A Portfolio of Academic, Therapeutic Practice 
and Research Work

Including 'Exploring differences in residents’ experiences of leaving a 
prison-based therapeutic community: a secondary analysis’

By
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Submitted to the University of Surrey 
for the degree of Practitioner Doctorate (PsychD) 
in Psychotherapeutic and Counselling Psychology
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Statement of anonymity

Throughout this portfolio names have been replaced with pseudonyms and identifying information has been changed or omitted to preserve the anonymity and confidentiality of clients and research participants.
Acknowledgments

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Appendices

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A secondary analysis.

Appendices
Introduction to the Portfolio

This portfolio consists of a selection of academic, therapeutic and research work that has been carried out as part of the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. The portfolio is divided into dossiers, each of which contains pieces of work that aim to demonstrate the abilities and competencies I have acquired during the course of my training across its three main components: theory, practice and research.

Before introducing the material included in each of the dossiers I would like to put the portfolio into context by providing an overview of how I came to the discipline of Counselling Psychology.

The path to my becoming a counselling psychologist did not start with that goal in mind. It was rather a natural evolution, a development leading from one aspect of my life to another. Having grown up in a large and chaotic family with myriad problems I developed a need for boundaries and concreteness from a very young age. After school I decided to study law, a subject that met these needs, but also would enable me to help others. Looking back I understand that the choice of subject permitted me to stay detached from problems and judge them 'objectively' without getting involved in emotions; it felt safe.

When I got married and moved to the Middle East I felt that my whole world had turned upside down. Being a housewife in a foreign country left me without prescribed structure to my everyday life and I felt completely lost. This was compounded by not having to struggle for basic needs, as the expatriate life provided everything. All I had to do was to live. Unexpectedly this was an ambivalent and difficult experience that led me to questions such as ‘who am I?’ and ‘why am I here?’ Today I understand these experiences and my need to discover my Self and my potential as the early stages of self-actualisation (as described by Maslow, 1954).
These questions set me off to explore myself and the world around me and were the beginning of my personal development. I spent years meditating, doing yoga and energy work, exploring new and old aspects of myself, as well as learning about the different culture I was living in. This process provided me with a thorough understanding of myself and 'the other', not only by being in relation with 'the other', but also by being 'the other' myself. Moreover, it changed me in that I felt I needed to accept the needs and responsibilities that come with this understanding. I needed to develop and fulfil my potential. Consequently I left 'my first life' behind.

I came to England to study psychology. Although I knew that this was the right thing to do the transition from one life to another was very difficult and my first year left me depressed. I questioned my need for self-actualisation and it felt like my whole life went back to struggling with basic needs. In order to help me survive this difficult time of my life I spent one year in therapy, which again furthered my understanding about myself. Graduating in psychology was important for me as it allowed me to see that I had the drive to do whatever I wanted to do, having coped with moving to another country, financial hardship, divorce and the English language while pursuing my goal.

I had enjoyed the degree, but missed the personal, the relational aspects, and was also aware of how easy it could be to revert to the concreteness of the academic world. At this stage I felt that, in order to become who I truly wanted to be, I had to move towards a profession that recognises the importance of relationships, the relationship to oneself and the relationships to others. Having become quite aware of myself and the world around me I was looking for a path that would not only reinforce, but also require a high level of personal and professional reflection. Additionally I had profited from therapy a great deal and felt that the discipline of counselling psychology mirrored my personal values.
This course provided me with the forum to develop on a variety of levels, academically (through theory and research) as well as personally (through practice and experiential learning), which is further outlined in the clinical paper. Looking back I think that my striving from needing structure and being concrete to being able to tolerate ambivalence and not knowing has been a major milestone, not only in my personal development, but also in my development as a reflective practitioner.

I will now introduce the contents of this portfolio, which is divided into an academic, a therapeutic and a research dossier. Each of the dossiers will be introduced separately and aims to provide an overview for the reader.

**Academic Dossier**

The academic dossier contains a selection of academic papers that were submitted during the course of my training. The first essay ‘How can a developmental approach aid in understanding the consequences of parental divorce? What might the implications of this understanding be for therapeutic practice/interventions?’ was submitted as part of the ‘Lifespan Development’ module in the first year. As a child of divorce I had always been interested in how my parents’ separation might have impacted on my development. Moreover, I was intrigued by the complexity of parental divorce, as I had observed my siblings coping differently as compared to me. This essay outlines difficulties in determining the consequences of parental divorce as well as those factors that promote or impede a child’s adjustment, and highlights the importance of a developmental approach for the facilitation of therapeutic interventions.

The second essay entitled ‘The concept of interpretation and its role in relation to the creation of power-dynamics in the therapeutic relationship.’ was submitted as part of the ‘Theoretical Models of Therapy’ module in my second year. The concept of interpretation lies at the heart of psychoanalytic ideas and for me was one of the marked differences between the person-centred and the psychodynamic approach.
My task as the therapist was to offer interpretations to my clients and I became aware very early on that interpretations could be experienced as illumination by the client, but also as oppression. The essay outlines the concept of interpretation in terms of its techniques, use and variations and further explores the concept in terms of possible power-dynamics between therapist and client. The paper highlights that it is crucial for therapists to be aware of the power that can accompany an interpretation and to use interpretations as interactive exchanges between themselves and clients that are based on an empathic relationship.

The last essay ‘In cognitive therapy, how would the therapist understand and work with the difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice.’ was part of the ‘Theoretical Models of Therapy’ module in my final year. This paper draws attention to recent developments in cognitive therapy, in particular the movement towards a more elaborate understanding of the therapeutic relationship. The traditional and mechanistic use of the therapeutic relationship has been developed towards an understanding in which the relationship is used as a powerful tool for therapeutic change itself. The essay briefly outlines the basic principles of cognitive therapies and highlights how the therapeutic relationship may be understood as a prerequisite for technical interventions or as an intervention in its own right. This has been illustrated with clinical examples.

**Therapeutic Practice Dossier**

This dossier includes a short description of the placement work undertaken during my training summarising the therapeutic work. Information about the context, type and duration of the placement, the client population and supervision is given. Further included in this dossier is the Final Clinical Paper, which offers a personal account of my development as a Counselling Psychologist. In order to convey this personal voyage miscellaneous personal and professional experiences that have shaped my identity are outlined and the integration of those into clinical practice is described. This includes the integration of intrapersonal and interpersonal experiences and
developments as well as the integration of theory and practice throughout the three years and the bringing together of scientific research and professional practice.

Research Dossier
The portfolio concludes with three pieces of research, one literature review and two empirical studies. The research dossier reflects my interest in the prison context and my belief that human beings are not born criminals. My curiosity about prisons and the people within started when I was a law student doing a legal internship at a high-security prison. While dealing with the bureaucracy of the institution I also had the chance to have more direct contact with inmates. This experience of ‘criminals’ as people took away the distance between me and ‘them’, and sparked my continued quest to understand why these individuals do what they do and how they could possibly overcome their difficulties. Years later, working as a psychology intern in an American high-security prison, I had the chance to speak to individuals on death row, which furthered my interest to question the psychological effects of imprisonment on the individual.

The first year literature review is concerned with how the forensic setting compromises interventions with offenders. I was interested in whether therapeutic and ethical considerations of counselling psychologists would be compromised in the forensic setting, and if so, how? Traditionally, work with offenders has been the domain of forensic psychologists. However, I feel very strongly that counselling psychology has a lot to offer in the treatment of offenders. Therefore both contexts, counselling and forensic, are explored in terms of aims and purpose and approach to dealing with inmates’ difficulties. This is followed by specific characteristics and difficulties of working therapeutically within this context (e.g. security before treatment, ethical problems such as confidentiality, dual relationships and power issues). Finally, two very different approaches to treatment in correctional establishments, namely the structured Sex Offender Treatment Programme and the prison-based Therapeutic Community, are outlined and discussed.
The second piece of research in this dossier is qualitative and describes an investigation into a prison-based therapeutic community. The study aimed to explore and comment on the experiences of the therapy director, the therapy managers and the offenders in terms of the therapeutic milieu. The data of individual interviews with the therapy director, four therapy managers and a focus group with five inmates were subjected to thematic content analysis. The analysis of participants' accounts of the therapeutic milieu could be organised under two main themes: ‘The living milieu’ and ‘Being in the community’. Sub-themes of these two themes were then explored in terms of the accounts of participants. The acknowledgement of residents' experiences allows for a more open approach to similarities and differences between residents and thus could facilitate dialogue and the breakdown of barriers. This in turn could lead to a more secure and more therapeutic environment.

After having researched the prison-based therapeutic community in my second year I was keen to investigate inmates' experiences of the mainstream prison. Unfortunately, I was not able to do so. Owing to a lack of participants and difficulties in gaining access to other institutions I was forced to abandon my initial research project. Luckily I obtained suitable data from the therapeutic community I had investigated previously. The third and last piece of research explored residents' experiences of leaving the prison-based therapeutic community. Qualitative data that had been collected as part of a service evaluation for the therapeutic community management was subjected to secondary analysis. The experiences of two types of therapeutic community leavers were investigated (those who were de-selected and those who asked to leave) using Multidimensional Scaling. This research report is concerned with resistance to treatment and the consequent dropout out of treatment, and thus has practical value for the therapeutic community.
Reference

ACADEMIC DOSSIER
How can a developmental approach aid in understanding the consequences of parental divorce? What might the implications of this understanding be for therapeutic practice/interventions?

The increased prevalence of divorce in the last decades comes with myriad problems, one of them being separation-related adjustment problems in children. The consequences of parental divorce are as varied and complex as the motives and need to be discussed in a developmental framework as it is only with the understanding of the dynamic relationship between the child and its environment that the complexity of parental divorce becomes clear. In order to develop therapeutic interventions where necessary some understanding of causes and outcome is required. This paper outlines the difficulties in determining the consequences of parental divorce, the factors that either promote or impede a child’s adjustment and highlights the importance of a developmental approach for the facilitation of therapeutic interventions.

Although the prevalence in the UK is slightly lower than in the US, a quarter to a third of marriages end in divorce (Carr, 1999); estimates indicate that only 50% of children and adolescents live with two biological, married parents (Wadsworth 1986; cited by Hetherington & Stanley-Hagan, 1999). This suggests that divorce cannot be regarded as an uncommon event any longer, but can be seen as an established development for a large number of families.

High rates of divorce do not only raise a high level of interest (Amato, 2000), but also of public and scientific concern (Amato & Keith, 1991a) since it has been argued that marital disruption can have long-term consequences on the child’s well-being and adjustment and thus on society at large (Blankenhorn, 1995; cited by Amato, 2000).

However, the literature is divided by an ongoing debate over the consequences of divorce with one side arguing that parental divorce has detrimental effects on
children and that healthy, competent children can only stem from a healthy and
cOMPETENT TWO-PARENT FAMILY (AMATO, 2000). ON THE OTHER HAND IT HAS BEEN ARGUED
THAT CHILDREN DO NOT NECESSARILY EXHIBIT SEVERE OR ENDURING BEHAVIOUR PROBLEMS AND
CAN DEVELOP SUCCESSFULLY IN NON-TRADITIONAL FAMILY SETTINGS (HEtherington ET AL.,
1999).

THIS CONTROVERSY IS STRONGLY LINKED WITH THE EXISTING THEORIES THAT AIM TO EXPLAIN THE
CONSEQUENCES OF DIVORCE. TWO POPULAR PERSPECTIVES ARE CONCEPTUALISED IN THE CRISIS
MODEL AND THE CHRONIC STRAIN MODEL. ACCORDING TO THE CRISIS MODEL DIVORCE IS A
STRESSFUL LIFE EVENT THAT MAY LEAD TO A CRISIS, BUT GIVEN SUFFICIENT TIME MOST
INDIVIDUALS ARE ABLE TO RETURN TO THE PREVIOUS LEVEL OF FUNCTIONING (AMATO, 2000). THE
CHRONIC STRAIN PERSPECTIVE, ON THE OTHER HAND, ASSUMES A DECLINE IN THE INDIVIDUAL’S
WELL-BEING AFTER THE DIVORCE THAT CONTINUES INDEFINITELY DUE TO THE PERSISTENT STAINS
(AMATO, 2000).

ACCORDINGLY CHILDREN’S REACTION TO DIVORCE AND SEPARATION DIFFER. OUTCOMES DEPEND
ON A NUMBER OF INTERDEPENDENT FACTORS SUCH AS THE CHARACTER OF THE CHILD, THE WAY
DIFFICULTIES ARE DEALT WITH AND THE KIND OF RELATIONSHIPS THEY HAVE WITH THEIR PARENTS
DIFFICULT TO PROVIDE A GENERAL OVERVIEW OF RESEARCH IN FAMILY LIFE, AS IT IS EXTREMELY
DIVERSE AND VARIED. HOWEVER, IT IS SUGGESTED THAT CHILDREN WHOSE PARENTS DIVORCED ARE
CONSIDERABLY DIFFERENT FROM THOSE WHOSE PARENTS REMAIN TOGETHER (RICHARDS, 1995).
CHILDREN OF DIVORCED PARENTS TEND TO SHOW DIFFERENCES IN TERMS OF BEHAVIOUR
THROUGHOUT CHILDHOOD AND TEND TO HAVE DIFFERENT LIFE COURSES IN ADULTHOOD. IN
PARTICULAR THE RELATIONSHIP WITH THEIR PARENTS IS MORE LIKELY TO BE DISTANT AS ADULTS;
THEY ARE MORE LIKELY TO SUFFER FROM DEPRESSION, TO ACHIEVE A LOWER ACADEMIC LEVEL, TO
SUFFER FROM CONDUCT DISORDERS AND TO HAVE LOWER SELF-ESTEEM (HEtherington ET AL.,
1999; AMATO, 2000). THEY TEND TO SHOW SOCIAL MATURITY EARLIER RESULTING IN ENTERING
SEXUAL RELATIONSHIPS, MARRYING AND BEARING CHILDREN EARLIER THAN THEIR PEERS FROM NON-
DIVORCED FAMILIES (RICHARDS, 1995). AMATO & KEITH (1991A) PRESENTED RESEARCH THAT
suggests that children who experienced parental divorce have lower income, are more likely to depend on welfare and to get divorced themselves.

Since the literature on consequences of parental divorce is varied and there is not a single set of outcomes for children of divorce, several factors have to be considered before conclusions can be drawn.

First of all consideration of the methodology is crucial: Emery (1988) and Hetherington et al. (1999) point out that research needs to be longitudinal since cross-sectional research does not capture the dynamic interactions of multiple factors on the child’s adjustment. Inadequate samples must be avoided; convenience as well as non-representative samples (e.g. pure clinical samples) do not allow general conclusions to be drawn. Furthermore, qualitative methods need to be used in order to capture the experiences and feelings of the children with divorced parents. Research on divorce should take social class, ethnicity and cultural differences into account as they may have a strong impact on the child’s adjustment (Hetherington et al., 1999). Thus differences in the outcomes of such complex family studies might be confounded in the research sample or the research design.

Additionally, divorce should not and cannot be seen as happening in a vacuum and the effects of divorce on children’s behaviour might have to do with a behaviour or a situation that occurred long before the actual separation. Pagani et al. (1997) stress the notion that pre-divorce marital conflict, unhappiness and troubled parent-child relationships need to be considered when examining the influence of marital disruption on children. The pre-divorce adjustment might therefore be a good predictor of the future well-being of the child. When considering pre-divorce adjustment the concept of causality becomes important and it is crucial to avoid attributing negative outcomes to the divorce per se. Emery (1988) highlights the importance of taking third-variable explanations into account as they may allow new directions for interventions. Amato and Keith (1991a), for instance, point out that
factors such as inter-parental conflict and parental mental health might be the consequences of parental divorce, but might also be relevant alternative origins for the child's decrement in psychological well-being and could lead to adjustment problems.

Another consideration for the diversity in outcome of divorce research studies might be the time in which the research was conducted. Differences in outcome might be due to improved research methods or to changed social representations of divorce. Divorce has become more accepted and is part of 'normal' life today, thus the effects of divorce might be less strong nowadays than in the past (Amato & Keith, 1991b).

However, the diversity in the consequences and outcomes of parental divorce might just mirror the reality. This diversity in the consequences of parental divorce is of increasing interest as the understanding of such wide variations may shed light on the factors that impede good adjustment (risk factors) and those that foster good adjustment (protective factors) (Richards, 1995). Many factors determine the child's adjustment and the developmental approach is useful in order to catch the complex interaction between the individual and its environment.

What are those factors that allow one child to recover from the divorce and impede the next? There seems to be some consensus that the single, most important factor for the well-being of the child is the well-being of the parents (Amato, 2000). Therefore the quality of parental functioning is a good predictor of children's behaviour and well-being.

The child's adjustment to parental divorce depends on the characteristics within the child, the characteristics of the family and peers, and the wider social context. A risk and resiliency perspective suggests that the factors in each context interact in a reciprocal and interdependent manner (Mash & Wolfe, 1999). Adopting this
developmental approach allows an understanding of the dynamics of such multidimensional processes and the importance of context and time.

Rutter (1989) agrees that simplistic concepts of effects should be abandoned and be replaced by more dynamic concepts that catch the constant interaction between the individual and its environment over time. Time is crucial when considering the child’s level of development and in determining whether the child’s development is appropriate or not (Wenar & Kerig, 2000). Furthermore, it allows an understanding of delayed effects since not all children show difficulties in adjusting to the initial separation, but suffer from problems later in life (Pagani et al., 1997).

Carr (1999) summarised certain characteristics of the child and certain features of its social context and suggested that these mediate the effects of parental divorce. The risk and protective factors are believed to negotiate the post-divorce adjustment with more protective factors being associated with a better outcome/adjustment and with a greater number of risk factors being associated with less good adjustment.

Risk factors on the intrapersonal level include not only being male aged between 3-18 years, but also factors such as previous psychological problems, low intelligence and external locus of control (Carr, 1999). These characteristics seem to be important in the way the child copes with the demands of adjusting to the separation.

It is often the interpersonal context, though, that is deemed responsible for the child’s adjustment problems. This includes factors such as the relationship between the parents and the relationship between the parents and the child. The characteristics of the parent/s, such as parental psychological problems, and the situation the parent/s might find themselves in, for example unemployment, can have an impact on the child’s adjustment (Carr, 1999).
Societal factors include a lack of community services, the loss of social support and the availability of social services (Carr, 1999). However, it is not necessarily the availability of resources, but the use made of them; thus the social support network might be available to the child, but he/she might not take advantage of it.

Protective factors on the intrapersonal level can function as moderators of the effects of divorce. They include the female gender, aged under 3 or over 18, easy temperament, mature defence mechanisms and functional coping strategies (Carr, 1999).

On an interpersonal level a secure parent-child attachment with both parents and parental co-operation seem to be important. Furthermore, good parental post-separation adjustment, good social support as well as continuous and predictable access to the non-custodial parent all foster the child’s post-divorce adjustment (Carr, 1999).

For a full list of risk and protective factors on all levels see table below (Table 1).

Table 1: Risk and protective factors on intrapersonal level, interpersonal level and societal level¹

<table>
<thead>
<tr>
<th>INTRAPERSONAL LEVEL</th>
<th>RISK FACTORS</th>
<th>PROTECTIVE FACTORS</th>
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<tr>
<td>male</td>
<td>Female</td>
<td></td>
</tr>
<tr>
<td>aged between 3 and 18</td>
<td>aged under 3 and over 18</td>
<td></td>
</tr>
<tr>
<td>previous psychological problems</td>
<td>functional coping strategies</td>
<td></td>
</tr>
<tr>
<td>low intelligence</td>
<td>high intelligence</td>
<td></td>
</tr>
<tr>
<td>difficult temperament</td>
<td>easy temperament</td>
<td></td>
</tr>
<tr>
<td>low self-esteem</td>
<td>high self-esteem</td>
<td></td>
</tr>
<tr>
<td>external locus of control</td>
<td>internal locus of control</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>high self-efficacy</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>optimistic attributional style</td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>mature defence mechanisms</td>
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¹ All factors are taken from Carr (1999).
<table>
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<tr>
<th>INTERPERSONAL LEVEL</th>
<th>continued parental conflict</th>
<th>secure parent-child attachment with both parents</th>
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<tr>
<td></td>
<td>inadequate parenting style, e.g. neglectful, inconsistent, diminishing parenting</td>
<td>parental co-operation, e.g. clear family communication, regular and significant contact with father</td>
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<td></td>
<td>parental psychological problems, e.g. emotional distress &amp; depression, parental substance abuse, criminality, previous separation, child abuse</td>
<td>good parental post-separation adjustment, e.g. self-efficacy, self-esteem, attributional style, defence mechanisms</td>
</tr>
<tr>
<td></td>
<td>parental situation, e.g. social disadvantage, unemployment, bereavement</td>
<td>good social support, e.g. family peers and school</td>
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<tr>
<td></td>
<td>-</td>
<td>low family stress</td>
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<tr>
<td></td>
<td>-</td>
<td>positive educational placement</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>high socio-economic status</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>economic stability</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>physical and social continuity</td>
</tr>
<tr>
<td></td>
<td>-</td>
<td>continuous &amp; predictable access to non-custodial parent</td>
</tr>
<tr>
<td>SOCIETAL LEVEL</td>
<td>lack of community services, e.g. availability of nurseries, playgroups &amp; childminder</td>
<td>good community service, e.g. availability of nurseries, playgroups &amp; childminder</td>
</tr>
<tr>
<td></td>
<td>loss of social support, e.g. through relocation</td>
<td>good social support</td>
</tr>
<tr>
<td></td>
<td>availability and use of social services</td>
<td>availability and use of social services</td>
</tr>
<tr>
<td></td>
<td>lack of positive interventions</td>
<td>environmental continuity</td>
</tr>
<tr>
<td></td>
<td>economic situation, e.g. employment</td>
<td>economic situation, e.g. employment</td>
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In this multifactorial approach, time is a considerable factor on two levels. On one hand, in terms of the child's developmental period (Pagani et al., 1997), it has been suggested that younger children have a higher initial vulnerability to their parent's divorce (Wallerstein & Berlin Kelly, 1980). There are, however, inconsistencies in
the literature as most studies found equally negative effects for older children and adolescents (Amato & Keith, 1991a). Thus, it is important to take the child’s age into account and to understand it in developmental context. On the other hand the passage of time reflects the mentioned crisis and chronic strain model: there might be an initial increase in adjustment problems that improves with time (Wallerstein et al., 1980), or there might be accumulating problems over time that may lead to enduring deleterious outcomes (Hetherington et al, 1989).

Considering the risk and the protective factors that mediate the child’s adjustment following divorce allows the design of interventions to reduce adjustment problems and facilitate a healthy adjustment. This has crucial implications since children from divorced families are two to three times more likely to receive psychological treatment than those children whose parents are not divorced (Hetherington et al., 1999). Often professional advice and guidance is needed in negotiating through this complex process (Wallerstein & Corbin, 1999).

Traditional individual and family therapy may be used as an intervention and would focus on the individual’s emotional concerns, the parent-child relationship and the establishment of a new identity (Vaughan, 1981).

Child interventions are run in groups and aim to clarify children’s possible misconceptions about the divorce, to enhance their perceptions of themselves and their families, to build up coping skills and to understand and improve negative feelings (Grych & Fincham, 1999). Such interventions are often school-based and offer short-term educational and therapeutic activities to enable the child to deal with the stressors of their parents’ divorce (Pedro-Carroll, 1997; cited by Hetherington et al, 1999).

Parent-orientated interventions help the parents to deal with the stressors of divorce with the help of group therapy that allows improvement of their own coping skills.
(Hetherington et al., 1999). Furthermore, parenting programmes teach parents concrete parenting skills, such as communication skills, how to engage in more positive activities with the children and the use of consistent discipline (Grych et al., 1999).

Research indicated that current interventions have little effect (Hetherington et al., 1999). This again suggests that either the research is unable to reflect the reality due to methodological limitations, or that the adjustment problems of children of divorce are so profound that the current interventions are ineffective.

Research offers an understanding of conditions that may lead to problems in the child’s adjustment and this knowledge should allow the facilitation of effective interventions. The developmental framework indicates the significant roles of the individual and its context in the post-divorce adjustment. Although current interventions do take notice of this understanding (e.g. by enabling the child to cope better and teaching the parent to parent in a more effective way), it is important to remember that parental well-being is crucial for the child’s well-being. Additionally, the basic assumptions of a developmental framework which takes multiple contexts into account is neglected as long as the main locus of change is expected to be within the child or within the parent/s. Interventions need to target not only the child’s abilities to cope but also inter-relational processes, such as parental conflict and the parent-child relationship (Grych et al., 1999). Interventions need to take a developmental perspective and facilitate well-being within the child, within the parent/s and take the wider context into account in order to deal with the psychological adjustment to parental divorce.

An insight of the consequences of parental divorce and the factors that mediate the process is important for therapeutic practice. The implications lie primarily in an awareness of the complexity of children’s adjustment to parental divorce and in an awareness of the methodological limitations of the research. When dealing with
individuals who experience parental divorce consideration needs to be given to age and gender, available resources and especially interpersonal relationships. An appreciation of risk and resiliency factors should allow a deeper understanding and a starting point for therapeutic work. However, caution is needed as each individual and his/her circumstances differ greatly, and knowing and understanding the context should not lead the helping professional to make hurried assumptions about the adjustment of a particular individual. The understanding should rather lead to an open and not prejudiced contact with the individual in order to facilitate the adjustment to this extremely complex process.
References


The concept of interpretation and its role in relation to the creation of power-dynamics in the therapeutic relationship.

Psychoanalysis was introduced by Freud in the 1890's and has been developed since then by his followers and himself (Rycroft, 1968). Over the years the conceptualisation and the aims of psychoanalytic treatment have changed (Lemma-Wright, 1995). However, despite differences between different psychoanalytic schools, there is agreement that the relationship between the analyst\(^1\) and the patient is essential to the effectiveness of treatment (Clarkson, 1995). In addition to the establishment of the therapeutic relationship the principal task is to reveal underlying conflict (Rycroft, 1968). The main aim is to extend the patient's understanding about him/herself, leading to insight and/or psychic reintegration (Lemma-Wright, 1995), as it is believed that the patient's understanding of unconscious processes minimises psychological problems. To 'analyse' means to use insight-furthering techniques, such as confrontation, clarification, interpretation and working through (Greenson, 1967; p. 37). The concept of interpretation lies at the heart of psychoanalysis and although it is not limited to psychoanalytic treatment settings, it is the 'ultimate therapeutic instrument' and it is what distinguishes psychoanalysis from other psychotherapies (Greenson, 1967; p. 39). Interpretations may replace confusion with meaning and/or may link symptoms with experiences, and consequently are believed to lead to a reduction in the patient's tension. It is the aim of this paper to firstly outline the concept of interpretation in terms of its technique, use and variations; and secondly, to explore the concept in relation to power-dynamics within the therapeutic relationship.

The aspiration of psychoanalytical treatment is to make conscious the unconscious in order to gain some form of insight (Rycroft, 1968). Psychoanalytical interpretations are statements made by the analyst to the patient that aim at making an aspect of the unconscious conscious by elucidating a meaning, event, source, history, cause or

\(^1\) The term analyst and therapist will be used interchangeably.
mode (Greenson, 1967). The therapist invites the patient to talk. When the therapist talks he/she talks to the patient about the patient. This is believed to increase the patient’s self-awareness to feelings that have not been explicitly articulated, and that are part of the patient’s psychological state (Greenson, 1967). Besides making conscious the unconscious interpretations are used to make the incomprehensible comprehensible, trace and uncover connections between events, symptoms and personality that are not/have not been obvious and/or point out discrepancies between behaviour and feelings (Storr, 1990). In practice, however, interpretation is not only concerned with revealing deep feelings, but also with pointing out contradictions in the patient’s narrative or drawing attention to unrecognised links (Storr, 1990).

The term ‘interpretation’ has been used in a variety of definitions ranging from ‘the analyst’s inferences and conclusions regarding the unconscious meaning and significance of the patient’s communications and behaviour’, ‘the communication by the analyst of his inferences and conclusions to the patient’, ‘all comments made by the analyst’ and ‘verbal interventions, which are specifically aimed at bringing about dynamic change through the medium of insight’ (Sandler et al. 1992; p. 154).

There seems to be no agreement, however, which communication of the analyst can be regarded as an interpretation. Loewenstein (1951), for example, suggested a differentiation between the analyst’s comments that facilitate freeing of the patient’s associations (such as instructions and explanations) and interpretations proper, which lead to those dynamic changes we call insight. Sandler et al. (1992) argued that such a distinction would lead to a focus on the effect that is to be produced through the interpretation; in other words does the interpretation lead to insight or not? If interpretations were viewed as interpretations only when the desired effect in the patient is evident then there will be instances in which the analyst’s communication to the client could be technically correct, but practically ineffective.
Strachey (1934) referred to *mutative interpretations* as those that describe immediate processes (in particular transference), arguing that only these allow for fundamental change and therefore can be considered effective. The interpretation of transference has been the focus of treatment suggesting that it is only transference interpretations that are effective (mutative). However, recently *extratransference interpretations* have been revived, as they may act as a supplementary and preparatory adjunct (Sandler et al., 1992). Blum (1983; as cited in Sandler et al., 1992; p. 159) argued that 'a transference only position ...could lead to an artificial reduction of all associations and interpretations into a transference mould'. The term interpretation in this paper will be used to describe a particular variety of verbal interventions made by the analyst, but will also be used as a synonym for all of the analyst's verbal (and sometimes also non-verbal) interventions (Sandler et al., 1992).

There are different kinds of interpretation, such as dream-interpretation, transference interpretation and inner-conflict interpretation. Freud’s theory of dreams (1900) was an extension of his theory of neurosis and he regarded the dream as an expression of a repressed wish (Stevens, 1998). According to Freud (1913) dreams have a manifest and a latent content; the manifest content is the content recalled by the dreamer and is expressed in a disguised form whereas the latent content is the underlying meaning or the repressed wish. The interpretation of a patient’s dream allows the therapist to elucidate unconscious processes and the dreamer can respond to the therapist’s interpretation. However, dream material, as well as any other material brought by the patient, should not be interpreted in a dogmatic or arbitrary way, but should allow the patient to contribute as much to the understanding as the therapist. Therefore, dream interpretation is not done to the patient but with the patient and it is the therapist’s responsibility to request the patient’s associations to a dream and to look for an acceptable interpretation (Storr, 1990).

The transference-interpretation involves linking the past and the present in terms of relationships. Transference refers to ‘the process by which a patient displaces on to
his therapist feelings, ideas, etc., which derive from previous figures in his/her life and relates to the therapist as though he were some former object in his life' (Rycroft, 1968; p. 185). The explicit statements referring to the relationship between the therapist now and a relationship in the patient's more distant past are called *transference-interpretation*.

Menninger (1958; as cited in Malan, 1979; p. 80) suggested a triangle that allows the therapist to conceptualise the patient's relationships, thus is useful in thinking about and making transference-interpretations:

![Triangle Diagram](image)

Inner-conflict interpretation involves linking the defence, the anxiety and the hidden feeling. Defences are those mechanisms that protect and safeguard the ego against anxiety, pain and/or danger (Greenson, 1967). It is the mastery and the control of the ego that may lead to neurosis (Freud, 1926), and it is resistance that defends and prolongs the neurosis and retains the familiar and the old (Greenson, 1967). The anxiety is the ego's response to heightened tension over a hidden feeling, which is often an impulse (Rycroft, 1968). The literature distinguishes between content
interpretations, more predominant in the first decades of psychoanalysis, and defence interpretations. Content interpretations refer only to unconscious impulses and the meaning of what is repressed, whereas defence interpretations are concerned with interpretations of the mechanisms that are used to deal with pain and conflict (Sandler et al., 1992). Content and defence interpretation are to be seen as complementary, as it is crucial that the patient is shown the mechanisms that he/she uses to deal with the conflict/impulse. Malan (1979; p. 80) has conceptualised the inner-conflict in the triangle of conflict:

![Triangle Diagram](image)

Malan (1979) pointed out that these two triangles, the triangle of person and the triangle of insight, represent most interventions the therapist makes. However, usually the therapist is only able to link two corners of a triangle in an interpretation; and often it is the patient him/herself linking two corners or even completing a triangle.

It is of high importance that the interpretations are not given in a dogmatic or authoritarian manner (Storr, 1990), but are utilised in a democratic and tentative way since interpretations can only be effective if the patient can make sense and agree to them. If the patient is confronted with continuous dogmatic and complex interpretations, he/she is not only likely to feel diminished and criticised, but also to
fall into compliance and will experience power-dynamics. For the interpretation to be effective it must be adequate for the patient’s emotional understanding; if an interpretation goes beyond the limits for comprehension it will not yield the desired effect within the client. An interpretation should lead to a constructive move, thus the patient’s response to an interpretation needs to be observed closely (Malan, 1979). If the patient is responding to the interpretation with mind and feelings, the interpretation can be considered successful. Thus, it is only through the patient’s response that verification of the given interpretation is offered (Greenson, 1967). Further, interpretations may be correct, but premature and therefore inappropriate. The timing of any interpretation is as important as the dosage of an interpretation and the therapist needs to weigh up whether the patient can bear a certain insight alone for a period of time, e.g. new and painful insights should not be given when there is a break (before weekends or holidays) (Greenson, 1967).

However, Greenson (1967) pointed out that even correct interpretations do not remain effective over time, but need to be repeated and elaborated to be successful. This does not only require the appropriate manner and timing, but also a deep understanding of the patient’s needs and history in relation to ‘where’ the patient is. Consequently, interpretations can only be effective if they are embedded within an empathic therapeutic alliance. Greenson (1967) described the patient-analyst relationship as necessary for ‘...the patient to identify with the analyst’s point of view and to work with the analyst...’ (p. 29). The alliance is established between the therapist and the patient’s ego, and since psychoanalytic technique is aimed at the patient’s ego, interpretations cannot be effective without a therapeutic alliance that allows the patient to collaborate with the therapist and to understand interpretations.

Classical interpretations are client-centred and refer to what the therapist believes is going on in a patient’s mind. However, it has been pointed out that this form of interpretation may lead to weakened feelings of containment if the therapist perseveres to elucidate the patient’s doing, feeling and thinking (Steiner, 1992).
Therapist-centred interpretations allow the patient to experience feelings of containment and 'being understood' in a more maternal way (Frosh, 1997; p. 105). These interpretations focus on what the patient believes the therapist might be feeling or thinking. This very subtle shift away from the classical interpretation allows for experiences of being understood by the therapist. Steiner (1992) suggested that the immediate concern of patient's experience of the therapist can be expressed by interpretations phrased in the following way: 'You experience me as...', 'You are afraid that I...', or 'You were relieved when I...' (p. 2).

However, interpretations do not always have to be verbal statements, but may also refer to the therapist’s use of silence. It may be seen as both active and passive intervention (Greenson, 1967). It can be used as an interpretative tool, as it allows the patient time to think, feel and fantasise, to stay with whatever he/she is experiencing and to explore what is happening for the client during the silences (Greenson, 1967).

Interpretations require a lot of skill and understanding on part of the therapist. The analyst uses empathy, intuition and theoretical knowledge to develop an understanding of the patient. For the interpretation to be successful it must reach the patient and it must have an impact. Once the therapist has an awareness of the patient’s material he/she will think about communicating it to the patient, when to communicate, what to communicate and how to do it (Greenson, 1967). Thus, it is not only the understanding gained, but also the timing, the use of words and the tone of the voice that make an interpretation more likely to be effective. But even before that the analyst will have to consider whether the patient needs to know now and whether he/she is likely to understand it, in other words does the interpretation have a therapeutic purpose? In order to evaluate this the therapist needs to be empathically connected to the patient’s thoughts and feelings, as it is only through empathy that the therapist can be aware of where the patient is and evaluate how effective an interpretation could be.
An interpretation may be considered successful when the patient’s response is rich in associational material, shows a change in the patient’s emotional state and alterations in the relationship with the therapist (Frosh, 1997). Interpretations that do not yield such effect can be considered ineffective; and interpretations that oppose the patient are usually understood in terms of resistance. Resistance is opposition, opposition to making the unconscious conscious, or even opposition against accepting the interpretations made by the therapist (Rycroft, 1968). As a counterforce in the patient it operates against the therapist, the therapy and its procedures and processes (Greenson, 1967). This becomes therapeutically important when the resistance actually indicates a defence against exploration or uncovering of unconscious conflicts; however, what happens when the patient resists the therapist’s interpretation because it is simply wrong? Disagreement between the therapist and the patient in psychoanalysis is likely to be construed as a manifestation of the patient’s problem, and ‘it is assumed that the therapist is more likely to be right (more objective, more disinterested, more knowledgeable, more experienced in interpreting human behaviour)’ (Masson, 1988; p. 41).

The power of the analyst is often denied, minimised and overlooked. Although therapists are in an exceptionally powerful position it has been argued that therapists do not exercise power in an obvious and direct manner (Storr, 1990). Masson (1989) pointed out, though, that, in particular in psychoanalysis, the power resides in the hands of the therapist. Interpretations lend meaning to what might be going on in the patient. ‘Lending meaning’ implies the existence of a conceptual schema on part of the therapist. Szasz (1978) suggested that ‘the power to name things, to classify acts and actors, is the greatest power in the world’. The therapist has the power to name what might be going on in the patient. And even before that there is a classification of the therapist, as the one who analyses and therefore ‘helps’, and the patient, as the one who is in need of help. It is this simple distinction that already reflects certain facts about the holders of power (Szasz, 1978). Thus, the analyst and the patient are not equals, and it has been argued that the patient sees the therapist in a position of
Power to illuminate and to interpret, but possibly in a controlling power he/she could be afraid of (Arieti, 1972). What does power mean and how may interpretations play a role in the power-dynamics of the therapeutic relationship?

Power can be defined as either a behaviouristic way to refer to categories of acts, such as ‘manipulative’ or ‘yielding’ behaviours, or as referring to role attributions, overt or implied (Ryder, 1972; p. 36). The interpretation given by the therapist can be aligned with those definitions. Firstly, the communication of the therapist’s interpretation ‘yields’ and ‘manipulates’ the patient’s behaviour in that the patient has to think and explore the interpretation. Thus, the very aim of interpretation, to make something unconscious conscious, may be considered an act of power. Secondly, it could be argued that the terms ‘analyst’ and ‘patient’ inherit implied role attributions, suggesting that the analyst ‘does’ something to the patient, therefore indicating a power-relationship. This seems particularly important when a patient disagrees with the analyst’s interpretation and the disagreement is automatically interpreted as resistance.

Viewing the concept of power from a sociological viewpoint the therapist’s interpretations can be seen as caused by or contingent on the patient and his/her narrative and history. This leaves the question whether the therapist controls the patient or the patient controls the therapist. If the therapist has power over the patient’s actions (to make the unconscious conscious) and the patient’s actions are more contingent on prior actions by the therapist (the interpretation) than the therapist’s actions on prior actions by the patient (narrative and history) the therapeutic situation could be defined in terms of contingency power (Ryder, 1972; p. 38). If there was no contingent relationship between the therapist and the patient there would be no power by definition, but there would be no relationship either. Thus, it can be assumed that some form of power exists and is exercised in every social interaction including the therapeutic interaction.
Gadpaille (1972) suggested that the therapist exercises expert power (‘derived from the degree of specialised knowledge possessed by the power actor’) and referent power (‘requires identification with the power wielder, such that the motivation to conform is internalised and the reasons for conformity become as much one’s own as pertaining to another’) (p. 175) and that the effectiveness of the psychoanalytic interaction is contingent on a mutual agreement concerning the methods of this endeavour. Not only the denial and minimisation of the analyst’s power, but also the attempt to avoid the use of power in psychoanalytic treatment, may lead to the danger of using power in an inappropriate way. Although modern psychoanalysis recognises that ‘active influence by an analyst when indicated is hardly a flaw of technique or acting out on the therapist’s part’ (Gelb, 1972; p.197), it appears to be important that the possible covert and overt ways in which power is utilised and avoided must be recognised, acknowledged and understood, so that the power is exercised in an ethical and appropriate manner.

Most approaches to therapy acknowledge that a therapist should not impose his own view on patients. Frosh (1997) argued that interpretation can never be ‘truth interpretation’ (p. 114) and that therefore there is no such thing as the correct interpretation. However, Masson (1988) argued that most therapists do impose their views on the patient. This might be over or covert, but every interpretation introduces the analyst’s view to the patient, and it is the therapist’s intention and the way the interpretation is given that may distinguish between a therapeutic intervention and a controlling act of power by the analyst. A therapist who assumes knowledge and a privileged understanding of the patient is bound to exercise oppression, and ultimately power. Interpretation is something that should happen between the analyst and the patient, it is not something that one does to the other. As an interactive and inter-subjective endeavour ‘it emerges out of the fluid meaning states which cross the boundaries between people, making it possible to explore something new occurring in the interpersonal space – something happening in the arena between one subject and another’ (Frosh, 1997; p. 115).
To summarise, interpretations can be an effective technique to ‘lend meaning to inner chaos’ (Lemma-Wright, 1995; p. 190) and may or may not lead to insight, reintegration and/or minimisation of psychological problems. Every interpretation suggests another point of view to the patient and this very act may be experienced as illumination or as oppression. Power exists in the therapeutic interaction between the analyst and the patient and it is crucial for the effectiveness of psychotherapy / psychoanalysis that the power is recognised and acknowledged by the analyst. There is no ‘one truth’ and therapists need not only be acutely aware of the way they give an interpretation, but they must also experience the interpretation as interactive exchange that is based on an empathic relationship between themselves and the patient.
References


In cognitive therapy, how would the therapist understand and work with the difficulties that arise in the therapeutic relationship? Illustrate with examples from your own practice.

Cognitive therapy has been described as 'the most effective short-term psychotherapy' and has come to be the treatment of choice for many clients and purchasers of healthcare (Allison & Denman, 2001; p. 144). Cognitive therapies are time-limited, highly structured and directed towards clearly defined goals (Hawton et al., 1989). Traditionally the active components of treatment, such as specific techniques and standard protocols, were emphasised and understood to lead to therapeutic change (Persons, 1989) and a good therapeutic relationship was considered to be a necessary but not sufficient condition for change to take place (Beck et al, 1979). This mechanistic use of the therapeutic relationship has often been criticised, in particular since the therapeutic alliance between the therapist and the client has been elevated to the most important predictor of a good therapy outcome (Luborsky et al., 1983). Recently cognitive therapies have moved towards a more elaborate understanding of the therapeutic relationship, in which the relationship is not only seen as facilitating the active components of treatment, but is also used as a powerful tool for therapeutic change in itself (Safran & Segal, 1990; Young, 1990, 1994). This essay briefly outlines the basic principles of cognitive therapies and highlights how the therapeutic relationship may be understood as a prerequisite for technical interventions or as an intervention in its own right. This will be illustrated with clinical examples.

All cognitive therapies are based on the notion that the way in which individuals structure, view and interpret situations, problems and events affects their mood and subsequent behaviour, as devised and elaborated originally by Beck (1967, 1979). Today there are various orientations within the field of cognitive therapy (such as cognitive-behavioural therapy (CBT) and cognitive-analytic therapy (CAT)); however, they all share a basic concept. ‘Cognitions’ refers to mental processes and
mechanisms, such as thinking and conceptualising, as well as to the products of these processes, such as perceptions and beliefs (Reber, 1995). Such processes are based on attitudes and assumptions derived from previous experiences, which help to classify, interpret, evaluate and assign meaning to a situation or event. Generally the interpretation or appraisal of a situation or an event is adaptive and useful; sometimes, however, the appraisal can take the form of exaggerated responses. The cognitive theory of emotional disorders states that dysfunction (such as depression, anxiety or obsessive-compulsive disorder) may arise when an individual is interpreting events in a negative and global way (Beck, 1976). Individuals might view themselves, others and the world in a negative way and might fail to correct initial perceptions and test them against reality (Weishaar & Beck, 1986). An unrealistic appraisal (danger, fear, loss, abandonment, etc.) may not only lead to a negative mood, but may also be followed by behavioural responses that help maintain emotional problems (Hawton et al., 1989).

Cognitive theorists have traditionally tended to emphasise the techniques and tools that are believed to lead to therapeutic change. Particular emphasis is placed on identifying, evaluating and challenging dysfunctional thoughts, assumptions and beliefs, which is believed to lead to changes in mood and behaviour (Padesky & Greenberger, 1995). In order to achieve cognitive restructuring a variety of tools and techniques can be used, for example Guided Discovery and Socratic Questioning in the sessions and Thought Records for the client to do as homework.

