structures and boundaries in a group, and to use behavioural techniques to reduce the potential for disruptive behaviour.

Delivery of program manual content – This describes therapists’ focus on ensuring that psycho-educational material is delivered as outlined in the program manual.

1. Delivery of the program manual: Therapists provide information outlined in program manuals to clients to educate them about topics relevant to their offending behaviour program. This might include explaining the link between thoughts, feelings and behaviour, discussing risk factors, or describing an offence process. The use of whiteboards or handouts to outline specific points and discussion of clients’ relevant experiences may occur. Therapists may specifically use their manuals to guide group content or refer to doing an activity because it is in the manual or part of the program content. The use of a program manual can also be inferred when therapists present topics for discussion that have not evolved on the basis of client questions or comments.

2. Practising skills in the program manual: Therapists will provide information outlined in program manuals to clients in relation to skills to assist in promoting an offence-free lifestyle. As in item 1, this may involve the use of whiteboards or handouts and might include discussion with clients of their attitudes and experiences of using this skill. Therapists might specifically use their manual to outline specific skills or refer to presenting a skill because it is in the manual or part of the program content. The use of a program manual can also be inferred when therapists present skills for discussion and practice that have not evolved on the basis of client questions or comments.

Group rules & boundaries of behaviour – Group rules are consistently developed within offending behaviour programs to develop a group culture conducive to therapeutic engagement. Group rules ensure there is clarity around behaviours that are both expected and not tolerated. In addition to group rules, boundaries of behaviour are reinforced to ensure the delivery of program material.
3. **References are made to group rules to encourage compliance:** Therapists will *reinforce the importance of adhering to group rules and/or point out deviations to established rules.* This may include directly pointing out the deviation to clients, or indirectly by asking what might be problematic about a specific group behaviour and linking the discussion to breaching group rules.

4. **Re-directs discussion back to the intended task:** Where group discussion has shifted from the tasks being directed by therapists or disruptive behaviour is demonstrated, therapists will suggest to the group that they should *go back to the intended task.*

5. **Shuts down client’s contributions if not relevant or dominating a group:** Where clients raise issues that are inappropriate, shift the topic of discussion to an area not related to the set topics, or dominate a group by making contributions that are disproportionate relative to other group members contributions, the therapist *shuts down their discussion.* Therapists would therefore state that the issues raised are not to be discussed due to a focus on other topics or another group member’s contribution, although they may suggest that the topic is discussed at a different time in the session, on a break, or after group.

**Behavioural techniques** – a number of techniques can be used which follow the principles of behavioural theory to reduce the likelihood that clients will be disruptive and to encourage compliance and engagement with a suggested task.

6. **Manages (potentially) disruptive behaviour by using behavioural techniques:** In response to disengaged behaviour, such as clients being rude, doodling, or talking amongst a number of clients while excluding the group, a therapist *invokes an activity that shifts the disengaged behaviour.* A number of behavioural strategies can be used to shift potentially unhelpful dynamics within a group. This might take the form of asking clients to swap seats or undertaking a range of experiential tasks to avoid unhelpful alliances between group members and/or to improve engagement.

7. **Positively reinforces clients who are doing well:** In an effort to encourage more appropriate client behaviour, therapists will *positively reinforce client’s behaviour,* such as by providing praise or encouragement, where a positive contribution to the group has been noted and/or the client’s behaviour demonstrates an improvement compared to their previous behaviour in group.
   Therapists may attempt to shape client behaviour by providing praise when only small differences or contributions are noted however a lack of contributions or disruptive behaviour would not be rewarded.

8. **Negotiates client involvement to reduce the potential for disruption:** Therapists will suggest clients undertake particular tasks within session (e.g., to make some meaningful contribution to a discussion, ensure everyone has a turn at undertaking an activity, ask clients to write their own or other group members responses on a whiteboard) to both encourage engagement in the task and reduce the possibility of disruptions occurring in group.
### Educatve Mode

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<thead>
<tr>
<th>Delivery of program manual content</th>
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<tr>
<td>1. Delivery of program manual</td>
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<td>2. Practising skills in the program manual</td>
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<td>4. Re-directs discussion back to intended task</td>
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<td>5. Shuts down client’s contributions if not relevant or dominating a group</td>
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<th>Behavioural techniques</th>
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<td>6. Manages (potentially) disruptive behaviour by using behavioural techniques</td>
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<td>7. Positively reinforces clients who are doing well</td>
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<td>8. Negotiates client involvement to reduce the potential for disruption</td>
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The Engagement Mode

The engagement mode emphasises working with clients in a way that is responsive to their individual needs. Therapists are, therefore, sensitive to factors such as cognitive capacity, mental health symptoms, defensiveness, literacy, anti-authoritarian attitudes, self-entitlement, and interpersonal problems. Tasks in this mode involve undertaking those activities that have been modified from the program manual to achieve relevant therapeutic goals for clients relating to their dynamic risk factors. A key therapist activity also concerns demonstrating positive therapist characteristics to optimise engagement; validation, expression of empathy, the development of common ground, and the use of experiential methods to assist strengthening the alliance and develop group cohesion are utilised. There is more emphasis in this mode, compared to the educative mode, in developing a robust bond in which the therapist encourages a trusting relationship underpinned by mutual respect and inspires behavioural change.

Coding

There are three forms of engaging clients in the treatment process observed in therapists using this mode. These are: fostering the quality of the therapeutic relationship, fostering treatment engagement to encourage clients to undertake relevant treatment activities, and the use of change strategies to inspire client involvement in session and/or use of pro-social skills.

Fosters therapeutic relationship – This describes therapists’ attempts at building and/or strengthening the quality of the therapeutic relationship with one particular client or more generally with group members. These items particularly focus on the connection between therapists and group members.

1. Validates concerns: If one or more clients in the group express dissatisfaction with their situation, tasks that need to be undertaken, or decisions that have impacted on the group (e.g., changes in program timetable, changes in facilitation arrangements, disclosure of personal information in life story activities), therapists validate these concerns by acknowledging and accepting the difficulty being expressed and conveying an understanding of the clients’ response.
2. Offers support: Therapists offer support to clients who demonstrate that they are having difficulty either in the treatment process or outside of group. Support can include conveying a level of emotional support towards clients and/or assisting clients by engaging in problem-solving to assist resolution of the difficulty in session. Support can either be offered directly to clients by therapists or by asking group members to convey their experiences to assist the client’s situation.
3. Encourages involvement: Therapists encourage clients to participate in the treatment process by asking specific questions about comments made, inviting clients to comment on whether they can relate to a topic of discussion, or by suggesting they provide more information if only a minimal response was made. The context in which this encouragement occurs is by therapists maintaining a level of interest and understanding in what is being said.
4. Establishes common ground: Therapists establish common ground with clients by conveying a shared interest and commitment towards their well-being. Specifically, therapists might agree with clients stated treatment goals and acknowledge the treatment tasks that have assisted in their progress. Therapists might also establish common ground more broadly by commenting on the commonalities between their goals, values, and experiences.

Fosters treatment engagement – This describes techniques to encourage treatment engagement. This
includes attending to issues of treatment readiness by modifying activities in the moment or responding to clients in a way that encourages their willingness to undertake tasks.

5. **Encourages group to assist in resolving group problems**: Where a group problem is identified in relation to either the task being nominated by therapists or the quality of relationships with therapists and/or clients, therapists will **encourage clients to explore the problem together**. The outcome of this process will be for the group to establish a means of continuing to undertake treatment together in a meaningful manner.

6. **Changes goals to meet clients’ needs**: When group members object to the goals of treatment, such as the relevance of topics and tasks being undertaken or direction of sessions, therapists agree to **respond to the issues raised** and then demonstrate appropriate modifications. This might include modification of tasks to focus on what is considered a more relevant treatment goal. For example, if the topic of anger management was viewed by participants as not relevant to them, the therapist might talk more generally about self-regulation. If clients deny they are at risk of re-offending, a therapist might suggest focussing on factors that will stop them getting into trouble again.

7. **Changes tasks if clients do not want to undertake prepared activity**: Should one or more client object to a suggested task, the therapists **change the request** to accommodate the perceived problematic nature of it while maintaining the same treatment goal. This might include therapists nominating a different activity or modifying a task to accommodate the difficulty raised.

8. **Reinforces goals of treatment**: When group members object to the goals of treatment, such as the relevance of tasks being undertaken or general pace and/or direction of sessions, therapists **reinforce the purpose and relevance** of the intended goals of treatment. This should occur without modifying the focus of the session or changing activities, but by providing an explanation as to why the focus is relevant to group members.

9. **Explains rationale for a task**: Should clients object to tasks set by therapists, they will **explain the rationale** of the task and perhaps its link to the therapeutic goal being addressed. This will include the therapist providing some explanation of the relevance and/or importance of undertaking the suggested task.