One of the most common criticisms of cognitive therapy, though, is that not enough attention is paid to the therapeutic relationship and that the therapeutic relationship is a mere vehicle, which enables the therapist and the client to work on the agreed goals. The aims of cognitive therapy are to relieve symptoms, resolve problems and to facilitate the development of coping strategies (Cave, 1999), and to ensure that a good therapeutic relationship has to be in place. The basis of a good therapeutic relationship lies, as in other therapies, in the provision of the core conditions of
empathy, genuineness, respect and unconditional positive regard (Rogers, 1957). In traditional cognitive therapy it is assumed that a good relationship with the client is easily achieved with the provision of the core conditions and that both the therapist and the client work in ‘collaboration’ (Beck et al., 1985). The emphasis lies on an ‘active partnership’ in which the therapist acts as the expert in cognitive techniques and the client acts as the expert in her/his own life, so together they act as a team to utilise each other’s expertise collaboratively (Beck et al., 1985). Collaborative empiricism reflects the idea of the client and the therapist work together using the client’s thoughts and assumptions as hypotheses that can be tested against reality (Beck et al., 1985). Collaboration is not only crucial in ‘selling’ the cognitive model to the client, but also in creating an atmosphere that allows for openness and trust, in which the client feels his/her inner world may be explored.

An example from my clinical practice might help in illustrating this. Mr K. was a 40 year-old man presenting with recurrent depression. The client was extremely shy and found it difficult to speak-up. It was challenging to find a level of engagement that would make him feel comfortable enough to work on a technical level. From the very beginning I took great care to encourage a collaborative relationship by reinforcing the client to speak-up, asking for feedback frequently and explaining that we needed to work as a team. In the 3rd session we agreed to start identifying and challenging his dysfunctional thoughts and beliefs by introducing a Thought Record. In the session we discussed how the Thought Record might be used as homework and why it could be helpful. In the following session Mr K. said that he had forgotten the Thought Record and that he was really sorry. It seemed important to explore why he might have forgotten it rather than whether he did genuinely forget it or not. Exploration was done collaboratively in a non-threatening and non-persecuting manner that allowed the client to be open. Our relationship seemed to be good enough for Mr K. to say that he was not really sure whether he wanted to change at all; this confusion made it difficult for him to work with the Thought Record, which in turn led him to leave it at home. Newman (1994) asserts that some form of
resistance is reasonable as therapeutic change is not only difficult, but also frightening. Mr K.’s resistance and the resulting collaborative exploration enabled us to explore important issues and to tailor interventions to his needs. Consequently we were able to explore the costs and benefits of changing and also whether there were parts that he wanted to change and others that he did not want to change. Thus, our relationship was a ‘necessary condition’ for the therapeutic work to be done.

However, the establishment of such a collaborative working relationship is not always easy. Since the application of cognitive therapy has moved towards client populations with more complex problems such as high co-morbidity, long-standing relationship difficulties or personality disorders, cognitive therapy has been modified to meet clients’ needs (Beck et al., 1990; Safran, 1990; Young, 1990, 1994). Clients with complex needs (diagnosed with Axis I and Axis II disorders) often exhibit engagement difficulties as their conflicts are interpersonal in nature, which in the past has been understood as non-compliance and therefore a hindrance to treatment (Newman, 2002). Until recently, difficulties in the therapeutic relationship were seen as technical problems that were unexpected and unwelcome and cognitive practitioners were urged to deal with difficulties in the same technical fashion as other issues in the treatment room (Beck et al., 1979). Such a conceptualisation seemed to reflect resistance as a problem and the resistant client as difficult.

Today this view seems outdated and anachronistic and difficulties in establishing and/or maintaining a therapeutic relationship are used as a source of information that allows for a better understanding of the client and his/her difficulties (Jacobsen, 1989; Sanders & Wills, 1999; Safran, 1990). So, resistance or ‘those aspects of clients’ functioning that seek to maintain the status quo in their psychological lives’ (Newman, 2002; p. 166) is not viewed as an obstacle to therapeutic change, but rather as a normal part of the therapeutic process (as therapeutic change is often frightening) and also as valuable information that allows for a better understanding and thus is a critical part of the therapeutic work. Newman (2002) not only lists
numerous examples of resistance, for example strong reactions to the therapist, like flirtation or anger, or avoidance behaviours, such as failing to do homework assignments or subtle avoidances in the session. He also asserts that it is important for the therapist not to respond inappropriately, for instance to get annoyed or defensive, but to be able to step outside the interpersonal process. It is only then that the client's resistance can aid further understanding and enables the therapist to conceptualise the process.

A theoretical framework that allows for the integration of cognitive and interpersonal theory is Young's schema-focused therapy (1990, 1994). The term 'schema' was originally coined by Beck and his colleges (1967); however, Young (1990, 1994) proposed specific treatment guidelines for the use of schemas. He defines 'early maladaptive schemas' as 'extremely stable and enduring themes that develop during childhood and are elaborated upon throughout an individual's lifetime' (p. 9). Early maladaptive schemas are the result of dysfunctional experiences with significant others in the first years of life and are characterised by being unconditional, self-perpetuating beliefs about oneself that once they are formed become central to an individual's self concept and may be activated by situations or events that are relevant to a particular schema (Young, 1990, 1994; Young & Klosko, 1993; Young et al., 2003). The activation of an early maladaptive schema is usually associated with high levels of emotion; for example, an individual with an abandonment/loss schema waiting for his/her partner to return from a trip when the roads are icy and the partner is late might have thoughts about the partner having a fatal accident. This would be likely to lead the individual to think about imminent loss and emotional isolation, which in turn leading to high levels of negative affect.

Similarly, Safran & Segal (1990) suggest a theoretical framework that systematically integrates interpersonal and cognitive theory and highlights the fact that

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2 Beck (1967) used the word schema to describe a cognitive structure for screening, interpreting and evaluating situations and events.
interpersonal schemas are not only activated by schema-consistent events, but also maintained through schema-consistent responses in others. Thus, a client’s schemas might lead to an interpersonal ‘pull’ in others to respond in a way that is consistent with their schema (Safran, 1990; p. 109). Unless others are able to ‘unhook’ from that pull the client’s schemas will be confirmed and maintained, which also leads clients to have limited interpersonal experiences (Safran, 1990; p. 111). In such cases the therapeutic relationship can provide a new interpersonal experience for the client if the therapist can ‘unhook’ from the interpersonal pull and not react to the client in a schema-consistent fashion. Moreover, it has been argued that the therapist’s reactions to the client can be an important resource (Young et al., 2003) in assessing a client’s schemas and help to avoid negative impact from the therapist’s own schemas; therefore it is crucial that the therapist is aware of his/her own schemas with regard to each client.

The following clinical example illustrates how the cognitive-interpersonal model (Safran & Segal, 1990) allowed me to use the relationship as the main vehicle for change. Mrs P., a 55 year-old female client, was referred by her GP with recurrent depression indicating that she had suffered from depressive episodes since her early teens and that she often required treatment with anti-depressants. A variety of difficult life events had contributed to Mrs P.’s depression and she pointed out that she had chronic relationship difficulties. She reported having no friends or partner and that she felt feelings of isolation and loneliness most of her life. She was living with her two grown-up sons who both depended on her financially, but did not seem to care for her. Everything she reported felt like rejection to her and Mrs P. appeared extremely hopeless.

The first few sessions were used to build a relationship with the client and to identify areas for change. From very early on I became increasingly aware of my feelings towards the client, in particular my lack of empathy for her. I also felt suffocated at times, as Mrs P. would overwhelm me frequently with letters (all around 10 pages
long) about her past experiences and the hopelessness of her situation. Also, as she had become dependent, it was difficult to end a session and the client would take a long time to get ready to leave and had made it a habit to ‘cling’ onto me (by hugging me) crying and complaining about her life before she would kiss me good-bye on both cheeks. I felt relieved, but inadequate, every time she left. In the 5th session the client started to complain that none of her problems seemed to shift and that she found it difficult to see how things could change. She also requested things she knew I could not offer her, such as working with chakras. She left that session without the usual long ending and, although similar in her usual ways, did not kiss me good-bye. Part of me was relieved, but the other part was left questioning what was going on. My responses and feelings provided me with not only a rich source of information about the nature and quality of the relationship with my client, but also an indication of the client’s relationships outside the consulting room (Persons, 1989).

Although I had taken a ‘participant-observer’ (Safran, 1990; p. 109) stance over our interaction, I initially found it difficult to put that understanding to good use as I felt 'locked in', what Safran described as, the ‘interpersonal pull’ (Safran, 1990; p. 109). However, my reactions to and feelings about the client had led me to think about the client’s dysfunctional interpersonal style, my own schemas and how our interaction was a replication of what seemed to happen outside the therapy room. For instance, Mrs P. reported how she complained to her two sons about her many physical problems and how she felt rejected by them when they withdrew instead of listening to her complaints on a daily basis.

It seemed that something had changed in that session and that the client was withdrawing from the interaction with me. In the following session I was able to address this by reviewing the last session with the client. The client felt that I was rejecting her by not doing what she wanted to do (to work on her chakras).
We used collaborative exploration to make a link between what happened in the therapy room and what seemed to happen outside the therapy room. This enabled the client to see enduring themes that were learned early in life and that were templates for her experiences. Through exploration of what was going on between us Mrs P. learned that her early maladaptive schemas were self-perpetuating. Her schemas related to connectedness, such as emotional deprivation, abandonment/loss and social isolation. Although she had been aware of her isolation and constant rejection of others, she had not been aware of her own part in this. Very slowly she learned to see how she maintained her schemas by selecting individuals that were unavailable to her, such as the husband who never loved her and the friends who never cared about her. While it was relatively easy for Mrs P. to see how she would avoid close relationship by imposing isolation on herself (schema avoidance) she found it difficult to see how she would at times compensate by being extremely demanding and wanting/need more attention (with me and with her two sons). The client overcompensated through her entitlement schema, which triggered my subjugation schema in sessions and prevented me from feeling empathy for her and her problems. However, when we explored early childhood memories, for example her father dropping her off with a stranger without explanation when her younger sister was born at the age of 5 and her parents' indifference upon her return, Mrs P. could see how she could have felt so lonely, abandoned and unloved that -at times- she would put a lot of effort into getting her needs met. In these instances the client would complain and demand to a degree that alienated others, in this case her two sons, whom she felt rejected by, and to some degree me, by ‘pulling’ me into an interpersonal process that not only confirmed her felt rejection and abandonment, but also reinforced her schemas. So, the emotions that were triggered off by me being non-empathic led the client to withdraw from the therapeutic relationship.

By exploring what was going on between us and relating it to relationships outside the therapy the therapeutic relationship was used as the active ingredient (Safran &

\footnote{As described by Young (1990, 1994).}
Segal, 1990; Young, 1999). Instead of using explicit techniques schema-therapy fosters change through empathic confrontation and limited re-parenting (Young et al., 2003). Through the understanding of my client's as well as my own schemas I became able to empathise with the client. In the safety of the therapeutic relationship genuine empathy about the client's schemas and the difficulties associated with them are used while confronting the client gently to change. Throughout this approach the therapist offers the client 'an approximation of missed emotional experiences' (Young et al., 2003; p. 201); thus I aimed at providing a nurturing, warm atmosphere and encouraged the client to express feelings of deprivation and also to feel entitled to have emotional needs and how to communicate them. Such a corrective emotional experience is likely to disconfirm Mrs P.'s perceptions about feeling unloved, uncared for and rejected.

In conclusion it seems that cognitive therapy has been developed and elaborated and has moved away from the mechanistic application of tools and techniques to clients' problems. Resistance and problems in developing and/or maintaining a therapeutic relationship are not perceived as problems to be overcome, but rather as an invaluable source of information about clients' dysfunctional interpersonal schemas. The therapeutic relationship therefore is not 'just' seen as a necessary condition for therapeutic change: it can provide an arena in which the client can challenge maladaptive schemas and practice new behaviours (Sanders & Wills, 1999), and therefore becomes a vehicle for facilitating emotional change in its own right.
References


THERAPEUTIC PRACTICE DOSSIER
My first year placement was a one-day placement in a Primary Care Surgery in the South East of England. The fund holding practice employed a team of 7 medical doctors, 12 nurses, 2 opticians, 1 dietician, 1 chiropodist, 1 chiropractor, one Counselling Psychologist and one Counsellor besides myself. The Primary Care Service served 12,000 registered patients.

The client group was unusual for the prosperous southern area in that it reflected a higher level of social deprivation and poor housing in the catchment area. Adult clients (aged between 17 and 72 years) were referred from their General Practitioner for brief individual therapy (six to eight sessions); in special circumstances up to 12 sessions could be offered. Clients' psychological difficulties were mild to moderate and presenting issues ranged from depression and anxiety to life crises and relationship difficulties.

I conducted initial assessments and either referred clients on or saw them myself for individual therapy. Individual supervision was provided on a weekly basis by an integrative psychotherapist; my approach was mainly person-centred.
Second Year Placement: Student Counselling Service
September 2002- August 2003

In my second year I had a one and a half day placement in a Student Counselling Service of a large University in the South East of England. The service for undergraduate and postgraduate students was free of charge. Clients could be referred from their personal tutors, the health centre or their departments, but most students self-referred. Appointments could be offered within a week and a crisis appointment system was in place for students who were in need of immediate support. Four professionally qualified full-time counsellors and five trainee counsellors (all on advanced postgraduate training courses) provided the service. The theoretical orientation was largely psychodynamic; however, there was a strong tendency to integrate other aspects, such as person-centred or cognitive-behavioural where indicated.

Clients seen were undergraduate, postgraduate and mature students from a variety of different cultures; presenting issues included identity issues, self-harming, sexual problems, anxiety, abuse, eating disorders and relationship problems. Both long and short term counselling was available although time-limited contracts were increasingly encouraged due to the rising number of clients.

My responsibility was to assess the client and to deliver psychological therapy. Integrative/psychodynamic supervision was provided on a weekly basis. This placement was very containing, which was partly due to working in a team. Team meetings were held every fortnight and involved a team member presenting a case study, which was then discussed amongst the group. This was followed by the presentation of topics (that were to be specified at the beginning of the academic year). In this forum I presented several case studies as well as the topic of developmental issues with students.
Third Year Placement (part A): Counselling for an HM Prison
September 2003- August 2004

This placement involved working one day in an all male, low security prison (Category C) holding approximately 400 inmates. The therapy service was located within the Health Care Centre of the HM Prison and was open to all inmates. Clients may have been advised to have counselling by their governor or the parole board, but most clients self-referred. Inmates had to apply in writing and were then interviewed by the ‘Through Care’ department (which is part of the internal probation system) about their current concerns and background history. This not only allowed for a preliminary risk assessment, but also established whether therapy was indicated or whether other agencies within the institution would be more helpful to the inmate. Clients were then on a waiting list for up to 2 months before they could be seen.

Appointments were usually made on a weekly basis and ranged from mini-commitments (up to 4 sessions) to short-term work (up to 12 sessions) and on occasions up to 6 months.

The service is not specifically aimed at reducing re-offending; however, clients presented with issues related to re-offending, such as drug misuse and anger, as well as issues not related to criminal behaviour, such as bereavement and relationship difficulties, and issues resulting from imprisonment, such as depression. One psychotherapist and myself provided the service. Clinical supervision was provided on a weekly basis; the theoretical approach taken was integrative.
Third Year Placement (part B): NHS Specialist Psychology Service

September 2003- August 2004

This placement in Secondary Care involved working in a Recurrent Depression and OCD Clinic for one day a week. The Specialist Psychology Service complemented psychological therapies in Primary Care and the local CMHT (Community Mental Health Team). Clients were referred from their GP, psychiatrists and the CMHT. The service is very busy and has a waiting list of several months. One Clinical Nurse Specialist, one Counselling Psychologist and myself provided individual psychological interventions. The Recurrent Depression Clinic accepted patients who had suffered three or more episodes of depression with good functioning in between. The OCD Clinic offered therapy to patients with OCD simple only (thus excluded Obsessional Compulsive Spectrum Disorders such as Trichotillomania). In some cases, particularly OCD, the active treatment process was followed up with top up and relapse prevention strategies to ensure that the progress is maintained over several months. Patients could also be offered a period following active treatment when they remained on clinician’s caseload, thus could ring in if necessary. The average number of sessions varied between 12 and 16, the maximum number of sessions offered was 20. The Specialist Service provide evidence-based practice, thus the theoretical orientation was cognitive-behavioural. However, there was great flexibility to work integratively.

Clinical supervision was provided by the Clinical Nurse Specialist on a weekly basis. Additionally I met with the senior psychologist in the service several times during the year to discuss issues of professional development. As a result of these meetings I took the opportunity to spend one week on an in-patient ward at the end of my placement. Multidisciplinary departmental meetings brought different departments within specialist psychology together (including Family Therapy, Direct Access and Psychotherapy) and addressed topics such as clinical governance, NHS directives on correspondence and departmental issues.
On becoming a reflective practitioner: Integrating theory, practice and research.

Overview
This paper aims to describe how I have developed my identity as an integrative counselling psychologist. This process has been portrayed as an ongoing journey (Goldberg, 1986), 'as a quest that has no end' (Hollanders, 2000; p. 41). In conveying my personal voyage I will draw upon miscellaneous personal and professional experiences that have shaped my identity and outline how those have been integrated into practice. Furthermore I will attempt to describe how various aspects of counselling psychology, such as its philosophy, research and different psychological theories, have impacted on my development as an integrative practitioner. However, integration refers to a reflective process and therefore it is inevitable that the following description can only be a 'snapshot' of this point in my journey.

Counselling Psychology as a distinct and integrative discipline
The realm of counselling psychology is distinct from other disciplines of psychology in that it is characterised by a humanistic value base, it emphasises the importance of the therapeutic relationship and links science and practice through the adoption of a scientist-practitioner model (Woolfe, 1996). Being firmly rooted in the humanistic tradition, counselling psychology rejects the medical model and regards individuals' difficulties as 'normative human experiences' (Woolfe, 1996; p. 9). The client is seen as a unique individual with a unique phenomenology within its context. Inherent to this philosophy is the centrality of the therapeutic relationship and what happens within, which is placed above the application of tools and techniques. Furthermore, scientific methods that evaluate practice are valued and research is used as a base to inform the practitioner about effective interventions (Woolfe, 1996). Through the adoption of the scientist-practitioner model and the co-existence
of various therapeutic approaches within the discipline, counselling psychology is - by its nature- an integrative discipline.

The history of counselling and psychotherapy has developed from competing schools towards a movement of disintegration and more recently towards integration and the development of various approaches to integrative psychotherapy (Hollanders, 2000). This movement has been spurred by findings that showed equivalence of outcomes of different therapy approaches (Lambert, 1983; Norcross & Goldfried, 1996). The integration of different approaches to therapy aims to go beyond the inadequacy of existing models and to formulate more comprehensive theories. Nevertheless, there is a debate as to how far theories can be integrated and it has been argued that it is impossible to overcome ‘the incommensurability of paradigms’ so as to produce a new, internally consistent and theoretical framework (Kuhn, 1970).

However, integration may be seen as happening outside or within the practitioner (Hollanders, 2000). External integration, or integration outside the practitioner, may be described in four categories: ‘theoretical integration’, ‘common factors’, ‘technical eclecticism’ (Arkowitz, 1989; Castonguay & Goldfried, 1994; Hollanders, 2000) and theoretical eclecticism. ‘Theoretical integration’ has been described as lying on the opposite pole to ‘technical eclecticism’ on the integration movement with ‘common factors’ integration lying somewhere in between these two approaches (Hollanders, 2000). Advocates of ‘theoretical integration’ suggest that integration can only be the result of the coming together of two or more theories leading to a new theoretical framework that will be more effective than its consisting theories (Norcross & Goldfried, 1992; Hollanders, 2000). ‘Common factors’ integration is based on the commonalities of effective ingredients across different approaches to therapy (Hollanders, 2000) and aims to create a new effective therapeutic approach based on effective similarities (Goldfried, 1982). Proponents of ‘technical eclecticism’ argue for the use of techniques from various therapeutic approaches. This approach has been described as ‘relatively atheoretical’ (Arkowitz,
1989), in which the therapist chooses the best treatment for the individual based on the empirically demonstrated effectiveness for specific psychological difficulties (Lazarus, 1967). Finally, 'theoretical eclecticism' refers to selecting out (as compared to bringing together as in integration) theoretical parts that already exist in the same form, which may be used to deal with difficulties that arise with problems of integration, for example when approaches are mutually exclusive. Having briefly outlined external integration I want to move on to integration that can be seen as being located within the practitioner.

Development of the personal and professional Self
Integration can also be seen as being located within the practitioner and thus captures the process of integrating experiences into clinical practice (Hollanders, 2000). This process involves the practitioner in taking a highly reflective stance (O’Brien & Houston, 2000) while being informed by literature, research and the experiences of others. The interaction between the practitioner’s experiences and reflections leads to an integration of those experiences and reflections into practice and thus become part of the clinician’s approach to therapy (Hollanders, 2000).

Gibson and Mitchell (1999) suggest that the personhood of the counsellor is one of the most fundamental elements in counselling. Whilst I agree with the notion that techniques are less important than the therapist’s unique character (McConnaughty, 1987) I also value the importance of theoretical understanding and its translation into practice. However, the techniques used by a therapist are likely to reflect, at least in part, the therapist’s personality and view of the world. Additionally, the quality of the relationship between the therapist and the client determines therapeutic process and outcome (Luborsky et al., 1983; Norcross & Goldfried, 1992; O’Malley et al., 1983). Thus therapeutic impact depends on the level of contact between the therapist and the client and the quality of interchange. If the therapist’s personhood and the therapeutic relationship are seen as the main vehicles for change, it seems that, for the integrative practitioner, a highly reflective stance and attendance to the
relationship she/he has to her/himself are pivotal for the relationship with the client. Therapy is the relationship between client and therapist; and it is the therapist’s intrapersonal and interpersonal awareness, understanding and skill that allow for the development and maintenance of an effective relationship with clients (Rogers, 1961; Clarkson, 1995). It is for this reason that the therapist’s self-discovery and ongoing reflection on his/her own view of the world, attitudes and beliefs as well as intrapersonal and interpersonal experiences are pivotal to the counselling process.

Intrapersonal integration

My experiences of personal therapy, peers and of course my clinical work are important sources of influences on ‘becoming’ an integrative practitioner.

My first year of training was characterised by the creation of a solid base for my development. My main objective was to avoid doing harm, which led me to be careful with myself, my clients and our relationship. This was heavily influenced by the humanistic tradition and consequently I concentrated on providing a safe space for both the client and myself in which exploration could take place. However, my awareness of trying to avoid harm might have led me to practice with a certain lack of playfulness and flexibility. Further, my perfectionist tendencies left me with a wish to observe and imitate experts, such as supervisors and professional tutors, so that I could learn how to work in the ‘right’ way. As a novice I often felt somewhat unprepared for problems needing specific solutions and at times was required to make decisions without the support of others. For example, in my first month I was presented with a young, suicidal woman who told me on a dreary Friday evening that she was scared for herself and of leaving the consulting room. In this instance I had to rely on my ‘not yet developed’ professional judgement, and I experienced this as frightening. Assessing and discussing the suicide risk with the client helped me to decide the best course of action. Consequently I spoke to her GP while she was waiting in the consulting room and she was referred to a crisis team. This incident helped me to see different elements of myself I could draw on, such as humanity,
common sense, gut feelings and my knowledge of the client. In hindsight, the lack of observational opportunities and the fact that my supervisor was not always available on site facilitated my search for my own epistemology.

Using the humanistic core conditions in my clinical practice led me to become more aware of providing these for myself. This meant that I had to learn to show, for instance, unconditional positive regard to myself, which seemed particularly difficult when at times I felt deskillled or ‘not good-enough’. It further meant that I had to take great care of myself and become more aware of my needs and limits, and to avoid overstretchedly myself, which is easily done while being quite resilient and having perfectionist tendencies. I also became increasingly aware that I wanted to do something about my clients’ difficulties and that it was easier for me to adopt a technique-oriented and practical approach; being with seemed difficult and so did the holding and containing of anxiety-provoking ambivalence and not knowing.

Personal integrative therapy was supportive and helped me understand and appreciate myself to a greater extent, to explore my phenomenological experiences of being with clients as well as with myself, to look at my strengths and weaknesses, to become more aware of cultural issues and how my past experiences impacted on my interaction with clients.

My second year was characterised by the difficulty of learning a new approach and it seemed that the psychodynamic approach to therapy would challenge my way of being. By then I had understood that my tendency to ‘make the client feel comfortable’ was really my own need. However this recognition did not instantly allow me to be different. After reflecting on these experiences I found it necessary to re-enter therapy (after having had to finish due to financial limitations) as I felt that being with clients, difficult feelings and myself was essential for therapy to be effective. I chose to work with a humanistic therapist who challenged my intellectualisation and rationalisation in response to difficulties instead of colluding
with it. The dismantling of defences, which had been adaptive and useful to me, made me feel like I was falling apart. The experience of inviting painful feelings back into my life without trying to make sense of them was extremely powerful, painful and frightening. However, I regard this process as a milestone in my development as a person and as a practitioner. It seems that a certain degree of disintegration was necessary for me for integration to take place. Once I allowed myself to experience painful feelings I was able to integrate those aspects of myself that seemed to be restricted by my strong defences, it ‘freed’ me up to be and therefore use myself in different ways. I became increasingly able offer clients doing as well as being, which is crucial for the integrative therapist (O’Brien & Houston, 2000). Since then I have become less rigid and concrete and more comfortable with difficult feelings, such as anxiety, ambivalence and not knowing; I am more flexible, open and playful. This has allowed me to work with much less anxiety about doing the ‘right’ thing and controlling my own feelings or the client’s. Also, my theoretical understanding about defences has been shaped through this experience. Consequently I conceptualise defences as necessary and important for the individual, which should not be deconstructed without the client’s understanding and careful consideration of what that would entail for the client.

My final year of training gave me the time and space to consolidate my personal and professional development. The integration of ‘forgotten’ aspects of myself has not only helped me to develop a stronger sense of myself, but has also led me to use myself to a much greater degree. I feel that the integration of being has come to be a core aspect of myself and my clinical work in that I am acutely aware which aspect predominates at any one time, being or doing. Such a reflection of what is happening with myself and between the client and myself not only informs me, but also allows me to intervene at a level most helpful to the client, with greatest flexibility. Generally I have become less perfectionist and afraid of ‘doing harm’, which has made clinical practice much more enjoyable. I was able to let go of excessive
structure and am more comfortable with ambiguity and not having clear, concrete answers.

**Interpersonal integration**

Personal development, however, also takes place on an interpersonal level. The course group, experiential group and process workshops as well as supervision and group supervision were used as vehicles for reflection on interpersonal interactions. The containment of my peer group has actively facilitated my ability to reflect on my interactional being. For example, being a part of the experiential group has helped me to see my tendencies to ‘rescue’ the group. Reflecting on this interaction I was able to use the experiential group as an arena to try out new behaviours. Supervision and group supervision have provided me with a regular and contained space that facilitated critical reflection and evaluation of my way of being and my clinical practice and how one influences the other. Further, it was a space where professional and ethical issues and dilemmas could be explored. I also learned a great deal from the reflection of my peers and developed skills in giving and receiving feedback. These experiences not only informed my practice, but were also integrated into my way of being with clients. Both individual and group supervision enabled me to develop an ‘internal supervisor’ (Casement, 1985) and allowed me to see ongoing reflection and evaluation not only as crucial components of integration, but also as an exciting enterprise.

Another interpersonal experience that impacted on my development was the video process workshop in the final year. The experience of sharing my way of being with a client with my peers was extremely liberating. Having experienced a ‘painful awareness of conscious incompetence’ during my training this workshop allowed me to move towards the development of ‘conscious competence’ (Connor, 2000; p. 299), thus enabling me to own not only my personal limitations, but also my personal strengths in being a practitioner.
Integration of Theory and Practice

It has been repeatedly demonstrated that the therapeutic relationship determines the effectiveness of psychological treatment more than any other factor (Luborsky et al., 1983; Norcross & Goldfried, 1992; O'Malley et al., 1983). The importance of the therapeutic relationship is well recognised within each individual therapeutic approach and thus lends itself to be used as an integrative paradigm (Clarkson, 1990, 1995b). Also, the therapeutic relationship is where integration takes place and integration could mean attending carefully to the client’s needs within the relationship, therefore placing the therapeutic relationship at the heart of therapy, which ‘may well take the therapist beyond the bounds of a single therapeutic approach’ (Hollanders, 2000; p. 39). Thus, as an integrative practitioner I am primarily guided by my experience of being with the client. Clarkson’s five relationship modalities (1990, 1995b) have facilitated conceptualising relationships with clients across schools and I regard the development and maintenance of a therapeutic relationship as the primary therapeutic goal. Although I found it necessary to understand and apply each distinct therapeutic approach, namely the humanistic, the psychodynamic and the cognitive-behavioural approach, on its own, I also found it helpful and enriching to conceptualise clients from different perspectives.

Year One

My first year was spent in a large, suburban Primary Care Surgery. This placement provided me with the opportunity to work with a broad range of presenting difficulties, such as anxiety, depression, self-harm and suicidal ideation, life-stage transitions and stress, with clients ranging from age 18 to 79.

My first steps into clinical practice were predominantly guided by the humanistic approach (Rogers, 1957a, 1961). I particularly like the holistic conceptualisation that recognises the interdependence of body, emotions, mind and spirit (West, 2000) and the acknowledgment of the client’s phenomenological world. Viewing the individual
as contextual and interactive also highlights the importance of the therapeutic relationship. The core conditions have not only been invaluable in my first steps as a practitioner; but have remained at the centre of my clinical practice. The following clinical example shows my initial attempts to provide the ‘necessary and sufficient’ conditions to build a therapeutic relationship.

Mrs L, a 39-year old single mother of three teenagers presented with feelings of depression and anxiety. Mrs L had been exposed to significant losses during her life, leaving her emotionally distressed and feeling empty. The client reported an array of problems ranging from difficulties in sustaining relationships to engaging in various risk-taking behaviours (such as unprotected sexual intercourse and ‘driving under the influence’). The client’s construction and evaluation of herself was mirrored in her behaviour (Mearns & Thorne, 1999), the way she was acting suggested internalisation of feelings of worthlessness and failure. Since such behaviours allowed her to abandon adult responsibilities and ‘escape’ from reality I interpreted them as repression (Bateman, Brown & Peddar, 2000). At the same time her 40th birthday was approaching leaving her to deal with a difficult midlife-transition (Levinson, 1978) and her feelings of depression and anxiety might have also be the result of a form of ‘mid-life crisis’ (Jaques, 1965).

The main focus of the therapeutic work was to create a non-threatening, safe and supportive environment and to offer a relationship that was characterised by unconditional positive regard, empathy and congruence. It was hoped that this would allow the exploration of feelings and experiences, moving towards self-regulation and personal responsibility allowing her to take control of her life and her self-actualisation (Rogers, 1957a). However, Mrs L was extremely chaotic, frequently not attending, arriving late or forgetting to switch off her mobile phone in sessions. It seemed difficult to build a therapeutic relationship with her. The sessions were characterised by a disorganised narrative, which I saw as a reflection of the way she lived her life. Her chaotic presentation suggested that she had no consistent way of
relating to others. My anxiety was high from the outset as I was unable to do a ‘proper’ assessment, because Mrs L needed instant support for her immediate problems, it felt like she was ‘all over the place’ most of the time. I wanted to do something about her problems and direct her, which was partly due to my personal and direct style (and limitations), but also to the context.

With the help of supervision I was able to let go of some of my perceived responsibility and my anxiety, which then allowed me to accept the client’s pace and focus on her needs. As a result I became much more aware of my needs and my client’s needs.

I realised that my thoughts of what was good/bad for Mrs L was a form of taking responsibility for her. Her ‘irresponsible’ behaviour had led me to become responsible for her, but I wanted to be responsible to her (Mearns & Thorne, 1999). Therefore, being with this client became the focus of therapy, which seemed difficult to me (for the reasons mentioned above). Although Mrs L found the sessions she attended helpful in that she could ‘air’ her feelings and feel supported, we were not able to maintain a relationship that allowed us to go beyond the immediate support she needed. After the termination of therapy she repeatedly scheduled emergency appointments. However, there was never a proper ending. I learned from this client that building and maintaining a therapeutic relationship can be an extremely difficult and lengthy enterprise. It helped me to see that I can offer support to maintain a client’s current status, but exploration and integration of thoughts and feelings can only take place when the working alliance is firmly established.

Year Two
My second year placement was spent at a student-counselling centre. This placement provided me with not only the experience of working with individuals of different ages and from a variety of cultures, but also presenting issues ranging from academic difficulties, depression, anxiety, childhood sexual abuse to relationship/marital
problems. The placement was challenging, but at the same time allowed me the space and containment to learn and practice a psychodynamic approach.

The psychodynamic approach facilitated my move away from relying solely on content and intellect towards meaning and understanding, accessing and using unconscious patterns, such as counter-transference and transference. Understanding early relationship dynamics has been particularly helpful in thinking about clients’ difficulties and their origins. I also came to appreciate the therapeutic frame and the microanalysis of therapeutic processes, which reinforced my capacity for reflection. The containment provided in the placement, supervision and personal therapy facilitated my capacity to ‘contain’ and ‘hold’ feelings that were often unbearable for the client. My respect and understanding for defence mechanisms have led me to challenge clients by ‘interpreting the meaning or function of the defences’ gently (Flegenheimer, 1982; p. 65) rather than confronting the client’s defences directly.

Miss F, age 21, self-referred early in the academic year. The postgraduate student presented with negative feelings about people around her and about herself, loneliness and fear of ‘going mad’. Her narratives lacked depth and expression of feeling. When it transpired that there had been considerable stressors surrounding her birth and early childhood I hypothesised that that these difficulties had impacted on her mother’s ability to provide in that she might have been less responsive, distanced and detached. With the mother ‘not being good-enough’ (Winnicott, 1965) the client might have reacted with initial terror and rage, but ultimately with the dissociation of thoughts and feelings. The client had incorporated the notion of ‘there is something wrong with me’ into her self-concept and had defended herself by creating a ‘false self’. Her ‘false self’ dealt competently with reality, which was evident in Miss F’s academic achievements. However, it seemed that the underlying fear of rejection, failure and annihilation led her to withdrawal from feelings. I conceptualised her fear of ‘going mad’ as a fear of disintegration, of a breakdown of her defences (Winnicott, 1974).
I focused on the provision of a 'holding environment' (Winnicott, 1965) from the very beginning and conceptualised the therapeutic setting as a 'transitional space' with my role as compensating for the 'not good-enough mother' (Winnicott, 1965). Initially I found working with Miss F in a psychodynamic way very challenging. It was difficult to find a space to make interventions, as most sessions were filled with defensive talking during which the client would speak through whole session without stopping to think, feel or reflect. At other times I felt like letting her talk without trying to engage with her; I became increasingly frustrated and detached. Supervision helped me to see the dynamic of our relationship and how Miss F was reproducing what she had learned from her mother while keeping me at bay (to avoid difficult material being triggered off). I had attempted client-centred interventions before, which were usually brushed off by the client. Only when I started to use therapist-centred interventions, using myself to a greater degree, we were able to explore the dynamic between the two of us and consequently opened up some very painful memories and fears (mostly of being rejected) for the client.

I found it difficult not to collude with Miss F on an intellectual level and at the same time wanted to avoid being overly feeling oriented so as to not rush her into a premature experience she was not ready for (the breakdown of her defences). Through the provision of a holding environment Miss F became increasingly tolerant of feelings and their expression, and consequently learned that this must not have consequences but can be survived (Johnson, 1994). Miss F increasingly started to connect with feelings of abandonment by her mother, anger and sadness, which was accompanied by depth and congruence of her experience. Shortly after she allowed herself to cry for the first time. Her fear of 'going mad' subsided and the slow and careful integration of feelings allowed her to start to acknowledge fears of rejection, failure and annihilation.
Year Three
In my third year I was able to do a split placement with one day working at an outpatient specialist clinic and the other day working in a prison establishment.

The Outpatient Clinic
The specialist service for depression and OCD offered secondary and tertiary care services using CBT; however, my supervisor allowed me to theoretically integrate other approaches. Most importantly my supervisor's attitude of flexibility and openness to other approaches enabled me to integrate CBT techniques into my practice in a curious and 'playful' way. I like the idea of collaboration of the CBT approach (Beck, 1976; Beck et al., 1979). However, I also found it helpful to incorporate the ideas of schema-focused therapy (Young, 1994; Young & Klosko, 1993; Young et al., 2003), in particular understanding the links between early relational patterns and current difficulties.

Mrs S, a 37-year old married full-time mother of two boys presented with obsessive-compulsive disorder (OCD). The client and I worked collaboratively on a shared formulation that took her developmental history into account. Mrs S had developed schemas relating to defectiveness, failure and unrelenting standards.

Cognitive-behavioural therapy (CBT) has been proven to be effective in treating OCD, in particular the combination of symptom-oriented techniques and general supportive techniques (Hawton et al., 1989; Salkovskis, 1990; Roth & Fonagy, 1996). We identified and tested beliefs and assumptions, but also used symptom-oriented techniques, such as exposure to previously avoided situations (in imagination and in vivo) and managing and restricting rituals and routines. The actual in vivo exposure was initially quite frightening as I had never seen a client outside the consulting room and the situation required sensitivity in relation to boundaries. For example, I had to be introduced to the client's children and we had a more social interaction before we did the actual exposure. The exposure was difficult
as Mrs S started to hyperventilate and panic. My natural instinct would have been to stop her from panicking and calm her down. However, the exercise required her to be exposed to those frightening feelings, which meant I had to be exposed to them as well (which is distressing for client and therapist alike, as described by Salkovskis (1990)). It was a great learning experience to actually be there and contain her difficult feelings and allowed me to see that I had overcome my initial need 'to make clients feel better'.

At the same time it became apparent that Mrs S's difficulties were also related to a number of feelings other than anxiety, such as guilt, shame, sadness etc., and it was important for us to find a space that allowed exploration of these feelings as well. Initially I feared that I could not provide her with the skills and techniques needed for her to overcome this difficult condition (therefore feeling like a failure just like my client). However, supervision has helped me to create a space for 'positive changes' on the agenda, which allowed the client (and me) to get a sense of mastery and achievement. Ethical issues arose with the concerns for the client's children. Mrs S reported to shout and at times slap the boys. This was assessed in detail and reviewed on a continuous basis in supervision.

The Prison
My second placement was in an all male prison with an integrative supervisor. I saw clients of different ages not only with a variety of presenting issues, ranging from anger management, drug & alcohol abuse and bereavement, but also from a variety of cultures. However, this placement was very different in that all clinical work was influenced by the prison context and its accompanying difficulties.

The clinical work was very challenging, as many clients had antisocial tendencies, which complicated the development of therapeutic relationships. Clients often attempted to charm, outsmart or intimidate me in order to test my integrity and reliability before committing to the therapeutic process. My aim was always to
engage clients in a relationship that was characterised by the core conditions. I
learned quickly that the building of such a relationship would not only have to be
based on the provision of the core conditions, but that I was required to be more
‘real’. Only the person-to-person relationship (Clarkson, 1990) seemed to allow the
building of trust in me as a person and consequently facilitated the move away from
being one of ‘them’.

However, I soon was confronted with a real dilemma: How could I integrate the
opposing philosophies of counselling psychology and the prison service? The notion
that criminals’ behaviour is ‘bad’ behaviour that must be punished leads to
correctional aims such as rehabilitation. However, the production of a ‘good’ and
law-abiding citizen was not my main therapeutic aim as a practitioner. The
mainstream prison service required me to ‘teach’ and reinforce what is ‘right’ and
what is ‘appropriate’, suggesting that the clients’ phenomenological experience of
being was ‘wrong’. How, as a counselling psychologist who does not subscribe to
objectifying individuals and their experiences, would I practice within the system?

On a theoretical level it seems that integration of such opposing philosophies is
impossible and that individuals who chose to work in this environment must find
their own way of working within the system while being true to themselves. My
main concern was how to resolve this dissonance in the consulting room. On lengthy
reflection alone and in supervision I have moved away from feeling that I have
responsibility to ‘reform’ the client. I have come to see that it is my responsibility to
work on allowing clients to have a choice. So, rather than suggesting that they are
‘wrong’, I aimed at providing a space where different ways of being could be
explored and tried out. I concluded that, as with clients in other settings, the ultimate
decision to change is not mine, but lies with the client and my role is to enable
clients to create choices by exploring different ways of being. This standpoint has

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1 There is a strong ‘us’ & ‘them’ dynamic in prison. ‘Them’ refers to anyone who is part of the
correctional system and not an inmate and is often perceived as a not trustworthy perpetrator.
helped me to open up and gain the trust of inmates who become much less defensive and open when they understand that my intention is not to take their identity and way of being away from them.

Working in this context though has challenged the assumption that 'human nature is essentially constructive' (Mearns & Thorne, 1988) and I have come to view human nature as evolving towards the best possible 'interpersonal strategies for dealing with suboptimal environments' (Holmes, 2001; p. 25), so human development is adaptive to survival, but not always constructive.

**Scientist-practitioner**

Another integral aspect of counselling psychology is the bringing together of scientific research and professional practice. The scientist-practitioner model reflects the inter-relatedness of theory, practice and research (Woolfe, 1996; Meara et al., 1988). My own understanding of being a scientist-practitioner can be described as being a producer as well as a consumer of knowledge (Strawbridge, 1997).

Producing research is not only crucial for the provision of a base for practice, but more importantly for the improvement of services. The notion of evidence-based practice reflects the need for therapeutic interventions to be informed by reliable knowledge about its effectiveness. Traditionally the purpose of research has been to determine: 'What treatment, by whom is most effective for this individual, with that specific problem, and under which set of circumstances' (Paul, 1967; p. 111). However, recently evidence-base practice has moved towards researching context and process issues and started to espouse more phenomenological concepts, and thus started to move beyond outcome and 'objectivity' (Corrie, 2003). As an integrative practitioner I employed research methods that were consistent with the philosophy of counselling psychology, such as qualitative content analysis and multiscaling analysis, to investigate inmates' experiences of the prison context\(^2\) and relationships

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\(^2\) The prison context in which investigations took place was a prison-based therapeutic community.
within this context with the aim of improving awareness of contextual difficulties (such as power dynamics, ethical difficulties and therapeutic interventions as being secondary to security). Thus, research could be seen as a ‘tool by which we can answer the difficult and challenging questions thrown up by practice’ (Hart & Hogan, 2003; p. 26).

As a consumer of research I allow research findings to inform and guide my practice. This is always guided by the wish to understand my client and his/her difficulties. However, rather than blindly applying whatever is suggested by literature, I aim to consume research in a critical and reflexive manner. If, after careful assessment and formulation about the origins and maintaining factors of a client’s difficulties, empirically supported guidelines meet the client’s needs (including the client’s aims and his/hers social, cultural, ethical and political context) research informs and guides my being with and doing to. However, clients, their unique and often complex difficulties and contexts do not always fit into homogeneous treatment recommendations and protocols and in order to deliver good, individualised practice research guidelines should always be secondary to the client’s needs. So, research needs to be critically evaluated and it is the reflective practitioner’s task to ‘tailor’ research findings to the client’s individual needs and the clinical context.

**Conclusions**

In this paper I have attempted to highlight the various aspects that have impacted on my personal development as an integrative practitioner. In my view integration is concerned with being open, curious and reflective about myself and my clinical practice. Attending to the therapeutic relationship, which is the context in which integration takes place, means attending carefully to each client’s needs. Understanding and meeting the client and his/her unique needs requires the practitioner to be informed by a wide theoretical knowledge base, which includes practice, theory and research. However, ultimately it is the practitioner’s
personhood, humanity and interpersonal skill that allow for the development and maintenance of a therapeutic relationship, which is the basis for any therapeutic change to occur.
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RESEARCH DOSSIER
How does the forensic setting compromise therapeutic interventions with offenders?

ABSTRACT Psychological services in the HM Prison Service have been established with the main aim of reducing recidivism. Increasingly forensic psychologists acknowledge that contributions from counselling psychologists could facilitate improvement of psychological services. However, therapeutic interventions within prisons are secondary to security, and consequently it is questionable whether therapeutic and ethical considerations of counselling psychologists are compromised in the forensic setting and if so, how. This paper investigates whether a marriage between forensic psychology and counselling psychology allows improvement of therapeutic interventions in prisons. First of all both domains are described individually; this is followed by general considerations of therapeutic interventions in prison settings. Secondly, two different treatment approaches, namely the Sex Offender Treatment Programme and the Therapeutic Community, are examined to find out how therapeutic interventions are compromised in the prison setting and how this could affect treatment outcome.

Keywords: counselling psychology, forensic psychology, offender treatment, therapeutic relationship, Sex Offender Treatment Program, Therapeutic Community

INTRODUCTION

Increasing crime rates and proposals for harsher punishment may not only reflect society's values, but also result in high numbers of imprisoned individuals. It is one of the aims of imprisonment to rehabilitate the offender and to help him or her to become a law-abiding citizen. In order to reduce the rates of re-offending therapeutic interventions are used today to facilitate change in the offender. However, effective interventions require resources and forensic psychologists working with offenders now acknowledge that potential contributions from other domains might be needed to intervene effectively. Counselling psychologists are becoming increasingly involved in the treatment of offenders.
It is suggested that counselling psychology differs in philosophy and practice from forensic approaches to treatment in that it accepts a humanistic values system. With its emphasis on the individual’s subjective experience and the importance of collaborative work between the therapist and the client it appears to be incompatible with forensic settings that aim at controlling and punishing the offender. However, it will be argued that there is a great need for collaboration between those domains and that therapeutic and ethical considerations of counselling psychologists might aid treatment and lead to more effective outcomes. This paper will explore both contexts, counselling and forensic, in terms of aims and purpose of each setting and their approach to treatment. This includes not only ethical issues, but also the content and delivery of the interventions highlighting the role of the therapeutic relationship and the individuals working with offenders.

THE CONTEXT OF COUNSELLING PSYCHOLOGY
Counselling psychologists may use psychological theories and theoretical concepts to think systematically about human development and therapeutic processes (Woolfe, 1998). Whilst the still evolving discipline appears to be working towards a clearer definition, there is still confusion (Spinelli, 2001) and a pre-occupation with identity issues (Brown & Lent, 1992). However, the British Association for Counselling states in its ‘Code of Ethics and Practice for Counsellors’ that ‘Counselling may be concerned with developmental issues, addressing and resolving specific problems, making decisions, coping with crises, developing personal insight and knowledge, working through feelings of inner conflict or improving relationships with others’ (BAC, 1998, p.1).

This rather practical list highlights specific areas of work, but it fails to capture the distinct essence of counselling psychology: the acceptance of a humanistic value system. By rejecting a medical model that reduces the individual to a passive object counselling psychology emphasises the individual’s subjective experience and the importance of collaboration (Woolfe, 1998). The Professional Practice Guidelines of
the British Psychological Society's Division of Counselling Psychology (2001) include a firm value base in its definition of counselling psychology by stating that it aims at engaging in practice as well as in research with subjectivity and inter-subjectivity, values and beliefs, knowing empathically and respecting individuals in their own right without assuming any form of superiority. It further aims at empowering the individual rather than controlling him/her (Professional Practice Guidelines, 2001).

THE CONTEXT OF FORENSIC PSYCHOLOGY

Forensic psychology can be defined as the application of psychological knowledge and principles to legal issues (Haward, 1990). However, the relationship between psychology and law seems blurred in its implications for practitioners (Gudjonsson & Haward, 1998). Historically, forensic psychology aimed at understanding criminal behaviour and communicating it to other professionals. Forensic psychiatry, on the other hand, differs in content, method and epistemology (Gudjonsson & Haward, 1998) and has been defined as 'the prevention, amelioration and treatment of victimization which is associated with mental disease' (Gunn & Taylor, 1993, p.2). The focus seems to be on forensic care, on individual treatment and rehabilitation of the mentally disordered who also exhibit various degrees of criminality (Mercer et al., 2000). Forensic psychology may thus be understood as a related specialism of forensic psychiatry. Contributions from forensic psychologists are mainly through prison research, for instance through the evaluation of offender programs and treatments, the validation of risk assessment procedures or improving the effectiveness of regimes (Clark, 1999).

In practice psychologists in prisons are expected to go beyond research and to formulate and deliver a wide range of preventative strategies, especially to train staff (McHugh, 1999). Moreover, McHugh (1999) states that psychologists in prisons conduct work in areas such as 'coping and problems of hopelessness among young offenders', 'working with women who self-injure' (p.24) and 'offending behaviour
programmes’ (Towl, 2002). It appears that the future direction of forensic psychologists requires a development that allows establishment, maintenance and development of therapeutic regimes (McHugh, 1999).

Having looked at the forensic and the counselling context the following question arises:

WHERE SHOULD THE PROVISION OF MENTAL HEALTH BE BASED?
Individuals with problems in mental health and law raise questions of definitions and responsibilities. The classification of mental disorders seems not only heavily value-laden, but also reflects a system that controls the socially deviant individual (Foucault, 1978). Thus, it reflects society’s cultural values about delinquency and leads to the question of whether the offender is seen as a patient or a criminal (Scheffer, 1996).

In Britain maximum security establishments detain a number of more serious offenders, and Regional Secure Units (RSUs) hospitalise offenders requiring psychiatric services at medium levels of security; however, there seem to be a number of disordered offenders being dealt with in the National Health Service, as outpatients on probation orders or open psychiatric hospitals (Blackburn, 1999). In spite of those provisions mentally disordered patients can find themselves in prison for different reasons (Blackburn, 1999). Patients classified as ‘untreatable’ (possibly non-conforming mentally disordered patients that seem difficult (Gunn & Taylor, 1993)), a lack of hospital placements or patients not consenting to treatment may be placed in prison settings. However, there is also the possibility of the offender becoming affected by the prison environment and developing psychological difficulties; or that it is only in prison that he/she shows signs of mental illness that have not been assessed previously.
THE NEED FOR THERAPEUTIC INTERVENTIONS IN PRISONS

Therapeutic interventions in prison are mainly concerned with the rehabilitation of the offender, the main aim being to enable the individual to live life outside the prison as a law-abiding citizen (European Committee on Crime Problems, 1986). Whether it is the therapist's aim to reduce the individual's tendency to commit or repeat offences or to change the offending individual and therefore facilitate personality change (Scheffer, 1996) seems to be a theoretical argument. The overall aim of therapeutic interventions is the reduction of re-offending. Besides focusing on the problems that led to the individual's incarceration therapeutic treatment might be necessary to alleviate problems that result from incarceration. A higher incidence of mental health difficulties in prisons than in the general population has been reported (Milan & Evans, 1987). However, it is not clear whether these difficulties are of contributory cause or the effects of incarceration. Walker (1983) argued that depression is an understandable reaction to the prospect of conviction, stigma, loss of job, rejection and deprivation of liberty. However, he suggests that prisoners who are psychopathic, depressed and overanxious are likely to have a history of treatment and come to official notice only as a result of observation in prison. Bukstel and Kilman (1980) concluded that it is the individual's specific variables that determine whether the incarceration is harmful or not. Therapeutic interventions must assist those inmates who have difficulty adjusting to the prison environment.

Thus, therapeutic interventions in prisons are necessary to overcome problems that led to the conviction in the first place. Secondly, interventions may assist the offender in adjusting to imprisonment. And thirdly, interventions may prepare the offender for the return to the community and aid re-socialisation.

The prison context, the therapeutic context and therapeutic interventions in prisons will be considered next.
THE PRISON CONTEXT

Imprisonment is the deprivation of an individual’s liberty after he/she has been convicted and sentenced. A prison is not just a building for incarcerating and securing inmates, but it is also a system with strict rules. Prison regimes can be described as the elements that constitute the inmate’s daily life, such as security, prison work, prison rules and regulations, management, etc. (European Committee on Crime Problems, 1986). There are different types of prisons (open, semi-open or closed) with different security levels, and different types of inmates (depending on age, gender and severity of crime).

It has been suggested that a prison sentence serves several functions, which can be summarised as punishment, deterrence and rehabilitation. Walker (1980) referred to the ‘retributive justification’ for the offender who deserves to be punished for his/her crime. His ‘reductive justification’ can be seen as deterrence; by penalising the offender criminal behaviour should be discouraged (Walker, 1980). Rehabilitation may be seen as a ‘reductive justification’ since it aims at reducing offending behaviour by helping the offender to overcome the problems that led to the sentencing. The idea of protecting the public by incarcerating offenders may be seen as another purpose of imprisonment.

Despite differences in prison regimes and differences among prisoners it can be assumed that every period of imprisonment is at least a very unpleasant experience if not a harmful one. Sapsford (1978) described the effects of those who are confined as ‘institutionalisation’ (p.128), leading to the inmate’s reduction in future time-perspective, introversion, dependency on routine and inability to make trivial decisions and decreased involvement with the outside world. In addition to the deprivation of liberty there is a deprivation of autonomy and relationships.
Psychotherapy has been described as ‘...a personal relationship with a professional person in which those in distress can share and explore the underlying nature of their troubles, and possibly change some of the determinants of these through experiencing unrecognised forces in themselves’ (Sutherland, 1968). There are a number of different therapies, all of which are based on different psychological theories (Drew & King, 1995). Furthermore, therapies can focus on the troubled individual, on couples or entire families, or on a group of individuals that share a specific problem.

The basic elements of counselling psychology and psychotherapy are similar despite different underlying theories and different techniques. Conventionally, the client and the therapist voluntarily agree to work together. ‘Contracting’ requires them to negotiate and agree on treatment goals and basic rules about the therapy, for example how often therapy takes place and how many sessions seem appropriate. The nature of therapeutic work requires the individual to be motivated; it seems necessary for clients to feel autonomy and control over their choice to have treatment. The therapist handles the client, information about the client and processes within the therapeutic relationship with strict confidentiality and is responsible to the client (Bond, 2000). Beauchamp and Childress (1994; as cited in Bond, 2000; Shillito-Clarke, 1996)) proposed four ethical principles that are binding for counselling psychologists and psychotherapists: respect for autonomy (freedom to make own choices and decide actions), beneficence (obligation to benefit the client), non-maleficence (obligation to avoid harm to the client and to use power and ability respectfully) and justice (the use of fairness and equal distribution). Fidelity, as a fifth ethical principle has been added (Thompson, 1990) and refers to honouring the value of the trusting relationship between the therapist and the client. It is cardinal to the relationship and requires trust, respect for the client’s autonomy as well as clear communication and boundaries.
Research has confirmed that the most important factor for the outcome of therapeutic treatment is the quality of the therapeutic relationship (Luborsky et al., 1993; Norcross & Goldfried, 1992). Treatment outcome can best be predicted by the characteristics of the client, the therapist and their relationship with each other (Clarkson, 1995). Assuming that this is the case, one should be able to expect that therapists make intentional use of the therapeutic relationship and are trained to do so. However, therapeutic interventions in prisons might differ from these ‘optimal therapeutic considerations’. This will be highlighted next.

THERAPEUTIC INTERVENTIONS WITHIN THE PRISON SETTING

Security before treatment

The presence of the Criminal Justice System imposes constraints on the offender that impact every aspect of his/her life. Consequently treatment differs from treatment in other settings. Security, control and discipline are necessary aims and means for conventional prisons and anything, including treatment, is secondary (Wexler, 1997). Security is assured not only through architecture, e.g. thick walls, size and location of rooms and the number of gates, but also through various procedures including lock-ups several times a day, constant observation of prisoners and cell searches (Rawlings, 1998). The implications of high security lead to practical limitations for treatment. Therapeutic interventions have to ‘fit in’ between meal times, lock-ups, drug-testing and cell searches. Rawlings (1998) asserts that control is maintained through the strong hierarchy, in which officers have power and control and offenders’ autonomy and responsibility is dismantled.

Ethical Problems

Any employment requires the psychologists to accept the means and aims of the organisation. This is especially difficult for the counselling psychologist working in a forensic setting since the rehabilitative aims are in many ways incompatible with
the punitive or custodial aims of the institution (Blackburn, 1999). Conflicts centre around the demands for security and control within the institution and treatment plans and priorities. The most common ethical dilemma is confidentiality (Gudjonsson & Haward, 1998; Blackburn, 1999). Difficulties not only arise from the nature of confidentiality, but also from its implementation into ethical practice. Confidentiality is considered to be a fundamental element of counselling and psychotherapy (Bond, 2000). The development of an intimate relationship that is based on trust and respect, crucial to therapy and its outcome, requires confidentiality. The client needs to know that whatever is disclosed in therapy will not result in any harmful responses.

This is potentially a difficult situation for the psychologist who might be confronted with information revealed by the offender that indicates a threat to safety (Blackburn, 1999). Here, the therapist is asked to engage in a dual relationship: on one hand the therapist aims at offering a safe and trusting relationship to the client, on the other hand he/she functions as an assessor and monitors the offender’s behaviour. Assessing whether a client is ready to be released or paroled not only leads to a dual role of the therapist, thus compromising the therapeutic relationship, but is also regarded as unethical (Shillito-Clarke, 1996). Other ethical problems that blur therapeutic interventions further include mandatory treatment, boundary and power issues.

Therapeutic interventions in the prison setting have to ‘fit in’ with the strict regime, its administration and purpose. There is no real collusion between therapeutic considerations and the prison regime as priorities are clear: the prison regime predominates. However, it appears that the authoritarian regime hinders the facilitation of a therapeutic relationship. The following exploration of a structured prison programme investigates how therapeutic interventions are compromised in a limiting and restricting setting such as a prison.
Towl and Bailey (1995) described the most commonly reported groupwork types in prisons today. In a national survey conducted by Towl and Bailey (1993) the majority of groupwork in prisons included groups for offending behaviour, alcohol, drugs and anger. This discussion will focus on the national Sex Offender Treatment Program (SOTP) because this structured cognitive-behavioural approach is the most widely used group work in prisons (Towl & Bailey, 1995).

Groupwork

Broadly, groupwork refers to a therapeutic process in which members of a group meet with a therapist or facilitator (Reber, 1995). Brown (1989) suggested that groupwork ‘can enable individuals and groups to influence and change personal, group, organizational and community problems’. ‘Grouptherapy’ (Moreno, 1948) is based on the assumptions that individuals are affected by relationships with other individuals (Bateman, Brown & Peddar, 2000). The integration of interpersonal and contextual aspects allows a facilitation of ‘social functioning’ (Konopka, 1963; as cited in Brown, 1989) by experimenting and expressing internal worlds in relation to others in a safe context (Gilbert & Shmukler, 1998). The safe environment allows group members to support and confront each other, new behaviours can be tried out and rigid interpersonal schemata exchanged (Gilbert & Shmukler, 1998).

Sex Offender Treatment Programmes

The commonly used format for Sex Offender Programmes is that of group therapy (Marshall et al., 1999). There are different types of Sex Offender Treatment Programmes with different exclusion/inclusion criteria. Programmes are designed according to the needs of medium and high-risk sex offenders (SOTP Team, Theory Manual, 2000). Prisoners are seen as suitable when convicted for a sexual offence (such as incest, rape, indecent assault or exposure etc.), when convicted for another crime that had a sexual element or when treatment is requested (SOTP Rolling
Programme, 2001). Exclusion criteria include an IQ below 80, mental illness and incapacities such as lack of honest disclosure, inability to experience emotions in depth, inability to take responsibility for behaviour and inability to experience empathy (SOTP Rolling Programme, 2001). When a prisoner meets the suitability criteria it has to be assessed whether the inmate is ready for treatment. Criteria that suggest that a prisoner is not ready for treatment include total denial of the offence, refusal of treatment, suicide or self-harming, poor literacy and inadequate language skills (SOTP Rolling Programme, 2001).

The SOTP Core Programme is used as a first-stage treatment and consists of 75-95 two-hour group therapy sessions (SOT Team, Theory Manual, 2000). Core 2000 comprises treatment goals of developing group cohesion, identifying patterns of offending, identifying motivations for offending teaching coping strategies, generalising from the programme to everyday functioning and role-playing new skills and strategies. The Core Programme treatment is administered in twenty blocks targeting specific and developing elements of therapeutic change (SOT Team, Theory Manual, 2000). Each block has specific treatment targets. The first seven blocks aim at recognition of causes of the individual’s offending and at increasing motivation to change; the remaining blocks are used to implement cognitive and behavioural changes within the individual. One of the main aims of the Core 2000 programme is the identification and restructuring of pro-offending beliefs into anti-offending beliefs (SOT Team, Theory Manual, 2000). Being in a group setting allows the group members to actively participate in helping each other, for instance group members are asked to offer their views on the individual’s attitudes and beliefs about his/her offence. This not only provides feedback, but also stimulates critical thinking about their own attitude and beliefs, which in turn challenges the individual’s thoughts and might aid change in the individual as well as in others (Marshall et al., 1999).
Outcome studies

How successful is this approach? Treatment outcome is measured in a reduction of re-offending. Most studies have focused on recidivism data, which is a limited and insufficient account of the value and effectiveness of the treatment outcome (Marshall et al., 1999). A delayed onset of re-offending, reduced violence when offending, the cost resulting from re-offending as well as refusal rates and treatment dropouts could illuminate how valuable the approach taken is. Recidivism, the relapse to a former behaviour pattern, for sex offenders is also difficult to establish (Furby et al., 1989), the main reason being that reconviction rates do not necessarily mirror sexual offences since these offences are often underreported (Furby et al., 1989; Hanson et al. 1993). However, it can be assumed that undetected re-offending is similar between those individuals who participated in a treatment programme and those who did not. The literature reflects a controversy over the efficacy of treatment of sexual offenders (Furby et al., 1989).

Positive outcome data suggest that treatment is effective in reducing recidivism. Data by Marshall and Barbaree (1988) suggest a lower rate in recidivism for treated offenders. The overall recidivism rate for treated child molesters two years post treatment was 5.5% compared with 12.5% for untreated offenders. The recidivism rate for four years post treatment was 25% for treated and 64.3% for untreated offenders. Nicholaichuck and colleges (1998; as cited in Marshall et al., 1999) reported that of the sexual offenders who took part in the treatment programme, 6.1% re-offended over a six-year period as compared to 20.5% of a matched group of offenders who did not participate in a programme.

Negative outcome data suggest that treatment is not effective in reducing recidivism. Rice et al. (1991) found that behavioural treatment did not affect recidivism. Over a follow-up of 6.3 years 31% were convicted of a new sex offence, 43% committed a sexual or violent offence and 58% were arrested for an offence. However, participants seemed to be problematic and in need of maximum security, thus it is
possible that no clinical treatment programme would have reduced recidivism for this particular sample. Hanson et al. (1993) investigated long-term recidivism of child molesters and found that 42% of the treated offenders were reconvicted. 10% of the sample was reconvicted 10-32 years after being released, which highlights the importance of addressing the long-term risks of sexual offences.

In a comprehensive and influential review of sex offender recidivism by Furby, Weinrott and Blackshaw (1989) reasons for the difficulty in establishing recidivism rates for sex offenders were described. After reviewing 42 studies from primary sources and 13 from secondary sources the researchers concluded that despite the large number of studies there is little knowledge about the recidivism rates. Referring to Quinsey's (1984; as cited in Furby et al., 1989) review Furby et al. agree that 'the differences in recidivism across studies is truly remarkable; clearly by selectively contemplating the various studies, one can conclude anything one wants' (p.101). Despite the practical difficulties and methodological shortcomings in all reviewed studies Furby et al. were able to specify some tentative conclusions: (1) longer follow-up periods reveal greater re-offending of a crime (not necessarily a sexual crime), (2) as yet there is no evidence that clinical treatment reduces recidivism and (3) some evidence suggests that recidivism rates could be different for different offenders (Furby et al., 1989).

This has been followed-up with a meta-analysis of treatment studies (Hall, 1995). Twelve studies were analysed. Of the sexual offenders who had completed their treatment 19% committed another sexual offence compared to 27% of those in comparison conditions (Hall, 1995). Hall (1995) concluded that the cognitive-behavioural approach to sex offender treatment has been effective; however, the positive outcome seemed limited to outpatient participants only. Consequently the treatment might be less effective with more pathological offenders.
The evaluation of treatment programmes for sexual offenders appears to be complex due to numerous factors that do not allow generalisations of the effectiveness of clinical treatment in reducing re-offending. Differences in outcome not only result from different samples (resulting from different exclusion criteria), different sample sizes, unrepresentative samples and demographic, criminal and personal attributes of the offender (Blackburn, 1999), but also from research designs, for example the lack of control groups or random allocation, mainly due to ethical constraints. With this diversity it might be assumed that there are more or different variables that affect the treatment outcome. It appears the existing literature fails to acknowledge the therapeutic relationship as an important variable within the treatment of sexual offenders.

What is the role of the therapeutic relationship in the treatment of sex offenders? There seems to have been little investigation of the relationship between therapist and offender. In light of the importance of the therapeutic relationship in individual therapy for the treatment outcome, the lack of acknowledgment and investigation seems unusual. It may be assumed that the value attached to the role of the working alliance differs from individual therapy settings. Possible reasons might include the cognitive-behavioural approach taken with sexual offenders, the prison setting or the attitude towards sex offenders in general.

Traditionally, in the arena of the cognitive-behavioural approach, the nature of the relationship between the therapist and the client has been secondary to the technical skills used (Marshall et al., 1999). With the main focus being on therapeutic techniques that examine and modify thoughts and beliefs it has been argued that a good relationship is necessary, but insufficient for therapeutic change to occur (Beck et al., 1979). As one of the most common criticisms of cognitive-behavioural approaches, this stands in contrast to other approaches that regard the therapeutic relationship as the most effective component (Rogers, 1961). Three core conditions of therapeutic style dominate the general psychotherapy literature: congruence, unconditional positive regard and empathy (Rogers, 1961). Attending to the
techniques rather than attending to the therapeutic relationship in the structured treatment of sex offenders might not allow the development of a fruitful working alliance and consequently might limit therapeutic intervention (Clarkson, 1995). Therefore, treatment outcome might be restrained.

The authoritarian custodial prison setting imposes constraints on the service delivered. Blackburn (1999) highlights ethical dilemmas for psychologists, for example custodial staff sabotaging treatment efforts, because of a moral view that the offender needs to be punished and not helped. Conflicts between the demands for control and security and the treatment priorities cannot facilitate the working alliance since the relationship between the therapist and the offender-client is to a great extent influenced and controlled by the Criminal Justice System. An intimate relationship is limited since confidentiality is not guaranteed for the offender. The offender has to surrender the right of confidentiality and it is the psychologist’s duty to discuss relevant clinical material with other professionals, such as probation officers (Salter, 1988). This not only places both the therapist and the offender in a ‘watchdog’ position (which could result in the development of an unethical dual relationship for the therapist), but it is also likely to result in a climate of suspicion and mistrust, which is likely to result in ‘alliance ruptures’ (Safran et al., 1990). Thus, the setting compromises ethical principles that should be binding for every counselling psychologist. However, Shillito-Clarke (1996) points out that this is true ‘unless, in a given situation, there is a more significant principle which overrides it’ (p.557). Even though this might be assumed for sexual offenders, it is questionable how a therapeutic relationship can develop when the client needs to be untruthful and when behaviour is likely to be monitored. Furthermore, coercion or compulsory treatment, in particular in sex offender treatment programmes, does not allow the offender to enter a voluntary contract. Such actions are likely to pre-empt the growth of a fruitful working alliance.
Furthermore it seems possible that the attitude towards sex offenders inhibits staff working with sex offenders from engaging in a therapeutic relationship. Programmes are usually administered by forensic psychologists, trainee forensic psychologists or prison officers (Towl, 2002). Attitude towards offenders is particularly important when providing treatment (Hogue, 1993). Commonly society responds with severe stigmatisation and negative sanctions of the sex offender (SOT Team, Theory Manual, 2000). It seems that this might also be true for individuals working with sex offenders. Shortcomings include staff expressing their personal feelings and disgust against sexual offenders using a confrontational style (Sheath, 1990; as cited in Garrison, 1992). Other offenders and prison staff see sex offenders as ‘prison outcasts’ (Hogue, 1993). This tendency has been supported by research using scales such as the Attitudes Towards Sexual-Offenders (ATS) scale (Hogue, 1993). Results suggest that police and prison officer groups showed more negative attitudes towards sex offenders than probation officers and psychologists did. This results in a dilemma: the negative attitude towards the sexual offender interferes with empathy and respect that are necessary for the development of a good working alliance and therefore crucial for the efficacy of treatment (Marshall et al., 1999).

It has also been argued that the therapist’s style affects the treatment outcome (Schaap et al., 1993). The SOTP Theory Manual (2000) comments: ‘In practice, many therapists have tended to focus on the confrontation and neglected the emphasis on care’ (p. 66); however, therapists are advised to ‘clearly communicate respect, liking and caring for sex offenders in treatment’ (p. 70). The effectiveness of groupwork is equally dependant on the therapist’s style (Barker & Beech, 1993). It has been argued that sex offenders in particular need very experienced group leaders who are able to recognise group processes and work effectively with them (Barker & Beech, 1993). This seems problematic in light of the current treatment modalities, which appear to be designed by psychologists, but often administered by prison staff that have not been trained appropriately to deliver psychological treatment. Professional competence is to some extent dependent on the setting in which therapy
is provided. Bond (2000) asserts that ‘failure to work within one’s own competence as a counsellor undermines many of the ethical principles considered essential to counselling’ (p. 114). Accepting that the therapist’s style is crucial for the effectiveness of the treatment, it seems paradoxical that ‘therapeutic techniques’ are passed on to prison staff expected to deal with the sex offender. Discussions with probation officers highlight the difficulty when expected to work ‘face to face’ with the offender: “I am not trained for this”, “I don’t like working with sex offenders” or “This is psychiatric work” (Garrison, 1992; p.19).

Positive therapeutic features must match the client’s needs; for example, if sexual offenders lack self-esteem it seems to be a necessity to provide treatment that is constructive to the increase of self-esteem. Consequently, treating sexual offenders respectfully and not engaging them in a confrontational style seems essential. Evidence by Schaap et al. (1993) suggests that respect is crucial for the efficacy of treatment (also Salter, 1988). Similarly, empathy, a capacity that is often lacking in sex offenders, can only be learned if modelled by the therapist; thus empathy must be an essential feature of the effective therapist (Marshall et al., 1999). Alexander et al. (1976) found that 60% of variance on outcome measures was due to therapist features.

Thus, cognitive-behavioural interventions for sex offenders appear to be highly researched in terms of treatment outcome and recidivism. As with most cognitive-behavioural interventions, evidence supports the usefulness of the approach in general even though results of outcomes do not seem to be clear. It appears that the therapeutic relationship, despite its proven importance in treatment outcomes, is not only complicated by specific difficulties with this client group, but also neglected. Instead the focus seems to lie on delivering a treatment service that concentrates on techniques and not the competence of the therapist. Reassessment of the competence of staff providing any form of therapeutic intervention is necessary. Not only does professional training seem to be crucial in working with sex offenders, also
interventions need to be tailored to the offender's needs in order to facilitate change and reduce recidivism. Instead of delivering an inflexible treatment that neglects the relationship between the offender-client and the therapist, psychologists must keep the basic question in mind: What treatment works best, with which clients, under what circumstances, delivered by whom? (Paul, 1967)

Another approach, trying to overcome the limitations of conventional treatments in prisons, is the therapeutic community. Next, how the therapeutic community works will be explored and whether the provision of a therapeutic environment means fewer compromises of therapeutic and ethical principles.

THERAPEUTIC COMMUNITIES IN PRISON

What is a therapeutic community?
A therapeutic community may be defined as a social, cultural setting established for therapeutic reasons and within which those persons needing therapy live (Reber, 1995). The term Therapeutic Community (TC) is generic for various kinds of therapeutic organisations that share four basic characteristics: (1) an informal atmosphere, (2) regular meetings, (3) participation in the work of running the community, and (4) validation of residents as auxiliary therapists (Kennard, 1983; as cited in Blackburn, 1999). Individuals living in a therapeutic community are referred to as residents and the community includes all residents and staff. The assumption that ‘...deviant behaviour, much of which is deemed criminal, represents a breakdown of the relationship between the individual and the structured society ...’ (Roberts, 1997, p.3) led to a philosophy of developing an environment that allows ‘living and learning’ (Blackburn, 1999). This environment is facilitated through the delegation of responsibility, the encouragement of expression of feelings and the facilitation of self-control. Roberts (1997) describes the primary task of therapeutic communities ‘to heal and/or correct by offering membership of an optimised social
environment, consciously designed to act as a \textit{therapeutic instrument}’ (p. 8). Thus, therapeutic communities are continually adapting and are not static treatment programmes (Jones, 1997).

The therapeutic community in prison
Entry into the therapeutic community in prison must be voluntary (Gunn & Taylor, 1993; Norton, 1992). Admission criteria differ from institution to institution; motivation to participate in group processes and the ability to communicate openly, however, are necessary components in all cases (Gunn & Taylor, 1993). For example, the Max Glatt Centre initially catered for inmates with addictions only but extended the criteria to include other compulsive behavioural problems such as gambling, sexual offences and ‘personality disorders’ (Jones, 1997). At Grendon Prison inmates are expected to serve at least 12 months and those inmates diagnosed as having a ‘personality disorder’ are believed to be ‘best suited’ for treatment (Gunn & Taylor, 1993; p. 751) whereas drug abusers and individuals over the age of 40 are considered unsuitable. At Henderson Hospital the majority of the admission population is considered as ‘personality disordered’ with a high number of personality disorder co-morbidity (Norton, 1992).

Selection of new residents is made by residents and staff together. During the interview notes are taken about the prospective resident, their difficulties, previous treatment, history and their aims and ambitions. This information is then presented to the whole community. There is also closed discussion of the candidates by staff and residents, followed by a democratic vote. The selection process allows residents to \textit{be part of the system} and they not only learn ‘communalism’ and ‘democratisation’ (Rapoport, 1960; as cited in Norton, 1992), but also experience some authority and empowerment in making decisions about other individuals (Norton, 1992). Additionally this allows residents to reflect on themselves and their own behaviour by realising how they appear to others.
There is a formal patient hierarchy depending on the length of stay and the positions and jobs held within the community. The use of a hierarchy facilitates feelings of containment and security. New residents enjoy a three-week induction and are unable to vote for the first week. Only residents can vote other residents for positions; elections are held once a month.

At Henderson all work is group based and residents have to adhere to a rigid timetable, which aims at facilitating containment within the group and structure. Groups include daily community meetings, three small group psychotherapy meetings, weekly art therapy and psychodrama as well as task-centred work groups such as gardening, cookery or maintenance (Norton, 1992). At the Max Glatt Centre there is also time for the gym, library and other educational and extra-curricular activities (Jones, 1997). The community meetings are central to the therapeutic community and all residents and staff on duty attend to discuss issues that are relevant in running the community. It is chaired by the ‘top three’ residents and is partly set agenda and partly open. These meetings allow the discussion of domestic and administrative activities as well as matters important to the community such as personality clashes between residents. The community meeting allows facilitation of cohesion of the group and feelings of belonging, but also the addressing of distressing matters or the examination of role-breaking behaviour.

The community is based on strict rules and residents struggle to adhere to these. Offences include proscribing violence or drug or alcohol intake and results in discharge from the community. If a rule is broken or a member of the community is extremely distressed the ‘top three’ residents can call for an emergency meeting for the whole community at any time of the day. Distressed residents are supported emotionally and practically by the community, for example by sharing a room with a distressed member.
The rigid structure of the therapeutic community in a prison setting is aimed at establishing a safe and trusting environment that facilitates exploration of the resident's criminal behaviour and their avoidance of responsibility (Shine & Morris, 2000). This requires a sense of 'owning the process' and 'belonging in the community' (Shine & Morris, 2000; p. 203). Therapy takes place not only during designated group sessions, but also through being in community therapy for 24 hours a day (Shine & Morris, 2000). The contents of smaller groups is not entirely confidential as it is shared with the larger community to some degree; confidentiality issues differ, however, to the conventional corrective setting since information is shared between the resident and the group as a community with the prison officer being a group facilitator rather than a 'watchdog'. However, it can be assumed that the professional guidelines concerning confidentiality for therapeutic communities and conventional prisons are identical. Staff consist of therapeutically trained prison officers or therapists, psychologists and psychiatrists (Rawlings, 1999).

Outcome studies

How successful is this approach? Treatment outcomes for therapeutic communities differ in that the focus is not solely on post-treatment studies, but also on in-treatment studies (Rawlings, 1999). Post-treatment studies are mainly concerned with reconviction rates whereas in-treatment studies regard differences in behaviour and psychological characteristics as an indicator for the effectiveness of treatment. Traditionally therapeutic communities were not committed to the evaluation of treatment outcomes arguing that outcomes were value judgements, that they were difficult to identify and that they took place over time. Thus two-year follow-ups were seen as unrepresentative (Rawlings, 1999).

Gunn et al. (1978; as cited in Rawlings, 1999) argued that the treatment in a therapeutic community should not be expected to have overthrown all social and environmental factors that affect the individual's reconviction. Recently, however, outcome research for democratic therapeutic communities has been generated
(Warren & Dolan, 2001), mainly because decreasing the reconviction rates is still regarded as the major goal in the treatment of offenders (Rawlings, 1999). Rawlings (1999) points out that therapeutic communities have been shown to have a positive effect on recidivism. Research at Henderson Hospital, said to be one of the ‘best known and most rigorous therapeutic community practice’ (Roberts, 1997; p.19), suggests that therapeutic community treatment is effective (Warren & Dolan, 2001). Copas et al. (1984) found that 36% of those admitted to Henderson Hospital committed no further criminal offences or hospitalisations in a 5 year post treatment period compared to 19% of the non-admitted comparison group. They further indicated which variables were more likely to lead to a positive outcome. According to their study, residents who were more emotionally expressive, anxious, intro-punitive and hostile, but not overly aggressive or self-damaging were more likely to succeed. Furthermore, the longer the offender spent in therapeutic community treatment the higher the success rate for the treatment with a period of 6 months being considered as ‘maximally effective’ (Copas et al., 1984; p.565).

Similar results have been reported for the therapeutic community treatment of borderline personality symptoms (Dolan et al., 1997). The study indicated that 42.9% of the admitted sample as compared to 17.9% of the non-admitted sample showed clinically significant reduction in the Borderline Syndrome Index (BSI) scores one-year post- treatment. Again, the reduction of symptoms was shown to correlate with the length of treatment.

However, a study of the Grendon Prison therapeutic community by Robertson and Gunn (1987) suggests that the regime cannot be regarded as a ‘treatment’, but rather as a ‘catalyst’ for motivated individuals (p. 677). In a ten-year follow-up they failed to find a difference in the frequency or severity of crimes committed by offenders discharged from Grendon and a matched control group. They further suggested that offender characteristics such as motivation and intelligence, and the exposure to a therapeutic community are likely to affect criminal behaviour.
The finding that the length of time spent in therapeutic community treatment is a crucial variable for rates of recidivism has been referred to the 'time in programme effect', in particular in the United States (Rawlings, 1999). This is not surprising as Prochaska and DiClemente (1984) asserted that behaviour change and maintenance occur in stages and over time. However, it seems to be unclear whether this effect is due to the treatment itself or to the therapeutic community that might elect offenders who are more likely to succeed and might reject those offenders who are more likely to fail (Rawlings, 1999). This would suggest that it is those variables within the offender or within the therapeutic community that lead to positive outcomes and not necessarily the treatment itself.

Jones (1988; as cited in Jones, 1997) found that reconviction rates correlated not only with the time in treatment, but also the reason for leaving the therapeutic community. Residents who had completed treatment showed less recidivism than residents who showed serious motivational and/or behavioural difficulties (such as drug misuse or acts of violence) that could not be contained in the community. This supports the view that outcome might not necessarily depend on the treatment provided, but rather be due to offender characteristics. Consequently research attempts to identify those individuals that are suitable for the therapeutic community treatment and will lead to positive outcomes, probably resulting in restricted admission criteria (Rawlings, 1999).

Research on therapeutic communities is still rare and in spite of limited evidence for its effectiveness the philosophy of a therapeutic community is popular. It seems that for many practitioners the humane and treatment-oriented approach is favoured over the authoritarian and punitive approach of conventional correctional settings (Blackburn, 1999). However, there seems to be no evidence for its superiority over other treatment approaches. Critics argue that therapeutic communities are neither a form of treatment nor rehabilitation and do not facilitate an adjustment to real life (Rapoport, 1960; as cited in Roberts, 1997). It has been suggested that therapeutic
communities may neglect specific skill training and fail to emphasise the learning of anti-criminal attitudes (Harris et al., 1989). Mohl (1995) observed that a poor structure of therapy led to a poor treatment outcome. Therapeutic communities might benefit from addressing behavioural methods in order to work on the specific deficits that led to the incarceration.

The therapeutic relationship in therapeutic communities

There is little specific mention of the therapeutic relationship between the therapist and the residents of a therapeutic community. With its emphasis on the whole environment as a therapeutic instrument and the importance of the relationships within this therapeutic environment (residents as helping, therapists as facilitating and empowering) it appears that the staff working in therapeutic communities in correctional settings are more caring, sensitive, empathic and respectful, or at least appear to be. In this form of treatment interventions are still considered as secondary (Wexler, 1997).

Despite its philosophy of empowering and respecting the offender, therapeutic communities are inevitably affected by the prison setting. Rawlings (1998) asserted that the physical setting, the prison routine, the impact of prison staff and other prison-therapeutic community boundaries not only affect, but potentially damage the therapeutic community as they are physically and managerially embedded within the mainstream conventional prison settings. The physical nature of prisons, e.g. small rooms and locked gates, cannot be overcome for residents' need for freedom to move around in their therapeutic community. Therapeutic meetings need to fit into the prison's regime and thus do not necessarily meet therapeutic needs. Also mandatory drug-tests and cell searches can intrude upon the therapeutic community, and are therefore reminders of the prison structure. The staff still wear prison uniforms that also suggest to the resident that he/she is still a prisoner. Rawlings (1998) argues that prison staff sometimes have to work in other areas of the prison which can lead to role conflicts: on one side being a prison officer who issues instructions and
examines behaviour, and on the other side is a member of therapeutic community staff allowing the residents space to make mistakes and learn from them. Old skills that are acceptable in conventional prisons do not seem to be adequate in the therapeutic community and have to be unlearned.

Custodial staff might not be directly sabotaging treatment efforts, but role conflicts between control and security, and treatment and autonomy can have a negative effect on the relationship between members of staff and residents. However, intimate relationships seem to be more likely to evolve in a setting that requires the resident to be motivated, where coercion does not exist and where the therapist’s or the prison officer’s role is closer to that of a facilitator that communicates liking and respect. The different philosophy and focus of therapeutic communities are likely to lead to different attitudes towards offenders, even though this might be confounded by initial role-conflicts. The rigid structure and emphasis on the community as a group allows for containment of the resident’s feelings and thoughts. Thus, it appears that the relationships within a therapeutic community allow greater chances of being therapeutic.

The highlighted differences in therapeutic and ethical considerations between optimal therapy conditions, the Sex Offender Treatment Programme and the Therapeutic Community are summarised in Table 1.
CONCLUSION

Assuming that any domain profits from contributions of other domains, this must also be true for the contributions of counselling psychology to forensic practice. As shown in this paper, counselling psychologists have to compromise therapeutic and ethical considerations when practising in prison settings: They have to accept that treatment might be mandatory rather than voluntary; that there are exclusion criteria and not just anyone motivated can expect treatment; that the client has restricted autonomy and must give up the right to confidentiality; that the contract is often non-negotiable (in terms of treatment goals and number of sessions) and that the focus is on successful outcomes rather than the therapeutic relationship, which leads to the dilemma of dual responsibilities.

It appears that Sex Offender Treatment Programmes could profit from a greater emphasis on therapeutic aspects, in particular on the therapeutic relationship that allows containment of the client’s feelings, and staff who are better trained in working with the particular client group. Future research should investigate variables such as the therapist’s characteristics, the offender’s characteristics and the match between them.

Therapeutic communities struggle with the natural lack of fit between the prison setting and therapeutic communities; however, they are able to acknowledge and incorporate as many therapeutic and ethical considerations as possible. Future research could explore whether the therapeutic environment would profit from an implementation of structural-behavioural interventions, and again, which offender characteristics are likely to affect the outcome.

The therapeutic practice of counselling psychology with its very distinct humanistic value system appears to be incompatible with the psychological treatment in correctional settings. However, a marriage between forensic and counselling
psychology might allow an incorporation of different values that facilitate improvement of psychological treatment of offenders. An awareness of therapeutic and ethical considerations may lead to a greater emphasis on the therapeutic relationship, better-trained staff and a focus on ethical standards, which might in turn lead to the delivery of a better-quality service.

Psychologists working in a forensic setting need to find their own moral stance in terms of therapeutic and ethical considerations. It appears crucial that the focus should be the working alliance and this might be facilitated through the therapist’s indifference to the outcome. Evidence-based practice and the reduction of recidivism are the reality in working with offenders. Consequently psychological interventions cannot be value-free and psychologists have to live with the ethical issue of ‘who determines what is desirable’ (Shillito-Clarke, 1996). Counselling psychologists working in prisons need to work with the system; however, a real contribution to the treatment of offenders can only be seen when therapeutic and ethical considerations are acknowledged, integrated and emphasised as it is those values and beliefs that are not only the foundation of counselling psychology, but also believed to be facilitators for change.
Table 1: Differences in therapeutic and ethical considerations in optimal therapy conditions, structured programmes (SOTP) and therapeutic communities.

<table>
<thead>
<tr>
<th></th>
<th>OPTIMAL THERAPEUTIC CONDITIONS</th>
<th>STRUCTURED PROGRAMME (SOTP)</th>
<th>THERAPEUTIC COMMUNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>PURPOSE</td>
<td>As set by the client</td>
<td>Reduce recidivism</td>
<td>Reduce recidivism</td>
</tr>
<tr>
<td>WHO DELIVERS?</td>
<td>Chartered counselling psychologist or psychotherapist</td>
<td>Forensic psychologist, trainee forensic psychologist or prison officer</td>
<td>Psychiatrists, psychologists, chartered therapists or therapeutically trained prison officers</td>
</tr>
<tr>
<td>WHO RECEIVES?</td>
<td>Anyone who is motivated and who has access</td>
<td>Sex offender who has no exclusion criteria and who is ‘ready’ for treatment</td>
<td>Motivation to participate, ability to communicate openly, particular admission criteria and selection interview</td>
</tr>
<tr>
<td>THERAPEUTIC AIM</td>
<td>As set by the client; may be exploring/understanding of feelings, thoughts and behaviour or changing behaviour through active and pragmatic tasks</td>
<td>Recognition of causes of offending and cognitive-behavioural changes</td>
<td>‘Living and learning’ through the delegation of responsibility, encouragement of expression of feelings and facilitation of self-control</td>
</tr>
<tr>
<td>CONTRACTING</td>
<td>Negotiation and agreement of treatment goals, length of therapy and other boundaries</td>
<td>Offender client has to accept a set contract with set goals and length of therapy</td>
<td>Resident has to accept community rules and regulations, which are partly set by the prison regime, but can also be set by the community</td>
</tr>
<tr>
<td>APPROACH TAKEN</td>
<td>As set by the client and the therapist</td>
<td>Cognitive-behavioural groupwork</td>
<td>Integrative/ eclectic with emphasis on humanistic values</td>
</tr>
<tr>
<td>NATURE OF RELATIONSHIP</td>
<td>Collaboration between the client and the therapist</td>
<td>Focus on techniques; offender and therapist are in ‘watchdog’ position</td>
<td>Focus on environment; resident as part of the system; therapist as facilitator and part of the community</td>
</tr>
<tr>
<td>CONFIDENTIALITY</td>
<td>Client, client information and processes are confidential</td>
<td>No right of confidentiality</td>
<td>No right of confidentiality; however, staff is seen as facilitating rather than monitoring</td>
</tr>
<tr>
<td>ETHICAL CONSIDERATION</td>
<td>Therapist shows respect for autonomy, beneficence, non-maleficence, justice and fidelity</td>
<td>Treatment is secondary to security. Lack of client autonomy, power issues, mandatory treatment, dual relationships</td>
<td>Treatment is secondary to security. However, client has limited autonomy, less power issues, treatment must be voluntary, minimising of dual relationships</td>
</tr>
</tbody>
</table>
REFERENCES


APPENDICES

Copy of instructions for authors: *The Journal of Forensic Psychiatry* (Appendix A)
Self Reflection (Appendix B)
Notes for contributors

Submission
Authors should submit three complete copies of their text, tables and figures, with any original illustrations, to Dr Alec Buchanan, Maudsley Hospital, Denmark Hill, London SE5 8AZ, UK. Legal submissions should be sent to Dr Bridget Dolan, 3 Serjeants' Inn, London EC4Y 1BQ.