**Change strategies** – Therapists will utilise a range of change strategies, including motivational interviewing techniques, to encourage engagement in treatment when clients are ambivalent to the process of change. Change strategies have a dual function, which is to encourage the development of skills and shift ambivalence to increase openness to enacting new behaviours.

10. **Encourages self-reflection**: Therapists maintain a stance of curiosity and engage in a Socratic style of questioning to **encourage clients to explore their own behaviour and situation**. This should involve therapists asking open-ended follow-up questions to facilitate clients reflecting on their own situation and/or consequences of their particular behaviour.

11. **Rolls with resistance**: If clients become argumentative and disagree with therapists, the therapist rolls with this resistance by not engaging in arguments or responding defensively but **acknowledging the clients’ difficulties and inviting (rather than imposing) them to view their problem from a different perspective**.

12. **Develops discrepancy**: Therapists develop discrepancy for clients when they **point to differences** between current behaviour (ie., issues raised or behaviours demonstrated in group) and goals the client has previously articulated as important to achieving. The therapist will openly explore the nature of a discrepancy while also inviting reflection on new behaviours that would be
expected to be more aligned with previously expressed pro-social goals.

13. **Promotes the possibility of change**: Therapists promote the possibility of change when they *explore clients’ self-efficacy* with respect to their ability and confidence to enact required behaviours to effect positive change, as well as encourage practice of new skills. This enables therapists to address views around clients’ ability to change and provides an opportunity to discuss relevant activities and goals to assist their situation.

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<tr>
<th>Engagement Mode</th>
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<td><strong>Fosters therapeutic relationship</strong></td>
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<td>1. Validates concerns</td>
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<td>2. Offers support</td>
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<td>3. Encourages involvement</td>
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<td>4. Establishes common ground</td>
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<tr>
<td><strong>Fosters treatment engagement</strong></td>
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<td>5. Encourages group to assist in resolving group problems</td>
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<td>6. Changes goals to meet clients’ needs</td>
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<td>7. Changes tasks if clients do not want to undertake prepared activity</td>
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<td>8. Reinforces goals of treatment</td>
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<td>9. Explains rationale for a task</td>
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<td><strong>Change strategies</strong></td>
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<td>10. Encourages self-reflection</td>
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<td>11. Rolls with resistance</td>
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<td>12. Develops discrepancy</td>
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<td>13. Promotes the possibility of change</td>
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The Therapeutic Mode

Coding
There are three types of strategies observed in therapists using this mode. These are: direct analysis of the quality of the therapeutic relationship, raising awareness in relation to clients’ behaviour as an important task to facilitate change, and the promotion of skill building to address dynamic risk as the primary therapeutic goal to be achieved.

Analyses the therapeutic relationship – Therapists will focus closely on analysing the strength of the therapeutic relationship to ensure that any ruptures created as a consequence of challenges can be repaired or to facilitate change through offering new relational experiences to clients.

1. Acknowledges difficulties in treatment relationship with a client: Where therapists identify problems in the relational experience with a client, they will acknowledge and explore the difficulty with a view to repairing problems. Acknowledgement of the strain in the bond is an important part of this process along with encouraging the client to communicate their preferred interpersonal responses (e.g., to provide opportunities for clients to describe their experiences).

2. Explores status of relationship with therapists: Therapists check-in with clients about their experiences in treatment and with the therapist to explore and resolve problems in the therapeutic relationship. This item is distinguished from item 1 in that the therapist’s behaviour is not instigated by any obvious difficulties in the relationship, although more subtle behaviours may be present suggesting problems (e.g., being evasive of therapists questions, not completing homework). Discussion will engage clients around means of better accommodating their treatment experience (e.g., to be less confronting when challenging behaviour).

3. Provides clients with new relational experiences: Therapists and group members provide new relational experiences for clients as signified by the therapist making links between a client’s appropriate behaviour towards therapists and/or other group members, and contrasting this with how they have previously responded to others in their lives who have been dysfunctional (e.g., in invalidating or abusive environments).

Awareness raising – Therapists will utilise a number of techniques to facilitate awareness of client’s behaviours to increase insight. The manner in which clients’ behaviour is processed not only raises a client’s awareness of their own behaviours and the link between this and dysfunctional behaviours, but should improve a client’s attitude to enacting behaviour change.

4. Provides client feedback: Feedback is provided to clients with a view to promoting a better understanding of their behaviour (e.g., motivations, desires, defences, affective experiences). This should provide some impetus for clients to consider how their behaviour has impacted on themselves and/or others, particularly in relation to their offending, as well as more helpful means of behaving to meet their needs.

5. Challenges clients to create dissonance: A discrepancy between a client’s ideal values and beliefs with current beliefs and/or behaviour is revealed resulting in the client demonstrating a level of discomfort. The affective response from the client has the impact of motivating different behaviours.

6. Reflects own responses to client’s behaviour to explore their dysfunction: Therapists reflect on their own responses to a client, referring to actual or expected responses to a client’s behaviour, as a means of exploring dysfunction. The feedback provided to a client considers the consequences of this tendency in conjunction with some impetus for clients to consider enacting more helpful behaviours.

7. Illuminates offence-paralleling behaviour: Specific reference is made to a client’s current
behaviours, either in or out of session, and the *link between this and their offending* behaviour. Discussion should include clear examples linking current behaviours with past offending and suggestions for alternative prosocial behaviours.

**Skill building** – This describes therapists creating situations in treatment where pertinent behaviour change is identified and encouraged to assist the client. This process may occur directly through therapists’ discussion but may also involve discussion with group members and encouragement by the group.

8. **Encourages changes to in-session behaviour:** In-session dysfunctional behaviour is identified and the client is *encouraged to enact alternative behaviour* in future similar situations. This might involve suggestions the client practice the behaviour during these discussions. Agreement might also be sought from other group members to provide feedback to the client on their progress to achieving positive behaviour changes.

9. **Creates opportunities for clients to express their difficulties:** Clients are encouraged to identifying their own emotional experiences and then *express these appropriately*. This might occur in-session initially to assist in the development of emotion regulation and interpersonal skills but then be generalised to outside of session.

10. **Explores pro-social means of achieving the clients’ dysfunctional behaviour:** The function of a client’s dysfunctional behaviour is discussed with a view to identifying alternative pro-social behaviours that will achieve a similar function. Behaviour change is encouraged both in and out of session.
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<th>Therapeutic Mode</th>
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<tr>
<td><strong>Analyses the therapeutic relationship</strong></td>
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<td>1. Acknowledges difficulties in treatment relationship with a client</td>
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<tr>
<td>2. Explores status of relationship with therapists</td>
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<tr>
<td>3. Provides clients with new relational experiences</td>
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<tr>
<td><strong>Awareness raising</strong></td>
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<td>4. Provides client feedback</td>
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<td>5. Challenges clients to create dissonance</td>
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<td><strong>Skill building</strong></td>
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<td>8. Encourages changes to in-session behaviour</td>
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<td>9. Creates opportunities for clients to express their difficulties</td>
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<td>10. Explores pro-social means of achieving the clients’ dysfunctional behaviour</td>
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References


Appendix 13 – Study Three Group Rupture Rating System (GRRS)

Group Rupture Rating System (GRRS)

A rupture denotes a client’s experience within treatment that challenges aspects of the therapeutic alliance. Bordin (1994) conceived of the alliance as comprising three elements: the negotiation of tasks, identification of and then working towards therapeutic goals that most pertinently capture a client’s therapeutic needs, and the development of a therapeutic bond to assist this process. The occurrence of ruptures within treatment is characterised by a client demonstrating either a lack of collaboration in undertaking a group task, having problems with the goals of treatment, and/or strains in the bond. This definition is drawn from Safran and colleagues’ conceptualisation, which emphasises a lack of collaboration between therapist and client as the critical aspect of a rupture (Safran, Muran, Samstag, & Stevens, 2002).

The Rupture Resolution Rating System (3Rs; Mitchell, Eubanks-Carter, Muran & Safran, 2011) provides a process for identifying both the occurrence of ruptures as well as efforts taken by a therapist to resolve ruptures. The Group Rupture Rating System (GRRS) for offending behaviour programs is based on this process but also draws on qualitative research conducted on the delivery of offending behaviour programs (Kozar & Day, 2013). The 3Rs provides a process to identify the occurrence of ruptures by focussing on client behaviours that denote either a withdrawal, confrontation, miscellaneous, or mixed rupture within a group treatment session while also determining the efficacy of a range of rupture resolution strategies implemented by therapists. Withdrawal ruptures occur when clients move away from therapists (e.g., avoid questions) or move towards the therapist but in a way that denies important elements of their own experience (e.g., by being deferential and appeasing). By contrast, confrontation ruptures occur when clients move against the therapist by expressing anger or dissatisfaction articulated in a non-collaborative manner (e.g., complaining in a hostile manner about treatment) or by trying to pressure or control therapists (e.g., making demands of the therapist). A mixed rupture occurs when both elements of withdrawal and confrontation ruptures are evident (e.g., saying ‘No’ in a hostile manner to a therapist’s request for more information, and then being silent). Other ruptures are classified as miscellaneous when they do not fit into any of these categories, such as when a client behaves in a seductive manner or is inappropriately casual for a therapeutic context. The GRRS similarly outlines a process of identifying ruptures, and categorising each as either a confrontation, withdrawal, or mixed ruptures, but then also determining personality dysfunction triggered during the rupture.

Kozar and Day found in focus groups conducted with therapists on issues relating to therapeutic ruptures within offending behaviour programs that a broad range of client behaviours were identified as signifying a problem in the therapeutic alliance. These behaviours were associated with personality dysfunction, such as when clients responded to therapist comments or requests by articulating high levels of grandiosity, anti-social and pro-offending attitudes, and/or statements in which they degraded therapists. In addition, some therapists identified clients withdrawing or limiting their participation from programs as problematic to the alliance. It would seem, therefore, that when maladaptively high or low personality traits are demonstrated, this should alert the therapist to potential problems in the alliance, and the Five Factor Model (FFM; Costa & McCrae, 1990) of personality was seen as an appropriate means of identifying a range of personality dysfunction triggered within a group program context to assist the process of identifying ruptures. Each of the behaviours signifying a potential rupture was mapped onto each of the five factors of Neuroticism (N; e.g., high levels of anger), Extraversion (E; e.g.,
being socially withdrawn), Openness to experience (O; e.g., denies their observed emotional state), Agreeableness (A; e.g., being derogatory to therapists or other clients), and Conscientiousness (C; e.g., habitually arrives late). This information can then be used to assist informing rupture repair strategies (e.g., to ‘roll with resistance’ when clients demonstrate Neuroticism – High Angry Hostility (rageful) responses in treatment).

Although the origins of a rupture may have emanated from a therapist’s behaviour (e.g., a therapist being critical or judgemental of a client) the GRRS focuses on clients’ behaviours as the critical element signalling the occurrence of ruptures. This is considered more indicative of the strength of an alliance as the client’s ability and willingness to engage in a collaborative process is fundamental despite how an observer might interpret a therapist’s actions. It requires clients to undertake relevant therapeutic tasks, enact behaviours consistent with stated goals, and to enter into constructive discussions with the therapist about this process. Ruptures are viewed as inevitable within this context as clients will have their own treatment agenda, such as beliefs about the goals they think are most relevant, what activities they think are most useful to achieve these goals, and views on the type of therapist attributes they best relate to, and these will invariably contrast at points with therapists’ views. When differences emerge, unresolved issues may impinge on the therapeutic endeavour.

Efforts by therapists to repair ruptures are referred to as rupture resolution strategies. Within a group context, the process of invoking rupture resolution strategies is markedly complex in contrast to those initiated within a dyad. Group treatment programs invariably comprise co-facilitators and perhaps ten group participants. Rupture resolution strategies might, therefore, be initiated by either a therapist or a group participant. This latter is more likely to occur when a level of group cohesion has developed within a group such that group members take responsibility for assisting other group members’ involvement in the group and in the process of achieving therapeutic gains. These types of behaviours would be typically encouraged and reinforced by therapists, although therapists should maintain leadership of a group. It is the efforts by therapists to initiate rupture resolution strategies that is the focus of this measure. While a therapist might address a client who has demonstrated behaviour indicative of a rupture directly, he or she may alternatively address the group as a whole, or one or more specific group participants, in an effort to resolve the rupture. Rupture resolution strategies are categorised on the basis of three different alliance modes: educative, engagement and therapeutic. In the educative mode, therapists are focussed on ensuring appropriate behaviour is demonstrated by clients so therapists may refer to group rules or redirect group participants back to a delegated task in an effort to manage participants engaging in disruptive behaviours. Therapists who are in the engagement mode are focussed on adapting their facilitation style and program content to meet the characteristics of clients, so they might respond to a rupture marker by validating the client’s concerns, changing tasks or using motivational interviewing techniques. In the therapeutic mode, therapists are focussed on eliciting therapeutic transformation, so will directly check in with clients in relation to the strength of the therapeutic relationship as well as utilise rupture markers as opportunities for increasing client’s understanding of their behaviour and opportunities for skill-building.

**Coding Procedure Summary**

To identify both ruptures and rupture resolution strategies using the GRRS, observers must be familiar with the FFM and rupture resolution strategies within the educative, engagement and therapeutic alliance modes. Observers then complete a number of stages:
This coding procedure is closely based on the 3Rs, although these processes have been enhanced based on qualitative research conducted on the delivery of offending behaviour programs (Kozar & Day, 2013).

1. **Watch the session**: An audio-visual recording of the session should be watched in its entirety as the observation sheet is completed. It is not possible to conduct this procedure from transcripts or audio-recordings alone as observations of non-verbal cues are critical, particularly in making judgements about rupture markers demonstrated by clients. Segments of recordings should be re-watched to ensure the accuracy of judgements being made, and it may be worthwhile to re-watch the entire recording to ensure subtle demonstrations of, for example, clients withdrawing from the treatment process have been captured.

2. **Complete a Session Running Sheet** while watching the video. A means of identifying therapists and clients consistently should be developed to facilitate identification of rupture markers demonstrated by each client, strategies enacted by each therapist, and rupture resolution markers for each client across the session. If clients’ names are unknown, for example, a consistent numbering system can be used to facilitate this process. Note the tasks undertaken (e.g., check-in, victim empathy exercise, paired-activities) and the contribution of therapists and clients to these tasks and discussions by summarising both actions and what is said. In addition, pertinent quotes can be recorded to demonstrate important behaviours relating to rupture markers, rupture repair strategies, and subsequent client behaviours.

3. **An Observation Sheet** is completed for ruptures while viewing the video in which the following are noted:
   i) **The timing and observations of client behaviours indicative of rupture markers as they occur**. The specific behaviours observed should be noted. As it is not possible to simultaneously note all client behaviours, those behaviours that are overt rupture markers as well as withdrawal markers relating to clients who demonstrate a consistent lack of engagement in a session should be noted. This might also include if a client is observed to be turning or moving away from therapists and/or clients. Once the behaviour denoting a rupture marker is noted, the personality factor (maladaptively high or low levels of N, E, O, A, C) and the facet trait within that factor are noted along with a rating of the likely impact of the rupture on the strength of the alliance (1 = no/little impact to 5 = profound impact). A note should then be made on whether the rupture signifies a confrontation, withdrawal, or mixed rupture.
   ii) **Strategies invoked by therapists to resolve ruptures**. The specific behaviour/s observed should be noted, then the category (educative, engagement, therapeutic) and sub-category (e.g., attend to quality of bond, boundary setting) of the strategy identified.
   iii) **Subsequent client behaviours**. Client behaviours subsequent to a rupture marker and (where present) responses to rupture resolution strategies are then noted. These might include behaviours indicative of clients re-engaging in the treatment process, as demonstrated through self-disclosure and reflection or other meaningful participation in tasks, or continuing evidence that the rupture remains unresolved, such as withdrawing participation and/or demonstrating hostility. The likely impact of the rupture on the strength of the alliance should then be re-rated (1 = no/very...
Ruptures

Observe a rupture: As described above, a rupture signifies a deterioration in the therapeutic alliance, which threatens the capacity of the interaction between therapists and clients to assist in achieving therapeutic gains. In group treatment, a rupture marker demonstrated by one client may not necessarily signify that all clients will not benefit from treatment, although the impact of any rupture should signal that close attention be paid to the extent to which it impacts on group cohesion, and therefore the subsequent demonstration of rupture markers by other clients. This is particularly important in situations in which therapists have not invoked rupture repair strategies to resolve a particular rupture.

Rupture markers are observed when a client demonstrates either a lack of collaboration in undertaking a group task, has problems with the goals of treatment, and/or is experiencing strains in the bond. The critical aspect observed in a rupture is a lack of collaboration, perhaps due to a client’s lack of trust or respect for the therapeutic process, demonstration of negative affect such as hostility and aggression, or demonstrating withdrawal and avoidance such that it impacts on elements of the therapeutic alliance. Clients might, on the other hand, articulate hopelessness, disappointment, or dissatisfaction in therapy without demonstrating a rupture provided that these experiences do not threaten the quality of the bond required to continue undertaking the work and that the client is engaged in the treatment process to continue negotiating the required tasks to achieve goals most pertinent for therapeutic gains.