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The manuscript
Submissions should be in English, typed in double spacing with wide margins, on one side only of the paper, preferably of A4 size. Articles should normally be between 3,000 and 8,000 words in length and preceded by an abstract of less than 200 words. The abstract should be followed by six keywords. Any notes or footnotes, tables and figures should not be inserted in the pages of the manuscript but should be on separate sheets. Tables and figures should be numbered consecutively in Arabic numerals with a descriptive caption. The desired position in the text for each table and figure should be indicated in the margin of the manuscript. Permission to reproduce copyright material must be obtained by the authors before submission and any acknowledgements should be included in the typescript or captions as appropriate. If possible a word count should be provided.
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Case Report
Case reports should be accompanied by the written consent of the subject. If a subject is not competent to give consent the report should be accompanied by the written consent of an authorized person.

References
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When an author's name is mentioned in the text, the date is inserted in parentheses immediately after the name, as in 'Dell (1982)'. When a less direct reference is made to one or more authors, both name and date are bracketed, with the reference separated by a semi-colon, as in 'several authors have noted this trend (Griew, 1984; O'Donovan, 1984; Ashworth, 1987)'.

When the reference is to a work of dual or multiple authorship, use only surnames of the abbreviated form, as in 'Friar and Matthews (1980)' or 'Fisher et al. (1974)'.

If an author has two references published in the same year, add lower case letters after the date to distinguish them, as in 'Bullard (1980a, 1980b)'.

For direct quotations of 40 words or more, which will be printed as prose extracts, page numbers are required. Always use the minimum number of figures in page numbers, dates etc., e.g. pp. 24-4, 105-6 (but using 112–13 for 'teen numbers') and 1968–9.

Format of reference lists and bibliographies
Submissions should include a reference list in alphabetical order whose consent and format conform to the following examples. Note: elements of information are separated by a full stop; authors' names are given in full; page numbers are required for articles in readers, journals and magazines; where relevant, translator and date of first publication of a book, and original date of reprinted article, are noted.

Law reports
In reference to law reports in the text care should be taken to distinguish between round and square brackets.

From the year 1891 onwards and where there is more than one volume per year the date is placed in square brackets: e.g. DPP v Camplin [1978] in the text and DPP v Camplin [1978] 1 AL ER 168 in the legal reference list.

For cases before 1891 and where volumes are serially expressed the date is in round brackets: e.g. R. v Dix (1982) in the text and R. v Dix (1982) 74 Cr App R 306 in the reference list.

The title of law reports is underlined to indicate that it will appear in italics. (The 'v' is in Roman.) Where there is a volume number it follows the brackets. An abbreviated form of the source of the law report follows, and then the page reference.

Legislation
Acts of Parliament and other legislation are referred to in the text only and appear in their shortened form: e.g. Mental Health Act 1959, with no comma before the date.
Proofs

Page proofs will be sent for correction to a first-named author, unless otherwise requested. The difficulty and expense involved in making amendments at the page-proof stage make it essential for authors to prepare their typescripts carefully; any alteration to the original text is strongly discouraged. Authors should correct printers' errors in red; minimal alterations of their own should be in blue. Our aim is rapid publication: this will be helped if authors provide good copy, following the above instructions, and return their page proofs to the editor on the date requested.

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Authors will have the opportunity to order offprints when they receive page proofs.
Self Reflection

Early thoughts
During an internship in a high-security institution as a law student I found myself intrigued by the prison setting and those working within it. My objective was to learn about prison administration; however, gaining access to the setting and being part of it allowed me to look beyond the bureaucracy of the institution and to consider the people. The highlights of the internship were occasions when I had the chance to have more direct contact with the inmates. It was at that time that I experienced a dilemma that would have great influence on my future direction in life. Experiencing 'criminals' as people took away the distance between me and 'them'. But I was somehow shaken by that discovery as on one hand I could share the experience of the other as a human being to some degree and on the other hand felt unable to relate to some of the more severe criminals. This was especially true for murderers, rapists and child molesters. I found myself in a philosophical confusion about human beings, human beings that commit crimes and the rights someone should have when violating rights.

Early exposure
Years later I visited another high-security correctional facility, this time in the US and as a psychology intern. I shadowed therapeutic staff and thus had the chance to be much closer to the individual. Besides doing file research, I had the chance to observe group therapy sessions and staff meetings, in which decisions were made about inmates' futures. I had the chance to talk to people in special units (e.g. special needs) and individuals on death row. Learning that the average inmate on that particular special needs unit had an IQ of 75-80 and suffered from severe emotional and psychological problems confirmed feelings that I had developed over time: I felt that the inmate who had violated the rights of others, who had done so much harm to individuals and society still
had some need for care. Locking individuals away and expecting them to ‘get better’ while confined in a cold and harsh prison environment seemed illogical.

The prison context and counselling psychology
During my final year as a psychology undergraduate I volunteered in a Young Offenders Institution. I liked the idea of working in a pre-release programme that allowed adolescents to learn basic skills, such as IT skills and CV writing. That was work that made sense to me and allowed an acknowledgement of societal responsibility. Staff in that programme did not expect the youngsters to finish their sentence, go back into society and have a different outlook. It seemed that they acknowledged, understood and were willing to facilitate the process of re-socialisation. I realised then that I would like to work with offenders. I considered studying forensic psychology – as it is the crossover between the domains I had been studying, law and psychology. However, I learned that forensic psychologists do not necessarily work individually with offenders. As my aim was to work with the person and not with the statistic I decided to study counselling psychology. I believe in the principles and values of counselling psychology and feel quite enthusiastic about incorporating them into other domains, in particular into the treatment of offenders.

Experience of the prison context and therapeutic values
The prison context feels ‘cold’ and ‘harsh’ to me. The therapeutic context appears as the opposite; it seems ‘warm’ and supporting. It seems like a bold dream to imagine those so different domains trying to work together. It also feels like the ‘best shot’ since it has become apparent that ‘harsh’ punishment does not aid re-socialisation. I certainly believe that counselling psychology has a lot to offer and see its integration into other domains as a future direction. This paper reflects my first attempt to argue that the therapeutic and ethical considerations of counselling psychology could benefit in the treatment of offenders, that we – as counselling psychologists- have
something to offer that cannot be delivered by other domains. My training teaches me humanistic values. The client's motivation, the negotiation and agreement of treatment goals and boundaries, confidentiality and other moral and ethical considerations are of highest importance to the therapeutic alliance and therefore to treatment outcome. In my clinical practice I experience the presence of these values as therapeutic for my clients and the lack of such values as counter-therapeutic. Consequently I believe that if we want to facilitate re-socialisation and it is our aim to reduce recidivism these considerations need to be acknowledged and incorporated into the treatment of offenders. My commitment to therapeutic and ethical principles and considerations, in particular the importance of the therapeutic relationship, has shaped the framework I have used in this paper. I investigated whether or not the offender treatment available meets these considerations and what that means for the outcome and the future directions of offender treatment.

Concluding thoughts
Researching offender treatment made me realise that there is, at least in the literature, a strong awareness about therapeutic and ethical considerations. The development of Therapeutic Communities reflects this development and I feel that there are many psychologists, trainee psychologists, prison officers and other staff that have drifted away from the punitive purpose of the correctional setting. For example, the aim of SOTP (Core 2000) to establish group cohesiveness at the beginning of the course acknowledges that it is the relationship that is crucial within treatment. However, awareness and acknowledgement are not enough. It seems that there are still cases of confrontational attitudes and disrespect. In order to achieve better service staff need to be therapeutically trained and supervised, interventions need to be tailored for the offender and disciplines need to collaborate.
Thus, I realise there is much to be done and funds are limited, but research, education and an increase of therapeutic and ethical considerations in offender treatment will allow future development which might lead to higher numbers of rehabilitated prisoners.
An investigation into a prison-based therapeutic community, exploring the experiences of the therapy director, therapy managers and offenders.

ABSTRACT: This study aimed to explore and comment on the experiences of a prison-based therapeutic community from the perspectives of staff and inmates. The therapy director and four therapy managers were interviewed about their views and experiences and a focus group was conducted to explore the views and experiences of five offenders. The data were subjected to thematic content analysis. Two main themes with sub-themes were identified through the analysis. The first theme, The living milieu, was composed of residents’ experiences of the therapeutic environment, such as views of what the therapeutic community is about, its aims, developments while in the therapeutic community and the impact of the prison setting. The second theme, Being-in-the-community, comprised residents’ experiences of feelings about themselves and the community, processes and relationships. The understanding of similarities and differences between residents’ allows the facilitation of dialogue and the breakdown of barriers, thus could lead to a more secure and therapeutic environment.

Introduction

One of the main aims of imprisonment today is the rehabilitation of offenders. Therapeutic interventions vary from setting to setting. One approach, trying to overcome limitations of conventional treatments in prisons, is the therapeutic community. The assumption that ‘...deviant behaviour, much of which is deemed criminal, represents a breakdown of the relationship between the individual and the structured society …’ (Roberts, 1997; p.3) led to a philosophy of developing an environment that allows ‘living and learning’ (Blackburn, 1999). The term Therapeutic Community (TC) is generic for various kinds of therapeutic organisations that share four basic principles: (1) an informal atmosphere, (2) regular meetings, (3) participation in the work of running the community, and (4) validation
of residents as auxiliary therapists (Kennard, 1983). Roberts (1997) describes the primary task of therapeutic communities as being 'to heal and/or correct by offering membership of an optimised social environment, consciously designed to act as a therapeutic instrument' (p. 8). However, there is a natural lack of fit between the needs and aims of a therapeutic community and the prison regime, its administration and purpose (Bobsien, 2002).

Roth and Fonagy (1996) argue that outcome research allows for an understanding of clinical effectiveness. The assumption is that therapeutic interventions in forensic settings are successful if the offender-client does not re-offend. This form of evaluation comes with a series of methodological difficulties and value judgements.

Marshall et al. (1999) suggest that the focus on recidivism data is limited and insufficient in measuring the value and effectiveness of treatment outcome. This seems to be true for therapeutic communities in particular: an emphasis on outcome opposes the philosophy and holistic approach to the individual's problems. If the focus on outcome is broadened beyond the reduction of recidivism, effectiveness could be defined in terms of the experiences of inmates. Parry (1992) suggests that not only the perspectives of service managers and practitioners are important when it comes to evaluate services, but that the perspectives of the recipients should be used as a complementary approach. Furthermore, data suggest that treatment outcomes are better than for the conventional prison setting (Shine & Morris, 2000), but that the mechanisms of change are unclear. Qualitative research can accommodate the complexity of such mechanisms of change by investigating residents' experiences of the therapeutic milieu, and take the accounts of staff such as the therapy director, therapy managers and the offenders into account.

Evidence has shown that the relationship between the therapist and the client is the most important factor in therapeutic treatment (Clarkson, 1995; Luborsky et al., 1993; Norcross & Goldfried, 1992). The literature on the therapeutic relationship
consistently assumes a traditional one-to-one setting and consequently there is little specific mention of the therapeutic relationship in therapeutic communities and a lack of research investigating its processes. Assuming that it is the therapeutic milieu\(^1\) that is used as the therapeutic instrument, an investigation into that milieu could illuminate residents' experiences of feelings, relationships and their processes.

This research aimed to explore and contrast the perspectives of the director of therapy, four therapy managers and five inmates of a prison-based therapeutic community in terms of their experiences of the therapeutic milieu. Concepts and issues from the existing literature on therapeutic communities were used in the analysis of the data.

**Method**

*Participants*

Participants were recruited from a Therapeutic Community of an HMP Category B Training Prison in the English Midlands. The criteria for participating in the study were (1) being a resident of the therapeutic community and (2) having been part of the therapeutic community for at least 6 months. Research suggests that the length of time spend in a therapeutic community is crucial for the treatment outcome (Rawlings, 1999). It was important that participants had some experience of living in the social milieu in order to have developed sufficient insight into and experience of the therapeutic community. The therapy director and four therapy managers were recruited to participate in in-depth qualitative interviews; 5 inmates were recruited to participate in a focus group interview. There were four male and one female staff participants; four were White and one was Black (mean age 44 years; age range 34-54; SD 7.5). The five inmates were all male and White (mean age 33 years; age range 26-44; SD 4.5). Two staff members were married whilst all other participants described themselves as single.

\(^1\) The term 'therapeutic milieu' is used to describe the multidisciplinary team (consisting of prison officers, probation officers, prison management and therapy managers) that is concerned with the application of a therapeutic environment
Procedure
The data collection took place in the prison's therapeutic community in spring 2003. As the study aimed to explore the experiences and perceptions of the staff delivering the TC service and the inmates receiving it, two separate but complementary data sets were required and so the research was conducted in two stages:

Stage 1: Semi-structured Interviews with the Therapy Director and the Therapy Managers
Five members of staff received a formal introductory letter stating the research aims and question and explaining what was involved in the study (Appendix A). Once participation had been agreed, individual interviews were arranged at the convenience of the participants. All participants completed a consent form (Appendix B) and filled out a basic demographic questionnaire (Appendix C). The interviews were mainly conducted in the participants' offices or in public places outside the prison. Each interview took about an hour and was recorded on audiocassette. A number of areas of questioning were specified in the semi-structured interview schedule (Appendix D). The aim was to investigate therapists' experiences of the therapeutic community; therefore the interview schedule was loosely structured around the philosophy, aims, delivery and outcome of the TC in terms of the provision of a therapeutic milieu. The interviews were semi-structured and allowed the researcher to 'invite' and 'facilitate' the exploration of participants' experiences (McLeod, 1994). Using the interview as a research tool not only permitted a flexible, detailed and personal account that did not assume pre-defined statements and offered the participants the opportunity to influence the content of the interview (McLeod, 1994) but also allowed for consideration of factors that the interviewees perceived as impacting on their experiences. Although staff and inmates are both considered as residents, and therefore could have all participated in a focus group, there is also a clear distinction between staff and inmates at the same time. This seems to be inevitable in the prison environment, in which staff is, besides being a resident, also responsible for security and order. Staff generally do not self-
disclose or take part in therapeutic work in the same way as inmates, and therefore it seemed important to offer a space that would allow staff participants to talk freely about their work and themselves. A focus group with all participating staff members was not possible due to logistics.

Stage 2: Focus Group with the Offender Clients

The TC staff circulated the formal introductory letter (Appendix A) to the inmates of the therapeutic community, inviting them to take part in a focus group interview. Participants who wanted to take part put their names on a list. Initially seven people volunteered. However, one client offender did not attend, whilst another took the opportunity to leave when participants were given the chance to do so before the focus group began. The remaining five participants signed a consent form (Appendix B) and filled out a basic demographic questionnaire (Appendix C). Another researcher, who was familiar with the participants, joined the focus group but did not engage in facilitating the discussion. This not only allowed the participants to feel connected with a familiar face, but also served as a potential source of help and advice as the second researcher had experience of focus groups in this particular setting. The time of the data collection was carefully selected so as not to clash with participants’ commitments in order to maintain the community’s timetable. The focus group took place in a community room inside the TC, which is usually used for small therapy groups. The interview lasted about 90 minutes and was recorded on audiocassette. A topic guide, derived from the staff interview schedule, was used to help the researcher recall the themes under investigation. Semi-structured questions were used. The use of a focus group enabled the researcher to respect the therapeutic community’s commitment to the group environment and so avoided having the inmates develop an individual relationship with someone who was not a resident, and also led to an understanding of participants’ experiences and perceptions of the therapeutic community.
Analysis

The interviews and the focus group tapes were transcribed verbatim (Appendix E for therapy director; Appendix F for therapy manager; Appendix G for the focus group). The transcribed data were subjected to qualitative or 'thematic' content analysis (Pauli and Bray, 1998; Smith, 1995). Qualitative content analysis uses recorded communication, such as transcripts of interviews, to make inferences in the form of 'units of meanings' (Cowie et al., 1998). Such units may be themes or ideas grounded in the data and their analysis allows for an understanding of the meaning in terms of the participants' 'own frame of reference' (Mostyn, 1985). The units open up the possibility of exploring variations between experiences of individuals. Analytic units can be based on the research question but at the same time may be carefully grounded in the data and 'revised within the process of analysis' (Mayring, 2000).

The first step in the analysis involved the researcher's immersion in the data. Through reading and re-reading each transcript, the researcher began to detect themes, i.e., commonalities and differences in content within and across the transcripts. Each theme was then labelled in a way which captured the essence of its content. Themes were examined and clustered together on the basis of overlap in content and meaning. Each cluster of themes was then examined closely, but with an open mind, and was assigned to a more abstract and general theme that reflected issues and processes identified in existing relevant literature (Bobsien, 2002; Cullen et al., 1997; Rapoport, 1960; Toch, 1980), which were also reflected in the interview schedule. So themes were derived from the data in an open coding analysis, which allowed participants' subjective experiences (along with differences and similarities between them) to be elucidated without imposing a priori categories, but at the same time reflected issues and processes described in previous literature.

Themes are illustrated by quotations drawn from the data set (which also allows readers to assess the extent to which the analyses are grounded in the data). In order
to take account of variations between the experiences of the therapists and the inmates, quotations have been identified as coming from ‘staff’, ‘inmates’ and ‘both’.

Evaluation of the research

The research might be evaluated according to Elliott et al.’s (1999) seven criteria for the evaluation of qualitative research. However, it seems that ‘owning one’s perspectives’ is particularly important since an account of the researcher’s reflexive involvement in the study contributes to the transparency of the research process (Wolcott, 1990) (the researcher’s personal experience of the research process is illustrated in ‘Use of the Self’ in Appendix K). Furthermore, participants’ accounts are fundamental to qualitative research and therefore it seems that ‘situating the sample’ is essential and that themes and clusters are ‘grounded in examples’, thus the analysis will be interspersed with participants’ quotations. Although it has been argued that inter-coder reliability is ‘pertinent’ to more structured, quantifying versions of content analysis (Krippendorf, 1980), it is less relevant to thematic content analysis used in this study, where the possibility of attaining one ‘true’ reading of the data is contested. Instead, what is aimed for is a persuasive, grounded, evidenced reading of the data. Nevertheless, in order to reduce the possibility of overly idiosyncratic interpretations being produced by a lone researcher, the emerging analyses were negotiated with two other people who were involved in the study in a supervisory capacity.

The quotations used to illustrate participants’ experiences contain the following symbols: empty square brackets “[ ]” indicate where material has been omitted; square brackets containing material “[xxx]” are used for clarification; and ellipsis points “(…)” reflect a pause in the participants’ account.
Analysis

The results of the analysis are presented in Table 1.

Table 1: Themes and sub-themes identified through the analysis of the data

The living milieu: Views of what the TC is about
- Staff: making meaning; culture of enquiry; open communication of feelings & processes
- Inmates: gaining understanding; creating a meaning; understanding as means of coping
- Both: open communication between all residents; explore & discover meaning and create personal change

Aims of the TC
- Staff: any form of personal change; institutional & therapeutic aims as inter-related; institutional aims as secondary to personal change
- Inmates: not to return to crime/prison; have a ‘so-called normal life’
- Both: reduction of re-offending and the number of victims

Developments over time
- Staff: no pre-determined way of developing; gaining enough understanding to develop skills to cope; conscience; responsibility
- Inmates: awareness; feelings; sense of community; sense of belonging; self-esteem & efficacy; changing reasons for coming into community; attitude change towards staff
- Both: understanding that changes take place over time and are very individual

Impact of the prison setting
- Staff: physical constraint as therapeutically containing; generally little impact; tension between mainstream prison and TC ideology; at times shared services impinging on therapy time
- Inmates: experienced staff as caring and understanding and warm; impact of prison setting not experienced; setting experienced as compared to mainstream prison therefore experienced as therapeutic

Being-in-the-community: Feelings
- Staff: very passionate, committed and positive; high-energy work; intense; scary at times
- Inmates: experience staff as ‘carebears’; community meetings experienced as ‘gladiator arena’; intense
feelings of insecurity, fear and death; therapy group experienced as intimate & safe where feelings may be shared

- Both: frustration with things that undermine the community, e.g. drug-subculture

**Processes**

- Staff: everything as therapy and process; deconstruction & rebuilding; permissiveness; reality confrontation; modelling; splitting on institutional level
- Inmates: processes as painful; hard work; scary; gain awareness & understanding; develop sense of belonging & community; splitting
- Both: process of gaining understanding as crucial; splitting

**Relationships**

- Staff: all relationships are therapeutic; create intimacy; relationships very different to one-to-one settings; being directive and allowing space for play; containment of fears and anxieties; affected by previous experiences
- Inmates: staff seen as not just 'key turning'; acknowledgement of different feelings in different groups
- Both: desire to break down barriers; encounter

The following analysis concentrates on ‘the impact of the prison setting’, ‘feelings’, ‘processes’ and ‘relationships’ as experienced by the residents in the therapeutic community, because it is these themes that are under investigation and that are believed to be important for understanding possible mechanisms of change. However, the main findings of the remaining themes ‘views of what the TC is about’, ‘aims of the TC’ and ‘developments over time’ will be briefly summarised.

The narrative presentation of the analysis will begin by examining how participants experienced the living milieu. ‘The living milieu’ is used here to describe subjective experiences of the social environment within which the residents live and reflects some basic issues around the concept of the TC. The main themes identified through the analysis centre around the residents’ set of beliefs and views of the therapeutic community, its aims, their personal developments over time when living in the milieu and the impact of the prison setting on the therapeutic milieu. The second part
of the analysis will consider participants’ experiences of *being-in-the-community* and will examine residents’ reported encounters with feelings, processes and relationships. The presented themes and their subthemes are not mutually exclusive and overlap at times.

**The living milieu**

*Views of what the TC is about:* This subtheme described participants’ viewpoints and their understanding of the nature and meaning of the therapeutic community. All residents experienced the community as an opportunity to explore meanings and to create some form of personal change. This reflects the existentialist idea that one of the most basic motivations is to discover meaning (Frankl, 1984).

Staff reported that making and exploring meaning was crucial for therapeutic process. This process was understood as being facilitated and stimulated through a ‘culture of enquiry’ that enabled open communication of feelings and processes from residents. All inmates identified understanding as the most important aspect of the TC. Residents mainly experienced ‘understanding’ as gaining knowledge or recognition of what has happened, but also as an instrument that may be used as a means of coping. What also appeared to be important was residents’ experience of open communication. The TC was seen as a space for open communication and engagement with the process between *all* residents. All staff members saw themselves as part of the community as much as any other member and processes were experienced as an involvement or encounter between *all* residents of the TC.

I suppose that’s one of the aims of the place, ain’t it, because one of the aims of the place that I can gather is to make us all competent therapists (...) for each other. (David – inmate)
This mirrors one of the main ideologies of the TC that has been discussed in the literature. Democratisation has been described as an important aspect of therapeutic community philosophy. Rapoport (1959) defined democratisation as 'the view that each member of the community should share equally in the exercise of power in decision making about community affairs – both therapeutic and administrative' (p.55). The philosophy of 'community as doctor' (Rapoport, 1959) is to allow 'living and learning' (Blackburn, 1999) by using the membership of the TC as a *therapeutic instrument* (Roberts, 1997). This was mirrored by Ralph (therapy director): 'So, it's eh [ ] the process of being in that place and being part of that system that actually creates the change or not that actually occurs to that individual.'

**Aims:** This subtheme refers to the participants’ desired personal results, intentions or their understanding of the aims of being a member of the therapeutic community. All residents described the reduction of re-offending and the number of victims as the main desired results and there was little variation between the views of the staff and those of the inmates. Staff saw any form of personal change as crucial. When asked about whether, and if, the aims of a therapist differed from the aims of the institution and whether that caused any difficulty, members of staff described the aims as inter-related. Ralph (therapy director) said: 'They are identical in that ehm (...) people cannot, they cannot get out of the cycle of re-offending unless they actually address their criminogenic needs or the reasons why they got into that (...)’ whilst Dan (therapy manager) described the aims as ‘Russian dolls’. Although the institutional aims and the therapeutic aims were described as highly inter-dependent, staff felt clearly that the reduction of re-offending was secondary to personal change. Inmates shared the institutional aim of reducing re-offending and reported a clear wish not to return to crime and/or prison. Andrew (inmate) said: ‘Just to lead a so-called normal life. And eh [ ] stop hurting people that I love and stop creating victims (...) (...). I mean, I am really ashamed of my offences and I eh [ ] I don’t want to deal with any new bad stuff again, I just don’t want to do this [committing crime and coming back to prison] any more.’
**Developments:** This subtheme refers to residents’ experiences of changes over time. A key aspect of understanding development has been described by Arthur (therapy manager):

> Some people will go through therapeutic experiences with tiny little gains, so that development, their change is almost not perceptible. But you can contrast that with the person who sits there and does nothing for seven months and all of the sudden a light bulb goes on and they say ‘Hold on, I know now what therapy is about’.

All staff acknowledged that there is no pre-determined way of developing within the community. Developments generally revolved around issues of gaining understanding and developing the skills to deal with difficult material in the future as well as developing conscience and responsibility. Inmates’ subjective experiences of changes over time evolved around developing feelings and a sense of community. Growing awareness and understanding were described as the chance to do things differently, again suggesting that understanding was experienced as an instrument. Another often reported aspect of development referred to changes over time in terms of reasons for being in the community. Most inmates said that their initial reasons for coming into the TC did change over time, so whilst they developed towards gaining an understanding and dealing with all sorts of issues, they were originally drawn to having an easy life in the TC.

One of the biggest changes described by the inmates was the attitude change towards staff. All inmates described the nature of the staff-inmate relationship as different compared to the mainstream prison. Inmates’ descriptions showed a shift from talking about ‘screws’ that only turn the key in the mainstream prison to staff that were experienced as ‘genuine’, honest, respectful and interested in the residents, which led to a different quality of staff-inmate relationships.
**Impact of prison setting:** This subtheme refers to the impact of the prison setting on the therapeutic milieu. Treatment in a prison-based TC is secondary to security; security, the physical setting and the prison routine have been reported to have an impact on ‘maintaining therapeutic integrity’ (Rawlings, 1998). Although the impact has largely been described as negative in the literature, there staff acknowledged that the control and boundaries of the prison setting have some value to the therapeutic process.

Our guys, no matter what happens; they can’t go anywhere, even if they fail in therapy initially, they are still confronted with the reality of it. And that, I think, is helpful. It’s kind of the acceptance (...) you cannot run away from this. (Ralph – therapy director)

So, the physical setting was described as helpful for processes such as reality confrontation but could also be seen as therapeutically containing, allowing individuals the chance to experience themselves as part of a system that is held by a physical container. However, the therapy director experienced the mainstream prison system as conflicting with the TC ideology.

What isn’t helpful is (...) ehm (...) a traditional prison regime is interested in [...] and in essence the organisation’s needs are rooted in the organisation. [...] In the TC the whole essence is that you start with the individual’s needs. (Ralph – therapy director)

So, you have two systems trying to co-exist (...) and the main prison system has all these rules and regulations, which the TC then has to try to live with and still produce what it does. So, there is a constant tension between the security needs, the operational needs and the therapeutic base.

(Ralph – therapy director)
The therapy managers experienced these opposing methodologies and the resulting tensions between the needs of the individual and the institutional needs as potentially interfering with the therapeutic milieu.

By and large it [the prison setting] doesn’t [impact on the delivery of the treatment]. [ ] There will be occasions in which it does. For example, if you have a security alert, you will lock the place down, people will not get their therapy session on that day. [ ] We share common facilities with the mainstream prison, for example, health care, reception, food issues (...) that sometimes, because of the organisation complexity, will interfere with the therapeutic process. [ ] So, it impinges on therapy time. (Arthur – therapy manager).

The most obvious difficulties are conflicts between (...) ehm security, segregation and us. So, for example, (...) if ehm somebody fails a drug-test [ ] they get awarded a punishment by the governor. Ehm [ ] a typical punishment, which is a loss of association, which means lock-up. Now, in therapeutic community for somebody who’s abused drugs to be locked behind their door is absolutely inappropriate. It just does not go with the therapeutic culture. So, in those contact points where people from the main prison have (...) make decisions about us ehm (...) there can be some real conflict. (Steve – therapy manager)

Although staff acknowledged that such instances disturbed the therapeutic milieu, the inmates experienced the setting as helpful and containing. Inmates seemed to focus on the relationship with staff rather than the relationship with the mainstream prison and experienced staff as more caring, understanding and not just turning the key at the end of the day.
So you hate them, don’t you, you hate them. And that’s how it is in other jails, because that’s how other jails are, all they do is just bang you up, it doesn’t interest them if you’ve got anything to say, they just want to turn the key. They just want to bang you up. Wham. That’s it. But it’s a different ballgame here, if you are honest with these, these will be honest with you. [ ] But you have to understand that certain part of it is the prison bit that they have to do, because it’s their job. [ ] If you are alright with them, they are alright with you, whereas in other jails, whether you are alright with them or not, they still think you are a horrible scumbag criminal, they’ll just get ready to bang the door up at the end of the day. (Eric - inmate)

In other jails you are just bits of meat. But these [staff members] want to know your name, not your number. (Carl – inmate)

These accounts were the result of a comparison between the mainstream prison and the therapeutic community. Although any form of imprisonment is likely to be experienced in a negative and harmful way, it appeared that inmates did not experience the prison’s impact on the community in a negative way. Inmates acknowledged that TC staff were still prison staff that ‘had’ to act in a certain way, thus showing acceptance of the prison’s impact on the therapeutic milieu. This reported positive experience might be due to the cultural impact of having been within the prison system for many years. Having been accustomed to the mainstream’s rather harsh setting, the therapeutic community with its therapeutic milieu was experienced as positive; thus it is likely to be more therapeutic. Inmates did not talk about the mainstream prison impinging on their therapy time; however, there was a lot of reference to the caring and understanding nature of the prison officers. So, although the prison-based TC does not appear therapeutic in a common sense and the therapeutic community is limited to some degree due to the prison setting, it must be stated that the residents - in particular the inmates - did experience it as therapeutic.
**Being-in-the-community**

The second part of the analysis will consider participants’ experiences of being-in-the-community and will examine residents’ reported encounters with feelings, processes and relationships. This theme is used to describe participants’ sense of being defined through various existential relations, in particular the experience of the individual, of others and their interaction.

**Feelings:** This subtheme refers to any expressed form of feelings about the resident’s self, towards other residents, the community or issues in the community. Residents agreed that their feelings about the community changed all the time and were dependent on what happened in the community on a given day:

How I feel about it depends entirely on what’s going on at any one time. It can be extremely rewarding, funny and the rest of it. Eh m (...) it can induce anger, depression (...) eh (...) rage at times. [ ] So, overall it’s a, it’s a good place to be, because the work is good and levels of intimacy between people are extremely high and yet overlaying all of that is all the kinds of emotions that go with the process at times, like what’s going on. (Ralph – therapy director)

Your mood changes every day. I mean like today is eh (...) it’s a pretty shite day [,] so one day is (...) wonderful, everyone is getting on with each other and you feel ‘Wow, this is good, why can’t it be like this all the time?’ Then the next day the person you was getting on with the day before will say you’ve been doing this, and you ain’t be doing it, because he’s been doing it. (Andrew – inmate)
All residents experienced the community as a place that could produce a variety of intense feelings. Staff members were very passionate and positive about community life, but indicated that the work was intense and required high levels of energy.

Intense. Ehm, very, very intense. Very, very needy. That might have something to do with my position of being sort of figure head or whatever. Ehm (...) demanding, it feels demanding, it feels needy, it feels, there seems to be an urgency and a speed to it that constantly needs to be slowed down. Ehm it never stops. It never stops and (...) you cannot predict what happens and you cannot predict how it’s gonna affect you on a given day. You, you got to be prepared to accept all sorts of feelings that get sort of thrown your way, and that will kind of dislodge certain feelings in you. And on a daily basis, you just don’t know what is coming your way. Most of the time it feels safe and sometimes it can feel (...) where there is conflict or whatever, if there is a serious conflict going on, if drugs are around or whatever it might be it can be quite scary.

(Steve – therapy manager)

So, staff working in the TC were very committed, but also reported that the community can feel scary and unpredictable in terms of having to deal with any emotion that may be produced. Staff talked about their feelings in a more general way whilst inmates discussed a number of feelings concerning staff, the community meetings and the small group meetings. Although feelings towards staff were disguised, quotations like the following allow insight into the offenders’ feelings towards staff:

They used to be called carebears. We called them carebears. We thought the name carebears up for these buggers, cause that’s what they’re like, you know. They don’t know about that (...).

(Eric – inmate)
The choice of words was rather unusual, soft and childish, in particular for the prison environment, and offered insight into how staff were experienced by offenders. "Carebear" could be interpreted as arousing feelings of warmth and comfort and safety. This appeared to be in stark contrast with feelings towards the whole community. Most inmates described their feelings in relation to others, for example, feelings of being overwhelmed and fearful of the community. In particular the community meetings were experienced as scary and unsafe:

You are putting yourself in the line of fire as well, because if you tell (...) if you pulled a man forward and said ‘Look, well, you are actually doing this wrong’, you are taking a chance, because the whole community, all the people that are up to bad things turn against you and you’re sitting there getting shot, they just put you up against the wall and they start shooting you. [ ] But it’s an overwhelming feeling.

(Andrew – inmate)

The words “shooting you” and other reported fears such as the experience of the community meetings as a “gladiator arena” in which people are “ripped to pieces” indicated strong feelings of fear, insecurity and metaphorical death. Such feelings within the community meetings can be understood in terms of primary relations and feelings of exclusion and/or inclusion of the individual within the therapeutic community. Hinshelwood (2001) described the danger and fear of being alone and excluded from a group and identified profound feelings accompanying such an experience; for example intense fear, hostility and victimisation. The experience of being part of a community meeting intensifies early relational feelings, which is experienced as unsafe and scary by its group members.

The small therapy group meetings, however, were experienced as a very different and rather intimate place where vulnerability could be shared:
You can share more feelings, I mean a lot of people cry in the small group but they won’t cry in the big group [ ]. I mean, I have only broken down and cried in here once but I only felt I could do it in that small group. I only felt comfortable in that. [ ] And a lot of people put a mask on when going in the big group and take the masks off in the little group. (Carl – inmate)

The smaller and more circumscribed therapy group was experienced as allowing for intimacy and the expression of feelings. The therapy group has been referred to as a ‘playgroup’, again a child-like work, as compared with the community’s ‘gladiator arena’. These small group meetings were described as the place where one could take off that mask and explore, share and communicate emotions and thoughts. Although the whole social environment is believed to be therapeutic, it was the small therapy meetings that were described as ‘that’s where the work is being done’ (Eric – inmate).

Feelings that were shared between staff and offenders referred to things that undermined the community, such as the drug subculture.

So, that’s a downfall, cause you’ve got other people come on and saying I’m gonna get into this therapy and then see somebody on drugs and say hold on a minute, I can still use drugs while I’m here, so I might get away with it. And you know and all that and it knackers it up for us. (Andrew - inmate)

We are all knights and we’re all going down the forest and all of a sudden someone is sending the dragon [used as synonym for drugs] in (...) to try to test one of us or break one of us and tear us away. Eh (...) and it’s grabbed hold of a few of us and had a struggle with a few others before that. [ ] I think the forest is growing stronger now
and we’re all sort of fighting them off. But we still get a few dodgy knights [used as a synonym for dealers], with the big swords stabbing each other in the back. So, the dragons got an easier meal.

(Andrew – inmate)

This image describing the inmates’ fears about ‘not being strong enough’ to decline the offer of drugs and the repeated image of fear and danger (“stabbing each other in the back”) highlighted intense feelings about certain aspects of the community. This was also suggesting that there was a sense of belonging and being part of a group. The drug-subculture and its members were experienced as attacking and intimidating. This shows a strong hierarchical demarcation not only between drug users and non-drug users, but also between those who are strong and those who are weak and who feel that they don’t have the skill and strength the resist temptation. Whilst offenders experienced a range of difficult feelings about issues such as the drug-culture, staff reported feelings of frustration about the community’s inability to deal with such issues:

What they can’t deal with adequately is the culture of drugs. Ehm (...) and that frustrates me, frustrates me entirely. I can’t (...) (...) and that’s the bit I suppose that I actually find quite difficult to grasp. [ ] But I can’t get a grip on why we’ve never been able to break the back of the drug subculture. (Arthur – therapy manager)

**Processes:** The following subtheme refers to processes within the individual, processes between individuals or between the individual and the institution. Processes may be therapeutic but they may also describe courses of unhelpful developments. Processes and the understanding of processes have been reported as being the crucial aspect of community living by all residents.
There are opportunities in absolutely everything for the process to be examined for meaning to be made. We are trying to make manifest the idea that everything really is therapy.
(Ralph – therapy director)

Besides the aforementioned developments over time, such as attitude change towards the staff, residents expressed clearly how processes were experienced. For example the development of empowerment was described in the following way:

If you actually take somebody and show them how, what they’ve been doing and how they’ve been doing it wrong and how they might be able to do it differently and then give them opportunity to practise it themselves, that’s important. It’s empowerment because it’s a process of deconstruction and then rebuilding it. And sometimes I picture myself as a builder.
(Eric – therapy manager)

All inmates, however, described this process of deconstruction and rebuilding as very painful. This experience has been expressed not only as “hard work” but also as something scary and unsure that was experienced for the very first time. Metaphors, such as ‘stripping yourself down to the bone’ highlighted feelings of being bare or naked, showing everything that one is in order to become someone different.

No, it’s horrible, it’s horrible. You just strip yourself down to the bone and build yourself back up again. You have to.
(David – inmate)

It’s the hardest thing I’ve ever done (...). It’s very unsure because you are looking at yourself, you know what I mean, and you don’t know what sort of damage you’re gonna rake up. So, that’s
hard work, it's really hard work. (Eric – inmate)

Processes, such as permissiveness, reality confrontation and modelling, have been recognised and described as intentional processes by staff members and have been described as desirable concepts for TCs in the literature (Cullen et al., 1997). For inmates, the most reported and most important process has been identified as understanding past and present processes. Inmates described that that understanding was believed to lead to awareness, which then was experienced as part of a “toolbox”. Although understanding and gaining awareness have been described in other themes, such as ‘aims of the TC’ and ‘developments over time’, they are also processes.

You just get awareness. Makes you aware of yourself, aware of other people. Aware of the person who you was and that you still are and the way I make other people feel (...) what victims you make. The idea is to give you a full toolbox of stuff so that you won’t go out there and re-offend. (David - inmate)

TC staff members are required to understand processes and feed them back to the residents. This process has been described as strange and unusual for offenders.

They put up with loads of shit [ ] There is always somebody going in [the office] and doing it [giving staff a difficult time]. And they laugh at you, you know what I mean ‘What’s all this?’ (...) you know, whereas anywhere else would get fucking clubbed. You’d be banged up. (Eric – inmate)

This account highlights several important aspects: firstly there was an acknowledgment that staff have to put up with difficulties caused by offenders; secondly the inmates experience the concept of permissiveness, which allows
individuals to express themselves freely; and thirdly that is experienced as a new concept (as compared to previous experiences).

Another process described by the inmates, in particular those who have been in the community for longer, was the process of getting a sense of the community. This was based on a sense of belonging, but also a strong sense of responsibility for the community and its residents.

After you’ve been here longer time than everybody else, you start to feel like it’s your responsibility to do certain things and say certain things. You all start to act like (...) like staff (...) and a adult, eh a parent in a way. (Andrew – inmate)

The process of developing feelings was recognised through being-in-the-community and there was a reported inter-dependence of feelings about the self and feelings in relation to others.

You come in here, the smackhead that is ignorant of other people’s feelings and yourself as well and as time [ ] goes on you gradually start to feel things like other people. You start to feel guilty like if you’ve done something wrong in the community. (Eric – inmate)

And by doing it [getting more in touch with who you are] you are becoming more in touch with everyone else. (Eric – inmate)

Another interesting aspect of developing feelings and dealing with them was outlined by one inmate in the following account, which suggested that the acceptance of feelings was a process of development:

When (...) you first come on the wing (...) it seems negative, you
know, (...) we’re tight and all stuck together like but slowly they get brought off and it was seen as negatives (...) that you are getting, that you’re dealing with your feelings, dealing with emotions and now it’s a positive thing. (Carl - inmate)

The meaning of having and expressing feelings developed into something positive that was experienced as useful and that might even be seen as part of the “toolbox”. However, the development from the negative to the positive also suggested that things are perceived as either positive or negative, thus being split. Splitting refers to a mechanism that is characterised by a tendency to view others and oneself as alternating polar opposites, so as either ‘all good’ or ‘all bad’ (Klein, 1946). This process was interesting in this study in that it was not only happening within the individual but also it was also happening on the institutional level, thus representing a parallel process.

There will be occasions where we will have to take charge of the situation to keep the place safe, right. When that happens the residents will accuse us of being the police or being screws or a copper patrolling (...) whatever, and kind of accuse all those things that we are not here to be. (Arthur – therapy manager)

Here staff described inmates’ splitting the roles of staff into ‘all bad’ when staff have to control the security of the setting. The splitting on an institutional level was described by the therapy director.

So, we are all good, we are trying to do the good stuff, the main prison or the rest of the system is all bad and stuff like that. And it’s fascinating really because they try and split the organisation and in some senses they replicate what the residents have very often done about splitting of the good of things and the bad of
things, having to have bad people and good people all the time.
(Ralph – therapy director)

**Relationships:** This subtheme refers to the residents' experiences of relationships. Relationships as the basis of community living are part of the therapeutic instrument and were recognised by staff as crucial in that they reported that all relationships in the TC were seen as therapeutic and that individuals become who they are through interpersonal relationships.

And the fact that everybody is embedded within that process
[of dealing with human's experiences] and there is a huge
connecting (...) network of relationships all doing that work (...)
creates (...) ehm (...) it creates intimacy that (...) it will become
(...) they will internalise it. (Ralph – therapy director)

The network of different relationships was reported to help create intimacy between individuals. This intimacy seemed important in that it was seen as a necessary condition for the individual to develop or become through the relationship with others (as described in the previous subtheme). In terms of therapeutic relationships, staff acknowledged that community living was experienced as very different to the usual one-to-one therapeutic encounters.

I'm not sure that the classic sort of therapeutic relationship that people think about does apply to the TC anyway, so any therapist working in a TC had to probably readjust their boundaries a bit because it's about kind of communal living, which is very different to going into a consulting room for an hour a week. So, I think therapeutic relationships that are required in TC are kind of different.
(Steve – therapy manager)
One aspect that was shared between the conventional one-to-one setting and the TC setting was staff’s understanding of being directive and allowing space for ‘play’ in the therapy.

There are times, there are times when therapists will be quite directive in terms of what they want out of that relationship. [ ] So, you use that [therapeutic] relationship and that kind of questioning, guiding the way - hopefully the group will join in and pick up on what that’s about. [ ] Other times I leave it quite free though, because I feel that that’s (...) that kind of spontaneity in therapy is quite important. (Arthur – therapy manager)

Another important similarity was the ability to contain individuals’ fears and anxieties, in particular about entering the therapeutic space.

When people come to us in therapy they (...) they have anxieties about what is going to happen to them and we have to contain those. They need to be reassured. Then they need to feel safe enough to be able to do the work they need to do and when they start to do it they need to be contained and helped in that way. (Ralph – therapy director)

However, staff indicated that the relationship between staff and inmates was affected by previous experiences and socialisation and that staff as well as inmates needed to learn to relate to each other in a new way.

What you get in the prison service (...) you automatically kind of, you get this kind of in-build kind of resistance [ ] if a con is nice to you they are trying to get something from you, they are trying to condition you. (Arthur – therapy manager)
We do have a lot of issues surrounding authority and officer-con sort of relationship, which ehm is a big barrier that kind of needs to be broken down. But ehm (...) it does, it does get broken down and people relate to us as people. (Steve – therapy manager)

Staff reported the desire and need to break down the barriers between staff and inmates and to be able to relate to each other as person-to-person.

I think staff see them, understand them as people and relate to them as people and ehm (...) on the whole adopt a caring approach and sort of understanding approach. (Steve – therapy manager)

Inmates described this barrier as a dividing line and acknowledged that over time both sides become closer through moving closer to the barrier:

They were all just screws. I didn’t want to talk to them, didn’t trust them but they (...). You got your line (...) criminal on one side and a normal Joe Public on the other and as you get to know the line, you start to accept them more. (Carl – inmate)

So, there was acknowledgement on both sides that initially it is difficult to relate to each other as people, mainly due to socialisation processes that foreclosed an encounter between person-to-person instead of staff-to-inmate. However, inmates generally experienced staff as people who were not scared or punitive, but open to the encounter.