Behaviours which are indicative of maladaptively high Neuroticism (e.g., high levels of hostility), low (e.g., emotionally cold towards others) or high Extraversion (e.g., dominant), low Openness to experience (e.g., concrete), low Agreeableness (e.g., mistrustful), and low Conscientiousness (e.g., irresponsible) are considered to pose particular difficulties in the therapeutic alliance. Based on a modification of Widiger’s (2009) Five-Factor Form, which outlines maladaptively high and low trait facets for each of the personality factors of the FFM, Table 1 details the range of behaviours that may be demonstrated within offending behaviour programs that may be indicative of therapeutic ruptures. It should be noted that these behaviours in and of themselves do not necessarily equate to ruptures, so attention needs to be paid to the context in which the behaviour occurs to determine whether it denotes difficulties within the therapeutic alliance. For example, a client may become visibly upset and either continue to engage therapeutically within the session (not a rupture event) or become socially withdrawn and shamed by the experience (potential rupture event in which the strength of the bond with therapists may be threatened and/or the quality of the client’s participation in tasks deteriorates and/or a lack of commitment to achieving treatment goals). Additional behaviours to those listed may also be indicative of ruptures when these impact on aspects of the therapeutic alliance, and can be categorised using the different personality facet traits as a guide.

The specific client, time, and the behaviours indicative of a rupture marker during a particular treatment task (e.g., check-in, a role-play or other experiential activity, a group discussion on emotion regulation strategies, mindfulness practice, an offence process discussion, or a victim empathy exercise) are then noted on the Observation Sheet as the audio-visual tape is viewed. A determination of the relevant personality factor (N, E, O, A or C) for the client’s primary presentation is then noted, along with whether it is indicative of high or low levels of the relevant personality facet. Although any one particular client behaviour may indicate the presence of a combination of personality factors, such as a client who impulsively responds that they ‘don’t know’ the answer to a therapist’s invitation to self-
reflect, the most prominent aspect of their behaviour should be noted on the observation sheet (ie. Neuroticism – High impulsivity (unable to resist impulses) or Openness – Low ideas (Close-minded)) depending on the observers judgement of what factor is likely to most impact on a client’s ability to form an alliance and engage in the therapeutic process.

Ruptures are further categorised as withdrawal, confrontation or mixed ruptures.

**Withdrawal ruptures** - when clients move away from therapists (e.g., avoid questions) or move towards the therapist but in a way that denies important elements of their own experience (e.g., acquiescing to treatment requests or appeasing therapists or group members).

**Confrontation ruptures** - when clients move against the therapist by expressing anger or dissatisfaction articulated in a non-collaborative manner (e.g., complaining in a hostile manner about treatment) or by trying to pressure or control therapists (e.g., making demands of the therapist or other group members).

Ruptures may be categorised as a mixed rupture if a client’s interaction demonstrates elements of both withdrawal and confrontation ruptures (e.g., angrily refuses to undertake an activity and then sits silently).

Other ruptures, which should be rare, are classified as miscellaneous.

**Decide the likely impact of the rupture on the strength of the alliance:** Once a rupture is identified and the relevant personality factor and trait facet have been identified, its likely impact on the strength of the alliance is then rated on a five-point scale:

- 1 = No/very low impact
- 2 = Low impact
- 3 = Moderate impact
- 4 = High impact
- 5 = Very high impact

Only those rupture markers rated a ‘3’ or higher are then considered on the observation sheet, including whether rupture repair strategies were utilised to respond to identified rupture markers.

**Table 1:**
Summary of personality facet traits indicative of a rupture in the therapeutic alliance with corresponding observable client behaviour

<table>
<thead>
<tr>
<th>Personality Factor &amp; Facet Trait</th>
<th>Observable Client Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neuroticism</td>
<td></td>
</tr>
<tr>
<td>High Angry hostility = Rageful</td>
<td>Threatens to leave treatment</td>
</tr>
<tr>
<td></td>
<td>Raises voice</td>
</tr>
<tr>
<td></td>
<td>Swears at therapist/s and/or clients</td>
</tr>
<tr>
<td></td>
<td>Becomes physically imposing towards others</td>
</tr>
<tr>
<td>High Vulnerability = Helpless &amp; Overwhelmed</td>
<td>Feels overwhelmed by therapist</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Trait</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Impulsivity = Unable to resist impulses</td>
<td>Leaves a treatment session prematurely</td>
</tr>
<tr>
<td>Low Self-Consciousness = Glib</td>
<td>Struggles with waiting to contribute</td>
</tr>
<tr>
<td>High Self-Consciousness = Uncertain of self</td>
<td>Presents as inauthentic</td>
</tr>
<tr>
<td>High Depressiveness = Depressed</td>
<td>Becomes defensive</td>
</tr>
<tr>
<td>High Anxiousness = Fearful &amp; Anxious</td>
<td>Highly sensitive to criticism</td>
</tr>
<tr>
<td></td>
<td>'Stuck' on experiences of victimisation</td>
</tr>
</tbody>
</table>

**Extraversion**

| High Assertiveness = Dominant & Pushy | Seeks therapist personal information                                         |
| Low Assertiveness = Resigned & Uninfluential | 'Competes' with therapist/s                                                  |
| Low Warmth = Cold & Distant          | Insists on talking about own issues unrelated to group agenda                |
| Low Gregariousness = Socially Withdrawn & Isolated | Acquiesces to therapist’s comment/suggestion                               |
|                                  | Moves away or is unwilling to sit close to clients                          |
|                                  | Turns away from clients/therapists                                           |
|                                  | Lack of relatedness with therapists/clients                                  |
|                                  | Resists attempts by therapists/and/or clients to build relatedness           |
|                                  | Avoids discussion with therapists/clients                                    |
|                                  | Provides minimal responses to questions                                      |

**Openness**

| Low Fantasy = Concrete             | High level of rigidity                                                      |
| Low Feelings = Alexithymic         | Difficulty grasping program content                                         |
| Low Aesthetics = Disinterested     | Does not reveal emotional state                                              |
| Low Ideas = Close-minded          | Denies emotional state                                                       |
|                                  | Disinterested in others’ contributions                                       |
|                                  | Aloof and casual                                                            |
|                                  | Insists they have already made sufficient changes                           |
|                                  | Unwilling to explore their behaviour                                         |
|                                  | Says they ‘don’t know’ in response to questions                              |

**Agreeableness**

| Low Altruism = Self-centred & Exploitative | Fosters a 'special relationship' with one therapist                          |
| Low Compliance = Combative & Aggressive   | Sexually provocative (e.g., touches own genitals)                            |
| Low Modesty = Arrogant & Pretentious | Makes unreasonable requests of therapist/s  
Complains about treatment/homework requirements |
|--------------------------------------|-----------------------------------------------|
| Low Straight forwardness = Deceptive, Dishonest & Manipulative | Does not agree with a therapeutic goal  
Unwilling to undertake nominated task/activity  
Derogatory to therapists/clients |
| Low Trust = Cynical & Suspicious | Dismissive of therapists/clients' questions  
Demonstrates sarcasm or mocks therapists  
Articulates that therapist/s do not know what they are doing and/or cannot help with treatment  
Interacts favourably with some clients and not others or therapists |
| Low Conscientiousness | Provides inconsistent accounts of their own behaviour  
Provides implausible account of their behaviour  
Demonstrates inconsistency between what is said and affect/behaviour  
Notice favouritism towards other clients  
'Tests' the therapeutic relationship  
Guarded in what is said |
| Low Achievement = Aimless & Desultory | Makes a lot of jokes  
Fails to accept responsibility for behaviour or their treatment  
Minimises the impact of their own behaviour  
Arrives late  
Describes their offending in a positive light |
| Low Dutifulness = Irresponsible, undependable & Immoral | |

**Miscellaneous**

- Client physical complaints  
- Limited understanding of English  
- Is effected by drugs/alcohol

Based on the Five Factor Form (Widiger, 2009)

**Rupture Resolution Strategies**

**Observe rupture resolution strategies:** A rupture repair strategy must occur within the context of a rupture. It may be enacted either immediately or sometime after a rupture is demonstrated by a group member, but be clearly linked to the initial rupture marker. This may occur by a therapist directly acknowledging the rupture within the context of attempts at repairing it (e.g., pointing out breaches and then asserting group rules that were broken by the rupture marker) or indirectly through strategies that accommodate the predominant personality factor demonstrated by the client (e.g., changing tasks to...
accommodate clients’ objecting to a suggested tasks, but without reference to the clients’ objections).

Details of the rupture repair strategy should be outlined on the observation sheet. The primary category (educative, engagement or therapeutic) and sub-category of rupture resolution strategies are also noted. It may be that a strategy is invoked that combines two categories, such as when a therapist suggests that group participants focus on the discussion (Educative – boundary setting) but then acknowledges the client’s hostility and observes the parallel between this behaviour and his offending behaviour (Therapeutic – process client experience). The observer should note the primary category and sub-category that seems most pertinent to assisting in the resolution of the rupture.

Table 2 outlines a range of therapist behaviours indicative of educative, engagement and therapeutic alliance mode rupture repair strategies. Specific therapists’ observable behaviours indicative of rupture repair responses not included in this table but which fit into the rupture repair sub-categories should be included in this analysis. Categories and sub-categories for each rupture repair strategy should be noted on the Observation Sheet. If no rupture repair strategies are observed during the session in relation to the rupture marker, the observer should note this in the space provided at the completion of the observation session.

**Observe subsequent client behaviour:** A rupture is repaired or resolved when there is a significant and positive shift back to the therapeutic alliance. This would result in observations around subsequent agreement on tasks to be undertaken or therapeutic goals, greater collaboration with undertaking tasks (e.g., an enhanced level of relevant self-disclosure, self-reflections, changes to identified problematic in-session behaviour), and improvements in the quality of relatedness between client and therapist/s. In this way, mutual respect, adherence to group rules, an ability to discuss differences in a collaborative manner and clients making contributions to group discussion as well as towards other group members would be typically observed when a rupture has been resolved or repaired.

It may be that clients spontaneously enact these behaviours without therapists making any discernible attempts at resolving a rupture or that group members assist in resolving ruptures. Regardless of therapist or other clients’ intervening behaviours, relevant observed client behaviours indicative of rupture repair should be noted on the Observation Sheet along with any continuing evidence that the rupture has not been repaired. This latter might include a continuation of behaviour consistent with the rupture marker but also includes behaviours such as not contributing to further group discussion, refusing to continue participating in a task, hostility and/or disruptive behaviour.

**Re-rate the likely impact of the rupture on the strength of the alliance:** Once any subsequent client behaviours have been noted on the Observation Sheet, the likely impact of the rupture or rupture/repair episode on the strength of the alliance is then re-rated on the same five-point scale:

- 1 = No/very low impact
- 2 = Low impact
- 3 = Moderate impact
- 4 = High impact
- 5 = Very high impact

If the client does not demonstrate any behaviours indicative of the rupture being repaired or resolved,
the same rating as initially observed should be placed in the space provided.

A change score is then calculated by subtracting the re-rated score from the initial score, and this number is then placed in the final column of the Observation Sheet.

Table 2: Summary of rupture repair strategy categories and sub-categories based on examples of therapist behaviour

<table>
<thead>
<tr>
<th>Alliance Sub-category</th>
<th>Observable Therapist Behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Educative</strong></td>
<td></td>
</tr>
<tr>
<td>- Respond to issues by asserting group rules</td>
<td>- References are made to group rules to encourage compliance</td>
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<tr>
<td></td>
<td>- Problem behaviours are reflected as breaches in the rules and compliance urged</td>
</tr>
<tr>
<td></td>
<td>- Consequences of non-compliance with rules are discussed</td>
</tr>
<tr>
<td></td>
<td>- New group rules are developed to address an issue of concern</td>
</tr>
<tr>
<td>- Boundary setting to limit difficult behaviour</td>
<td>- Re-directs discussion back to intended task</td>
</tr>
<tr>
<td></td>
<td>- Shuts down client’s contributions if not relevant or dominating a group</td>
</tr>
<tr>
<td></td>
<td>- Issues regarding client safety are raised to identify and shift difficult behaviour</td>
</tr>
<tr>
<td></td>
<td>- Boundaries of appropriate behaviour are articulated and expectations communicated around future behaviour</td>
</tr>
<tr>
<td>- Negotiation with participants to compromise on needs</td>
<td>- Suggest a client leaves if they cannot contain themselves</td>
</tr>
<tr>
<td></td>
<td>- Negotiates client involvement such as the amount of contribution expected</td>
</tr>
<tr>
<td></td>
<td>- Suggest that the issue of concern is discussed out of session</td>
</tr>
<tr>
<td></td>
<td>- Suggest that the issue of concern is discussed with a manager</td>
</tr>
<tr>
<td></td>
<td>- Provide opportunities for clients to demonstrate group leadership, such as writing on the white-board</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td></td>
</tr>
<tr>
<td>- Demonstrate positive therapist characteristics</td>
<td>- Validate concerns</td>
</tr>
<tr>
<td></td>
<td>- Encourage participation</td>
</tr>
<tr>
<td></td>
<td>- Foster acceptance of the difficulties encountered by clients</td>
</tr>
<tr>
<td></td>
<td>- Express empathy</td>
</tr>
<tr>
<td></td>
<td>- Demonstrate transparency when discussing a problem</td>
</tr>
</tbody>
</table>
- Develop opportunities for self-reflection to respond to difficulties
  - Offer support
  - Create a shared commitment to client change by communicating an affinity with desired goals
  - Encourage group to explore group process or client behaviour
  - Have the group explore and assist in resolving group problems
  - Invite the client to reflect on a motivation, desire or concern

- Respond flexibly/modify approach to respond to client needs
  - Change goals to meet clients’ needs
  - Change tasks if clients do not want to undertake suggested activity
  - Use an experiential activity to foster cohesion
  - Reinforce goals of treatment
  - Explain rationale for a task
  - Encourage change
  - Engage in Socratic questioning
  - Roll with resistance
  - Develop discrepancy between observed/reported behaviour and stated goals

**Therapeutic**

- Focus on the quality of the therapeutic bond
  - Acknowledge difficulties in treatment relationship with a client
  - Explore status of relationship with therapists

- Process client experience to inspire change
  - Process the issue and provides client feedback to motivate change
  - Reflect on own responses to client’s behaviour to explore their dysfunction
  - Illuminate offence-paralleling behaviour

- Create change opportunities in response to dysfunction
  - Encourages changes to in-session behaviour
  - Creates opportunities for clients to express their difficulties
  - Explores pro-social means of achieving the clients’ dysfunctional behaviour
GRRS Observation Sheet

Date: __________   Group: _________________   Therapist: _________________   Therapist: _________________

Personality Factors and Trait Facets

Neuroticism (N): High Angry Hostility; High Vulnerability (helpless & overwhelmed); High Impulsivity; Low Self-Consciousness (glib); High Self-Consciousness (uncertain of self); High Depressiveness; High Anxiousness

Extraversion (E): High Assertiveness (dominant and pushy); Low Assertiveness (resigned & uninfluential), Low Warmth (cold and distant); Low Gregariousness (socially withdrawn and isolated)

Openness (O): Low Fantasy (concrete); Low Feelings (alexithymic); Low Aesthetics (disinterested); Low Ideas (close-minded)

Agreeableness (A): Low Altruism (self-centred and exploitative); Low Compliance (combative and aggressive); Low Modesty (arrogant and pretentious); Low Straightforwardness (deceptive, dishonest and manipulative); Low Trust (cynical and suspicious)

Conscientiousness (C): Low Achievement (aimless and desultory); Low Dutifulness (irresponsible, undependable and immoral)

Rating the likely impact on the strength of the alliance

1 = No/very low impact; 2 = Low impact; 3 = Moderate impact; 4 = High impact; 5 = Very high impact

Rupture repair strategy categories and sub-categories

Educative (Edu): Group Rules; Boundary Setting; Negotiation
Engagement (Engt): Positive Therapist Characteristics; Opportunities for Self-Reflection; Respond Flexibly/Modify Approach; Change Strategies
Therapeutic (Ther): Quality of the Bond; Process Client Experience; Create Change Opportunities

<table>
<thead>
<tr>
<th>Rupture event #1</th>
<th>Client Rupture Marker</th>
<th>Personality Factor (circle)</th>
<th>Impact Rating (1 – 5)</th>
<th>Re-rate Impact (1 – 5)</th>
<th>Change Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td></td>
<td>N E O A C</td>
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</tbody>
</table>
### Rupture resolution strategy

**Client:**

- **Category (circle):** None Edu Engt Ther

**Sub-category:**

**Therapist behaviour:**

**Rupture event #2**

<table>
<thead>
<tr>
<th>Client Rupture Marker</th>
<th>Personality Factor (circle)</th>
<th>Impact Rating (1 – 5)</th>
<th>Re-rate Impact (1 – 5)</th>
<th>Change Score</th>
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</table>

**Time:**

### Rupture resolution strategy

**Client:**

- **Category (circle):** None Edu Engt Ther

**Sub-category:**

**Therapist behaviour:**

**Rupture event #3**

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<tr>
<th>Client Rupture Marker</th>
<th>Personality Factor (circle)</th>
<th>Impact Rating (1 – 5)</th>
<th>Re-rate Impact (1 – 5)</th>
<th>Change Score</th>
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</tbody>
</table>