I expect everybody’s relationship with staff is better, but they, they are like (...) passive, they are not aggressive, they won’t shout at you, they won’t cow back neither [ ]. (Eric – inmate)
What appeared to be important in the understanding and working of the therapeutic community was the notion of ‘encounter’ (Spinelli, 1996) between staff and inmates, which acknowledged that all residents needed to be willing and able to encounter each other as human beings in a relationship.

**Overview**

Although there is a natural lack of fit between the prison setting and the therapeutic community, this research suggests that a therapeutic environment can exist within a punitive mainstream system and that this therapeutic milieu, even though it may lack aspects of non-prison based therapies, is generally experienced as therapeutic by its residents.

Due to the study’s commitment to explore the residents’ subjective experiences and limitations in time, the sample size in this study was relatively small. Furthermore, the ‘living’ nature of a therapeutic community has to be acknowledged in that any exploration can only be seen as a snapshot of what residents experienced at the time of the data collection. This might have been confounded by the fact that the researcher was not part of the community and did not have ongoing relationships with the participants. Also, the inconsistent use of data collection (individual interviews with staff members and the focus group with inmates) could be seen as problematic in that it might have produced different data. It would have been desirable to have a focus group that includes staff and inmates. However, the use of focus groups can limit or change the data collected, because participants might feel unable to share their unique experiences or might feel under pressure to conform. So, staff or inmates could feel inhibited to share parts of themselves with ‘the other’. This is equally true for the use of focus groups with either staff or inmates. However, since it was important to do a focus group with the inmates, so as to adhere to the main TC philosophy, it would have been desirable to run a focus group with staff as well. This was not possible due to the difficulties of the context (e.g. it is not possible to have all staff attending at one time without disturbing the timetable of the TC).
Thus, any conclusion will have to take those limitations into account and therefore cannot be generalised beyond the therapeutic community in this study.

However, despite its limitations, this study provides a snapshot of how the therapeutic milieu was experienced by its residents, their accounts allowing insight into subjective thoughts, feelings and processes and highlighting themes and variations between individuals. The identification of these processes has several implications. An understanding of the complexity of mechanisms of change within therapeutic communities should allow for acknowledgment and exploration of residents’ experiences in a more open manner. For example, similarities and differences between residents could be addressed more openly to facilitate dialogue between TC members and break down barriers. This could lead to a more secure and therapeutic environment in which difference can be allowed and similarity can be intentionally used. Additionally this would aid an awareness of parallel processes such as individual/group and organisational processes.

Further implications for practice lie in developing heightened awareness of the potentially intense feelings that may arise in group processes, how these might affect the individual and how these may be contained. This is particularly true for the community meetings and it might be important to consider educating the inmates about basic group processes and encouraging them to use this understanding to make sense of what is happening in those meetings and why that feels frightening at times. Also, heightened awareness among staff attending those meetings might help to recognise, contain and even counteract difficult situations. This seems particularly important in the forensic setting as the individual might not be able to leave the community for periods of time, so although the prison boundary may be seen as containing, it could potentially be experienced as a punishing constraint. If it is not possible to work with group processes in a way that minimises reported difficulties, it could be helpful to create a space in the small group meetings to ‘work through’ frightening issues and feelings that have been created in the community meetings.
This would not only lead to a sense of containment by the small group, but might also alert other group members who do not experience difficulties.

By exploring mechanisms and processes of change through the accounts of those who deliver and those who use the service, this study not only started to overcome limitations of conventional outcome studies, but also took service users’ views and experiences into account, which is in line with NHS Guidelines. Conventional research is generally post-treatment or in-treatment research with a focus on the offender. It is noteworthy that there is a lack of research investigating both, the offender and staff. Being a Therapeutic Community it is crucial that the members of the community work together and thus it seems necessary to involve staff into research about Therapeutic Communities. This research produced new knowledge by including staff views and experiences and thus can improve practice by augmenting the knowledge base.

Further research therefore should continue to take the experiences of prison staff into account and could even include prison officers views and experiences, as they are a vital part of the therapeutic community life. Furthermore, future research could attempt to link outcome and process research. It can be assumed that how individuals experience the therapeutic milieu will have an impact on its effectiveness. A study exploring residents’ experiences linked with an outcome study could shed light on which processes are likely to lead to the desired outcome.
References

Bobsien, A. (2002). *How does the forensic setting compromise therapeutic interventions with offenders?* Unpublished literature review, Department of Psychology, University of Surrey.


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APPENDIX
Appendices:

Copy of Information Sheet (Appendix A)
Copy of Consent Form (Appendix B)
Copy of Background Information Sheet (Appendix C)
Copy of Interview Schedule (Appendix D)
Transcript of interview with Therapy Director (Appendix E)
Transcript of interview with a Therapy Manager (Appendices F)
Transcript of focus-group interview (Appendix G)
Copy of the letter granting ethical approval (Appendix H)
Copy of Instructions for authors: Therapeutic Communities (Appendix J)
Self Reflection (Appendix K)
I am a Counselling Psychologist in Training at the University of Surrey and I am conducting a research study with the title: *An investigation into a prison based Therapeutic Community, exploring the experiences of the therapy director, the therapy managers and offenders.*

The study aims to explore the experiences of the therapy director and the therapy managers of the therapeutic community (TC) in delivering a therapeutic environment and offenders' experiences of living in the therapeutic environment. By investigating the experiences of residents this research might help to determine which aspects of the TC are important to staff and which are important to offenders, and whether there are similarities and/or differences in how the environment is experienced.

The research is conducted in two steps: Firstly, I will interview the therapy director and the four therapy managers to investigate their experiences and views on the philosophy, aims, delivery and outcome of this therapeutic community. Secondly, I am interested in the offender's opinion and experience of the therapeutic community. For this purpose I am looking at recruiting 6-8 offenders that would like to participate in a group discussion.
Unfortunately only offenders that have been in the TC for at 6 months and who do not have any other commitments during the data collection time may take part. There is no preparation necessary and all I will ask the participants to do is to take part in the interview (for the therapy director and the therapy managers) or the group discussion (for the offenders). Each interview will take about one hour, the group discussion will last between one and two hours. Both, the interviews and the group discussion will be recorded on audiocassette, which will then be transcribed by me. I will make every effort to protect confidentiality and all names and other identifying features will be changed. All data will be handled in accordance with the Data Protection Act 1998.

After transcription you can request the opportunity to review the transcript of your interview or your group discussion to ensure sufficient anonymity, and, if necessary, changes can be made. After completion of this research all tapes will be destroyed.

You will be asked to sign an ‘informed consent’ form before the data will be collected, however, you have the right to withdraw from the research at any time without having to give a reason or any form of penalty.

If you have any questions please contact my supervisor Prof. J. Brown or me. You can contact us via my course secretaries (Mrs. K. Hambleton and Mrs. M. Steed) on 01483-876 931 or in writing to the above address to the Department of Psychology.

THANK YOU very much for participating in this study. Please keep this Information Sheet for your reference.

Yours sincerely

Amelie Bobsien
Counselling Psychologist in Training
**Consent Form for Volunteers**

**Title of Research:** An investigation into a prison based Therapeutic Community, exploring the experiences of the therapy director, the therapy managers and offenders.

- I have read and understood the Information Sheet provided. I have received a full explanation by the researcher of the nature, purpose and likely duration of the study, and of what I will be expected to do.
- I agree to take part in the above study voluntarily, to comply with any instructions given to me during the study and to co-operate fully with the researcher.
- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.
- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without penalty.
- I confirm that I have read and understood the above and freely consent to participating in this study.

<table>
<thead>
<tr>
<th>Name of participant</th>
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<th>Signature</th>
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<tbody>
<tr>
<td>Name of witness</td>
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<tr>
<td>Name of researcher</td>
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</tbody>
</table>
BACKGROUND INFORMATION

To begin, I'd like to get some basic information about you (such as your age, education and occupation). The reason that I'd like this information is so that I can show those who read my research report that I managed to obtain the views of a cross-section of people. The information that you give will never to used to identify you in any way because this research is entirely confidential. However, if you don't want to answer some of these questions, please don't feel that you have to.

1. Are you (tick the appropriate answer)
   Male ___ Female ___

2. How old are you? [ ] years

3. How would you describe your ethnic origins?*

   Choose one section from (a) to (e) and then tick the appropriate category to indicate your ethnic background.

   (a) White
   □ British ___
   □ Irish ___
   □ Any other White background, please write in below ________________________________

   (b) Mixed
   □ White and Black Caribbean ___
   □ White and Black African ___
   □ White and Asian ___
   □ Any other mixed background, please write in below ________________________________

* The format of this question is taken from the 2001 UK census.
(c) Asian or Asian British
□ Indian
□ Pakistani
□ Bangladeshi
□ Any other Asian background, please write in below

(d) Black or Black British
□ Caribbean
□ African
□ Any other Black background, please write in below

(e) Chinese or Other ethnic group
□ Chinese
□ Any other, please write below

4. What is your highest educational qualification? (tick the appropriate answer)
None
GCSE(s)/O-level(s)/CSE(s)
A-level(s)/AS-level(s)
Diploma (HND, SRN, etc.)
Degree
Postgraduate degree/diploma

5. What is your current occupation (or, if you are no longer working, what was your last occupation?)
6. What is your current legal marital status?
(tick the appropriate answer)

Single
Married
Divorced/separated
Widowed

7. a) Do you have any children?
(tick the appropriate answer)

Yes ___ (go to part b)  No ___ (end of questionnaire: thank you)

b) How many children do you have?

[   ]
An investigation into a prison-based therapeutic community, exploring the experiences of the therapy director, therapy managers and offenders

Preliminaries:

Introduce myself and the nature and aims of the research. Explain that the interview may take between one and one and a half hours and that it is confidential; explain that the interview will be taped and transcribed by me, and that the interviewee will have the chance to review the transcript. Point out that the interviewee has the right to withdraw from the research at any time. Allow the participant to ask questions.

Have the participant sign the consent form.

Explain why background information is important and ask if the participant is willing to complete a standard demographic questionnaire.

Begin taping.

*It would be helpful if you could start by giving me a general picture of your position in or your involvement with the Therapeutic Community.*

(PROMPT): For example, whether you are a therapist manager (if yes: what is your background and your approach, how did you come to work in a TC?) or what your position is? What does a typical day look like for you?

(Warm-up the participant by eliciting contextual information; look out for therapeutic approach and therapeutic community timetable. This also aims at acknowledging the importance of being seen as an individual within the group.)

**Philosophy behind the TC**

*To begin with it would be helpful if you could give me a general picture of what, in your view, the therapeutic community is about.*

(PROMPT): For example, from your perspective, what beliefs and values lie behind the concept of this therapeutic community?

(Elicit information about the participant’s understanding of the TC. I am interested in:

- the framework, e.g. concerned with the cure/amelioration of maladjustment/criminality or assuming individualism in that everyone is taking responsibility for own activities
- treatment approach, e.g. humane, empowering and respecting vs. punitive or correctional
therapeutic instrument, e.g. 'optimised social environment', 'living and learning', offences as symptomatic for psychological disturbances).

*If you had to describe the TC, what words or images come to mind?*

*What do you think the concept of the TC?*

(PROMPTS): Which principle of the TC is particularly important to you Can you tell me more about that? Why do you think this is particularly important?

*How do you feel about this concept / these principles?*

(Elicit information concerning feelings associated with the TC and/or its concepts).

**Aims**

*I'd like to move on now to talking about your views about the aims and objectives of this therapeutic community. Can you tell me what, in your view, are the aims of this TC?*

*Can you give me an example?*

*Can you tell me a bit more about that?*

(PROMPT): Perhaps it is easier if you start by thinking about your work as a therapist in the institution. What are your objectives when you work with the residents?

(PROMPT): Do your aims as a therapist differ from the overall aims of the institution?

(PROMPT): (if yes) What are the differences? Can you give me an example?

(Elicit information about possible ethical dilemmas – who determines what is desirable? Also, institutional requirements vs. therapeutic needs and how the therapist resolves this (or not).)

*Can you differentiate between long-term and short-term aims?*

(Elicit information about different foci, for example long-term aims such as reduction of reconviction rates- and short-term aims such as facilitation of self-control).

(If participant is a trained psychotherapist/counselling or clinical psychologist):

*Thinking about therapeutic relationships in the TC, can you describe any type or form of therapeutic relationship in the TC?*
(If participant has no background in psychotherapy): *Thinking about the relationships you have with the offenders, can you describe such a relationship in your own words?*

(PROMPTS): Could you describe such a relationship to me? What does the relationships you have with the offenders remind you of? How does it feel to be in a relationship with the offender?

(PROMPT): Can you tell me more about that? Are there any other types of therapeutic relationships?

(Elicit information about the importance of the therapeutic relationship and its different aspects. For example, is the aim to use the therapeutic relationship intentionally? Which kind of therapeutic relationship is aimed for?).

*Can you tell me a bit more about the use of therapeutic relationships?*

(PROMPT): What are the aims in terms of therapeutic relationships?

(Elicit information about the participant’s view of the focus of the TC. I am interested in:

- environment as therapeutic instrument (safe & trusting)
- emphasis on groupwork & rigid structure (containment of feelings)
- encouragement of expression of feelings
- facilitation of self-control
- facilitation of exploration of criminal behaviour
- exploration of avoidance of responsibility
- ‘owning the process’
- ‘belonging in the community’
- therapists as facilitating and empowering (not as watchdog))

*How do you see the therapeutic relationship/s as different or similar to a therapeutic relationship that is not in a prison-based TC?*

(PROMPT): For instance, compared to therapeutic relationships in the NHS.

(Elicit information about the importance of the therapeutic relationship in the TC and its possible difficulties/deficiencies due to the correctional context).

**Delivery**

*Having talked about the aims of the TC I want to move on now to the translation of those aims into the context of the setting. The ‘therapeutic milieu’ has been described as the multidisciplinary team (consisting of all the staff, such as prison*
APPENDIX D

officer, probation officer, prison manager and therapy manager) that is concerned with the application of the therapeutic environment.

Would you agree with that or would you prefer a different definition? (If yes): How would you describe a therapeutic milieu?

(If participant is unsure): When I use the term ‘therapeutic milieu’ I mean the social environment that has been created in this part of the prison.

What is your experience of this ‘therapeutic milieu’?

(Elicit information about the plurality of relationships, the recreation of a community, but also participation in groups, use of the hierarchy, rigidity of timetable...).

In your experience, what is the most important aspect in the delivery of this particular treatment?

Do you feel that the mere provision of a therapeutic milieu is sufficient or would you like to see anything else implemented?

(If yes): What would you like to see implemented? Can you tell me more about that?

(If no): Is there anything that could improve this treatment approach? Can you tell me more about that?

(Elicit information about the participant’s view of lacking aspects of the treatment, for instance behavioural interventions).

In your view, how does the prison setting, if at all, impact on the delivery of the treatment?

(PROMPT): How does the prison setting affect the delivery of a therapeutic milieu – in either a positive or a negative way?

(Elicit information about difficulties, such as confidentiality issues, power dynamics and/or other constraints that impact on the delivery of a therapeutic milieu, such as impact of physical setting and prison routine).

(PROMPT): Can you tell me more about that? Can you give me an example? How do you, as a therapist, deal with this?

(If applicable): With the prison setting having an impact on the delivery of the treatment, what is your personal experience of the impact on the therapeutic relationship?
In what way does it affect the therapeutic relationship?

(If participant is trained): *In your experience, is the use of the therapeutic relationship intentional?*

(If participant is not trained): *Do you use the relationship you have with an offender as a tool?*

(PROMPT): Can you tell me whether the majority of staff working in the TC are therapeutically trained (including prison officers)?

(Elicit information about the use of the therapeutic relationship, is it used intentionally, if yes, is it by the therapists only)?

*What is your experience of the general attitude of staff towards the client offender?*

(Elicit information about the use of necessary conditions for change. For example, the use of the core conditions or therapy-interfering behaviours from the side of the staff).

**Outcome**

*Before we end, I would like to talk about outcomes. Therapeutic communities are designed to serve a purpose. In your view, what constitutes a good outcome?*

(PROMPT): If we look at the effect of treatment in the TC, we can look at in-treatment effects or post-treatment effects.

(I am interested in: reducing reconviction rates, reducing distress of psychological symptoms and improving behaviour in prison).

*In your view, what is a bad outcome?*

*The main purpose of treatment in prisons is the reduction of reconviction rates. In your work with the offender-client, does this mirror your personal view?*

(If not): How do you deal with dual responsibilities (towards the client and towards the institution)? (Thinking about the idea that the therapist needs to be indifferent to outcome)

*In your experience, what is the main reason for a good/bad outcome?*
(Elicit information about the interviewee's view of what is important in order to achieve a positive outcome. I am interested in the acknowledgement of offender variables, TC variables and treatment variables).

**Rounding off**

*I have no more questions. Is there anything you would like to add, or to ask me?*

*Thank you very much for participating in this research.*
Transcript of Interview with RALPH (Therapy Director)

I1: To begin with it would be helpful if you could give me a general picture of your position or your involvement with the Therapeutic Community (TC).

P1: Eh... That's quite straightforward. I'm the director of therapy. Eh... which means I'm responsible for the delivery of the therapeutic community.

I2: I would like to know a bit more about your background. Are you a therapist or a forensic psychologist?

P2: My background is... I'm a forensic psychologist, but my MSc was in therapy, so I've worked all my professional working life in prisons really, forensic, but I've actually sort of done other work outside within therapy.

I3: Thank you. It would be helpful if you could give me a general picture of what, in your view, the TC is about.

P3: It's about making meaning. It's about how each individual makes a new meaning of their lives and how they make sense of the universe and their place in it. Eh... so it's really about enabling people to change their basic schema and to acquire the, the skills to be able to live that new understanding and that new meaning. That's basically it.

I4: And if you had to describe the TC in words or in images, what comes to mind?

P4: Eh... a moving garden. A place of change where... eh... in which people have the opportunity to grow and to develop, with the recognition that some people don't actually grow or develop, some grow and develop blossom and move on and some actually don't grow and just wither. But that garden in itself is actually moving and changing all the time, providing different environments, in which those people sort of grow. So, yes, that's my kind of picture, really. I suppose one of the fundamental bits for me is that how those people grow and how they change is dependent on the people in that garden at any one time, in that garden at that time. So, it's eh... the process of being in that place and being part of that system that actually creates the change or not that actually occurs to that individual. So, that's the overall picture.

I5: Thinking about the concepts of the TC, which is particularly important to you?

P5: The process of exploring the interpersonal relationships within the TC process.
I6: We talked about the idea and the concept of the TC. Thinking about feelings, how do you feel about the TC, the concept and/or its principles?

P6: Ehm (...) (...) it has a sense of rightness about it, in terms of ehm (...) it fits (...) how people actually change. And how people develop. So, there is a sense of it’s ehm (...) it has a good intrinsic value in itself and the work is good and it’s a good way to earn a good way of living. How I feel about it depends entirely on what’s going on at any one time. It can be extremely rewarding, funny and the rest of it. Ehm (...) it can induce anger, depression (...) eh (...) rage at times. But underneath that all there is a sense of rightness, which is caught up in the (...) in the really high levels of intimacy in the place, which is engendered by the work. So, overall it’s a, it’s a good place to be, because the work is good and levels of intimacy between people are extremely high and yet overlaying all of that is all the kinds of emotions that go with the process at times, like what’s going on.

I7: What do you mean by rightness of it? Can you say a bit more about that?

P7: Ehm (...) it’s ehm (...) it’s the right that offers people the opportunity to actually explore what it means to be a person. How they became the person they are and to actually change it. And that that whole process involves everybody; it’s a culture of enquiry not only for the residents, but for every member of staff, as well. You cannot be involved in this place without being involved in that process. And the rightness of it is eh (...) everybody is engaged in that process that at times makes a new sense, a new meaning out of everything that goes on. So, that’s the rightness of it. It (...) it (...) it reduces to a level of interpersonal intimacy that is not found elsewhere and it’s (...) that’s what feels right about it. You can genuinely, sort of, endeavouring to explore each other’s experience of being alive and here and it doesn’t come any more fundamental than that. That’s why it feels so right, it’s dealing with the real fundamental issues of existence and life and shreds out all the superficiality.

I8: So, would you say then that the intimacy in the therapeutic community is different to other communities outside the prison?

P8: Yes. Yes. I mean it’s one of the huge strengths of the therapeutic community that (...) you deal with material and you deal with human’s experiences that very often you don’t deal with in the same way elsewhere. And the fact that everybody is embedded within that process and there is this huge connecting (...) network of relationships all doing that work (...) creates (...) ehm (...) it creates an intimacy that (...) it will become (...) they will internalise it. And it becomes natural for them and one of the dangers for people is that they become dissatisfied with the level of intimacy that they experience outside
the community. And that is vulnerability issues perhaps for (...) for staff. Anyway, some of the residents as well.

I9: Mmh (...) I'd like to move on now to talking about your views about the aims and objectives of this therapeutic community. Can you tell me what, in your view, are the aims of this TC?

P9: Change. Personal change. For the residents... personal change so that they ehm (...) no longer have their criminogenic needs, that they are (...) that the risk of them committing further offences is significantly reduced. And that in their lives, in their relationships in the future they create no more victims.

I10: Is this difficult to do while still connected with the mainstream prison where it's all about reducing re-offending?

P10: No, they are identical. They are identical in that (...) ehm (...) people cannot ehm (...) they cannot get out of the cycle of re-offending unless they actually address their criminogenic needs or the reasons why they got into that (...). The therapeutic community provides the opportunity for an individual to find out how they became that person who actually committed the offence and then to actually make changes and develop the skills and learn the things they need to in order not to that in the future. So there is no difference. It (...) it (...) ehm (...) a therapeutic community within a prison must have as its ultimate goal being able to produce people who come out at the end of it who do not commit further offences.

I11: And do you differentiate between long-term and short-term aims?

P11: Ehm (...) the short-term aims, I mean there is a number of therapeutic short-term aims (...) ehm (...) most of it is related to containing the anxiety of the particular phases within therapy. When people come to us in therapy they (...) they have anxieties about what is going to happen to them and we have to contain those. They need to be reassured. Then they need to feel safe enough to be able to do the work they need to do and when they start to do it they need to be contained and helped in that way. So, at various stages (...) ehm (...) there are various tasks for the therapeutic community to carry out. Ehm (...) and it's being able to sort of know what those goals are for each individual and then work it through. Overall, there are, there are overarching aims of (...) we obviously want to contain people and keep them in therapy long enough for that therapy to take place. There are goals in how many people we are able to keep for how many months in therapy.

I12: When you think about therapeutic relationships in the TC, what forms or types of therapeutic relationships are found in your TC?
P12: Ehm (...) (...) well, I suppose the thing about therapeutic communities is that all relationships are therapeutic (...) ehm (...) it’s the roles that people take and the boundaries that they hold in those particular roles that actually create situations in which the therapeutic material is produced. So, it’s about the interaction of the relationships through the roles that people take and all that the therapeutic community does, I think, is to put structures into place that enable those to be examined. So, we have a core of formal therapy, like the small groups and the community meetings and things, and the assessment of therapy, the sort of cycle of assessments the people go through, which structures (...) ehm (...) the way in which those can be looked at. Ehm (...) everything else in the therapeutic community is grist to that mill in terms of everything that everybody does is open for examination and can form part of the process of how somebody makes sense of how they operate and what they do. It’s about important things like communism and (...) particularly important is reality confrontation. Being able to give people feedback about how they actually are all the time by having a mechanism by which you can actually deal with (...) so, so contain the anxiety and the feelings and emotions get raised when you do that. It’s (...) yes, it’s everybody’s relationship in whatever role all the time. It’s hard to process and it’s about having structures that are actually able to contain that. 

I13: How do you see the therapeutic relationship, if at all, as different or similar to a therapeutic relationship outside the prison-based TC?

P13: Ehm (...) (...) it’s actually the population. We select a population for which we know the therapeutic community works, so (...) ehm (...) our residents are average IQ, motivated, psychologically minded (...) and they are sane, they are not on psychotropic medication (...) ehm (...) they come into a model which is based very clearly on the, the (...) ehm (...) premise that you become who you are through your interpersonal relationships, not through kind of (...) what organic things going on before you physiologically. So, that’s a difference with other TCs, for example. Other TCs as well, it seems to me, is sort of (...) they are patients, they are cared for. Although some of the best TCs have struggled and broken away from that mould and really allow their patients to be very democratic. Ehm (...) the prison by its nature have to have a set of boundaries related to security and I actually think that helps. I think the fact that there is a kind of real physical ehm (...) containment actually helps build psychological containment inside it. And I actually think that’s a plus and works well.

I14: Interesting. I always thought of it as a constraint.

P14: No, no. It’s (...) if you work in say (...), for example, somewhere like a community for substance abusers and addicts (...) they can walk out at any time. And because of the nature of the addiction, whatever they do, they quite
frequently just disappear to the community or whatever. Our guys, no matter what happens, they can't go anywhere, even if they fail in therapy initially, they are still confronted with the reality of it. And that, I think, is helpful. That helps. It's kind of the acceptance (...) you cannot run away from this.

I15: Ok. Now I want to move on to the translation of those aims into the context of the setting. The 'therapeutic milieu' has been described as the multidisciplinary team, consisting of all the staff, that is concerned with the application of the therapeutic environment. Would you agree with that or would you prefer a different definition?

P15: Ehm (...) I suppose the definition that we use is (...) ehm (...) we talk about everybody being everybody else's therapist. Ehm (...) and that's across the board, I mean everybody, and we talk about ehm (...) it isn't just about when we are doing therapy. We keep using the phrase over and over again, the generative power of everyday life and the process of being together and living together (...) there is huge opportunity for change and learning and everything else. So, it's kind of like everything (...) there are opportunities in absolutely everything for the process to be examined for the meaning to be made. And just the sheer fundamental process of living together as a community has a huge generative power to it and it's getting people to realise that absolutely everything that I do contributes to that kind of ehm (...) kind of process. So (...) we are trying to make manifest the, the idea that everything really is therapy. Although we have formal structures in place, it's kind of (...) yes, they are very important. But everything else that goes on is just as important.

I16: That sounds different to the definition in that you don't do something to them, but that there is more of an interaction.

P16: Yeah. You can't (...) it's a nonsense to sort of think that we are doing something to them. What happens in therapeutic communities is when everybody sits down and says 'I want to change my life and let's look at what I do'. Ehm (...) or 'There are things about me that I need to change and I haven't got a clue' or (...) 'There are things about life I don't understand' or 'In my world I am constantly miserable and I need to find out why' or (...) just the sense that something is wrong 'I cannot go on within my life like this, I know there is something wrong, so I am going to go and enter into this and try to find out what it is'. That's what it's about, the whole process that actually brings about change. It's the, the staff team's job to kind of understand what the process is and feed it back and help that culture of enquiry, but also to focus on the individual in terms of the change that they want to make and the change also that needs to take place if they are going to be able to live a life outside the prison, in a kind of (...) prosocial way. So, they don't do any more damage or they don't create any more victims.
I17: OK. Now (...) what’s you experience of the therapeutic milieu?

P17: It’s ehm (...) (...) communal living and families are ehm (...) are interesting. I have always been interested in sort of living systems. Ehm (...) early recognition that lots of families don’t work is lots of myths, the myth of the perfect family that raises perfect children clearly is a myth (...) and the alternatives ehm (...) certainly communal living and certainly (...) (...) I was, I was raised amongst quite a lot in a community ehm (...) where issues were raised in terms of child development and that sort of a whole new radical way of bringing up children and stuff. So, I’ve always been interested in that and it seemed to me very early on that ehm (...) that groups had a much greater influence of the development than individuals and when I started to work professionally, I suppose, you flog yourself for hours with an individual to get somewhere and if you put them in a group then (...) you speed it up. It’s a much more natural kind of ehm (...) habitat for people really. So, ehm (...) I just seems to me (...) that a community where there is the sort of acknowledgement that there is a task for everybody to do, is much more powerful way of inducing change or get people to change. Especially if you believe that people can become who they are through their interpersonal relationships. So (...) yeah (...) (...) so I am very quickly moved into working with groups ehm (...) and that just seemed so right. And yes, I progressed from there really. I opened a TC for lifers and then I got involved with this project. I jump shipped from the prison service.

I18: So, communities have a big meaning for you.

P18: Yes, yeah.

I19: I think you might have answered this partly earlier in that you suggested that the prison setting can be helpful. In your view how does the prison setting impact on the delivery of the treatment?

P19: The physical constraint is. What isn’t helpful is ehm (...) mhm (...) a traditional prison regime is interested in Monday being very much like Tuesday, of having x number of people going to education, having x number of people going to work, x number of people doing that (...) and (...) it being peaceful and quiet ehm (...) and in essence the organisation’s needs are rooted in the organisation. Yes, it provides work, yes, it provides chaplains and everybody else (...). In the TC the whole essence is that you start with the individual’s needs. And not only do you start with the individual’s needs, but you have to allow them to be expressed. So, the place is permissive to act out. Ehm (...) if somebody on the second tier landing in a large nick starts screaming and shouting and waving the arms around, the anxiety levels across the entire wing goes up, and the underlying thoughts are ehm ‘Crisis, he is dangerous, this could be a riot, get him to quieting down, let’s try to
keep the place calm (...) and whatever'. In the TC if someone gets angry and starts waving their arms about, hopefully everyone will say ‘Oh, that’s interesting’ and don’t try to sort of shut him up, and don’t try to (...) (...) being more interested in ‘This has got meaning, this behaviour has got meaning, what is going on for this person, why are they dealing with this this way, what is it that they are dealing with’ and they’ll say things like ‘Let’s sit with this guy and well what is going on, we’ll call a special group meeting, let’s look at what’s going on for you’. So, it’s the need is rooted in the individual. Now, what that means is (...) you end up with ehm (...) with a standard prison trying desperately to be orderly and non-chaotic ehm (...) and sort of keeping these boundaries very clear. And the TC would be much more relaxed and tolerant and sort of saying ‘Well, these things happen, you know, let’s talk it through, let’s take the long route, what was the history to this, where is it going to go?’ Now, it looks like it’s very relaxed, and it looks like it’s very chaotic, but it actually isn’t. There is an underlying process going on. So, you have two systems trying to co-exist (...) (...) and the main prison system has all these rules and regulations, which the TC then has to try to live with and still produce what it does. So, there is a constant tension between the security needs, the operational needs, and the therapeutic base. Now, (...) I other places, they’d be split, there is therapy and there is one group that does the security stuff and everything else, but what we’ve done in this community is very much trying to whirl the two together, so there is a huge amount of dynamic security that will do hold the security, but it’s all part and parcel of the therapy work that happens as well. I mean even the way the place is designed as designed to reflect that. So, there are very real differences. And TCs have ehm (...) they feel like they are misunderstood and then they, they tend to get very angry with sort of the host organisation and ehm (...) accuse them and everything else, like plotting against them. And there is real ehm (...) there is real scope for splitting. So, we are all good, we are trying to do the good stuff, the main prison or the rest of the system is all bad and stuff like that. And it’s fascinating really, because they try and split the organisation and in some senses they replicate what the residents have very often done about splitting of the good of things and the bad of things, having to have bad people and good people all the time. Staff noted when they tried to do it and then it happens at an organisational level. And that’s one of the biggest problems ehm (...) it’s about getting both sides to actually see each other in a reasonable rational light and understanding that either side isn’t out to get the other side, they are just doing things, but they are doing things that are different. And they come from a different perspective, it’s a constant education and translation job, but it’s really ehm (...) it’s the managing that boundary, which is the thing that takes all the effort and the energy to actually kind of produce understanding and sort of co-existence, really. In some sense it’s no different from a guy that comes into a group trying to make sense of himself, it’s all very strange, very alien and then he has to get into the process and learn. It’s exactly the same.
on an organisational basis as well, the organisations have to learn about each other and be able to co-exist and enter into a process, which is kind of mutually beneficial. Setting up a TC the size that we have done whatever is an immense task, because that process of mutual understanding is going to take years, you know there is a whole process to be gone through by everyone involved, all the staff teams, the managers and the residents and the prisoners. So (...) yeah (...) so there are some very real fundamental differences.

I20: So, there are pros and cons to the setting.

P20: Eh (...) the containment bit is a pro, but the wrestling you have to do to reach the point where there is peaceful co-existence or co-operation (...) is the downside.

I21: With the prison setting having an impact on the delivery of the treatment, what’s your experience of the impact on the therapeutic relationship? How does the struggle on the organisational level impact, if at all?

P21: It depends on how complex it is, but when you are a TC or a host organisation you are dependent on shared services. Shared services, TCs are usually viewed as the smaller partner and therefore there tends to be ehm (...) degradation of the boundaries, so for example the easiest on is the health care centre, which will start booking residents in the TC for their medical problems during therapy time. Not necessary, but they just do and so then we have to go back and we have to fight that battle, so there is all sorts of things there. And TC tend to be a bit stroppy as well, they won’t accept poor service from services, they’ll say ‘What’s wrong with it’ whereas with others it’s easier to get away with stuff. So, there is constant tension, and that’s not helpful. That’s quite difficult.

I22: And how does that affect the therapeutic relationship?

P22: Well, the danger is that the staff collude with the residents and say ‘You know it’s all those people who are providing the services, they don’t know what they are doing, they don’t understand that they are doing it deliberately’ and that’s unhealthy in terms of eh (...) therapeutic relationships, because the staff should be saying ‘Well, we need to look at this, do you really think they’re doing this to (...)’ so we need to look at that. So that can get in the way. And also, it makes it difficult for the staff to hold the boundaries consistently if there is an intrusion.

I23: In your experience is the use of the therapeutic relationships intentional?
P23: I’d say. That’s what we train them to do. Ehmm (...) we keep giving them messages about ‘You are the residents’ model of reasonable rational adulthood’. There is an ethical and moral responsibility to actually model how you would want the residents to actually be. And we also remind them that (...) ehmm (...) that they do all the things that our residents couldn’t do, you know. They do all those things like they do earn a living, they raise families, they have long-term relationships, they have a roof over their head and food in their bellies, they work and are able to support themselves. They are all those things a lot of our residents aspire to and it’s kind of like, it’s going back to the kind of generative power of everyday life. The staff themselves have these things and they do these things and they way they do them are important models for the residents. So, yes, it is (...) being involved in the way they are there. In terms of intentionality, I suppose we are saying, yes, you need to be aware of that, so there is an intention. But also the way they deal with stuff all the time. I mean we give them messages about ‘Every time you do something for a resident, you’ve taken an opportunity to learn something away from them, so stop doing things for them. Push it back on them’. And the big one at the moment, over and over again is, ‘Don’t get bogged down into content, think about what the process is’, so we are actually asking the staff to sort of interact with them in a different way, not to do the sort of content bit, but say ‘What’s going on here, what’s the meaning of this’.

I24: So, are they therapeutically trained?

P24: Ehmm (...) we train them. We train the staff in terms of what a TC is about, what they should do and also what the roles are. And the crucial roles for us are the formal group therapist role and the prison custody officer. Because if they hold the boundaries in both of those roles and perform those roles, everything else in between is containable. They’ll be able to do the rest. So, we put a lot of work into (...) ehmm (...) the way they process and analyse the data that comes out of it.

I25: And does that mirror the actual (...) ehmm (...) attitude of the staff towards the residents?

P25: Ehmm (...) (...) yes, I think generally it does. I hope it does. Ehmm (...). When (...) I mean everybody has sort of feelings about residents. Everybody has natural likes and dislikes, everybody has residents that really irritate them or they really like. The difference, I think, with TC staff is (...) that they acknowledge that and they ask themselves ‘What part that plays in an interaction with them’ and, you know, ‘Where the therapy is going’. So, yeah (...) (...) they are aware (...).
I26: Mmh (...). Ok. Before we end, I would like to talk about outcomes. Therapeutic Communities are designed to serve a purpose. In your view, what constitutes a good outcome?

P26: Ehm (...) (...) I want every resident to leave and ultimately return to the community, lead a pro-social lifestyle, be able to ehm (...) form and maintain long-term relationships, which are ehm (...) which are positive and intimate. And you are able to continue the process of their own development and, and growth into the future.

I27: Ehm (...) in your experience, what is the main reason for a good or a bad outcome?

P27: Ehm (...) (...) whether it makes sense to the resident. It being in the process at some point makes sense to them, then they'll do the work. Or they will attempt to do the work and they put energy into it and they'll strive and they'll achieve. If it never makes sense to them and the making meaning of their life or challenging it (...) in the way that it makes no sense whatsoever, they will not change. Because (...) we will never be able to get where they are to start with. And I think that's somehow in any kind of therapy the most crucial is being able to start where the client is. And if they can’t make sense of what you are doing (...) they might never get there (...).

I28: Do you feel that the mere provision of the therapeutic milieu is sufficient or would you like to see anything else implemented?

P28: (...) (...) (...) it’s been tricky though, because given that I have sort of said that everything about living together and whatever is therapeutic (...). You could almost argue that you could bring anything in. And it’s about how you bring things in and how it’s then used and everything else. I mean we (...) we’ve now got (...) SOTP in, we’ve got art therapy, we’ve got psychodrama in, we’ve got the dance sort of going, the arts festival is going to take place (...) and my bit in that is about (...) providing as many experiences which are able to access material and ways of making sense to thing which might then be explored (...) provided (...). That they are not just entertainments, but that there is always the focus on (...) the process. ‘What did you get out of that? Why are you doing that?’ and the mechanisms are there for doing that. I think that’s the important thing. Ehm (...) (...) you probably could introduce almost everything and if you’ve dealt with it properly then you get therapeutic mileage out of it. Ehm (...) (...) the biggest danger is TC doing things, because you can. Because (...) you know, the temptation (...) it’s a bit like ehm (...) you could put so much in there it becomes like stuffing turkeys (...) here is another bit of therapy, here is another bit of therapy (...) there has to be a balance in there and there has to be enough space to play, guys need time to just sort of be, play and whatever else. Because in a TC that’s all
part of the process, but they still need that in there. So, (...) it's not about what you bring it, it's about balancing what you have in there already.

I29: Ok. I have no more questions. Is there anything you would like to add, or to ask me?

P29: I think there are some philosophical bits in there about importantly about (...) things like (...) you don't have to be sick just to get better. You know, just being alive means that there are things, which about to learn and grow. We don't talk therapy language and we don't talk diagnosis labels either. We will go into conferences for example and we will not mention PD, basically because we don't find it useful. Ehm (...) people aren't labelled. Ehm (...) (...) I think, probably, it's about taking people the way they are, accepting them as they are and then working with them on the basis that they've got the capacity to do anything (...) that we kind of need to remove the blocks that enable them to move on. Very often if you remove the blocks (...) they just spring on themselves. Apart from that (...) I don't think.

I30: Thank you very much for participating in this research.
Transcript of interview with ARTHUR (Therapy Manager)

I1: It would be helpful if you could start by giving me a general picture of your position in or your involvement with the therapeutic community (TC).

P1: Eh (...) easier said than done, I suppose. Eh (...) Right, obviously as therapy manager eh (…) when I came down here, obviously my task was to eh (…) was basically to open a therapeutic community and to establish that culture of enquiry in which you can operate, ok. So, that was me bringing my experience of therapeutic communities into this establishment and fit it to prison level. Eh (…) and giving people enough information and guidance for them to do themselves basically, but to come back to me for any help. That’s how I envisaged it and that’s how it sort of works.

I2: So, your background is in therapeutic communities and you translated that into the prison.

P2: Right. I'll give you a bit of an idea about my background. Right. I initially didn't train as a therapist or a psychologist or anything. I, I've actually been to university and came out and did stuff that was not related to this kind of work at all (…) and I didn’t like that. I got a job in a children’s therapeutic community. Eh (…) I worked there; I ended up working there for fifteen and a half years and progressed from being an assistant to being the senior group worker. Right. I decided that I wanted to become a psychologist. So, basically I trained, all my training has been part-time whilst I’ve been in work. Most of it has been done in employment. So, eh (…) so I did that and then I went to, I had sort of fifteen and a half years of therapeutic community experience, and then eh (…) went to work in social services, because I wasn’t qualified as a psychologist then. Eh (…) I worked in a disability team; I did quite a lot of work with learning disability sex offenders. Eh (…) when I finished the first part in psychology I was actually employed by this company in their juvenile establishment, because of the experience I had with children and adolescents. And that’s where I came across the therapy director of this place. So, I was already quite interested in the TC concept and how that fit into the prison setting (…) so when this post came up I decided that (…) ok let’s put the background that I’ve got in therapeutic communities and let’s kind of see how this works in a prison.

I3: Ok. Now, to begin with it would be helpful if you could give me a general picture of what, in your view, the therapeutic community is about.

P3: Well, change. And I would like to say that, I mean, (…) the philosophy is loosely based on psychodynamic theory, ok. Now, that’s fine with me, because I’m not the great cognitive-behavioural person. Eh (…), but tend, even though
I'm the sex offender treatment manager, I'm not a great lover of cognitive-behavioural programs in prisons, because they tend to be sausage factories (...) ehm (...) you know, each year they put thousands of people through (...) and I came to feel that, and ok it has its place, I mean I am not completely decrying it, I think that would be a mistake (...) but (...) I think the philosophy here in the living milieu (...) and where you (...) have to live it (...) and where you have to live with therapy (...) as a kind of (...) it kind of has a effect with a number of people. So, ehm (...) basically from that point of view, we've got quite simplified psychodynamic model. We like to keep it simple. The one thing not to do is overcomplicating things. Ehm (...) (...) and I think there is a kind of view of therapists and therapy (...) they are some kind of magical experience, there is some kind of mysticism. So, to me the important thing is to debunk the mysticism and to have people experience sort of living together and sharing their feelings. That's basically what it's about, and to rely and to actually learn to rely on other people, because (...) obviously those are all those skills that they haven't kind of grown up with. For one reason or another they haven't been able to go through that sharing experience. They might have lived with people, but they actually never shared what they are about. And obviously this is what this is all about.

I4: If you had to describe the therapeutic community in words or images, what comes to mind? (...) (...) Even movies or songs?

P4: Ehm (...) (...) you are asking on the wrong day here, because I watched 'Clockwork orange' last night (laughing) and (...) I was kind of, I was kind of feeling that I was part of some big experiment and all that (...) to change the behaviour of prisoners. Which is largely true, but not in that 'Clockwork orange' sense. Ehm (...) I think what I do see is kind of ehm (...) there is actually very little difference between this TC and working with children and adolescents in TCs, strangely enough. Often the issues are the same. So, when you think about songs, I think about songs the children used to pick for our community meeting, because we would start the community meeting with a song and a prayer and things and ehm (...) so I suppose I've been sitting there quite often getting a song in my head that the kids used to (...) kind of (...) really go on about. So, (...) that would be stuff like Dexies Midnight Runners 'Come on Eileen' (...). They just latched onto the simple things and sometimes quite offensive things like Dua Dolce song 'Shut uppa your face' (...) that's kind of quite appropriate, because you can hear them in a community meeting dealing with a difficult issue and they'll say 'Shut up you are digging us out' (...). And there is no difference (...) to the adult saying it and to the children saying it and for myself (...) ehm (...) (...) I find it actually quite hard to describe, I mean it's kind of (...) it's a village, there you are. Ehm (...) the reason I came to say that, because I look at the small groups almost like they are their families, like family groups (...). And you see I had an issue last week with one of the guys as to why he behaved
differently in the small group. I actually called the community, the village, because he has an issue and his behaviour in his village is a lot different from what he was like at home with his wife. Eh (…) so I came to say to him (…) ‘Look, this is family, that’s the village, what’s the difference?’ So, I actually see it almost like a village. Eh (…) it actually has a dilemma to the village, because you have subgroups. Obviously you have a drug-subculture, and there are certain groups of people that are bound to go by interest, certain friendships etc. and that kind of (…) actually is like a microcosm of what really goes on at the site.

I5: When thinking about the concepts that you have just talked about, which are particularly important to you?