**Time:**

### Rupture resolution strategy

**Client:**

- **Category (circle):** None Edu Engt Ther

**Sub-category:**

**Therapist behaviour:**

**Rupture event #4**

<table>
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<tr>
<th>Client Rupture Marker</th>
<th>Personality Factor (circle)</th>
<th>Impact Rating (1 – 5)</th>
<th>Re-rate Impact (1 – 5)</th>
<th>Change Score</th>
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<tr>
<td>Time:</td>
<td>Trait Facet</td>
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<tr>
<td>Client:</td>
<td><strong>Rupture resolution strategy</strong></td>
<td><strong>Client subsequent behaviour</strong></td>
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<td>Category (circle): None Edu Engt Ther</td>
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<tr>
<td>Sub-category:</td>
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<tr>
<td>Therapist behaviour:</td>
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<thead>
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<th>Rupture event</th>
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</thead>
<tbody>
<tr>
<td>Time:</td>
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</tr>
<tr>
<td>Client:</td>
<td><strong>Rupture resolution strategy</strong></td>
</tr>
<tr>
<td>Category (circle): None Edu Engt Ther</td>
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</tr>
<tr>
<td>Sub-category:</td>
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<tr>
<td>Therapist behaviour:</td>
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</table>

<table>
<thead>
<tr>
<th>Client Rupture Marker</th>
<th>Personality Factor (circle)</th>
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<tbody>
<tr>
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<td></td>
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<tr>
<td>Impact Rating (1 – 5)</td>
<td>Re-rate Impact (1 – 5)</td>
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<tr>
<td>Trait Facet</td>
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<td>Change Score</td>
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<table>
<thead>
<tr>
<th>Rupture event</th>
<th>#6</th>
</tr>
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<tbody>
<tr>
<td>Time:</td>
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</tr>
<tr>
<td>Client:</td>
<td><strong>Rupture resolution strategy</strong></td>
</tr>
<tr>
<td>Category (circle): None Edu Engt Ther</td>
<td></td>
</tr>
<tr>
<td>Sub-category:</td>
<td></td>
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<tr>
<td>Therapist behaviour:</td>
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<thead>
<tr>
<th>Client Rupture Marker</th>
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<tr>
<td>Impact Rating (1 – 5)</td>
<td>Re-rate Impact (1 – 5)</td>
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<td>Trait Facet</td>
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<td>Change Score</td>
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<tr>
<td>Rupture event #7</td>
<td>Client Rupture Marker</td>
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<td>Client:</td>
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<tr>
<td>Rupture resolution strategy</td>
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<td>Sub-category:</td>
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<thead>
<tr>
<th>Rupture event #8</th>
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<th>Personality Factor (circle)</th>
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<td>Therapist behaviour:</td>
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<thead>
<tr>
<th>Rupture event #9</th>
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<th>Impact Rating (1–5)</th>
<th>Re-rate Impact (1–5)</th>
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<td>Trait Facet</td>
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<td>Sub-category: Therapist behaviour:</td>
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References


Memorandum

To: Prof Andrew Day  
School of Psychology

cc: Ms Christina K

From: Deakin University Human Research Ethics Committee (DUHREC)

Date: 30 January, 2014

Subject: 2013-279

Alliance modes and rupture resolution strategies in offending behaviour programs

Please quote this project number in all future communications

Approval for this project was granted by the Deakin University Human Research Ethics Committee Executive on 30/01/2014.

Approval has been given for Ms Christina Kozar, under the supervision of Prof Andrew Day, School of Psychology, to undertake this project for four years from 30/01/2014.

The approval given by the Deakin University Human Research Ethics Committee is given only for the project and for the period as stated in the approval. It is your responsibility to contact the Human Research Ethics Unit immediately should any of the following occur:

- Serious or unexpected adverse effects on the participants
- Any proposed changes in the protocol, including extensions of time.
- Any events which might affect the continuing ethical acceptability of the project.
- The project is discontinued before the expected date of completion.
- Modifications are requested by other HRECs.
In addition you will be required to report on the progress of your project at least once every year and at the conclusion of the project. Failure to report as required will result in suspension of your approval to proceed with the project.

DUHREC may need to audit this project as part of the requirements for monitoring set out in the National Statement on Ethical Conduct in Human Research (2007).

Human Research Ethics Unit
research-ethics@deakin.edu.au
Telephone: 03 9251 7123
10 December 2013

Andrew Day
Deakin University

**Re: Alliance modes and rupture resolution in offending behaviour programs**

Dear Andrew,

The Department of Justice Human Research Ethics Committee (JHREC) considered your response to the issues raised in relation to the project *Alliance modes and rupture resolution in offending behaviour programs* at its meeting on **4 December 2013** and has now granted **full approval** for the duration of the investigation. The Department of Justice reference number for this project is CF/13/17675.

However, please address the following items:

1. Ensure that updated items on response letter are reflected accordingly in the Application Form.

2. **Application Form. Q22 – Other ethical issues regarding participation:** In the sentence commencing “The researchers will not remove…….” Please remove the word “not”

3. **Attachment E: Plain Language Statement and Consent Form**
   Please remove the below dot points, with sentences beginning:
   - “The research is being monitored by the Department of Justice Human Research Ethics Committee and…..”
   - “Funding is not needed for this project as there are…….”
Please note the following requirements:

- To confirm JHREC approval sign the Undertaking form attached and provide both an electronic and hardcopy version within ten business days.
- The JHREC is to be notified immediately of any matter that arises that may affect the conduct or continuation of the approved project.
- You are required to provide an Annual Report every 12 months (if applicable) and to provide a completion report at the end of the project (see the Department of Justice Website for the forms).
- Note that for long term/ongoing projects approval is only granted for three years, after which time a completion report is to be submitted and the project renewed with a new application.
- The Department of Justice would also appreciate receiving copies of any relevant publications, papers, theses, conferences presentations or audiovisual materials that result from this research.
- All future correspondence regarding this project must be sent electronically to ethics@justice.vic.gov.au and include the reference number and the project title. Hard copies of signed documents or original correspondence are to be sent to The Secretary, Justice Human Research Ethics Committee, PO Box 4356, Melbourne, Victoria, 3001.

If you have any queries regarding this application you are welcome to contact me on (03) 8684 1514 or email: ethics@justice.vic.gov.au.

Yours sincerely,

Ms Melinda Dundas on behalf of:
Ms Nicole Wilson, Secretary
Department of Justice Human Research Ethics Committee
Project Title: Alliance modes and rupture resolution in offending behaviour programs

Reference No. CF/13/17675

I acknowledge that I have read the conditions outlined in the current guidelines of the Department of Justice Human Research Ethics Committee (JHREC), and undertake to abide by them.

Reporting requirements:

- **RE: Amendments**: I will ensure that an Amendment Request Form is submitted to the JHREC if amendments to the project are required (e.g. staff changes, extension of completion date and adjustments to aims/methodology).

- **RE: Amendments**: If my JHREC application included a Department of Justice (DOJ) letter of support, I will advise the DOJ contact officer of proposed amendments before an amendment request is submitted to the JHREC.

- **RE: Annual Reports**: I will ensure that annual reports are provided if my project extends 12 months in duration.

- **RE: Completion Reports**: I will ensure that a completion report is provided at the conclusion of the research.

- **RE: Long term/ Ongoing Projects**: I acknowledge that if my project is an ongoing/long-term project I need to provide a completion report at the end of every three-year period and renew by submitting a new JHREC application.

Name of Principal Researcher: __________________________________________________________

Signed (Principal Researcher): __________________________________________________________

Date: _______________________________________________________________________________
TO: Therapist and Observer participants

Plain Language Statement

Date: 10 February 2014
Full Project Title: Alliance modes and rupture resolution in offending behaviour programs
Principal Researcher: Professor Andrew Day
Student Researcher: Chris Kozar

- Your name was provided to me by your Senior Clinician as someone eligible to participate in this research or by therapist participants who have already given their consent to be part of this research project.

- The purpose of this research is to examine the way in which therapists develop and respond to problems in the therapeutic alliance in offending behaviour programs. This will assist in developing appropriate models of supervision and training packages to better inform therapists about strategies that will reduce the likelihood that clients will drop out of treatment as well as increase therapeutic opportunities.

- Audio-visual taped group sessions of a number of community-based Sex Offender Programs will be viewed and checklists scored to determine the types of strategies that are used to develop and respond to problems in the alliance. Problems that occur and therapists’ efforts to respond to these will be noted.

- The research requires that all therapists and clients involved in a program to consent to participate for their recordings to be used. Firstly, therapists will be approached then other group members will be asked and, secondly, any new therapists or group
members will also be asked when the researchers are aware that they will be attending group sessions. If you consent, you will be also asked to complete a brief demographic sheet asking about your qualifications and experience. The researchers will complete the measures by viewing the recordings. You will not be required to attend these viewings and senior therapists/managers will not be involved at any stages of the project except to provide names of therapist pairs who are eligible to participate in this research or to consent to the inclusion of any group sessions they attend which are part of the research. They will not be provided any feedback about any of the group sessions observed by the researchers.

- When new clients, new therapists, student observers, senior clinicians, or any other person participates in a group session included in this research project, it would be appreciated if the researchers are contacted at your earliest convenience to negotiate an informed consent process to occur with this person so that the group session/s they are/were participating in can be included. The researchers can be contacted using the details below or you may send an email to ckoz@deakin.edu.au. If an oversight occurs and the researchers become aware once recordings are being viewed that there is someone in attendance who has not provided informed consent, data collection will not occur for this session until you have been contacted and a process to negotiate a meeting to discuss their potential inclusion in the project occurs.