P5: (…) (…) (…) (…) Eh (…) (…) I think, I think (…) (…) (…) the crux of understanding that (…) that we kind of (…) (…) your behaviour doesn’t come from nowhere at all (…) people come here and think that the act are a random act or whatever. Even if it’s part of the pattern, they don’t see the pattern. The crux is (…) and the crux is that the more you share (…) the more you reflect your experiences and all of this and that (…) (…). It’s about identifying what these patterns of behaviour are about, where they come from, because obviously most people develop a pattern or patterned behaviour in childhood. And it’s (…) the therapy, and I know I kind of refer to therapies as a kind of magic or mystical experience. For them the mystical bit is understanding why, how and why the behaviour from childhood affects the adulthood. Eh (…) (…) so, I suppose what I’m trying to say is that the process is the crux.

I6: So, we have talked about the concept of the TC. Now - thinking about feelings, how do you feel about the TC, the concept and/or its principles?

P6: Eh (…) I’m actually very happy (…) with the therapeutic community and the principles of therapeutic communities. Eh (…) I mean I suppose I have been part of them for so long I don’t even need to be kind of (…) convinced. When I look at my own community here (…) I kind of think about bringing them from eh (…) the state of nothingness to a state of being, you know, I take great pride in that. Ok, I get frustrated, like everybody else I have frustrations. For example, why do some groups tackle certain things and why do groups not tackle things. So, for example, community can deal with issues of theft, can deal with issues of fraud, can deal with issues of violence. What they can’t deal with adequately is the culture of drugs. Eh (…) and that frustrates me, frustrates me entirely. I can’t (…) (…) (…) and that’s the bit I suppose that I actually find quite difficult to grasp. Why is that such a persistent thing? So, although I am very proud of them and what they’ve done and the achievements of many people in the community in terms of where they were when they came in as to how they are now. Absolutely
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brilliant. But I can’t get a grip on is why we’ve never been able to break the back of the drug subculture.

I7: So, there is frustration. And you also mentioned that you are happy, but also proud (...) that sounds a bit like a parent really.

P7: Well, yeah. Because, I mean they quite often, whether it being the community or whether it being ehm (...) in some of the small groups. I think there is the recognition that they see me as being breed of the community, therefore I’m the Daddy of the community and eh (...) one of the things we have to ask them is like ‘Why were you misbehaving when Daddy wasn’t here?’ for example. And we actually talk to them in terms like that, because that’s what we are representing. Ehm (...) ‘Why can’t you speak when Dad isn’t here, is that because you feel unsafe?’ So, I think it is a fairly good analogy to make.

I8: Now I’d like to move on to talking about your views about the aims and objectives of this therapeutic community. Can you tell me what, in your view, are the aims of the therapeutic community?

P8: Well, obviously being a prison therapeutic community the main aim is to reduce re-offending. And even though that is the stated aim, what my (...) (...) particular thing is, is to see change. There are some people who may find it difficult not to re-offend and where I would always hope that we kind of ehm (...) put in (...) put in some sort of moral conscience where there wasn’t one before. Ehm (...) (...) and just to let people take responsibility, to get people to take responsibility for themselves instead of leaving it to everybody else, which is usually the case.

I9: I am also interested in whether there is a difference between personal aims you have as a therapist and the aims of the institution.

P9: Ehm (...) I mean, I suppose there is to some degree (...) in terms of the institution looking for things that are measurable. Now, where I have a problem with that is where some aims, such as small attitude change, isn’t quantifiable in numbers. So, in terms of that kind of change, yes, I would be at odds with what the organisation (...) and this is not just this prison, this is the about the way of the prison estate, you know, and the Home Office and so on (...). If I can get someone to kind of change about a piece of anti-social behaviour in however smallest way, I have actually achieved something, but sometimes that is not measurable and it is not measurable by conventional means.

I10: Does it ever come to the point of an ethical dilemma?
P10: Ehm (...) I haven’t as yet had any kind of real ethical dilemma, because, you know, I’m bound by the Code of Ethics as a psychologist, so, I kind of must not step out of those bounds. There is also my, my personal boundaries as well. And then there is the boundaries of the kind of (...), you know, that I’m here, I am under contract, I’m in employment, I actually have to do certain things. So, in terms of that (...), you know, I have to keep that. Ehm (...) (...) there have been times where I’ve been curious or even angry about a decision that was made by the organisation, because prison is a strange animal. So, yes, I’ve felt frustrated, but it ends in terms of I don’t have great moral dilemmas.

I11: Ok. Ehm (...) to some extent you already touched on the next question, which is: Can you differentiate between long-term and short-term aims?

P11: Yeah, some short-term aims might be anything from improvement of social skills, from people, when you first came across them, they had no concept of personal space, they have absolutely no concept of how others might perceive them. So, when I come into contact with someone new in the TC I’ll have a number of small aims, for example stop shouting, you know, stop being so aggressive or whatever. Obviously all those little things contribute to the long-term aims, reducing the re-offending, but some aims (...). There can be some very, very basic things missing. Ehm (...) you know, for example, the person who always stands in your personal space is kind of intimidating, that’s a very, very simplistic kind of ehm (...) piece of well-known psychology, but how many people actually say ‘Hold on, you are actually intimidating me, because you stand in my space’, because they’ve gone through life and nobody’s ever said that to them and yet it’s a very simple and basic concept.

I12: Moving on to thinking about therapeutic relationships in the TC, what forms or types of therapeutic relationships are found in your TC?

P12: Ehm (...) this is kind of a wrestling. If we take the starting point (...) is unconditional positive regard, regardless of what the person is, having said that (...) there are times when that’s actually quite difficult. Ehm (...) (...) especially when the person (...) because the therapeutic relationship is obviously, as you know, in the group based on a series of dyads, which are going on all around you. Ehm (...) so, basically what you get is the client who gives you their transference there and they give you all of that to carry. Obviously you as a therapist decide how to deal with that and how to use that. But of course you do a lot on many levels, because you’re working within the group. Ehm (...) so, we’ve got to kind of see the relationships on that scale, ehm (...) that I go in there and I interpret the dyadic process of what’s going on between two people in any one point within a group setting. Eh (...) I think I, I’m friendly enough without being a friend. So, so basically
I do show people unconditional positive regard, but I make it very clear that I’m not there to be their friend. So, that’s that kind of thing, ok I accept people, but I’m here to work with you. And I think all of the relationships with clients are on that basis, have to be on that basis. Mmh (...) I have witnessed it several times over my career where a boundary has been crossed and that is very destructive, can be destructive, not only for the individuals, but for the community as well. So, all my relationships are based on that. And that goes for the staff as well, I’m here to do a job, to help you understand process, I’m here to supervise you, I’m here to make sure you do not harm yourself or anybody else. But that’s as far as it goes, so I’m friendly without being their friend.

I13: So, it sounds very much like a person-to-person relationship. And you also spoke about the transference relationship, that you look at it and interpret it. Are these the main types of relationships that come to mind?

P13: Yes, yeah (...) I think, there is one thing though that I’m aware of that I didn’t used to be aware of (...) ehm (...) and that sometimes the relationships just want acknowledgment and it’s kind of important to recognise that (...). I remember that I was subject to a study some years ago and somebody was looking at therapeutic styles and techniques and ehm (...) I noticed myself (...) this guy, who was actually doing the research, fed back to us in a debrief session, (...) ‘Why do you always stand by the kitchen door?’ I said, I wasn’t aware of that. He said whenever the kids come back in you stand by the kitchen door, just where they come in and you greet everyone of them. And I actually found myself doing that, subconsciously here (...) I’ll kind of be at the office door or the front door, so I’ll be greeting people to come in. It’s the acknowledgment and being part of belonging. That’s kind of important.

I14: Mmh (...) very. Thank you. Can you tell me a bit more about the use of the therapeutic relationship, or the intentional use?

P14: I mean (...) (...). Ok. There are times, there are time when therapists will be quite directive in terms of what they want out of that relationship. Ehm (...) I can give you an example: there was a guy I’ve been working with who killed his wife. Ehm (...) (...) and although he presents as being very male, (...) but my observations suggest, suggested that in actual fact he has quite a lot of female characteristics. Ehm (...) I specifically went into his group to look at some of these issues, so, in actual fact I’ll guide him through, because it is an area he actually found quite, quite difficult. Ehm (...) so, so, yes I sometimes go (...) and I’ll do this with anybody where, where I feel that there is an issue which hasn’t been brought out, which needs some kind of confrontation. But the thing is it’s not a confrontation in the sense of ‘You are this’ it is ‘Right, let’s examine what this is about and how you feel about that’. So, you use that relationship and that kind of

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questioning, guiding the way, hopefully the group will join in and pick up on what that’s about. Eh, so you bring other people in, ok, I might go and make a start off by saying ‘Let’s look at this avenue’ and kind of come to ‘Have you all been in that situation and does that mean that that’s the same as it is for him?’ So, we do that kind of guidance. Other times I leave it quite free though, because I feel that that’s (...) that kind of spontaneity in therapy is quite important, so (...) it’s almost like a stream of consciousness and ehm (...) (...) people will say something (...) ’Can you understand where that has come from?’ (...) (...) so that’s kind of equally important as well in the therapeutic ehm (...) milieu, so you have to allow for both kind to go on.

I15: How do you see the therapeutic relationships as different or similar to a therapeutic relationship that is not in a prison-based TC?

P15: Eh (…) actually I see more similarities than differences. It’s kind of, as I said earlier, how the men in prison sort of react to me is kind of not too dissimilar to the children that I used to work with. It’s like a range of stuff, from those people who need my approval constantly in order for them to feel safe and wanted to those people who go to all lengths to avoid being around me in case they’re seen as identifying with authority (...) (...) ehm so you can do (...) so you have all shades of grey between two extremes, from the very clingy ones who are there all the time, who will be there when I open the door, they will be in my face and they repeat that process all day every day to those people who I never ever see (...) hiding. And every variation in between (...) and there is absolutely no difference, no difference at all.

I16: Having talked about the aims of the TC I want to move on now to the translation of those aims into the context of the setting. The ‘therapeutic milieu’ has been described as the multidisciplinary team, consisting of all staff, that is concerned with the application of the therapeutic environment. Would you agree with that or would you prefer a different definition?

P16: Eh (…) I agree with it, but at the same time I suppose it sounds too technical. Eh (…), because I think, because the multidisciplinary team kind of almost negates the residents. And I think that’s the important bit. Ok you might have an office and you might have uniforms, whatever, but there are time when we just (...) when we are the community as much as any member, and I think that kind of description actually separates out and I think it doesn’t give the flavour of what it actually is like to work as a community. Eh (…) (...) and I think that becomes really, really important, especially when (...) when the whole community is sharing one issue. Eh (…) so for example, I can remember on one occasion where the community was having difficulties with one of its residents, who was in fact a paedophile. And there was a guy who reacted by leaving the room, but the (...) the great revelation to all of us, none of us, we all realised at the same time that he had been a
victim of sexual abuse even though he hadn’t disclosed. So, in that split second you are not a prison officer, you are not the therapy manager, you are not the psychologist, you are just one of the people who experience a feeling. And I think that’s the bit that’s missing from that definition. But I don’t know how you qualify that, because it isn’t the multidisciplinary team, but I think you’ve got to make it very clear that there are, that the residents are part of the multidisciplinary team.

I17: Ehmm (...) in your experience, what is the most important aspect in the delivery of this particular treatment?

P17: Uh (...) yeah, the most important aspect really is the interpretation of, of, of what goes on ehmm (...) within both, community and group meetings. Ehmm (...) (...) because without that ehmm (...) (...) the other staff members who act as facilitators ehmm (...) there are in there as well. So, I think (...) obviously you want to keep boundaries (...), you want to do all the very basic things, but if you asked me for what I can define as the most important thing is to offer some kind of process interpretation. Ehmm (...) because that gives meaning and context to what goes on, and I think without meaning and context it is very easy to get lost in what goes on.

I18: And I wonder if that also serves as the main vehicle for change, because only with a new form of understanding of what has been going on change can happen.

P18: That’s right, yeah.

I19: Ok, ehmm (...). Let’s move on to the next question: In your view, how does the prison setting, if at all, impact on the delivery of the treatment?

P19: By and large it doesn’t. Ehmm (...) in general I’d say it doesn’t. There will be occasions in which it does. For example, if you have a security alert, you will knock the place down, people will not get their therapy session on that day. It’s those very, very simple things. We sometimes have difficulties with the organisational set-up because obviously in this particular establishment we share some common facilities with the mainstream prison, for example, health care, reception, food issues (...) that sometimes, because of the organisation complexity, will interfere with the therapeutic process. Ehmm (...) at times that is extremely frustrating, it’s extremely frustrating for me, it’s extremely difficult for staff, it is extremely difficult for a resident, because sometimes it’s about not understanding what the process is, because they just separate out and think it’s their fault. So, it impinges on therapy time, but I have so say at times, because the vast majority of stuff that goes on is actually kind of (...) happens here. And by and large they are masters of their own destiny in terms of where the therapy is going, in terms of (...) of the
therapeutic process and what that's actually about, so (...) (...) ehm (...) (...) by and large they have that, even though they don't understand that they have that, so (...) that's why it actually has as little impact as it does, but you do know when it is impacting.

I20: I was also thinking about the prison routine, like meal times, the physical set-up (...).

P20: Well, yeah, I mean, ok that's one difference, where I kind of ehm (...) bring up things where it was kind of different from the experience of working with children and adolescents (...) obviously, because of the size and the place and the safety restrictions etc., the meals are brought down on trolleys. Technically there shouldn't be any meals there for the officers (...) ehm (...) so in actual fact it makes it very difficult to eat together. Sometimes, especially when there is not as much food (...). Now obviously eating is quite a therapeutic experience for quite a lot of people, ehm (...) (...) I was in a conversation earlier on with a guy who actually was saying that he was kind of very, very nervous when he was eating with one of the officers on the wings. Quite often he dropped food and all that and he couldn't understand what that anxiety was about, and I felt I needed to understand that. So, sometimes stuff like that gets in the way (...) (...) ehm (...) and that kind of (...) (...) bullocks (...) having said that (...) it still, there is still kind of valuable things to be gained even from the separation bit that the groups go through. It is very interesting as you can see which residents kind of includes staff 'Look there is some extra food' and then you discover the ones who resent staff getting anything, so (...) everything has its equal and opposite place.

I21: How about issues like confidentiality?

P21: It's ehm (...) I think between (...) (...) that's actually quite a difficult one, because (...) everybody is told what the concept of confidentiality is about. Ehm (...) (...) sometimes what you see from the small group feeding back to the community group what their issues are (...) right, I know there are some things that the small groups hold back, because they are frightened that information could leave the community and go to another community. So, there is quite a lot of apprehension about that (...) ehm (...) (...) The residents still haven't got the concept that confrontation in a therapeutic sense is different from grassing on somebody. They can't get those concepts separated out (...) ehm. So, I think (...) people can be rather guarded and yet the issues of confidentiality really kind of (...) because they know what they are entitled to, they know what they are entitled to say, they know what's entitled not to be said about them, basically, and even though we kind of say 'Well actually, you know, the confidentiality is that that there is no kind of, if you want, gossip on the community', you know, obviously people's issues or
what they are in the community (...) we know that in reality at times stuff gets out, ehm (...) (...) stuff gets around through gossip or whatever (...) ehm (...), you know, but we do try, we do try to keep tap on that in any way. We go back to the community and discuss confidentiality. Occasionally it happens with staff, that staff doesn’t happen to be the most confidential lot, not necessarily outside the prison, but actually within the prison itself. And I think there are issues there, but I think my, my understanding of confidentiality is pretty much the same as your understanding of confidentiality, and most of the residents and most of the staff have that. There are some people, however, who will go beyond the boundaries of confidentiality, and that does create problems, because it undermines the community, it undermines confidence.

I22: Do you experience problems in terms of a conflict between a duty to report and confidentiality?

P22: Ehm (...) that doesn’t cause me a problem, because once again, my code of ethics would actually, unlike psychiatry, in psychology we kind of say actually that nothing is that confidential and are kind of bound by a code if we feel that is something to take action on. We will do that and eh (...) (...) and I’ve made that distinction very clear on several occasions that in actual fact they are responsible for their level of self-disclosure. If they disclose, for example, to me, that they have committed a serious crime, then it is my duty to actually report that on. However, saying that, I would not kind of discourage people from actually dealing with their issues, but they need to be aware of those kinds of pitfalls in that they are responsible for their own level. So, I think, that kind of (...).

I23: Thank you. So, you said that actually the prison’s impact on the treatment is not as big as one would assume. Thinking in terms of personal experience of the impact on the therapeutic relationship, how do you see therapeutic relationships in here as different, if at all, to a therapeutic relationship that is not prison-based?

P23: Ehm (...) the bit where it kind of impacts on the relationship is kind of a really funny thing. They may not want to deal with the issues and leave it (...) there is a tendency to leave staff to deal with the issues, right. Ehm, my kind of, my viewpoint on that is (...) I will try to leave any issue or pass any issue back to the residents if at all possible. Perhaps there will be (...) occasions where we will have to take charge of the situation to keep the place safe, right. When that happens the residents will accuse us of being the police, or being screws or a copper patrolling (...) whatever, and kind of accuse all those things that we are here not to be. Ehm (...) (...) and occasionally that will happen, that will happen from time to time, it has happened (...) and it doesn’t matter what you do, because of what it is, it’s a
prison, you have security issues, people break security in some way. When there is a security issue we will take it into our hands ehm (...) you know, I would like to think that the community would kind of say ‘Actually if he was acting that way that was threatening our safety in terms of a general security’. But ehm (...) they are not quite there yet.

I24: Ok. We’ve talked about using the therapeutic relationship intentionally. Can you tell me whether you think the majority of staff working on the TC uses relationships intentionally?

P24: Definitely.

I25: So, is that different from the mainstream prison setting?

P25: Ehm (...) I think there is ehm (...) I don’t want to kind of, I have to generalize to explain this. Ehm (...) within the prison system it’s ehm (...) by and large prison officers are there to (...) do a job. Eh (...) basically locking people up, counting them at regular intervals, feeding them and make sure that they are at the right place at the right time. Now, and I know this is a generalisation, there are some very, very good prison officers within the system who are very good at relationships and dealing with relationships and nobody can take that away from them. However, quite often when they are together in groups they will revert back to the old-fashioned, standoffish position. Ehm, we had a very interesting experience here, as part of the community peer review we had some (...) (...) well our reviewers here were from the lay-prison project, HM people, and the project leader asked me if she could come on a second occasion and bring in prison officers, to which I replied ‘Yeah, we’ll do that’. Then I talked to the community and the community kind of said ‘Yeah, we are quite happy to participate, we’ll have a second community meeting’. So, ok, in pile all these prison officers, some of them knew some of the residents from previous prisons and previous jobs and some of them said ‘Good grief, I actually never thought you would have said that’ or whatever. Ehm (...) (...) and although you could see some reasonable quality one-to-one interaction going on, in the group setting that completely changed. Basically the prison-officers became very, very standoffish, some of them became a bit hostile, very, very defensive and very, very critical of the concept of the TC in terms of what we do. Now, and I know that’s kind of (...) that’s kind of an interesting observation to see that happening, because what you’ve seen is paradoxes happening in terms of people being capable of very, very good (...) with social skills, they are very good at making social relationships and actually doing stuff on one-to-one, but when it comes to the group they were identifying with their group. And if their group happens to be ‘Well, we are HMP prison officers, we are screws, who will in fact, if you step out of line, (...) we would put handcuffs on, we carry sticks and we carry handcuffs’. There are differences in the equipment, there are differences in
(...) well, basically our approach. So, I think you have to acknowledge that for what it is.

I26: So, do you think that TC staff is trained to be more aware of relationships?

P26: Oh, very, very much so. I mean that's (...) we deliver very basic training. The initial group of staff we all trained together. Eh (...) so they actually had quite a lot more knowledge, new members of staff don't get that kind of in-depth thing. Ehm (...) (...) (...) (...) Sorry, I completely missed the point you were asking.

I27: The point was whether you think TC staff is trained in terms of relationships.

P27: Yeah. Ehm (...) generally speaking yes. I mean it is a very basic training, a lot of it is about what relationships are about. So, I mean ehm (...) the delivery is kind of formal, but we are actually here to understand people. Now, what you get in the prison service (...) you automatically kind of, you get this kind of in-build kind of resistance, because it's about 'Don't get too close, because they will condition you and they will condition you to go and get drugs or cigarettes or whatever (...)'. And I think there is a difference, because in a normal prison setting you are almost in that bit where (...) if a con is nice to you they are trying to get something from you, they are trying to condition you. Ehm (...) so, right, some prison officers form good relationships, which in some places would be frowned upon. But that depends on the prison culture, because not every prisoner is the same. Some prisons are very good at encouraging human relationships, other prisons are not. Other prisons are very old-fashioned, strict, regimented ehm like things whereby the ordinary prisoner will not speak to the prison officer until spoken to. So, I think you kind of have to acknowledge the differences really in establishments. And the TC is different again.

I28: Before we end, I would like to talk about outcomes. Therapeutic communities are designed to serve a purpose. In your view, what constitutes a good outcome?

P28: Ehm (...) (...) well for me a good outcome is any possible change in behaviour I can bare witness. Ehm (...) bit like I said before (...) if somebody spent their life stepping into your personal space (...) to learn not to step into your personal space that to me is a good outcome. Ehm (...) because it is about all that stuff that goes with that. Outcomes don’t have to be big or spectacular (...) it’s about just observable change, if you feel that, you know, somebody has difficulties speaking in groups (...) suddenly speaks in the group that is a positive outcome. Ehm (...) (...) so it can be small things, you know, (...) and to kind of (...) (...) some people will go through therapeutic experience with tiny little gains, so that development, their change is almost
not perceptible. But you can contrast that with the person who sits there and does nothing for seven months and all of the sudden a light bulb goes on and they say ‘Hold on, I know now what therapy is about’.

I29: In your experience, what is the main reason for a good or a bad outcome?

P29: Ehm (...) (...) (...) ok, I’m quite an optimistic person, so I am always kind of saying there is a reasonable good outcome about virtually anything that happens. So that, even in a bad situation, for example, somebody gets voted off by the community, good outcome is that the community has learned that they have responsibility for themselves and not tolerate. So, even though it was a bad outcome for one person (...) as the community (...) it has been a good outcome. In most things you can actually judge on that. The bad outcomes are based on the bits where the community refuses to accept that responsibility for their own behaviour and for the community behaviour in general. Ehm (...) (...) if that happens, that is a bad outcome, but generally speaking most outcomes are quite good in terms of actual recognition of what’s going on and challenging ‘Why do you say that? What does that person have to do with it? Why did you look at them in that way?’ (...) so any of those. Even when people ask the question ‘What is that about?’ that is an outcome and that is a positive outcome, because that’s saying ‘I’m actually thinking about (...)’. Before you’d just do it with no conscious thought. But when you hear people ask the question, when you hear people doing all that stuff (...) that’s when there is development. So, I would say that kind of most things I observe are good outcomes. Ehm (...) (...) bad outcomes (...) (...) ehm (...) (...) that’s quite a difficult one. I’ve had people say that therapy has actually made them worse and they kind of acted in a delinquent way (...) but I really see that as refusing to engage in the process completely, alright. So, whereas they might accuse us of that, also they might feel bad, it is still good to be had all of that, you know, because somebody else is going to see that for what it is (...)’ Actually that person is deflecting’. So, I think that any kind of therapeutic experience really, in terms of what goes on, is good for you, is a good experience.

I30: Let’s move to the last question: Do you feel that the mere provision of the therapeutic milieu is sufficient or would you like to see anything else implemented?

P30: Ehm (...) can you expand on that question?

I31: Well, I am interested in whether there is anything else you could see as being helpful besides what is already there, for example cognitive-behavioural groups.
P31: I think there is some room for cognitive-behavioural work. Ehmm (...) I think it's (...) and I know that earlier on I said pretty much (...) (...) from the psychodynamic corner and that I didn't like it, but there are certain things where it would have its benefits, for example, depression and anxiety. The application of cognitive-behavioural interventions in those particular instances can be a quite useful thing. Ehmm (...) (...) one of the side-effects of therapy is that people can become quite depressed and realise that they are not the person that they thought they were or that they don't like certain things about themselves, so in actual fact you have to make some cognitive-behavioural interventions. Ehmm (...) (...) my experience of being in the treatment management in the Sex Offender Treatment Program would actually suggest that (...) I mean I understand that there is some research as well(...) but I think that therapy in terms of the therapeutic milieu with Sex Offenders is tremendous, because they become skilled so that it becomes easier to facilitate Sex Offender Treatment Groups, which can be quite resistant to change. So, I mean I wouldn't preclude on the basis that it is cognitive-behavioural stuff. But I wouldn't like to see the place gunked up with too much therapy in terms of different styles. I like to keep the concepts here very, very simple, ehmm (...) for example, the whole thing is very de-jargonised (...) the only concepts really that we look at (...) (...) we look at the transference and countertransference, because I kind of feel that's important. Ehmm (...) (...) we look at attachment (...) ehmm (...) (...) and in terms of psychoanalytic principles (...) there are just two, basically the pleasure principle and the death instinct. Apart from that I don't use, I don't really use anything else (...).

I32: I have no more questions. Is there anything you would like to add, or to ask me?

P32: Ehmm. No, not really. Can I look at the research when it's accomplished?

I33: Yes, of course. I will send you a copy. Thank you very much for participating in this research.
Transcript of Focus Group

I: To begin with it would be really helpful to get a general picture of what you think this therapeutic community (TC) is about, for example your beliefs or values.

Andrew: I don’t know, I think a lot, I think (...) my opinion on it now after being here for 13 months is ...it’s to do with issues, re-offending, like bereavements, being forgiven for what you’ve done, drug problems. A multitude of things, usually like bad things in your life you’re trying to avoid. Like learning how to cope with things without using drugs or violence or crime or things like that.

Bob: I think (...) I think it differs on the person, I mean (...) it definitely does, because I mean there’s a lot of people that come here that have been offending or re-offending since they were like teenagers. And yet, there is always one like myself (...) I have done one offence, but here I am in jail. So, I’ve, I’ve come here more to gain an understanding of eh (...) I was capable of doing what I did, whereas other people, I think, have come here eh (...) to check the re-offending, so they don’t end up coming back here again. I doubt very much that I would ever re-offend anyway (...). But if I hadn’t come here, I would probably be in some Victorian hole with my head up my arse, so, because this place has helped me gain a much better understanding of how I was capable of doing what I did.

Eric: Yeah (...) I think therapy is all about it gives you an understanding of (...) eh (...) your offending. Whether you are a re-offender or just the one offence. And an opportunity to turning your life around by taking the negative things out of it and making them positive. So you understand them. Rather than not deal and shove them to the back of your head. You understand them and then you can fit them into a great plan in your mind. And that’s it, yeah, it gives you the tools to cope out there.

Bob: Yeah, which, which is a good point. Because, again myself, because I hadn’t dealt with things throughout my life, that’s how I’ve ended up committing the crime I did. So, I mean, obviously it’s never going to happen even again (...) but I do feel a lot better for gaining an understanding. And I surmise that other people (...) if they have been committing crimes all their life, it’s going to give them better understanding so that they can turn it around.

I: So, it sounds like it’s a place where you can deal with difficult issues.
Eric: Eh (...) don't know (...), but I think it opens up older wounds.

All: Yeah. Yeah.

I: Can you say a bit more about that?

Eric: Well, yeah, I mean (...) people come here and they think they just got issues with crime (...) eh (...) thieving, stealing, hurting people, but you talk about them and you go on to issues behind the crime, you go right back to your childhood. And you (...) do make connections and you figure out that people that you’ve looked at all these years, that you love, like family or whatever (...) may have had a part to play in the road that you took. I mean them didn’t make you do these crimes, but their actions pushed you towards this road that these crimes were at the end of. And it hurts you to think that these people that you love, they may not love you, may somehow play a part in that. And you lose some respect when you think about it. I don’t know, it just opens up old wounds.

I: Mmh. So, it’s more like recognising the whole issue and getting an understanding of how others fit in.

Eric: Yeah, I mean obviously, you come here (...) eh (...) a lot of people come in here and they just think it’s them. Why am I in prison, why is the society picking on me (...) but you do realise the other people that you hurt. Eh (...) what your actions have done to them, all through the years. It helps you. You come here, and it also helps you to understand other people coming in, work out where they are coming from (...) eh. I believe that through it, it helps you to see through other peoples’ masks that they’ve got on, cause we’ve all got masks on. You (...) what kind of shit they are coming out of. It’s just my beliefs. It helps you to see people for who they are.

David: You just get awareness. Makes you aware of yourself, aware of other people. Aware of the person who you was and that you still are and the way I make other people feel (...) what victims you make. The idea is to give you a full toolbox of stuff so that you won’t go out there and re-offend. Once you know yourself (...) you know where your problems are then, don’t you, you wonder what you can deal with rather than shove them to the back of your head, because eventually it just all explodes and then you are in trouble or someone around you is in trouble. But then again you got to have what you put in, if you put 100% in you, you get something out. But if you put 50% in expecting to get 50% out, you wouldn’t get nothing. You’ve got to
put it all in to get something. It’s no good putting a little bit in to get anything.

I: So, it’s about getting to know yourself, the good bits and the bad bits.

Bob: Yeah, I mean for myself, I wanted answers as to how and why and stuff. And eh (...) I got a lot of answers, I don’t like all of them, but I have to accept them, because that’s how it is.

David: You can see traits in other people as well. You can see they way that we were, or the people that I believe are still the same, but I’ve got connections we (...) everybody in the small group (...) I mean, I know we may not have the same offences and we may not have the same lifestyle, but there is connections, all of us. You see a lot of traits in other people that you have yourself, and they see it in you, so if you are not aware they point it out. If they are not aware you point it out. It’s all about awareness as far as I’m concerned.

I: So, is the TC is a place where you have the chance, if you wanted to, to get more in touch with who you are?

David: Yeah.

Eric: Mmh (...). And by doing it you are becoming more in touch with everyone else.

I: Mmh.

Andrew: But it’s not all roses.

David: No, it’s horrible, it’s horrible. You just strip yourself down to the bone and build yourself back up again. You have to.

Eric: You are not the same person really. You come in here, the smackhead that is ignorant of other people’s feelings and yourself as well and as time, not everybody, but as time goes on you gradually start to feel things like other people. You start to feel guilty like if you’ve done something wrong in the community, because you usually confront people in the community if you doing something wrong like to take drugs – it’s against the constitution. And you are sitting there, you know say you took drugs and you start to feel guilty and (...) that’s little things that kick me off. Feelings of guilt and things like that. And then I think about my offence and what I’ve done to people. As they say: one thing leads on to another, you open, you look at one thing and then the next minute, you have to sit and think about it, it’s
like 10 different things. And that spans off in a lot of different things (...) (...) and it is painful. It hurts a lot when you are sitting there and then you are tempted to take more drugs (...). But in all I think that self-awareness is the biggest thing in here.

I: Mmm. So while you are becoming more aware for yourselves, through everything you do in the therapeutic community, you also are able to connect to other people and you can imagine how they feel.

Eric: Well, you can relate to them, because you are aware of what you do.

I: Mmh.

David: And you can point out things that you are aware about yourself and that you see in other people that they might not see about themselves, so you can go and say ‘Hey, look we’ve got the same thing in common and I found out that this was the reason why I do this. What’s your reason why you do it?’ You know what I’m saying? So, as well as drugs and all that (...).

I: And you already said that that’s very painful. Are there any other consequences of allowing yourself to feel more?

David: If you start to feel more (...) I mean (...) I came in here, I didn’t have any self-confidence, I didn’t have no self-confidence. But I didn’t think I had a brain in my head, I just thought all I was good for was using drugs and doing the things that I was doing, like attacking people, smashing things up, but it’s kind of weird, cause things like fit into place without you even trying to do it. You are concentrating on one thing (...) and just before I came here I was always smashing things up and arguing. That seemed to disappear as soon as I started talking about problems, not dealing with them, as soon as I just started to speak about them. I don’t feel like smashing something up or going in the office and arguing (...) it’s not how it works. I don’t think that anybody can really explain properly, because it is hard to know how it works. It’s little things that click into place, like ‘Why did that happen?’(...) and it’s all happening in your own head. So, it’s been so much happening that I thought I had some kind of disorder, or something, because this is happening and I don’t know why, I can’t work it out. And like four weeks later, I’ll be lying on my bed and shouted “Eureka” (...) you just sit there and you think that’s what it is. And that’s what gets to me, how you get all this knowledge in your head, you know exactly what’s wrong, but it’s like you’ve repressed everything and you can’t remember.
I: Mmh. So, this is a place where you are allowed to open that up a bit and to explore (...).

Eric: Yeah. You have to do it like that. You have to explore. You feel it and all the bad things in your life, you've normally just chucked to the back of your head. To understand them, you've got to understand them to have them fit comfortable in your mind. Because if you don't have to fit them comfortable then you're going to react in a negative way, because they are always going to be there in a horrible way. Another way of doing it is just taking vast amount of drugs. And then (...) that's where the offending comes in, because somebody's got to have to pay for it. So, it's banks and building societies and bookies where I'm doing robberies. And that's where the jail comes into it. It's all a big cycle (...) that's what it is. Actually I think my feelings and emotions and that (...) (...) I have a real problem with everything for a while. I understand it now, but only because it has been put to me in a really blunt way. You're just nothing (...) you if you've got no feelings, you're just like a robot, you just don't care what other people (...) (...) cause you don't know what you're feeling like yourself. So, you don't think 'well, I feel horrible about the fact that I just robbed, because I couldn't give a shit', because you are not feeling anything yourself.

I: Do you think the growing awareness allows you to get into the cycle a bit?

Someone: You have to break it, don't you?

David: That cycle is weird, because my wife found that I was at my computer, I mean I'm 26 years old and I was acting like a kid and I was going to people, do you know, like a little child goes to their Dad. Daddy I've done this and so they pat them me on the head. I was doing that in everyday life and not even realising it. And when you become aware of it you feel (...) you feel (...) I am fully grown guy, 26 years old and you feel pathetic because you are doing it. So, that (...) just that little thing which seems nothing, it's like kind of manifested itself in me committing crime, because what I do in the subgroups, I was in on the drug culture and all of that, I do things for acceptance, off people I respected. You get what I'm saying? So, when you become aware of it you are able to break the cycle, you're able to go (...) alright, I'll do this, I feel bad about it and I don't need to do it and you can stop it. Or, if (...) it's like I think I never get rid of it, because it's an unconscious thing I do, but because I'm aware of it I can use it positively and not negatively. So, being aware does help you break the cycle of what you are doing.
I: Do you want to say anything to this? [directed at Carl]

Carl: Eh (...) I’ve stopped smoking and all I can think about is cigarettes.

I: Ok.

[Everyone is laughing]

Carl: Honestly. I’m sitting twitching and I’m listening to what people are saying, but I want a cigarette. But (...) I have got positives out of being here. Mmh (...) I have a lot of guilt at that and that from the past. I’m dealing with it now, it’s (...) in a lot of ways I have regret for what I’ve done, but I’ve stopped punishing myself for it by just taking more drugs to work it all out (...) mnh and that’s (...) you got to get the negatives before the positives, but it’s the things that you think are negative are exactly the same things that turn positives. And I think (...) it’s hard to explain, but it does work.

I: Well, I think what you’ve just said (...) that there was all this guilt and now you are kind of dealing with that or how did you say that (...)?

Carl: I have (...) that’s how it was so I can’t change it. I’ve done what I’ve done (...) for the last 15 years. And by being here I’ve realised there is no point worrying about it all the time, taking more drugs to get away from the past. I’ve got to face up to the past and then move away from it.

I: Mmh. And you were describing that the negative things can turn into positive things. What do you mean by that?

Carl: Yeah, cause when (...) you first come on the wing (...) it seems negative, you know, (...) we’re tight and all stuck together like but slowly they get brought off and it was seen as negatives (...) that you are getting, that you dealing with your feelings, dealing with emotions and now it’s a positive thing. I mean there are still people here now think that you’re talking shite if you talk about your feelings or whatever but in time they’ll see. Because it is easier to slag someone off for speaking your feelings than it is to speak about your own, in the early stages.

I: Ok. Let’s move on to the next question. If you had to describe the TC in images or pictures what comes to mind? (...) (...) Or a movie or a song?
Bob: One Flew Over The Cuckoos Nest.

[Everyone is agreeing]

Andrew: I think it’s (...) eh (...) I don’t know what film it is. You know in the old days when you got the knights and they fight the dragons, right. We are all knights and we’re all going down the forest and all of a sudden someone is sending the dragon in (...) to try and test one of us or break one of us and tear us away. Eh (...) and it’s grabbed hold of a few of us and had a struggle with a few others before that. That’s the kind of way I see it. The certain issues are the dragons and they’re delving between us trying to break us up. I think the forest is growing stronger now and we’re all sort of fighting them off. But we still get a few dodgy knights, with the big swords stabbing each other in the back. So, the dragons got an easier meal.

I: That’s a really good image.

Someone: It’s fantastic (...).

[Everyone is agreeing]

I: You were talking about dragons and bad knights. Can you tell me what’s that about?

Andrew: Ah. I give you an example. Well, not an example, but (...) right say dragons are drugs and bad knights are the dealers. Eh (...) and these bad knights are chucking these dragons at people. Now some of us have grown strong enough to say ‘Now listen, we don’t want your dragons’, so the dragons have to go and find somewhere else that is weak. That’s the kind of thing that comes across.

I: When you talked about the forest growing stronger (...) what did you mean by that?

Andrew: A lot of people help each other and a lot of people have drug problems, so (...) and a lot of people get together and eh (...) give each other a pat on the back. Just for saying ‘No’. That’s a big thing to a lot of people, that’s something they’ve never done that in their life before. And you’ve got people saying to someone ‘Well done’, so they give them the courage to do it again. And then the next person is saying that to the other person.

Bob: A lot of people will follow them (...).
I: Yeah.

Bob: But there's an awful lot of us skipping around the woods like that. Do you know what I mean?

[Everyone is laughing]

Bob: Still, drugs, I don't think it will ever be able to be 100% drug free, 'cause people are coming on all the time.

I: Mmh.

Andrew: But eh (...) it's better than what it was. It's still a bit shitty at the minute, because of the drugs again, but it's better than what it was when we originally came on the wing. We've had 14 or 15 months of being in jail and a few of us have been here for that, so anyway they know what it was like, it was shit (...) cause people were just buying everybody's vote and giving drugs to them and then that undermines it all, because they know that all them people that dealt drugs to them are gonna vote whatever they want them, where they want and they can do what they want, cause these geezers are all gonna back them up as well, which sort of undermines it all. But because (...) there is this thing called you put your 48 hours up, and what you do is put 48 hours notice and say (...). And the idea behind it is, I think, that you put your 48 hours in and you go off the wing after 48 hours, but it don't work, because of overcrowding of the system, so you've got cases that have been on here for 6 or 7 months, same as the problems I've got. And obviously they're just using drugs and I'm saying I'm not, cause there is nothing you can do about it, cause you can't vote them off, they are no longer here. So, that's a downfall, cause you've got other people come on and saying I'm gonna get into this therapy and then see somebody on drugs and say hold on a minute, I can still use drugs while I'm here, so I might get away with it. And you know and all that and it knackers it up for us.

Carl: I think with therapeutic community life (...), because it is, because it is a prison as well, people, some people will come here out of a sense of eh (...) I can't think of the word (...) they come here solely to take advantage of the community. They think if they can sit through to years and they can put across this personality where they are caring and full of remorse and guilt and they will never do it again (...) and they can explain this, that and the other (...) they will get good reports. Some people are here for the wrong reasons, so you got them mixed in there and people, and some people might be convinced they are here for the right reason and what they are really doing is sitting
there and manipulate meetings and throwing up this issue and that issue, you know what I mean (...) just to deflect all these other issues, so it is hard work if (...). If you just landed here you'd be sitting there, you'd be looking around and you wouldn't know what to believe, you know, whether this, a group of people is this or that (...), you know what I’m saying. So, there is a lot of downfalls, but if I expect this to be outside, which we are not talking about, it would be different, because you chose to be there, you don’t have to be there to get out of prison.

Bob: Well, yeah, I mean, again, we all chose to be here as well, haven't we?

Eric: For different reasons (...), I know what you are saying, because some people come here solely to get out of jail, I mean we have guys, you know (...), one come on here 16 year tariff, he got life and he racked up no more than 12 years, cause they are purely on here for a tariff reduction (...) that’s the only reason why they are on it, but I think there is a couple of others that are on here purely because they want to get out of jail (...). They don’t really want to, they think if they say the right things, still take the piss at night, still take drugs and all that, but say the right thing and they’re gonna get good reports, they’re gonna get out on parole and blah blah blah. But it ain’t about that, it has never been about that for me. I just don’t want to come back to jail, I am only doing 7 years, that’s nothing and I don’t want to come back to jail again, that’s the only reason I’m on it. As simple as that.

David: I suppose then again there’s them people they might think they are here, because they are blagging it, but deep down inside like therapeutically they are screaming out for help. You know when you get people where you think you could say that.

Eric: It’s the hardest thing I’ve ever done (...). It’s very unsure because you are looking at yourself, you know what I mean, and you don’t know what sort of damage you’re gonna rake up. So, it’s hard work, it’s really hard work.

I: That was a really interesting discussion, but I want to move on now to talking about what your views of the aims and objectives of the therapeutic community. Some of you already spoke about some people who are here, because they really want to change, and some people might be here for the wrong reasons. So, what’s your view about why you are here, what’s the aim of being in a TC?
Bob: As I said before, mine, well (...) basically to get an understanding of how I was capable of committing the crime I did. There is nothing that (...) I have never been committed before or owt, I had a few minor skirmishes when I were a kid. Ehm (...) we had proper battered (...) I didn’t know where I were going, I didn’t know what I were doing, and if I had stayed in mainstream jail (...) I’d have just been banged behind my door. I would have either gone down the drugs road and just obliterated everything or I’d have topped myself or just shut myself off. Become an automaton, a robotic sort of just going to work, coming back, whatever. So, I think I had to do something like this just to sort my head out and that’s and that was my main reason for coming here.

I: That’s your personal aim, do you think that differs from the aim the TC sets out for you?

Bob: I think every eh (...) I think everybody who comes here is not going to have the same reasons, no. I don’t believe some, as I said, some people come here to actually change, and that wasn’t my initial reason for coming here. I have changed. I mean if I look back 12 month, 15 month and look at how I’ve been to how I am now, then I can see a massive difference. But my initial reasons for coming here wasn’t for change, it was to gain an understanding. To sort my head out basically (...) (...) (...) to a greater degree that has worked, I still suffer a lot with guilt and (...) it’s not eh (...) it’s not something I’ve yet learned to cope with properly, I don’t think. I’m still here (...) (...) so, I’m still trying (...) (...) but as I said I’ve gained a much better understanding of how and why. And as I said, I’ve got a lot of answers. I don’t like them, I don’t like a lot of them, but (...) they are the answers and I have to accept, because that’s how it is, they are the answers and I can see them. In some ways it has even put more guilt on me at times, you know.

Carl: My aim is just to get out and not come back. For 15 years I had like little sentences, I’ve been me behind the authority. I don’t care, don’t you know, I didn’t like them. Somewhere down the road things have gone a bit (...) crazy really. And I got (...) I’ve gone from committing, what I considered acceptable crimes to unacceptable crime for greed. And like (...) one of the aims, I think is, to look at what all the anti-authority stuff was about. Why did I not like the place? What was behind it and all? And when you asked about the song earlier (...) what song would (...) I think ‘The Boy With A Thorn In His Side’; a Smith’s song. It’s like my aim is to get that thorn out of my side (...) (...) (...) I mean if all I get out of this is that I don’t use heroin again the job is done. Some of us (...) we were onto
the firm (...) one of us was getting bits of drugs in on visits, the others, well, they were going to smoke it. And like between us we’ve gone a full circle. And that’s like one aim that’s been achieved. And I think that’s it (...) just not to come back to prison, understand what it was about.

Eric: I think my aims, initially when I first decided to come here, I think, if I’m honest, I didn’t really have any specific (...) I didn’t have an idea what this place was gonna be like. I thought it was gonna be like: clinical interviews, sitting there (...) man with a white coat in front of me, writing things down and telling me all like my mother was this and my father has done that and how do you feel about (...) I didn’t realise what it was going to be like. And I had seen a video about this place and it had showers in the cells, no other prison in the country has got showers in the cells, it’s a new prison (...). So I half came here for that reason and thought I could smoke drugs and have shower in my cell and watch telly every night and get paid for nowt really. But I’d say half of me wanted to deal with issues that I never knew I had. But as I said they are all in my head, I know they are there, but I just ignore them. And then when I arrived there (...) as time has gone on I’ve become more (...) it’s like I’m obsessed with the therapy, it’s like it’s eh (...) my aims have become more like to deal with every, with every single issue that I’ve got while I’m here. If that makes any sense. It’s like it started off with nothing really, but when I realised what it was about my aims have been more (...) (...) demanding, I suppose, of myself, because I am becoming more aware of myself, I can see what I’m capable of and I’ve got a brain and I’m worth something and things like that.

I: And you earlier talked about this, you said everyone has one part in themselves that wants to change, that wants help and that’s crying out loud.

Eric: I think, I think (...) (...) I’ll give you an example of eh (...) (...) when I was using drugs and I smoked heroin one day and I came down to the office and the therapy manager was sitting in the office and I asked how (...) I can be really devious, you know what I mean, but it bewilders me why I would ask to speak to this man while I’m smashed out my face and I mean I was like that, and it was in this room and I was sitting there talking to him like that and I was nodding off on heroin and he was sitting there looking at me. And this is for about an hour, I’ve sat in this room with him for an hour talking to him. Instead of going ‘No, I don’t want to talk to you, I’m going to my cell’, hiding to get away with it, I’ve sat there and I’ve spoke to
him and I have to ask myself why did I do that? If I’m so desperate to get away, why do I speak to the therapy manager?
The main man on the wing. And he’s confronted me, he’s brought me out there, and he’s told me to look at my face in the mirror and that, tell him what he sees and I say ‘I’m not on any drugs’ and then a couple of months later, as the process is continuing I’ve went into the community and I put my hands up and said ‘I’ve been using drugs’.

I: OK (...). That links into my next question. I want to talk about relationships now and the relationships you have with each other and with staff. Ehmm, can you describe any of those relationships in your own words?

Andrew: I’ve got to say something on this (...) eh falseness. Alright? Ok, you got a few acquaintances in here, but a lot of people in here are false with each other. It’s like in my last review I was told to come out of my landing and associate with people. Now, my point of view to that was ‘Why should I talk to people I don’t like’, I’m being me, I’m being myself, to talk to them people would be me being false. And I was told to have (...) eh, what’s the word (...) confrontations to see how I’d react. I don’t see the point in going out on the landing and having an argument with someone just to see if you’re gonna win it or not. There is a lot of falseness in here, but ehmm (...). What I found in here, someone might get on with you one minute and then (...) they just go behind your back or trying to stitch you up the next minute, I, I honestly can’t say 100% that I trust anyone in here 100%, because you don’t know what’s being said behind your back. And someone gets into a situation and they’re trying to work their way all around it, but then you’re getting chucked in just so that they can get a way out. I don’t like, I don’t like it in here for that, it’s very false. I mean, obviously, you’ve got genuine people, but maybe it’s my idea about trust issues, but (...) that’s just the way I see it.

I: And that’s very different from what you said before when you gave us this beautiful image about the trees. So, how does that fit in?

Andrew: I said it’s not always roses. But the tree is a poison ivy (...).

[Everyone is laughing]

Andrew: Your mood changes day to day. I mean like today is eh (...) it’s a pretty shite day, because (...) we’ve had all these meetings (...) and there was all sorts of rubbish being chucked about when the dodgy knights are avoiding the real issues, you know what I mean (...) so (...) one day is (...) wonderful, everyone is getting on with each other
and you feel 'Wow, this is good, why can't it be like this all the time?' Then the next day the person you was getting on with the day before will say you've been doing this, and you ain't be doing it, because he's been doing it. It's just trying to make you look bad, alright. So, it's a lot of falseness here.

I: I understand what you say about falseness. In your view, does that make relationships more difficult to work?

Andrew: I don't think they want you to make relationships work, I think they want you to have conflicts with each other. To see how you are going to react in the face of that conflict. That's the way I look at it (...) that's what I was told. I was told 'Go and talk to people you don't like and see how you get on with the confrontation'. What do I want to do that for?

David: I don't know, but you said about the relationship with staff. Eh (...) in a normal prison, it's not the done thing to have a relationship with a member of staff like on a 'stuff him'-like relationship, kind of thing, and speaking to him (...) people would look at you a bit funny, class you as an informant or whatever. But eh I had a right problem with that before I came here. I had a big problem with talking to staff, even if they'd come to my door to lock-up, I didn't say a word, I'd just push my door and expect them to lock it, because I think that (...) people would think that I was saying this or that to them. But since I've come here, I mean I ain't had one problem, one, one, well actually I had one problem with a member of staff. It's seems to me that staff-inmate relationships can be alright if you ain't got nothing that you feel guilty about. That's what I think. If you ain't doing nothing wrong the relationship will be alright. And if you give them a chance, because the majority of time if you treat somebody bad they'll treat you bad back, you know what I mean? So, I suppose it's what you eh (...) you get, you get back what you give out. And the same with what Andrew was saying with inmates (...). There is a lot of falseness (...) people are being nice to you because they are frightened that you confront them about this issue or that issue in the community and that, but on the other hand (...) trying to build relationships with people you don't like is eh (...) it's helpful, I think, for future reference in life, if you get a job and you don't like your boss or (...) it's like a common example, but just situations like that.

I: Can I just link back into this staff relationship idea, because you said when you were in a normal prison that it was much more difficult and you didn't want a relationship. How come that it is different in here?
APPENDIX G

David: Well, I've tried to work this out myself. I didn't like them, I'd been like placed on a report few times for just being abusive, for (...), or just destroying prison property and things like that, because I know it's prison property, because I didn't like the staff. But now that (...) my own issue, I think is with rebellion, because I lost my parents when I was young and I couldn't rebel against them anymore, because they weren't there. So, my parents were authority figures and the way I am seeing it is (...) the police, the prison service, all them other authority figures took their place. They become my parents, because I came to prison when I was 15. And eh (...) as soon as I was aware of that I just didn't feel doing it anymore. It's like the process (...) when you are a child and you rebel against your parents, move away from home and then you make up your differences and you get on fine together. And that's what I feel the process is gone with me. It's gone that way with me, but instead of being my parents it's been staff and authority.

I: So, the awareness we talked earlier about had an impact on how you relate to the prison staff. Is that correct?

Andrew: Yeah, yeah.

Eric: But it's (...) it isn't them, they are not the coppers who put us in jail, they are the ones who shut the door at the end of an isle. So, they are not the coppers who put us here in the first place, so you hate them, don't you, you hate them. And that's how it is in other jails, because that's how other jails are, all they do is just bang you up, it doesn't interest them if you've got anything to say, they just want to turn the key. They just want to bang you up. Wham. That's it. But it's a different ballgame here, if you are honest with these, these will be honest with you. If you go in there and say 'What do you think of me?' they'll tell you. Whether they think it hurts you or not. And if you're honest with them (...). I'll talk to them like I do everything, but you have to understand that certain part of it is the prison bit that they have to do, because it's their job. But I do, I don't talk any different to them as I do to these, but in other jails I wouldn't have nowt to do with it, because I wouldn't be all that confident. They'll bang me up, they're punishing me every day and now looking back I know (...).

I: So, you are saying that it's also the fact that they are interested in you as a person, they are not just doing their job.

Eric: I think it's a bit the respect thing that I, that I appreciate out of it (...) if you are alright with them, they are alright with you, whereas in
other jails, whether you are alright with them or not, they still think you are a horrible scumbag criminal, they'll just get ready to bang the door up at the end of the day. But these (...) will give you the benefit of the doubt, and they are patient with it, but if you are a shitbag, you know what I mean (...) they ain't going put up with it forever.

Andrew: I mean when you was going on about relationships now, I think, this place breeds a lot of jealousy, cause eh (...) I like going in the office and talk to staff, because I've been in jail over 12 years, I don't want to talk to inmates all the time about prison. If you talk to staff they talk a lot of things, outside world or whatever. I mean other people go in the office we talk about the same thing, but, you know, other people on the wing are jealous of me 'Why are you in there?' Then they start saying you're a grass in there, doing this and doing that (...), but they are not, they are in there. And a sensible conversation with someone where you're not talking about prison all the time, but these people on the wing think 'Well, I'm not in there, why am I not in there? Why are they talking to him and not me?' They get jealous. And then they think 'Is he telling them things that I've done?' So, there is a jealousy coming out, because they ain't got the confidence to go in there and say, well, to the men on the wing (...) I don't talk to a screw, because they are mates and everything and they're a grass. So, it's just jealous.

Eric: You get a view of what's happening out there, I mean you can't tell anybody outside where it's at. It's there, but like Andrew says, you've got people going 'Well, what's he doing?' And they're the ones that are bad at it. The paradox there is that they are the ones that are doing all sorts of shit.

Carl: I think the majority of the staff here are genuine, they're not just for the money. Because they don't get very good pay (...) rubbish pay (...).

Eric: Put up with a lot of shit as well.

Carl: In other jails you are just bits of meat. But these want to know your name, not your number.

I: So, do you experience them as caring?

Eric: Yeah, we've all gone in there and (...) blah blah blah and you fucking this and give them a right fucking horrible (...). They put up with loads of shit and there is 40 geezers on here, so there is always somebody going in and doing it. And they laugh at you, you know
what I mean ‘What’s all this?’ (...) you know, whereas anywhere else would get fucking clubbed. You’d be banged up.

David: They do put up with a lot. I mean, a lot of them are used for eh (...) (...) a lot of the staff are used for (...) they are an object to people’s guilt as well. When people have done something bad on it what they’ll do is (...). They’ll scuttle down the stairs and they’ll see somebody like a member of staff or the manager and go ‘Oh, how do you think I’m doing in therapy?’ to relieve their own guilt, you know what I mean. So do they know about last night? It’s weird people use them just for reassurance, just for a pad on the back, you know what I mean. So, I expect everybody’s relationship with staff is better, but they, they are like (...) passive, they are not aggressive, they won’t shout at you, they won’t cow back from you neither, but say ‘Well, what’s that about?’ And they respect you for being (...).

Andrew: [interrupting] Which puts you on the back foot sometimes, because you are expecting another game (...) 

David: Oh yeah, but you don’t get a reaction, do you?

Bob: No, sure.

Carl: Sometimes they don’t mind, because they’re too passive.

David: If you don’t get a reaction then eh (...).

Eric: You don’t want to talk to cons all the time, because you get bored (...).

Davis: It’s prison.

Eric: You seriously get bored in prison, bullshit. You talk to someone in here and I had a brother-in-law who were out there and, you know what I mean it ain’t interesting and it’s just bullocks stories about robberies or whatever 58 million ton of smack out there or whatever (...) we are bored to death, we all are. You are just glad to get away from it.

I: So, the relationships with staff sound a bit like (...) if you are really angry you can just throw it on them and if you just want to talk, you can just go and talk to them and it’s ok either way.
Eric: They used to be called carebears. We called them carebears. We thought the name carebears up for these buggers, cause that’s what they’re like, you know. They don’t know about that (…).

Carl: It’s like a time thing. When I came out, they were just all screws, I didn’t want to talk to them, didn’t trust them, but they (…). You got your line (…) criminal on one side and a normal Joe Public on the other and as you get to know the line, you start to accept them more. I’d say it was painful. I didn’t used to. Maybe the first 4 or 5 months in here I was out of order with them. That’s one of the problems in here that everyone started at different times, so there are lads that have been on for 15 months, with lads that have been on a fortnight. And then the lads that’s been on a fortnight think anyone who talks in the office is up to no good. I don’t know, if it weren’t that way and we had just one group of people start together and all finish together that would be a better way of doing it.

Andrew: I mean that relationship thing though, it’s like, if you think about it, we start (…). After you’ve been here longer time than everybody else you start to feel like it’s your responsibility to do certain things and say certain things, you all start to act like (…) (…) like staff (…) and a adult, eh a parent in a way, because you are teaching the kids how to move on, but those people are older than you. And that’s a bit, that’s (…) a bit (…) like of a nasty feeling. And you sit there and you think ‘Oh, I have to say something, I have to say something’, because you see something is going wrong and you’ve already been through this process and they are still at the beginning.

I: And how is that nasty? What do you mean by nasty?

Andrew: We are all the same, we’ve all been convicted for a crime, whatever that crime may be and alright, some of us got more eh (…) sense about us than others and we’ve already have been through this process. You’re still, on a prisoner term, you are still in the same boat as them and you are putting yourself in the line of fire as well, because if you tell (…) if you pulled a man forward and said ‘Look, well, you are actually doing this wrong’ you are taking a chance, because the whole community, all the people that are up to bad things can turn against you and you’re sitting there getting shot, they just put you up against the wall and they start shooting you. And then other people aren’t prepared to say anything, they just gonna sit back, and go ‘Well, I don’t want that happening to me’, you know what I mean? So, you are on your own. So, it’s like all the work you’ve done, they’ll just try to rip it all to bits, and saying things like ‘Oh you are false, we think you are blagging it, you are just saying this for
brownie-points and you climbing over people’s backs’. It’s just the same thing over and over again. But it is an overwhelming feeling.

Eric: The pressure of responsibilities are higher probably, because you are expected to do and say the right things 24/7. And you know, people come knocking on your door all the time ‘What do you think about this?’ and you think (...) if you tell them what your view is and then they’ll go away and you think ‘I wonder if that’s right (...)’, just the pressure of responsibility you get (...). It’s a lot of pressure, a lot of pressure. And you, you obviously you are dealing with your own shit as well, you know what I mean. And people come up and ‘Oh, what do you think of this?’ and if you have 4 or 5 people a day doing it and your head’s up your arse. And then you’re still expected to do the right thing, say the right thing, not doing nothing wrong innit. It is overwhelming. Fucking Hell, you know.

David: I suppose that’s one of the aims of the place, ain’t it, because one of the aims of the place that I can gather is to make us all competent therapists (...) for each other.

Andrew: But is has worked, hasn’t it?

Eric: Yeah, it does work, yeah.

Andrew: You wouldn’t have felt responsible before you came here, would you?

Eric: No.

Andrew: Now got them feelings, so (...) (...). It’s kind of useful.

Eric: But the pressure behind the idea (...) is a lot, because the expectations really are (...) and you know if you said anything wrong they’re going to be on you like a pack of wolves, because of the things you’ve said.

Bob: In some ways I think that worked backwards for me that. Honestly.

I: How do you mean?

Bob: Because when I first came here I would do anything for anybody and the longer I’ve stayed here the more cynical I’ve become; and basically I’m saying I don’t trust any of them, I don’t trust anybody, I honestly don’t.

Someone: I well believe it.
Bob: Whereas before I did.

Andrew: I think that’s because people, they haven’t told you things to help you, they told you things (...) to dig you out.

Bob: Yeah (...) to have a go. Yeah.

Andrew: You see, that’s why you took it cynically, because they have been (...) they haven’t been doing it for the right reasons.

Bob: Definitely not. So, basically (...) I, I think it’s coming to a (...) point where, I basically don’t give a toss about anybody else. And (...).

Andrew: You have to earn trust, you don’t just give it out, you know what I mean?

Bob: Yeah, yeah.

Eric: You just use it, I mean I would have done as with you, Andrew. If I as someone who thought (...), yeah, I don’t trust you all day long, I remember the other side of it, because that’s the mentality of it, when I was an old bastard. You know, just ‘What am I going to get out of this geezer’, and that’s why the way I were and that’s why a lot of people are still there.

Bob: That’s maybe why I mean (...). If I come out my pad (...) (...).

Eric: But you’re aware of that and that’s why you’re not there.

Bob: Definitely, yeah. I mean I do a lot of work in the small group. I’ll pass pleasantries with anybody all day, but I don’t trust any (...) anybody.

Andrew: And a lot of it is because you are not your own man, because you are an individual, because you’re your own man, and you’re not firmed up. That’s why you get a lot of flak (...) but if you’re firmed up four or five geezers all will say ‘Yeah, but you can’t say this’. You won’t get half the shit you do (...), but because you are an individual and you are your own man, you agree with your own issues, people will just jump on it if they are a bit fucking bored if they don’t like what you’re saying to them, because it’s a bit too near the mark. So, they’ll try and hit you back, you know what I mean, which is, you know, you can see it every fucking day....

Bob: Every day in it.
I: So, you said you don’t trust anyone, and you can’t give a toss about people. How does that make you feel?

Bob: It’s difficult, because it’s not how I was. That’s not how I (...) to some extent that’s a negative thing.

Eric: But it’s reality though.

Bob: Yah, as Eric says, it’s reality, yeah, because I, basically I don’t know most of these people and they are, they are acquaintances. There is none of them I could actually call a friend. I mean I get on with most everybody and I’ll pass pleasantries, but I wouldn’t give them the keys to my car and that’s how it is.

[Some inmates are laughing]

I: So, how does reality feel to you?

Eric: It slaps you in the face, but it’s reality I think is really had. And the way you are as a person is, it comes to you here, because you get reality at you, because people say ‘you’re an horrible bastard’ you’re just joking it’s gone round robin we don’t give a shit about how they felt and that’s what you are, a horrible shitbag. And that’s why nobody in jail wants anything to do with you. Reality is a big flap in the face on it. And it does, it brings it all up, this is the real bit of it all. This is where you have to look at yourself, fucking hell, you know maybe you are that. Then you look at it how far ahead he is, which is not the nice bits (...) but that’s the worst thing about it (...). Becoming aware in this therapy is that you realise that how much of a horrible shitbag you was.

David: It’s so hard (...) I suppose it shows you (...) as soon as you become aware of things, as soon (...) it’s like eh (...) this is the only example I can think of, I must have said this about a hundred times, but I suppose it’s like having this watch, or having this ball (...) it’s made, you think it’s made of 22 carat gold and you are telling everybody it’s 22 carat gold, you believe it and you’re proud of it and then (...) somebody pulls you to the side, brings you to the factory where it’s made and you find out it’s, it’s brass. You never gonna believe that it’s gold again. So, your whole opinion and outlook changes on that ball of gold. I suppose it’s the same about your own opinion and views on life, you know what I mean?

Eric: Cause the reality is that it’s brass.
David: Yeah, and you never ever gonna believe that it’s gold again.

Eric: This world that you’ve made up in your own head, is a crock of shit.

[Inmates agree]

Bob: I think, I think we can all agree on that one to a certain degree. I mean I suppose not as far as crimes are concerned, we dealt with committing crime, but I was still, I was still painting this rosy colour garden for my life. I mean it weren’t like that (...) it just weren’t like that. I run away from problems and ignore them or don’t want to, at the end of the day it’s gone like that [snaps fingers] and I’ve gone off.

Eric: The little bit of reality is that grief in the garden you can’t handle it. So, why fuck the rest up and it all goes tits up and your glasses fall off and you see it for what it is (...).

Carl: Being made aware of how, how I was, because I would just deal with it (...). I got, I was in a relationship for 10 year with two kids, nice house and that. Majority of what my ex-girlfriend paid for all of that because I spent all my money on drugs, but when I came here (...) it was all her fault that she’d left us. It was nothing to do with me. It was her problem, and she was this, that and the other (...), but ditched us when I got sentenced. But by (...) (...) people on the wing pointing things out for us, it has made us aware that it’s all my fault. I mean I am the one who has... messed it up, so by being aware of that (...) I’m not going down that road again.

Eric: I am trying to get as far away from the person that I was (...) alright it was me, but the only bit I want still the same is like the outside shell bit. I want to get as far away (...) I want to find myself (...) as long as drugs, you know, cause I was taking class A drugs at 13, started using drugs at (...), and that’s been like that for 23 years bang at it. So, I want to find myself, so I can understand myself. So (...). That’s what it is.

I: I want to move on to the next question, which is very similar to what you’ve just started to talk about. I’m interested in what, in your view, the most important aspect of the therapeutic community is.

Carl: I think everyone will have a different aspect of what’s most important. It is for me it’s awareness, because I was blissfully unaware (...). Of how I made people feel outside. As long as I, I as just selfish, as long as I was alright, I didn’t care. My girlfriend was sat at home crying for 2 days at a time (...) (...) I (...) (...) like for me
I need to be aware of (...) things that I didn’t think had anything to do with anything else or affected them, I (...) by just not making them mistakes again like that’s the most important thing for me. And what started was a little thing time and time again. It’s turned out to be a big thing, like one, a five pound bag of Heroin turns into 100 pound-a-day habit, and it might have took us 6 or 7 times to realise that. But that applies to everything else. If you treat someone bad once, they let you get away with it. Let’s just stop that cycle and starting again but that’s just form my point of view. We are all in here for different crimes for different reasons.

Eric: I think if you, if you could all make, cause now I do it, I didn’t used to, if you could all make me look at what’s gonna be the consequences of your actions, and think, what did I do yesterday, and then you think ‘well hold on if I do this, who is going to get hurt, how is it going to effect them, what trouble am I gonna get in, and what prison rules am I breaking’, maybe it’s paranoia, but I think about all them things before I do anything now. Who is gonna grass me now, who is gonna say this, who is gonna say that. And it stops you doing a lot of things, so in the future, I mean in the past I have just done whatever, for me to get money, hurting people (...) (...) ending up killing someone, I’ve robbed this, I’ve robbed that, and just not thinking about any actions while robbing a house, I didn’t think robbing a house is gonna end up me murdering someone, but if I had another time, I wouldn’t have done it. So, now in the future, if I’m thinking about these consequences for my actions for the silliest little thing, you want to get out and think about everything, hopefully. It might drive me mad, but it might save someones’s life.

David: It’s having thoughts for other people’s feelings and (...), it’s all mixed in (...) and then you start thinking ‘Well, if I do this, who is it gonna affect?’ If I do things outside me it just affects me I know 100%, it’s only gonna affect me, not hurt anyone else or not cause anyone else any grief, I’d do it. I haven’t got a problem with that. But it’s when you start to think ‘Well if it hurts him or it hurts her’ (...) I reckon I might still be able to do it, but at least if you are thinking about that, then you’ve come a step forward. But I don’t hurt anyone, cause before I just done whatever didn’t care about anyone. I think that’s what I get out of therapy (...) I haven’t finished yet (...) I could do another 20 years and still have plenty of problems.

Eric: I think there’s awareness and the ability to be able to deal with the awareness or with whatever it is you are aware of. Will it be right or wrong? (...) (...) Not just knowing something, like well, I know I’m a junkie, but the ability to deal with that, whether it’s the right or wrong.
thing that's come into your head that you've become aware of, the
ability to deal with it (...) in a positive way and the awareness that's
what I've got out of it. Plus the confidence that comes with, you know, (...). And whilst you are at it, I mean you get that,
you know, cause your head's is as fucked as it can be after 23 years of
drugs. That's me: awareness and the ability to deal with whatever I
want to become aware of whether it be right or wrong and not do it in
a negative way.

David: I don't know, you know. The funny thing is, this might sound a bit
weird, but I think (...) the constitution, like not taking drugs and eh
(...) no violence and no (...) them, them things been put in place, that
constitution, if that constitution wasn't there, I wouldn't have felt half
the things I felt that led me to like eh (...) deal with certain issues, if
that constitution weren't there. Although I was a bit sly and devious
about things, I was still feeling, you know, I was still feeling bad, I
was still 'Oh shit, I don't want to say nothing'. Eh (...) so I think that
was like (...) playing a massive part in my therapy. And eh (...) (...) I
don't know, small groups, if it was just the big group of lads every
day, then I don't think therapy would have been very positive, I don't
think it would get done at all really. Or you never know, might have
been a better place, but it just (...) from experience to a week. I don't
think it would go very far.

Andrew: It would drive me mad.

Bob: I don't think we'd be half way to where we are now.

I: So, what's so different about the smaller groups?

Andrew: It's everybody, it's eight, is it eight or nine in small groups?

Eric: Nine now.

Bob: Instead of forty.

Andrew: It's more a circle.

David: It's more like this, it's more intimate. Like this.

Carl: You can share more feelings, I mean a lot of people cry in a small
group, but they won't cry in a big group, which I find a bit strange,
because I do it as well. I mean I'll feel really sad about something, but
I won't cry in a big group. I mean I, I have only broken down and
cried in here once, but I only felt I could do it in that small group, I only felt comfortable in that (...).

Andrew: It’s like sacred, ain’t it, it is, it is hard to explain, because in a big group everyone’s in there, so (...) I haven’t got, I am sort of like alone on the wing, but (...) you might have three mates in there, like we were saying before, things are going bad for you, they stick their hands up and give you a bit of, a bit of a boost, you know you’ve done something, that’s done it a bit, but in a small group you get it put on you, because (...) it’s in a nice way though, it’s in a way that’s trying to help you, because you are all friends in there, or you’re all meant to be, but everyone seems to be wanting to help you in there in the right way. In the big group people put their hands up, and help you in the wrong way, because they think they are doing you a favour by protecting you. They are not, they are just pushing you further away from the truth and further away from what your problem is.

David: I think in the small group as well, you can see people for what they are much clearer in the small group, they are there three times a week, I mean, you know even when they’re lying, it’s like when your Mum and Dad used to say ‘You are lying’ and ‘I’m not, I wasn’t there, I put a brick through the window, it weren’t me’, it’s like that and you can see that they are lying, so (...) because you are more confident that you know what they are all about, you’re more confident about yourself, you can then say what you want to say without having to worry whether you trust them or not, cause you know what they are all about.

Bob: It’s easier to get to understand eight people rather than thirty-nine of them. Because that’s what you have to do, you’d have to remember every issue ‘Remember that issue in I had in February?’ (…) Thirty-nine other geezers, you can’t deal with that, plus your own shit. It’s hard work with nine so with forty I think you’d be in right trouble.

Eric: Personally, myself, that’s where I think my work has been done: in a small group, not out there, because they are just (…) (…) it just turns into a slanging match I’m afraid people accusing you of this and that and all that sort of rubbish. I never really got a lot out of the community meetings. I understand, I know how precious and what it’s supposed to be and all that, but for me (…) it’s all been in here, cause this is my small group, this is where I’ve dealt with my shit, you know.

Bob: I’ve always seen the big community meeting as some kind of strange arena, where people go to throw mud at each other, honestly.
Eric: Yeah.

I: What else comes to mind when you think about the community meetings?

Andrew: It’s like, it’s like (...) it’s like a gladiator arena, you are all set around watching then you think ‘who’s gonna stick their head out and have a fight?’ So he sticks his head out. And he’ll say what he’s got to say even though he’s in the right, and you get the next person over there will rip him to pieces, because he knows what he’s saying about him is true, but he don’t want to admit it.

Eric: You take sides, don’t you? It just becomes a bit battle. I agree with him (...).

David: I think that’s a really hard question to answer really, because there is no one specific answer to that question.

I: I think that was a really good image for the big group, the gladiator arena. Now, how would you describe the small groups?

Andrew: Playgroup.

David: It’s a bit like that.

Eric: Yeah, playgroup. I don’t really care saying anything in front of anybody up there but, at one time I did obviously, but I felt more comfortable about saying anything in front of eight other people because it’s more intimate, I know them more intimately than I do the forty up there. That, that’s (...).

Bob: You are able to get a better understanding (...).

Eric: The trust thing.

Bob: (...) from the small group, because they know where you’re coming from. They understand you’re issues as good, or nearly as good, as yourself. So, when you’re in the big group (...) it’s an arena, and it’s something I’ve never, I mean, I’ve had arguments with Bill and Ben time after time, I’m not interested, I don’t want to get involved, I don’t want to go in there and rip somebody to pieces, no, I don’t, cause that’s not why I’m here. I’m not here to destroy some poor bugger (...) it’s not what I’m about, so (...) I don’t do it. I don’t get involved.
Carl: I think it’s different how everyone else sees the big group. Sometimes I say it’s an arena but I have got a lot of confidence out of them big groups, speaking in front of a lot of people. I mean, I was only (...) the assessment (...) and there was a difference with me then to now. And I have got a lot of problems with my offence, mainly, I caused a vulnerable person to die from greed. And if I’d been told in assessment that I would be able to sit and talk about that offence in front of forty people (...). There is not way, I’d never do it, but I can now. And that’s (...) and if I’d only just kept it in the small group it would have been more secret, a taboo sort of thing.

Eric: He had troubles saying things if there was just me and him, but he come and told me. I knew before, but I never told him that I knew, but he come and told me and it were hard work for him just to say owt to me.

I: Do you need to acknowledge things for yourself before you can acknowledge them in front of many people?

Eric: I think it’s the other way around.

Carl: I think it’s a bit of both. I didn’t look forward to (...) I don’t like talking, but I didn’t used to like talking to strangers, I’d rather sit back and let them come to me, if they didn’t come then it wasn’t no skin off my nose. I’m quite happy to be left alone. But I think (...) (...) the big groups have made us a bit more sociable, like I’ll talk, I’ll give opinions on things where I never would have before, it’s done my self esteem good, cause if the other thirty nine people in that room say I’m talking rubbish, I’ll still be pleased with that the fact that I’ve given my opinion anyhow (...). Part of my defending is been not say nothing to nobody and just go out and get smashed. But if I start communicating with people a bit rather than just sitting in my box. That’s not taking away what the others have said that it can be used as an arena sometimes. And a lot of people put a mask on when going in the big group and take the masks off in the little group.

Andrew: That’s the (...) I think the therapeutic value of the big group as well. Carl has just said for himself, for people who feel like Carl to get the confidence to do that.

I: Ok, I’m aware of time (...), but before we end, I would like to talk about outcomes. TCs are designed to serve a purpose. What do you think is a good outcome?
David: A good outcome for me is (...) for myself is to get (...) eh (...) have much better awareness of myself, be able eh (...) have faith in myself and my abilities. Yeah. Be able to deal with my guilt. Be able to deal with bereavements and things that have happened in my life, but also by dealing with them be able to deal with anything that comes up in front of me. So, I suppose it’s eh (...) to make sure that what I’ve done never happens again. But also, to find myself, like Eric says, it does sound hippy-like, but to be able to think about myself. Since I’ve been here all I seem to do is think about ‘Why do I do this, why do I do that, and why did he say that?’ so (...). That would be my perfect outcome.

Eric: To not come back to jail again. To take responsibility for my kids, I’ve got two kids and I’ve never been their father because of the way I was. To be a benefit to society. Little bit of redemption in there. And just to turn my life around, you know, and take all the negative shit that’s happened in my life and turn it positive, cause I know it’s gonna be all good then, cause it was all shit.

Andrew: Just to lead a so-called normal life. And eh (...) stop hurting people that I love and stop creating victims. And it’s frustrating, cause you lay in your cell and after these years you get so frustrated because (...) and then you start thinking ‘Why did I turn into this sort of like (...) freak that used to rebel against everything and hurt everyone?’ that’s what you want to stop, you want to stop committing crimes, stop hurting people. Like everyone said, understand yourself: why did I do it? And the outcome I want is to (...) eh (...) in the future, when I am put into situations when I don’t know how to deal with, is not to resort to violence or taking the easy option by robbing people, cause that’s the easy option.

Bob: I want to gain an understanding of how I came to doing what I did. Get some tools to cope with guilt and remorse I guess. I don’t eh (...) I don’t think in my case it’s ever, ever gonna happen again anyway. It’s just not even on the cards (...), but eh (...) it’s, it’s given me some tools to deal with shit instead of ignoring it all. Just blanking it out whatever (...).

Carl: My outcome would be (...) eh, not, not to have a self-destruct button anymore, like the one I had for years. It’s the first thing I press when I get any stress. And just to be normal (...).

I: What is, in your view, the main reason for a good or a bad outcome?
Andrew: I think one reason is when people want to stop creating victims again. I mean, I am really ashamed of my offences and I eh (...) I don't want to deal with any new bad stuff again, I just don't want to do this anymore.

Eric: Yeah, I agree, if you don't want no more victims, if you ask 'What right have I got to create victims?' you know, if you don't want that sick behaviour anymore. But also to be able to cope with the past offences, if you are not able to deal with the guilt (...). A bad outcome means you haven't dealt with all the issues, and I think commitment, commitment is crucial. I think I want a decent life and I am committed to work on that.

I: I have no more questions. Is there anything you would like to add, or to ask me?

Thank you very much for your participation in this focus group. Thanks.
18 March 2003

Ms Amelie Bobsien
PsychD Student
Department of Psychology
University of Surrey

Dear Ms Bobsien

An investigation into a prison based therapeutic community, comparing the experiences of therapy managers, the experiences of offenders and the aims and objectives of the institution (ACE/2003/06/Psych)

I am writing to inform you that the Advisory Committee on Ethics has considered the above protocol (and the subsequent information supplied) and has approved it on the understanding that the Ethical Guidelines for Teaching and Research are observed. For your information, and future reference, these Guidelines can be downloaded from the Committee’s website at http://www.surrey.ac.uk/Surrey/ACE/.

This letter of approval relates only to the study specified in your research protocol (ACE/2003/06/Psych). The Committee should be notified of any changes to the proposal, any adverse reactions, and if the study is terminated earlier than expected, with reasons.

Date of approval by the Advisory Committee on Ethics: 18 March 2003
Date of expiry of approval by the Advisory Committee on Ethics: 17 March 2008

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Advisory Committee on Ethics

cc: Chairman, ACE
Dr A Coyle, Supervisor, Dept of Psychology
Copy of instructions for authors: Therapeutic Communities

Guidelines for Contributors

Therapeutic Communities were bom out of the radical and creative forces that established alternative forms of mental health care, from the 1950s to the present day. Therapeutic environments, influenced by the ideas developed by this movement, exist in psychiatric, social work or penal institutions, in community schemes, in projects for the homeless, drug and alcohol field, educational and industrial settings. The Journal aims to build upon this creative legacy by stimulating a continual critical re-thinking of the possibilities for developing therapeutic and relational potential, in whatever communities readers work and live within. It aims to provide a forum in which those engaged in developing, managing and sustaining therapeutic cultures can communicate their experiences, the effects of political and social policy on their own settings; their ideas developments and findings; disseminate good practice and explore what happens when things go wrong.

The Journal publishes academic papers, case studies, empirical research and opinion. The Journal is interested in publishing papers that critically creatively engage with ideas drawn from a range of discourses: the therapeutic community movement and other related professional practice, psychoanalysis, art, literature, poetry, music, architecture, culture, education, philosophy, religion and environmental studies. It will be of value to those who work in health services, social services, voluntary and charitable organisations, and for all professionals involved with staff teams in therapeutic and supportive organisations.

General Guidelines

Original contributions that fall within the scope of the journal are welcomed, including articles on current issues, practice and research (academic papers), case studies of particular communities or organisations, and personal contributions arising from the experience of the author. The Editorial group uses different criteria to assess contributions in these categories, and the following guidelines are provided. It will assist us in assessing papers if authors indicate which guidelines they have followed.

Final articles for publication should be typed in double spacing and submitted as an email attachment where possible, to the Editor’s Assistant (c.thoday@uea.ac.uk). Articles should be anonymised, with author contact details (name(s), e-mail and mailing address(es)) provided on a separate sheet. All articles are submitted for blind review by assessors drawn from the Editorial Board of the journal, and the International Advisory Panel. Authors will be acknowledged when sending in papers for review upon receipt. Note: For authors submitting an article where English is a second language, it is recommended that the article be proof read by a fluent interpreter prior to sending, in order that intended meanings can be checked in the translated article.

Academic Papers

These can include reports of original research, papers developing original links between theory and practice, review articles and critiques of current practice. The normal conventions of academic papers should be observed, with a brief abstract (up to 150 words), followed by a review of the relevant literature, statement of the problem, method, findings, discussion and conclusion. References should follow the style of the journal. Academic papers should normally not exceed 5000 words excluding references.

Case Studies from Practitioners

These describe examples of practice, innovation, action research or evaluation in the practitioner’s own unit. They should include: a brief description of the setting, of the piece of work undertaken and the reasons for doing it; a clear account of the process and findings with relevant data in easy to read tables or graphics; a brief conclusion with discussion of the findings and their implications for practice within the unit and perhaps more widely. A small number of relevant references may be included, following the style of the journal, but no literature review is needed. Case studies should normally not exceed 2500 words.

Commentary/Response

The journal would welcome short papers (up to 2000 words), which address topical issues. These issues may arise from recent themes or views addressed within the papers in the journal, from within therapeutic communities, they may emanate from strategic developments within the Association of Therapeutic Communities (for example the issue of accreditation of communities and training), or be generated by national and international policy initiatives that have an effect on therapeutic practice, the way in which it is thought about or conducted. We are seeking relevant commentaries which are reflective and thoughtful, yet critical and perhaps at times controversial; views and opinions which will stimulate debate, provoke thoughtfulness and hopefully new ideas, with which to approach contemporary issues.

Letters

We would welcome short letters (up to 200 words) from readers picking up on issues raised within the Commentary/response section, that develop and debate issues further.

Personal Contributions

Readers are invited to send in personal accounts of some aspect of their work that may be of interest to others. The intention of such contributions is to share experience and problems, raise questions and encourage discussion. These may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as novices are welcomed. The account should begin with a brief description of the setting, participants and background, followed by details of the particular event or situation and, if appropriate, the responses of the writer and others involved. No literature review, theoretical exposition or references are needed. Confidentiality should be maintained by disguising the identities of individuals or organisations, and authors may request that contributions are published without attribution. Personal contributions should normally be limited to 1500 words. With the author’s permission comments may be sought from practitioners with relevant experience to appear alongside personal contributions.
Self Reflection

Gaining access
The first step in conducting my research was to get access to the prison-based therapeutic community. Communication with the prison’s therapeutic community (or rather its administration) left me frustrated, as I felt unable to have any impact on proceedings. When administration staff made a mistake handling my security check (and thus delaying it) I experienced the bureaucracy of the institution – even before I set foot into the setting. This experience left me powerless and frustrated and wondering how staff working within the institution coped with such instances and what its impact on therapeutic practice would be.

Experiencing the prison-based therapeutic community
When I eventually gained access I felt relieved and happy to be able to do what I had set out to do. The mainstream prison atmosphere was exactly what I had experienced before and therefore expected. I am not sure what I expected from the therapeutic community, but even walking towards it made me feel differently. The therapeutic community was located in a separate section of the prison. The housing looked rather like a school with “funny windows” than a prison. Outside the buildings was a decorative fountain. This was very different to the usual cold, harsh and purpose-built physical prison setting and it gave me an immediate sense of an environment that aimed to be therapeutic. However, as I was not a key-holder with the institution I depended on someone else to move around the building at all times. This complete dependence on someone to open and lock doors left me feeling like a child. I couldn’t go anywhere and had to ask even to be accompanied to the toilet. At one point during the data collection I had to wait for my next interviewee (and since there was no designated space for me to sit around) I had to be locked into one of the offices. I had nothing to do, nothing to eat (it was lunchtime and I felt hungry) and I couldn’t just go and get whatever I wanted. I had over an hour locked in this office
alone and I could not imagine how boring prison-life must be as all I could think of was the time someone would come to pick me up.

The therapeutic community itself, although subject to similar security with locks, gates and uniforms, gave me a sense of freedom within the walls of the physical setting. I had the chance to walk around, talk to some inmates and get a feel for the setting. Some inmates had requested paint so that they could paint their therapy room. They had developed a need to personalise their environment. They cared about the colour they lived and breathed in and they had the chance to do something about that. So, although they were imprisoned and deprived of many rights, there was a sense of freedom, motivation and care about matters. One inmate took great pride, and justifiably so, in showing very creative paintings he had painted on the prison walls that expressed the way he felt about things. So, even before I collected my data, my impressions about the 'institution' and the therapeutic community were strong.

Collecting data
I felt enthused by the experience of collecting data. Staff appeared extremely committed and were very helpful and interested in my research. However, I experienced the interviews with staff much more a something I had to do in order to interview the inmates. This was confounded by the fact that staff did express textbook material (which I had studied in my literature review and in preparation for this research project) and I felt there was little new or unexpected information. Conducting the focus group was an amazing experience though. I felt privileged to learn about each individual's transitions and experiences and I was amazed how open and clear their feelings were expressed and the depth of processes were described. I couldn't help but compare what and how they were sharing their inner world with my clinical practice, where I see individuals on a one-to-one basis for an hour per week. The depth of insight the inmates had about their feelings and actions was remarkable. I understood that such a level of reflective being takes time and is
hard work for the individual and everyone else involved. I was particularly touched by inmates' accounts of having had no feelings (especially when they committed their crime) and having developed into a being that feels. As I practitioner (and as a human being) I am aware how painful and scary it can be for individuals to allow themselves to feel, and I could only begin to imagine how difficult it must be to feel the pain, guilt and shame that has been created through committing crime. I was reminded of why I wanted to become a therapist and felt confirmed in my beliefs and values.

Transcription and the analytic process
Transcribing the data was extremely difficult and disenchanting, because I not only underestimated the impact of participants' dialects on tape, but also that English is not my mother tongue. Thus, it was difficult to start analysing while transcribing and consequently the analytic process could not begin before all interviews were transcribed. Also, I was not sure about how to organise the analysis as I had collected different kinds of data. My aim was to get an understanding of the different experiences of the therapy director, the therapy manager and the offenders; however, I felt very strongly that this must be done in accordance with the TC ideology. Consequently, I decided not look for emerging themes within each distinct group of participants, but analysed all the data in the same fashion and looked for emerging themes and sub-themes across all residents, consisting of staff and inmates. This not only reflected TC ideology, in which staff and inmates are seen as residents alike, but also fulfilled my desire to avoid splitting data and creating another parallel process.

Deciding what to write up from the given data was also frustrating, as I felt constrained by the word limit. The data I obtained were extremely rich and often I felt 'lost' in the depth of the data. I felt that I was diminishing the participant's experience by cutting it short and picking certain concepts and possibly disregarding others. I was very careful not to hijack participants' experiences through far-reaching
interpretations, as I feared diminishing the individual’s experience and overriding it with my experience of their experience. I would be very interested to learn how the themes and sub-themes resonate with the participants.

Final thought
The experience of collecting data in the therapeutic community was an enriching experience. The process of transcribing, analysing and writing-up the research report was difficult at times, but left me feeling that a therapeutic environment can exist within the punitive prison system.
Exploring differences in residents’ experiences of leaving a prison-based therapeutic community: a secondary analysis.

ABSTRACT: This study aimed to explore and further the understanding of residents’ experiences of leaving a prison-based therapeutic community. The experiences of two types of ‘leavers’ were investigated: those who were de-selected from the therapeutic community and those who chose to leave the community through the 48-hour procedure. Qualitative data that had been collected as part of a service evaluation for the therapeutic community management was obtained and subjected to secondary analysis. Thematic content analysis of 60 questionnaires was used to identify 39 variables relating to why residents left the therapeutic community, how they experienced being part of the therapeutic community, how they experienced the adjustment back to mainstream prison and whether they had gained anything from being in the therapeutic community. The variables were analysed using Smallest Space Analysis (SSA). The SSA was partitioned into four conceptually similar regions, which were labelled therapeutic change, gains, negative experiences and resistance. The differences between the two types of therapy leavers were explored using univariate methods (Kruskal-Wallis) and multivariate methods (Multidimensional Scalogram Analysis). MSA regions not only corresponded with the conceptual regions of the SSA, but also revealed distinct profiles of leavers. De-selected residents showed more covert resistance whereas residents who asked to leave showed more overt resistance, but also reported more therapeutic gains.

Introduction

The primary task of therapeutic communities (TCs) has been described as ‘to heal and/or correct by offering membership of an optimised social environment’ (Roberts, 1997; p. 8). Prison-based therapeutic communities also target residents’ criminogenic needs and they have been shown to be effective in reducing re-offending (Rawlings, 1999; Shine & Morris, 2000), although they can have high rates of premature
departure. Prison-based therapeutic communities-as well as mainstream prisons-have a duty to work towards the reduction of re-offending, and therefore are dependent on outcome research. This study aims to explore residents’ experiences of prematurely leaving the TC.

Generally, therapy dropout is seen as problematic not only for the service in terms of time and cost, but also for the individual. There is an assumption that dropouts are ‘treatment failures’. However, whereas ‘treatment failures’ usually concern the service provider and the service user only, dropout from groups or therapeutic communities might have implications for others within that context. High dropout rates are likely to have some impact on the therapeutic milieu and can be unsettling for the dynamics within a TC (Campling, 1992). So, investigating and understanding therapy dropout is also crucial so as to avoid loss of resources and maintain a safe therapeutic milieu for residents.

Researching therapy dropout is difficult for a number of reasons. Difficulties can stem from problems in tracking down participants who left services prematurely and/or individuals’ unwillingness to participate due to negative feelings towards the service, such as disillusionment or even anger. Research might also be difficult due to flawed and inconsistent data, for instance caused by the use of different definitions of what constitutes a ‘dropout’ (Condelli & Dunteman, 1993; Roback & Smith, 1987). Premature therapy dropout can be difficult to define. Dropout in the very early sessions, for example immediately after assessment, differs from individuals who drop out of long-term treatment after a few months (Roth & Fonagy, 1996). In either case dropout is also complex because of the variety of reasons for which it may occur, ranging from factors within the individual and the service to external circumstances. So, dropouts are not a homogeneous group.