- The student researcher was recently employed as a Senior Clinician within Sex Offender Programs. Your participation, refusal to participate, or withdrawal from participation will not effect any existing relationship you might have with the student researcher and you should be aware that you should only consent to participate in this research if you would like to and have no concerns about your involvement. It will also not effect any aspect of your employment, future opportunities or have any other negative consequences.

- You might experience some discomfort or distress at the thought of the researchers observing group sessions. Should this occur, you are free to withdraw your participation from the research at any time by contacting the researchers by telephone or sending the Withdrawal of Consent form attached. The researchers’ details are included below. There is also a possibility that you, group members, or people you talk about in groups can be identified by the researchers. To reduce this from happening, the researchers will not use any names or identifiable information (like personal stories or details of offences) when reporting results. The research aims to improve therapists’ ability to respond to difficulties in offending behaviour programs by developing supervision and/or training packages, so you may benefit from this research by receiving supervision or training informed by it.
By improving therapists’ ability to respond to difficulties in offending behaviour programs, it is anticipated that clients will respond better to treatment and therefore risk of re-offending will be reduced in the community.

Should you or any other research participant experience difficulties due to being part of this research, you should contact your supervisor immediately. Deakin University will be able to broker services to assist you at no cost to yourself, as required.

Audio-visual recordings will not be removed from Sex Offender Programs, all checklists and measures completed by the researchers will not have names on them and will be kept separately from informed consent forms. No names or identifying information (such as ‘Sex Offender Programs’) will be included in publications about the research, Corrections Victoria staff will not have access to information collected but will check articles written for journals before they are published.

A summary of the results of this research will be made available to Sex Offender Programs to be distributed to all staff. Results will also be reported in a PhD thesis as well as possibly presented in conferences and/or in peer-reviewed journals.

Once the researcher’s degree has been completed, all information is stored by Deakin University for at least five years. After that, the university destroys the information.

You have a right to withdraw from this research at any time, and you may elect for any or all of the group sessions you may have first agreed to be part of this research to be taken out of the analysis at any time before it is written up in a PhD thesis.

If you want any more information, wish to withdraw from the project or if you have any problems with it (for example, feeling stressed), you can contact the researchers:

**Principal Researcher:** Professor Andrew Day  
**Student Researcher:** Ms Chris Kozar

School of Psychology  
Faculty of Health, Medicine, Nursing & Behavioural Sciences  
Geelong Waterfront Campus, 1 Gheringhap St., Geelong 3217  
**Phone** - (Business Hours) 03 5227 8715  fax 03 5227 8621

**Complaints**

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

The Manager, Research Integrity, Deakin University, 221 Burwood Highway,  
Burwood Victoria 3125, Telephone: 9251 7129, research-ethics@deakin.edu.au
Please quote project number 2013-279.

Or contact the Secretary to the Department of Justice Human Research Ethics Committee, 21/121 Exhibition St., Melbourne, 3000.

Please quote project number CF/13/17675
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Therapist/Observer participants

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<th>Consent Form</th>
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<td>Full Project Title:</td>
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I have read and I understand the attached Plain Language Statement.

I freely agree to participate in this project and have audio-visual recordings of relevant group sessions viewed according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant’s Name (printed) .................................................................

Signature ................................................................. Date  ..........................
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Therapist/Observer participants

Withdrawal of Consent Form

(To be used for participants who wish to withdraw from the project)

Date: 10 February 2014
Full Project Title: Alliance modes and rupture resolution in offending behaviour programs
Reference Number: CF/13/17675 & 2013-279

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University or Sex Offender Programs.

Participant’s Name (printed) ...............................................................

Signature .................................................................................. Date .........................

Please mail or fax this form to:

Principal Researcher: Professor Andrew Day
Student Researcher: Ms Chris Kozar
School of Psychology
Faculty of Health, Medicine, Nursing & Behavioural Sciences

Geelong Waterfront Campus, 1 Gheringhap St., Geelong 3217

Phone - (Business Hours) 03 5227 8715  fax 03 5227 8621
Study Three

Therapist Demographics Form

Name: _________________________________

Program: _______________________________

Co-Facilitator: ___________________________

Date: ____________

**Therapist information:**

Date of birth: _____________________________

Completed degrees: _______________________

Years/months delivering offending behaviour programs: _______

Total years/months involved in therapeutic work: _______
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Client participants

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<tr>
<td>Date: 10 February 2014</td>
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<tr>
<td>Principal Researcher: Professor Andrew Day</td>
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<tr>
<td>Student Researcher: Chris Kozar</td>
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</table>

- You are being invited to participate in some research on how programs are delivered.
- The purpose of this research is to look at how therapists deal with problems in offending behaviour treatment programs. We hope this will help support therapists better in the future by looking at the training and support they get.
- Audio-visual taped group sessions of a number of community-based Sex Offender Programs will be viewed and checklists scored to look at how group members are working together and the way therapists deal with any issues.
- The research requires that all therapists and clients who attend group sessions of a program to consent to participate for their recordings to be used. Firstly, your therapists and all other group members will be asked and, secondly, any new therapists or group members will also be asked when the researchers are aware that they will be attending group sessions. The researchers will complete the measures by viewing the recordings without you, therapists, or senior therapists/managers involved.
• The student researcher has also worked as a psychologist for many years. If you have been a client of this researcher before, please let the researcher know as you will not be able to do the research.

• You might experience some stress at the thought of the researchers observing group sessions. If this happens, you are free to withdraw from the research at any time. There is also a possibility that you, group members, or people you talk about in groups can be identified by the researchers. To reduce this from happening, the researchers will not use any names or identifiable information (like personal stories or details of offences) when reporting results.

• By improving therapists’ ability to respond to difficulties in offending behaviour programs, it is hoped that clients will respond better to treatment and therefore risk of re-offending will be reduced in the community.

• Should you or any other research participant experience difficulties due to being part of this research, you should contact your program therapist immediately. Deakin University will be able to get services to assist you at no cost to yourself if needed.

• Audio-visual recordings will not be removed from Sex Offender Programs, all checklists and measures completed by the researchers will not have names on them and will be kept separately from informed consent forms. No names or identifying information (such as ‘Sex Offender Programs’) will be included in any publications about the research, Corrections Victoria staff will not have access to information collected but will check articles written for journals before they are published.

• A summary of the results of this research can be made available to you if you provide an address for them to be sent. Results will also be reported in a PhD thesis as well as possibly presented in conferences and/or in journals.

• *Once the student researcher’s degree has been completed, all information is stored by Deakin University for at least five years. After that, the university destroys the information.*

• You have a right to withdraw from this research at any time, and can do so by telling your therapist who will contact the researchers, or you may contact the researchers yourself either by telephone (the number is below) or by filling in the attached form and sending it by fax or mail. You may elect for any or all of the group sessions you may have first agreed to be part of this research to be taken out of the analysis at any time before it is written up in a PhD thesis.

If you want any more information, wish to withdraw from the project or if you have any problems with it (like feeling stressed), you can contact the researchers:

**Principal Researcher:** Professor Andrew Day

**Student Researcher:** Ms Chris Kozar

School of Psychology
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If you have any complaints about any aspect of the project, the way it is being conducted or any questions about your rights as a research participant, then you may contact:

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Or contact the Secretary to the Department of Justice Human Research Ethics Committee, 21/121 Exhibition St., Melbourne, 3000.

Please quote project number CF/13/17675
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Client participants

Consent Form

Date: 10 February 2014

Full Project Title: Alliance modes and rupture resolution in offending behaviour programs

Reference Number: CF/13/17675 & 2013-279

I have read and I understand the attached Plain Language Statement.

I freely agree to participate in this project and have audio-visual recordings of relevant group sessions viewed according to the conditions in the Plain Language Statement.

I have been given a copy of the Plain Language Statement and Consent Form to keep.

The researcher has agreed not to reveal my identity and personal details, including where information about this project is published, or presented in any public form.

Participant’s Name (printed) ……………………………………………………………………

Signature ……………………………………………………… Date …………………………
PLAIN LANGUAGE STATEMENT AND CONSENT FORM

TO: Client participants

Withdrawal of Consent Form

(To be used for participants who wish to withdraw from the project)

Date: 10 February 2014
Full Project Title: Alliance modes and rupture resolution in offending behaviour programs
Reference Number: CF/13/17675 & 2013-279

I hereby wish to WITHDRAW my consent to participate in the above research project and understand that such withdrawal WILL NOT jeopardise my relationship with Deakin University or Sex Offender Programs.

Participant’s Name (printed) ............................................................................................................

Signature .................................................................................................................. Date .................

Please mail or fax this form to:

Principal Researcher: Professor Andrew Day
Student Researcher: Ms Chris Kozar

School of Psychology
Faculty of Health, Medicine, Nursing & Behavioural Sciences
Geelong Waterfront Campus, 1 Gheringhap St., Geelong 3217

Phone - (Business Hours) 03 5227 8715  fax 03 5227 8621
The Therapeutic Experiences in Offending Behaviour Programs Draft Measure

The Therapeutic Experiences in Offending Behaviour Programs Measure (TEOBP) is a twenty-item questionnaire developed for participants to complete and discuss with the researcher. Responses are made on a five-point Likert-type scale from Strongly Agree, Agree, Unsure, Disagree, or Strongly Disagree and the measure comprises four subscales: Clients' experience of the TA, Clients' perception of therapists' characteristics that help or hinder the TA, Clients' experience of ruptures and Clients' experiences of rupture repair. Items were developed on the basis of the outcomes in Study One in conjunction with drawing on empirical research and theoretical models of the alliance and ruptures.

The Client's experience of the therapeutic alliance subscale comprises four items and was developed based on the outcome in Study One that a consistently held belief by therapists was that better outcomes were achieved for clients when a strong alliance was formed. This subscale is designed to measure the extent to which clients perceive the strength of the alliance with the program facilitator with respect to each of the three elements of Bordin's (1994) model of the therapeutic alliance: identification of a pertinent therapeutic goal (e.g., 'The program activities helped me get closer to achieving my goals'), negotiation of tasks to achieve that goal (e.g., 'I am very satisfied with the activities (exercises, discussions, other work we did in the program'), and development of a therapeutic bond (e.g., 'I got a lot out of the program because I worked really well with the program facilitators').

The client's perception of therapists' characteristics that help or hinder the therapeutic alliance subscale comprises five items and was developed on the basis of the finding in Study One that therapists utilise a range of positive characteristics to assist the development of the therapeutic alliance. This included the development of common ground, being transparent, genuine, honest (e.g., 'The program facilitators were very honest and open'), understanding, empathic and respectful (e.g., 'There was a lot of respect shown between the program facilitators and me'), with therapeutic work based on trust (e.g., 'The program facilitators worked hard to develop trust in our group'). In addition, Ackerman and Hilsenroth's (2001) review of research on therapist characteristics suggests that clients find a range of therapist characteristics helpful in general psychotherapeutic contexts. They found that therapists who are unresponsive, closed off, and unwilling to change their view despite client feedback, form poorer quality alliances. This subscale, therefore, seeks to measure the extent to which clients perceive therapists demonstrating positive attributes as strengthening the TA.

The Client’s experience of ruptures subscale comprises six items and was developed on the basis of findings from Study One suggesting that therapists experience a significant number of ruptures in the delivery of offending behaviour programs due to a myriad of circumstances. These included aggressive and other overt client behaviours (e.g., ‘I often disagreed with the program facilitators’) as well as more passive behaviours (e.g., ‘There were many times I wanted to say something in group but didn’t’). These different categories of ruptures are consistent with Safran and Muran’s (2006) notion of there being two different types of ruptures: ‘confrontation ruptures’, where the client confronts the therapist about issues they are experiencing in the therapy, and ‘withdrawal ruptures’, in which the client complies, defers or withdraws when they are confronted with difficulties. This subscale attempts to gain insight into clients’ experiences of a diverse range of rupture situations.
The Client’s experience of rupture repair subscale comprises five items and was developed on the basis of the finding in Study One that a diversity of approaches are taken by therapists in response to ruptures such as respectfully intervening with clients’ dysfunction (e.g., ‘I got a lot out of the program facilitators challenging me’) and encouraging shifts in behaviour (e.g., ‘The program facilitators helped me to talk about how I felt’) ruptures. There is some research to suggest that therapists’ identification and acknowledgement of ruptures are critical initial responses to ruptures followed by allowing the client to reflect on the nature of the problem (Bennett, Parry & Ryle, 2006; Safran, Muran, Samstag & Stevens, 2002). This final scale attempts to capture clients’ experiences of having ruptures responded to in helpful ways. This may be a critical aspect of their program experience given that challenges that are successfully negotiated achieve better therapeutic outcomes (Strauss, Hayes, Johnson, Newman, Brown, Barber, Laurenceau & Beck, 2006; Bennett, Parry & Ryle, 2006).

Written instructions on the questionnaire advised participants to answer the questions in relation to the Violence Intervention Program they attended and for each statement to circle the number for the scale most representative of their experiences.
**Programs Questionnaire**

This questionnaire asks you about how things went in the Violence Intervention Program you attended. Please think about how much you agree with each statement and circle 1 (Strongly Disagree), 2 (Disagree), 3, (Unsure), 4 (Agree) or 5 (Strongly Agree) to reflect your experiences of the program. There are no right or wrong answers.

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<tr>
<th></th>
<th>STRONGLY DISAGREE</th>
<th>DISAGREE</th>
<th>UNSURE</th>
<th>AGREE</th>
<th>STRONGLY AGREE</th>
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</thead>
<tbody>
<tr>
<td>1. I am very satisfied with the activities (exercises, discussions, other work) we did in the program</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>2. I am glad I did activities that I didn't really want to do at first</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>3. I didn't get what was happening in the group most of the time</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I got a lot out of the program facilitators challenging me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>5. The program facilitators worked hard to develop trust in our group</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. The program facilitators were too critical and negative</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. There was not much respect shown between the program facilitators and me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<td>8. The program facilitators were very honest and open</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>9. I often disagreed with the program facilitators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. The program facilitators didn’t really understand my problems</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. The program facilitators were great at dealing with whatever problems came up in the group</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. There were many times I wanted to say something in group but didn’t</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. The program activities helped me get closer to achieving my goals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. The program facilitators didn’t help the group sort out arguments</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. The group dragged on</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. The program facilitators helped me to talk about how I felt</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. The program facilitators and I worked towards different program goals</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. The program facilitators ignored me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. The program facilitators were very good at working together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. I got a lot out of the program because I worked really well with the program facilitators</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Scale Definitions and their Items

**Client’s experience of the therapeutic alliance:** Item 1, 13, 17, 20.

Bordin (1994) suggested that the therapeutic alliance (TA) comprises three inter-related elements - the tasks undertaken within therapy, the therapeutic goal that describes therapeutic change required, and the bond that develops throughout this process. Focus groups with offending behaviour program facilitators found that evidence of a consistently held belief that better outcomes were achieved for clients when a strong alliance was formed. This subscale is designed to measure the extent to which clients perceive the strength of the alliance with the program facilitator with respect to each of these three elements.

**Client’s perception of therapists’ characteristics that help or hinder the therapeutic alliance:** Items 5, 7, 8, 10, 19.

Ackerman and Hilsenroth’s (2001) review of research on therapist characteristics suggests that clients find a range of therapist characteristics helpful in general psychotherapeutic contexts. They found that therapists who are unresponsive, closed off, and unwilling to change their view despite client feedback, form poorer quality alliances. The first study conducted by the authors of this measure also found that therapists who deliver offending behaviour programs believed that common ground had to be established with clients for the TA to develop. This was achieved by being transparent, genuine, honest, understanding, empathic and respectful, with therapeutic work based on trust. This subscale, therefore, seeks to measure the extent to which clients perceive therapists demonstrating positive attributes as strengthening the TA.

**Client’s experience of ruptures:** Items 3, 6, 9, 12, 15, 18.

Safran and Muran (2006) distinguish between two different types of ruptures – ‘confrontation ruptures’, where the client confronts the therapist about the therapy, and ‘withdrawal ruptures’, in which the client complies, defers or withdraws when they are confronted with difficulties. Within offending behaviour programs, a range of ruptures can occur that include aggressive and other overt client behaviours (e.g., put downs, hostility, threats) as well as more passive behaviours (e.g., not contributing to discussions, giving limited responses when asked a question). This subscale attempts to gain insight into clients’ experiences of a diverse range of rupture situations.

**Client’s experience of rupture repair:** Items 2, 4, 11, 14, 16.

A number of different approaches exist to respond to ruptures. Identification and acknowledgement are critical initial responses to ruptures followed by allowing the client to reflect on the nature of the problem (Bennett, Parry & Ryle, 2006; Safran, Muran, Samstag & Stevens, 2002). This final scale attempts to capture clients’ experiences of having ruptures responded to in helpful ways. This may be a critical aspect of their program experience given that challenges that are successfully negotiated achieve better therapeutic outcomes (Strauss, Hayes, Johnson, Newman, Brown, Barber, Laurenceau & Beck, 2006; Bennett, Parry & Ryle, 2006).
**Scoring Rules**: No more than 10% of the test’s items (i.e., 2 items) can be missing for the measure to be valid. For scales in which items are missing, replace missing item scores with the mean value of the remaining scale scores.