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1 The TC investigated in this research reported that 55.7% of residents leave prematurely.
Research investigating therapy community dropouts is comparatively scarce. Much of it is quantitative and therapeutic outcome is measured in terms of symptom reduction, cost effectiveness and service usage. Research seems to focus on investigating the predictors of dropout in order to be able to direct services to those who can make best use of them. Quantitative research is used to analyse individual predictors, therapist predictors and interactive factors (Roth & Fonagy, 1996). However, dropout from therapeutic communities has received little attention and qualitative research may offer an alternative approach to shed light on the process of dropout from therapeutic communities.

Chiesa et al. (2000) suggested that there is a need for qualitative explorations of the predictors of dropouts. This is not only in line with the principles of the therapeutic community, but also follows Department of Health recommendations to improve service delivery quality and to include service users’ views in audit and research (Appleby, 2000; DoH, 1998). Further, it has been pointed out that quantitative research generally examines single variables; however, therapeutic community leavers are not a homogeneous group and it seems that qualitative multivariate analysis could be helpful in investigating a variety of variables associated with leaving the TC.

Generally, therapy dropout is associated with resistance, particularly early on in treatment (Miller & Rollnick, 2002). Resistance or ‘those aspects of clients’ functioning that seek to maintain the status quo in their psychological lives’ (Newman, 2002; p.166) have often been regarded as an obstacle to treatment and therapeutic change. Newman (2002) lists several examples of resistance, such as strong reactions to the therapist, failure to adhere to the treatment program and other avoidance behaviours. However, today resistance is seen as part of the therapeutic process. Resistance to change is not construed as the client’s problem any longer, but is understood in a relational context, in which the client’s resistant behaviour is a ‘signal of dissonance in the relationship’ (Miller & Rollnick, 2002; p. 45). Resistance
in a group or community setting appears to be even more complex and this is further complicated by the specificity of the prison context. Prison culture leads inmates to adopt attitudes that promote pride about the crimes committed. This 'self-same culture' (Doctor, 2001; p. 57) can lead to an unwillingness and inability to express feelings or insight so as to maintain the necessary respect to survive in the prison culture. Thus, it is not surprising that therapeutic community residents are ambivalent or show resistance towards change and it can be assumed that resistance is associated with dropout.

Within this research study 'dropout' and 'therapy leaver' are used interchangeably. 'Therapy leaver' refers to individuals who were members of the therapeutic community and who left the therapeutic community before completing the programme, who were (1) either de-selected from the therapeutic community for breaking TC rules or failing to make an effort or (2) asked to leave early (within the 48-hour procedure\textsuperscript{2}) for personal reasons. In both instances leavers are transferred back to mainstream prisons.

This study uses data collected by other researchers for the purpose of a TC service user evaluation\textsuperscript{3}. Secondary analysis refers to 'the re-analysing of original data from a research study using different statistical techniques, perhaps to examine alternative questions or explanations' (Wood, 2000; p. 417). The advantage of secondary analysis in this case was that it permitted the investigation of an otherwise inaccessible population\textsuperscript{4}.

\textsuperscript{2} The 48-hour procedure describes instances where a resident chooses to leave the TC; the resident has 48 hours to think about and consider his decision before it is seen as final.

\textsuperscript{3} The original research was designed by the TC Team of the University of Surrey, led by J. Brown and K. Fritzon, in liaison with the TC management; the data were collected by S. Miller.

\textsuperscript{4} For an account of the researcher's original research attempts see Appendix H.
Research aims
This exploratory research aims to generate hypotheses about TC leavers. More specifically, the study attempts to distinguish between two types of therapy leavers, those who were de-selected and those who asked to leave, in terms of their experiences of being in and leaving the TC. It is hoped that an understanding of residents’ experiences of leaving the TC prematurely furthers the development of theory about psychological processes associated with leaving. Such an understanding could be used to understand and monitor residents’ experiences and lead to interventions that allow residents to deal with difficulties in adhering to the program.

Method
Participants
The data for this study came from a sample of 60 male inmates. Participants were selected on the basis of their previous membership of a prison-based therapeutic community in the English Midlands. Participants left the therapeutic community because (1) they were de-selected, (2) they requested to leave early (through the 48-hour procedure) or (3) graduated from the therapeutic community. The mean time spent in the therapeutic community was 9 months (SD 1.1) ranging from 1-2 months to over 18 months. Sentences ranged from 4 years to life with a mean length of 9 years (excluding 16 lifers) (SD 3.6). The age of the participants ranged from 22 to 56 years of age, with a mean age of 34 years of age (SD 8.5).

Procedure
This study used existing data collected for the purpose of investigating TC leavers’ experiences of the therapeutic community. As the researcher was the secondary analyst, it was important to assure participants’ consent and continued anonymity (for details see Appendix A). The questionnaire was designed for and in liaison with the manager of the therapeutic community; however, its aim was more in line with a brief service evaluation rather than the construction of a psychometric tool. The
questionnaire consisted of four open-ended questions and 18 dichotomous questions; it therefore had qualitative as well as quantitative aspects (see Appendix B for a copy of the questionnaire). The data were collected over the period of 2 years, from November 2001 to October 2003. Residents, who had been members of the TC and had left, were contacted in writing by the TC manager (see Appendix B for a copy of the letter). 100 questionnaires were sent out; the response rate was 60%.

This study concentrated on analysing the qualitative data. The four qualitative questions asked the participants to write about their reasons for leaving the TC, their experience of being in the TC and their transitions to a mainstream prison. Preliminary analysis of the demographic data showed that only one participant had graduated from the TC and two further participants failed to fill in the qualitative questionnaire. These cases were not used in the analysis, leaving a usable sample of 57 questionnaires.

Analysis
The written responses were analysed using thematic content analysis (Pauli & Bray, 1998; Smith, 1995). The first step in the analysis was the researcher’s immersion in the data. By reading and re-reading each response, the researcher started to detect themes. Themes are ‘units of meanings’ (Cowie et al., 1998) grounded in the data. Themes were noted down and clustered together on the basis of overlaps in content and meaning. Each cluster of themes received a label that described its content. A list of themes with individual labels for each cluster emerged, which also reflected the questionnaire. During this process the researcher stayed very close to the data and used participants’ words and language in order to avoid over-interpretation of participants’ responses, as the questionnaire responses were relatively short and it was often difficult to obtain a general sense of the inmate and his world. This inductive classification of the open-ended material led to the creation of 39 themes that were then used as variables in the analysis. Four groups of variables relate to leaving the TC, the experience of having been to the TC, adjustment to mainstream
prison and gains/lack of gains of having been to the TC (see Appendix C for a complete list of variables).

Total agreement on every variable was achieved based on another researcher rating four questionnaires; inter-rater reliability was 100%. A database was created by entering the presence or absence of every variable for each participant into SPSS (2001); 1 = present, 0 = absent. The analysis is based on investigating differences between those who were de-selected (N = 29) and those who requested to leave early (N = 28).

The database was used to conduct three types of analysis; Smallest Space Analysis (SSA) was used to explore relationships between the variables. This was followed by a nonparametric analysis of variance (Kruskal-Wallis Test) to explore whether the variables themselves could be used to differentiate between the two groups of leavers.

Finally, a Multidimensional Scalogram Analysis (MSA) (Lingoes, 1968), a more detailed analysis of variables that allowed exploration of similarities and dissimilarities of individual cases was performed. From here on each type of analysis will be discussed separately.

Analysis

Conceptualising leavers' experiences of therapeutic process and outcome
Smallest Space Analysis (SSA) computes association coefficients between variables and converts these into linear distances. The variables are then projected into a geometric space, showing distances between the variables. The three dimensional SSA of the variables relating to the TC and leaving the TC had a Guttman-Lingoes coefficient of alienation of 0.17 on 37 iterations. The coefficient of alienation (stress level) ranges from 0 (indicating perfect fit) to 1, the smaller the coefficient the better
(Brown & Barnett, 2000). A coefficient of less than .20 is considered an acceptable degree of fit (Donald, 1995). Figure 1 shows the projection of the first two vectors of the three-dimensional space. Each of the 39 variables relates to one of the four clusters generated from the content analysis: leaving the TC, the experience of having been to the TC, adjustment to mainstream prison and gains/lack of gains of having.

![Diagram](image)

Figure 1: SSA of experiences of leaving the TC, having been in the TC, having gained/not gained something and adjusting back to mainstream prison

For a table with variable labels and descriptions see Table 1.

According to the principle of continuity (Lingoes, 1979; p. 38), the closer the variables are together, the more likely it is that the variables co-occurred in
participants. For example, as can be seen in Figure 1, the proximity of 'dealtdiffiss' (having dealt with difficult issues) and 'incraware' (increased awareness of self and others) suggests that the increase of awareness in self and others is likely to involve dealing with difficult issues. By contrast, it is unlikely that the feeling of being 'overanalysed' co-occurs with increased awareness, because of the distance between the variables in the SSA space.

Table 1: SSA variable labels and descriptions

<table>
<thead>
<tr>
<th>VARIABLE LABEL</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>REASONS FOR LEAVING THE TC</td>
<td></td>
</tr>
<tr>
<td>'breakrule'</td>
<td>not adhering to TC rules, e.g. misuse of drugs or violence</td>
</tr>
<tr>
<td>'failprobs'</td>
<td>failure to deal with problems</td>
</tr>
<tr>
<td>'timing'</td>
<td>Timing ('it's the wrong time for me')</td>
</tr>
<tr>
<td>'failureadjust'</td>
<td>failure to adjust to environment/system, e.g. not fitting in, not liking groups, prison politics, lack of work</td>
</tr>
<tr>
<td>'misunderstood'</td>
<td>felt misunderstood &amp; not listened to</td>
</tr>
<tr>
<td>'staffissues'</td>
<td>staff issues e.g. incompetence, lack of control, staff shortage</td>
</tr>
<tr>
<td>'notacceptothers'</td>
<td>non-acceptance of others ('they just want an easy life' or other's drug misuse)</td>
</tr>
<tr>
<td>'pressure'</td>
<td>others' pressure, e.g. grassing, backstabbing, non-acceptance</td>
</tr>
<tr>
<td>'personalreas'</td>
<td>personal reasons, e.g. parole issues, repatriation, court appearances</td>
</tr>
<tr>
<td>EXPERIENCES OF THIS TC</td>
<td></td>
</tr>
<tr>
<td>'positiveexp'</td>
<td>positive experience, e.g. rewarding, learning experience</td>
</tr>
<tr>
<td>'openwounds'</td>
<td>opened up old wounds</td>
</tr>
<tr>
<td>'challengex'</td>
<td>challenging, hard work, most difficult experience ever</td>
</tr>
<tr>
<td>'gainsomething'</td>
<td>gained something, e.g. 'I'm a better person now' or 'I have an idea of what I need to work on'</td>
</tr>
<tr>
<td>'dealtdiffiss'</td>
<td>having dealt with difficult issues</td>
</tr>
<tr>
<td>'overanalysed'</td>
<td>Felt overanalysed</td>
</tr>
<tr>
<td>'uncomfexp'</td>
<td>strange &amp; uncomfortable experience</td>
</tr>
<tr>
<td>'lackhelp'</td>
<td>no help experienced (dealing with difficult stuff)</td>
</tr>
<tr>
<td>'negexper'</td>
<td>negative experience, e.g. 'disgraceful', 'haunting', 'unproductive'</td>
</tr>
<tr>
<td>'frustrate'</td>
<td>Frustrating experience</td>
</tr>
<tr>
<td>'nochance'</td>
<td>not given a chance &amp; non-acceptance</td>
</tr>
<tr>
<td>ADJUSTMENT TO MAINSTREAM PRISON</td>
<td></td>
</tr>
<tr>
<td>'noimpact'</td>
<td>no impact</td>
</tr>
<tr>
<td>'fittingdiff'</td>
<td>difficulty fitting back in &amp; being different</td>
</tr>
<tr>
<td>'feelvul'</td>
<td>feeling vulnerable (after having been stripped down)</td>
</tr>
<tr>
<td>'incredifences'</td>
<td>increased defences, e.g. 'guards', 'shields up'</td>
</tr>
<tr>
<td>'easierprison'</td>
<td>easier, e.g. 'to bottle things up', 'less stressful to cope'</td>
</tr>
<tr>
<td>'envharsh'</td>
<td>environment seems harsher, e.g. 'officers are strict &amp; unhelpful'</td>
</tr>
<tr>
<td>'nohelp'</td>
<td>lack of help &amp; difficulty to talk to others</td>
</tr>
<tr>
<td>GAINS/LACK OF GAINS OF HAVING BEEN TO TC</td>
<td></td>
</tr>
<tr>
<td>'regrets'</td>
<td>Regrets</td>
</tr>
<tr>
<td>'impcomm'</td>
<td>improved communication skills</td>
</tr>
<tr>
<td>'imprbehav'</td>
<td>improved behaviour, e.g. 'I'm a better person now', 'no nickings'</td>
</tr>
<tr>
<td>'candealdiff'</td>
<td>able to deal with difficulties &amp; solve problems, e.g. confrontations, frustrations, asking for help</td>
</tr>
<tr>
<td>'avoidviol'</td>
<td>able to avoid violence</td>
</tr>
<tr>
<td>'nogains'</td>
<td>no gains</td>
</tr>
<tr>
<td>'controlemotion'</td>
<td>ability to control emotions</td>
</tr>
<tr>
<td>'inc+feel'</td>
<td>increase in positive feelings, e.g. confidence, like oneself</td>
</tr>
<tr>
<td>'incraware'</td>
<td>increased awareness &amp; reflection of self and others &amp; utilising defences</td>
</tr>
<tr>
<td>'tolerant'</td>
<td>greater tolerance</td>
</tr>
<tr>
<td>'drugfree'</td>
<td>remain drug free</td>
</tr>
<tr>
<td>'determined'</td>
<td>being more determined, e.g. follow things through, being self-disciplined</td>
</tr>
</tbody>
</table>

**Themes**

As the distances between the points reflect their likelihood of co-occurring, a regional split is a strong indication that the points within a spatial region are strongly interrelated and related to similar processes. The SSA in Figure 2 shows how the variables can be distinguished in accordance with particular experiences or psychological processes; the variables in the SSA are partitioned into 4 regions. These are labelled, in order to describe the variables plotted within them. Regions in Figure 2 were labelled as 'therapeutic change', 'gains', 'negative experiences' and 'resistance'. Table 1 shows variables positioned in each cluster.
Figure 2: SSA with partitioned regions

Table 2: Variables in each region

<table>
<thead>
<tr>
<th>Therapeutic change</th>
<th>Gains</th>
<th>Negative experiences</th>
<th>Resistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to deal with difficulties</td>
<td>Greater tolerance</td>
<td>Overanalysed</td>
<td>Mainstream prison is easier</td>
</tr>
<tr>
<td>Improved behaviour</td>
<td>Being more determined</td>
<td>No gains</td>
<td>Regrets</td>
</tr>
<tr>
<td>Increase in positive feelings</td>
<td>Ability to control emotion</td>
<td>Uncomfortable experience</td>
<td>Failure to deal with problems</td>
</tr>
<tr>
<td>Increase in awareness of self and others</td>
<td>Able to avoid violence</td>
<td>Negative experience</td>
<td>Increased defences</td>
</tr>
<tr>
<td>Gained something</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Challenging experience</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling vulnerable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of help adjusting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

229
<table>
<thead>
<tr>
<th>Difficulty fitting back in</th>
<th>(backstabbing, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environment seems harsher</td>
<td>Not given a chance &amp; non acceptance</td>
</tr>
<tr>
<td></td>
<td>Felt misunderstood</td>
</tr>
<tr>
<td></td>
<td>Opened up old wounds</td>
</tr>
</tbody>
</table>

**Therapeutic change**

This sub-group of variables can be found in the top left hand side of Figure 2. It is characterised by having a centre, which shows close proximity of variables, that describe different aspects of therapeutic change: increased awareness self and others, improved behaviour, increase in positive feelings (e.g. confidence) and having gained something. These core variables are surrounded by peripheral variables relating to therapeutic change, such as being able to deal with difficulties and solve problems (e.g. confrontations). Alongside variables relating to therapeutic change, there are variables that seem to be an intrinsic part of therapeutic change. For instance, having dealt with difficult issues and experiencing the TC as challenging and hard work seem to be part of processes relating to therapeutic change, demonstrated by the close proximity of these variables, whereas variables such as feeling vulnerable on return to the mainstream prison, experiencing the mainstream prison regime as harsher, experiencing a lack of help in adjusting and difficulty fitting back in seem to be the result of having experienced therapeutic change. Hence, therapeutic change gained in the TC seems to have led to difficulties in adjusting back to the mainstream prison, so increased awareness may lead to feelings of being vulnerable or difficulties in fitting back in. The core and peripheral variables relating to therapeutic changes and variables relating to consequences all appear in close proximity to each other and therefore reflect interdependence.

This region of therapeutic changes is relatively central in the plot, which suggests that these variables have been mentioned most frequently. This is surprising in that the data were obtained from individuals who left the TC prematurely, often quite early on. This finding challenges the implicit assumption that those who do not finish
the program are treatment failures, and that only those who graduate from the treatment program will have to come to make significant changes in their lives. It also suggests that it is relatively easy to create change. However, it is not known whether participants were able to maintain changes. The distinction between change and maintaining change has been conceptualised by Prochaska and DiClemente (1983) in their transtheoretical model of change. The model describes four stages of readiness with the maintenance stage as the final stage. Sustaining change is seen as a dynamic process that is often very difficult (Miller & Rollnick, 2002).

The aims for therapeutic change may be different with each client and with each therapeutic approach; however, there seems to be consensus that the main aim of therapy is to create change - that is, any form of change. It is good practice for the therapist and the client to explore and agree on therapeutic goals (Leiper & Kent, 2001). Unfortunately we do not know the inmates’ expectations of the outcome of having been to the TC, but we may assume that they vary to a great extent, possibly the only common expectation being some form of change. So, for the purpose of this study, it is sufficient to state that inmates did experience changes that may be described as being therapeutic in a general sense.

**Gains**

As can be seen in Figure 2, the gains cluster relates to four variables. These variables are located on the bottom left side of the SSA output and thus are plotted on the same side as ‘therapeutic change’; however, they not only seem to create their own region, but they are also a little further out of the centre. These variables relate to inmates’ experiences of gains of having been to the TC: greater tolerance, ability to control emotions, ability to avoid violence and being more determined and self-disciplined.

So, how do these gains differ from those in the region of therapeutic change? It has to be noted that these variables are plotted further out and that they have greater distances and therefore less inter-correlation between them, as compared to the
‘therapeutic changes’ in the previous region. There were fewer co-occurrences of these variables within individuals. The ability to control emotions seems to be associated with greater tolerance as well as the ability to avoid violence. It seems possible that these gains are not only more difficult to achieve, hence the lower frequency, but also that they are more related to reducing re-offending. The ‘therapeutic changes’ plotted in the first region could relate to many presenting problems, as they are much more general, whereas the gains in this region relate to changing criminal behaviour and thus are criminogenic. This mirrors the therapeutic community approach, in which both general psychological difficulties and criminogenic needs are explored; however, initial treatment sets out to explore general psychological difficulties and only thereafter the treatment focus shifts towards exploring residents’ criminogenic needs (Shine & Morris, 2000).

One of the main aims of imprisonment today is the rehabilitation of offenders and therapeutic interventions are used to enable the individual to live outside the prison as a law-abiding citizen (European Committee on Crime Problems, 1986). In order to achieve this, it is necessary to modify offenders’ behaviours and attitudes ‘so that their internal and external conflicts are resolved in constructive rather than antisocial ways’ (Mathias & Sindberg, 1985; p. 265). Although the therapeutic changes in the previous region are crucial in the context of rehabilitation, it seems that it is the avoidance of violence, the ability to control emotions and being more tolerant are necessary to increase constructive behaviour and become law-abiding. Therefore, the variables in this region seem to relate to the specific aims of reducing criminal behaviour and hence are specific to the prison population.

The fact that those variables relating to criminogenic aspects are not co-occurring to a high degree, which is revealed by the distances around each variable, suggests that single participants reported single changes. In order not to re-offend, though, all those gains seem necessary, as just a single one is not enough to change criminogenic behaviour. Thus, although there has been change, the lack of
interdependence between those variables indicates that the change is not sufficient to reduce re-offending.

Negative experiences

The region of negative experiences lies in the lower two/thirds of the right side of the SSA. The following variables relating to negative experiences of being in the TC can be found in this region: feeling overanalysed, not having gained anything, uncomfortable experience, negative experience, staff issues (incompetence, lack of control), frustrating experience, no help experienced (in dealing with difficult issues), others’ pressure (‘grassing’, ‘backstabbing’), not given a chance and not feeling accepted, feeling misunderstood and old wounds being opened up.

The plot shows a close proximity between staff issues and having had a negative, frustrating experience and not having experienced any help. This finding can be interpreted in a number of ways. On one level, it could be seen as a reflection of staff difficulties on an institutional level, for example, that staff are not trained appropriately or are lacking in numbers. On another level, it is also possible that the offenders have assumptions about therapy and the therapeutic milieu that do not fit the therapeutic community. Therapeutic community staff aim to work ‘alongside’ the TC member (Barnes et al., 1997; Griffiths & Hinshelwood, 1997), so care is not provided in the traditional sense, but rather in helping the individual to become a carer for himself.

However, this finding can also be interpreted as transference to the institution. Hinshelwood (2001) hypothesises that institutional aspects are significantly determined by the unconscious functioning of those within the institution. Such unconscious functioning could be offenders’ feelings and attitudes to the institution. Transference refers to the way in which feelings or attitudes derived from a previous relationship can be transferred to someone new (Bateman, Brown & Peddar, 1991). Transference to the institution, therefore, refers to previous attitudes and feelings
being transferred to the institution and/or the staff/residents in it. It can be assumed that the offenders' previous experiences, such as attachment to primary caregivers as well as experiences with mainstream prison and staff, are likely to have been negative and frustrating. So, experiences of the uncaring parent or the punitive prison officer could be transferred to the TC and lead to negative experiences such as viewing staff as incompetent or feeling misunderstood and not helped.

**Resistance**

The last region lies in the top right corner of the SSA and plots variables that relate to resistance. This region shows the following variables: mainstream prison is easier, failure to deal with problems, increased defences, no improvement, non acceptance of others, not adhering to the TC rules and having regrets.

The variables in this region suggest resistance at different levels; for instance not experiencing improvement or failing to deal with problems show concealed resistance. However, experiencing the mainstream prison as easier, as it is 'easier to bottle things up' does rather show an obvious resistance to the TC, because the TC concept and reality challenge such defences. Also, having regrets could imply that the individual did not allow himself to work through resistance, but maintained the psychological status quo. Similarly, the increase of defences (‘guards up’) on return to the mainstream prison also suggests the wish or need to maintain the status quo. Interestingly, variables in this region are in relatively close proximity to the region of ‘therapeutic change and its side-effects’, which indicated an interrelationship between therapeutic change and resistance.

Resistance seems to continue to be misunderstood, as it is often assumed that it is something ‘bad’ or an obstacle to therapeutic change (Leiper & Kent, 2001). However, resistances provide stability for our internal and external worlds (Mahoney, 1991) and are therefore an inevitable part of therapeutic change. It seems though, that whereas in other therapeutic relationships resistance can be ‘survived’,
resistance in the TC can be too much for the community, e.g. in terms of not adhering to the rules, or too intense for the inmate’s own resources, e.g. in terms of failing to deal with problems.

The SSA analysis was used to examine the interrelationships among variables common to both types of TC leavers (individuals who got de-selected and individuals who asked to leave) and allowed for the categorisation of those variables in four distinct regions. This allowed for further exploration of whether variables differ between the two types of leavers on a univariate level.

Differentiation between the two groups of leavers through nonparametric analysis of variance

A Kruskal-Wallis Test was performed. The analysis shows differences in ranked position of scores in different groups (for ranks and test statistics see Appendix D). Four variables showed significant differences in how often each group of leavers reported them. The first variable 'not adhering to TC rules' showed a significant difference ($\chi^2 (1) = 4.043; p<0.05$) and the ranking shows that those residents who were de-selected reported 'not adhering to TC rules' more often. The second variable 'felt misunderstood & not listened to' showed a significant difference ($\chi^2 (1) = 6.361; p < 0.05$) and ranking shows that de-selected residents reported this variable more often than those who asked to leave. The variable 'challenging & hard work' showed a significant difference between the leavers ($\chi^2 (1) = 4.001; p < 0.05$) and ranking reveals that residents who asked to leave within 48-hours reported this variable more often. The fourth variable that showed a significant difference was 'no gains' ($\chi^2 (1) = 5.828; p < 0.05$) and ranking shows that de-selected individuals reported 'no gains' more often.
Table 3: Percentages of variables reported for each group of leavers

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>DE-SELECTED (N=29)</th>
<th>48-HOURS (N=28)</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Not adhered to TC rules</em></td>
<td>27.6%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Failure to deal w problems</td>
<td>20.7%</td>
<td>42.9%</td>
</tr>
<tr>
<td>Timing</td>
<td>17.2%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Failure to deal w environm.</td>
<td>37.9%</td>
<td>50%</td>
</tr>
<tr>
<td><em>Felt misunderstood</em></td>
<td>20.7%</td>
<td>0%</td>
</tr>
<tr>
<td>Staff issues</td>
<td>34.5%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Non-acceptance of others</td>
<td>17.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Others’ pressure</td>
<td>3.4%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Positive experience</td>
<td>58.6%</td>
<td>71.4%</td>
</tr>
<tr>
<td>Opened up old wounds</td>
<td>6.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td><em>Challenging</em></td>
<td>10.3%</td>
<td>32.1%</td>
</tr>
<tr>
<td>Gained something</td>
<td>48.3%</td>
<td>67.9%</td>
</tr>
<tr>
<td>Having dealt w diff. Issues</td>
<td>17.2%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Overanalysed</td>
<td>6.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Uncomfortable experience</td>
<td>17.2%</td>
<td>14.3%</td>
</tr>
<tr>
<td>No help</td>
<td>27.6%</td>
<td>21.4%</td>
</tr>
<tr>
<td>Negative experience</td>
<td>34.5%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Frustrating</td>
<td>13.8%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Not given a chance</td>
<td>17.2%</td>
<td>7.1%</td>
</tr>
<tr>
<td>No impact</td>
<td>44.8%</td>
<td>25%</td>
</tr>
<tr>
<td>Lack of help</td>
<td>27.6%</td>
<td>25%</td>
</tr>
<tr>
<td>Difficulty fitting in prison</td>
<td>48.3%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Feeling vulnerable</td>
<td>27.6%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Increased defences</td>
<td>20.7%</td>
<td>25%</td>
</tr>
<tr>
<td>Easier in prison</td>
<td>3.4%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Harsher environment</td>
<td>24.1%</td>
<td>39.3%</td>
</tr>
<tr>
<td><em>No gains</em></td>
<td>48.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Regrets</td>
<td>6.9%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Improved communication</td>
<td>20.7%</td>
<td>25%</td>
</tr>
<tr>
<td>Improved behaviour</td>
<td>37.9%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Able to deal w difficulties</td>
<td>24.1%</td>
<td>25%</td>
</tr>
<tr>
<td>Able to avoid violence</td>
<td>6.9%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Increased awareness</td>
<td>41.4%</td>
<td>53.6%</td>
</tr>
<tr>
<td>Ability to control emotions</td>
<td>13.8%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Increase in + feelings</td>
<td>34.5%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Greater tolerance</td>
<td>10.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td>Remain drug free</td>
<td>6.9%</td>
<td>0%</td>
</tr>
<tr>
<td>Being more determined</td>
<td>6.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Personal reasons</td>
<td>6.9%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

Variables in *italics* have shown to be statistically significant (Kruskal-Wallis).
Univariate analysis led to the identification of differences between the two types of leavers in four reported variables. However, both groups of leavers are not homogeneous and it seems that what distinguishes them from each other is likely to be more complex. The use of multivariate methods allowed for a more sophisticated understanding of factors involved in leaving the TC.

Multidimensional Scalogram Analysis (MSA) was used to compare individual profiles of variables. Multidimensional analysis can be used to explore the structure of the data, that is 'all the relationships in the data, between the items, between the variables, and between the variables and the items' (Wilson & Hammond, 2000; p. 284). The SSA plots variables and the MSA plots cases. In both techniques, the plots are used to understand the data by partitioning and interpreting regions. However, the purpose of the MSA was not only to explore the structure of the data, but also to investigate whether the MSA recreates the conceptual regions relating to the experiences of being in and leaving the TC (therapeutic change, gains, negative experiences and resistance) as seen in the SSA.

Classification of leavers using individual profiles
Multidimensional Scalogram Analysis (MSA) (Lingoes, 1968) was conducted to examine profiles of cases, based on a number of variables. The analysis examined the interrelationships among variables common to both types of TC leavers - inmates who were de-selected and those who asked to leave (48-hour procedure). MSA produces two types of plot; the item plots show individual variables that allow identification of why cases have similar and/or different profiles; the overall plot is a summary of the relationships between items in the analysis.

MSA was performed concerning nine variables that were chosen on the basis of their location within the matrix. These variables were on the outside of the plot, indicating lower frequency. Low frequency variables show differences between cases and so are useful to distinguish between cases. Of the variables chosen for this analysis, four
variables related to the TC experience: opened up old wounds, challenging experience, having dealt with difficult issues and having felt overanalysed. Four variables related to gains/lack of gains: having regrets, being able to avoid violence, staying drug-free and being more determined. One variable related to the adjustment to the mainstream prison: easier (to bottle things up in mainstream prison).

**Individual item plots**

Each variable under investigation was plotted, and the space was partitioned into regions using the principles of selectivity and sensitivity (Brown & Barnett, 2000). Each item plot shows the regions that correspond to the categories for each variable. All plots are partitioned into whether the variable is present or absent.

**Opened up old wounds**

![MSA item plot for the variable 'opened up old wounds'](image)

Figure 3: MSA item plot for the variable ‘opened up old wounds’

The variable ‘opened up old wounds’ showed that individuals who were de-selected fall into the partitioned region in which individuals reported this variable more frequently, while individuals who chose to leave within 48 hours were less likely to
report this variable. However ‘opening up old wounds’ seems to be something painful that would lead individuals to choose to leave. Therefore this is a surprising finding in that the ‘opening of old wounds’ seems to be a process that is associated with experiencing difficulties in the community and hence leads to de-selection. This could mean that the mere process of ‘opening old wounds’ weakens the individual, that defences are broken down, which the individual is left to deal with. If the community is unable to contain this painful and difficult process the individual is likely to break down. This may result in some form of acting out such as breaking TC rules, or it leaves the individual unable to deal with the pressures of the therapeutic community. In both instances the individual is likely to be de-selected. ‘Breaking down’ as well as ‘acting out’ are part of the process of change. However, in either case, the individual must be contained in order to survive his experience. Interestingly it seems that it is the community’s choice to ‘reject’ individuals who cannot be contained and not that the individual chooses to leave the environment that cannot contain him. One de-selected resident reported:

‘Because I didn’t know how to handle the TC ... I was lead [sic] into a false sense of security and analysed to [sic] much for everything I did or said and when I opened up all my old wounds I was shipped out with no help to put myself back together...’

(resident 15)
The variable 'challenging experience' shows very clear partitioning with almost all individuals in the region having reported the TC to be a challenging experience. Over 70% of those who found it challenging left within 48 hours. It is not surprising that individuals who found the TC challenging and 'hard work' were more likely to leave on their own account, rather than be de-selected. Here, the power to leave stayed with the individual; it could be interpreted as resistance. The leaving individual is not willing or not able to deal with the TC experience. One 48-hour leaver wrote:

'It was a living hell for me. And felt so low and unhappy within myself. I lost myself and who I was. I seen the real me and could not handle that.'

(resident 11)
**Dealt with difficult issues**

![Figure 5: MSA item plot for the variable 'dealt with difficult issues']()

The variable 'having dealt with difficult issues' is partitioned into those who reported this variable in the top right half of the plot. Within the partitioning, nearly 65% of residents left within 48 hours. What is not clear though is whether they left because they dealt with difficult issues, which would suggest some form of resistance, or whether they left because they felt they had dealt with difficult issues and were therefore ready to leave. It is likely that those who leave within 48 hours and have dealt with difficult issues are not a homogenous group, as can be seen in the following comments:

'I opened up a door in my life that had been closed for a number of years I was sexually abused as a child and I couldn't sit in my small group and talk about the details and how I feel.'

(resident 39)

'I left because I didn't feel comfortable doing therapy with people who were two faced or who were blattenley [sic] into heroin. ... It was a hell of an experience ...
because I actually felt feelings and emotions which I forgot due to me hiding or running away by using intoxings [sic].’

(resident 54)

These comments show that, for some residents, the mere process of opening up and talking about difficult issues is too much whereas, for others, leaving can be the result of something that has to do with the community and not necessarily themselves. So, those who have dealt with difficult issues and have left within 48 hours can be described as either unable to deal with difficult issues or as unwilling to deal with difficult issues in this form/forum. However, residents who reported others to be the reason for leaving could still be seen as resistant, as it seems much easier to reject the system or others within the system than dealing with one’s own issues.

Felt overanalysed

Figure 6: MSA item plot of the variable ‘felt overanalysed’
The plot for the variable ‘felt overanalysed’ was partitioned in the bottom left hand corner. All individuals in this region felt overanalysed and all of them were deselected.

This variable is interesting in that it suggests that the system and the individuals within it did something to the resident, which could lead the resident to choose to leave. However, for these individuals to be de-selected suggests that there is an association between feeling overanalysed and being unable to cope, so resulting in de-selection. It is also possible that the de-selection is not directly associated with being unable to cope, but rather that individuals got de-selected and used ‘felt overanalysed’ as a means of making sense of their experience. In this way the de-selection is experienced less as a rejection and more as a logical step. This is supported by the questionnaires, in which the first question states: In your own words, why did you leave the TC? A de-selected resident wrote:

‘Because of the way in which the psychology department twisted the truth, and also because of the drug culture.’

(resident 59)

However, this resident was de-selected and it would be expected that he might comment on his rule breaking, but not about what he did not like. In order to protect himself the individual is not looking at his own behaviour (that led to his de-selection), but rather at everyone else’s.
Mainstream prison is easier

The region partitioned for this variable is located in the lower half of the right hand side of the plot and contains individuals who reported that the mainstream prison was easier ('as one can bottle things up'). 66% of those who reported this variable asked to leave within 48 hours. Again, this shows that being in the TC is challenging and that, for some individuals, the mainstream prison is an environment that is easier to deal with. This can be seen as resistance, as the TC environment challenges mechanisms such as 'bottling things up', or it could show some individuals' inability to adjust to an environment in which they not only have a voice but also are required to be part of the community. A resident who asked to leave wrote:

'Being back in a normal prison is a lot easier. You don't have to deal with what's in your head. Just bottle it all up. Because you no [sic] you can't get help even if you ask for it.'

(resident 11)
Having regrets

Figure 8: MSA item plot for the variable ‘having regrets’

The plot of this variable is also partitioned in the lower right hand side. In the partitioned region, 62.5% of those who had regrets asked to leave within 48 hours. This variable relates to whether the ex-resident has experienced any gains from having been to the TC and/or whether the individual regrets leaving. As one individual from this profile explains, it seems easy to put in the 48-hour notice. In particular the first days in the TC are likely to be unsettling, disorienting and challenging and settling into this new environment may be difficult:

‘I didn’t give myself the chance to settle down in the TC. I put my hours in and by the time it ran out it was too late. I was transferred back here and have regretted leaving the TC since.’

(resident 6)

Here, the regrets expressed by a leaver highlight that resistance is something that some individuals wish to overcome. Such comments suggest that, for some, there is a real need to be contained, in particular in the early days, and that the opt out option can lead to later disappointment.
Being able to avoid violence

Figure 9: MSA item plot of the variable ‘being able to avoid violence’

The plot of this variable was partitioned into those who reported avoidance of violence as a therapeutic gain and those who did not. The top left hand region contains only profiles of individuals who reported this variable with half of the individuals having been de-selected and the other half having asked to leave within 48-hours. So, although everyone in that region reported being able to avoid violence, there is no difference between the two types of leavers. This finding suggests that this variable is not associated with the reasons for leaving the TC, so it might rather describe an aspect of therapeutic change that is independent of reasons for leaving.
Figure 10: MSA item plot for the variable ‘remain drug-free’

Few individuals reported this variable and there is not a clear region to be partitioned in the plot, as they all share the same profile and therefore are plotted in the same space. All were de-selected. This is a surprising finding in that it is unexpected that those who were de-selected remain drug-free, as de-selection is often associated with the usage of drugs. However, residents can be de-selected for breaking other rules, such as violence or not making an effort (Rawlings, 1999). Therefore it is possible that, although de-selection has happened, the individual was able to make significant changes. It is possible that those who asked to leave the TC are more likely to leave earlier than those who were part of the TC and then were de-selected; thus it could be argued that it is not surprising that de-selected residents are more likely to remain drug free. This also challenges the assumption that only those who follow and finish the program are willing and able to achieve therapeutic change and suggests that either unknown factors are responsible for the change or that individuals make changes if they are ready to do so. An ex-resident stated that he was able to remain drug free as a result of having been to the TC:
‘I’ve been able to complete the RAPT course because of my experience.’

(resident 29)

**Being determined**

Figure 11: MSA item plot of the variable ‘being determined’

The variable ‘being more determined, self-disciplined and able to follow things though’ plotted individuals who reported this variable in the top right half of the item plot. 80% of those in this region asked to leave within 48-hours. This is not a surprising finding in itself; however, the causality is not clear. Individuals might have learned to be more determined and self-disciplined while in the TC or they might have had those characteristics already and therefore were more likely to ask to leave. To be able to decide to leave within the first 48-hours of being in a new environment requires the individual to be relatively determined. Alternatively it could be argued that, if someone was truly determined and able to follow things through, they would be less likely to withdraw from the program voluntarily and

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5 RAPT stands for Rehabilitation of Addicted Prisoners’ Trust.
more likely to stick to it. Ex-residents who asked to leave and were questioned about which aspects of being in ‘normal prison’ have been easier because of their previous TC membership said:

‘Honesty whether it brutal or not and self discipline.’

(resident 13)

‘It has made me more determined to succeed with my aims and not let prison politics stop me.’

(resident 30)

The following table summarises the number of leavers for each group for the nine variables used in the MSA.

Table 4: Number of leavers for each group for the MSA variables

<table>
<thead>
<tr>
<th>MSA Variables</th>
<th>De-selected</th>
<th>48 hour procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opened up wounds</td>
<td>N= 3</td>
<td>N= 2</td>
</tr>
<tr>
<td>Challenging experience</td>
<td>N= 5</td>
<td>N=18</td>
</tr>
<tr>
<td>Dealt with difficult issues</td>
<td>N= 6</td>
<td>N= 11</td>
</tr>
<tr>
<td>Felt overanalysed</td>
<td>N= 5</td>
<td>N= 0</td>
</tr>
<tr>
<td>Mainstream is easier</td>
<td>N= 2</td>
<td>N= 4</td>
</tr>
<tr>
<td>Having regrets</td>
<td>N= 3</td>
<td>N= 5</td>
</tr>
<tr>
<td>Able to avoid violence</td>
<td>N= 5</td>
<td>N= 5</td>
</tr>
<tr>
<td>Remain drug free</td>
<td>N= 3</td>
<td>N= 0</td>
</tr>
<tr>
<td>More determined</td>
<td>N= 2</td>
<td>N= 3</td>
</tr>
</tbody>
</table>

Overall plot

The MSA overall plot shows the cases in a geometric space, dependent on the similarities or dissimilarities. The closer the cases appear together, the more similar the profiles, and the more distant they appear, the more dissimilar the profiles
(Wilson & Hammond, 2000). If cases share an identical profile, they are presented as one point in the plot.

The overall plot (Figure 3) shows the 19 profiles of the 59 cases based on the nine variables described as item plots above. The partitioned region of each item plot was overlaid on the case plot in order to aid interpretation. The plot was partitioned into four regions that correspond to the regions of each individual item plot. These regions are consistent with the theoretical concepts derived from the SSA.

![Figure 3: MSA overall plot of 19 profiles (for all cases of each profile see Appendix E)](image-url)
Each region shows differences between the two types of leavers in relation to the variables analysed. Interestingly the profile with the highest frequency (profile 1 with 24 cases) did not show group differences (with 12 cases de-selected and 12 cases having asked to leave) and is in the middle of overall plot. So, 42.1% of plotted cases do not show differences in frequency but also all cases in this profile did not report any of the variables analysed in the MSA. Therefore, the following regions of the MSA overall plot are based on those cases that allow for differences and further, allow for profiles of those who were de-selected and those who asked to leave to be established. However, the overall plot and its partitioned regions also reflect each region of the SSA.

Region 1
This region at the top left corner plots cases that reported the variable ‘able to avoid violence’. 50% of those were de-selected; 50% asked to leave. Although there is no difference between the leavers, this variable is situated in the top half of the plot, which shows more cases of de-selection than ‘48-hours’. Further, being situated on the right hand side of the plot, this variable corresponds with the SSA where it was conceptualised as a ‘gain’ related to offending behaviour.

Region 2:
This region is situated in the top right hand side of the plot. The variables ‘dealt with difficult issues’ and ‘being more determined’ have been mostly reported by residents who asked to leave within 48-hours. These variables can be found in the SSA region of ‘therapeutic change’, and are also located on the right hand side of both plots. Interestingly, taking the right hand side of this plot into account only, those who reported gains were also more likely to ask to leave prematurely. Again, this challenges the assumption that those who leave early are treatment failures, as they have had some therapeutic gains, such as ‘being more determined’, although they decided to leave.
Region 3:
This region is located in the bottom right corner. The variables 'mainstream prison is easier', 'challenging experience' and 'regrets' have mostly been reported by individuals who asked to leave within 48-hours. 'Mainstream prison is easier' and 'regrets' can be found in the SSA region of 'resistance' and although 'challenging experience' is not plotted in that region, the variable lies within relatively close proximity to the region. The variables relating to 'resistance' are also located in the left hand side of the SSA. It is an interesting finding that 'challenging experience' was reported by individuals who also reported variables relating to 'resistance'. This suggests inter-relatedness of therapeutic change and resistance and that the experiences can be distinguished on a theoretical level (as in the SSA), but not on the level of individual cases (as in the MSA).

Region 4:
This region is situated in the bottom left corner of the overall plot. The variables 'feeling overanalysed' and 'having opened up old wounds' were reported more frequently by individuals who were deselected. This suggests that these individuals were not able to cope with the TC system and environment; however, it is surprising that they did not ask to leave, but were de-selected. They might have appeared to be not coping and were therefore de-selected, or they were de-selected for other reasons unknown to them and 'made sense' of their experience by attributing their leaving to these experiences. The variables correspond with the 'negative experiences' region in the SSA. In either case, both variables relate to some form of resistance, although covert, in that the therapeutic process (of analysing and possibly opening old wounds) is kept at bay.

The MSA overall plot shows that leavers differ in their level of resistance: deselected residents seem to be more resistant in a covert manner characterised by unconscious processes, which leaves them unable to deal with the processes of the TC, whereas residents who asked to leave not only show a higher level of overt
resistance characterised by observable behaviours, but also regrets. De-selected individuals attribute their leaving to factors in the therapeutic environment; residents who asked to leave seem to attribute their leaving to their own avoidance of the environment. Further, the plot shows that leavers do not differ in terms of ‘being able to avoid violence’, but that those who asked to leave show further gains of ‘having dealt with difficult issues’ and ‘being more determined’.

Overview

The SSA of 39 variables, generated through content analysis, resulted in four conceptual clusters relating to therapeutic change, gains, negative experiences and resistance. An interesting finding from the SSA was that therapeutic changes have been reported frequently although all participants left the TC prematurely; this challenges the notion that only those who adhere to and graduate from the therapeutic community achieve therapeutic change.

An MSA of nine variables was performed resulting in individual profiles. These profiles, in combination with the overall plot, allowed for exploration of differences and similarities between residents who were de-selected and residents who asked to leave. The MSA regions correspond to the SSA regions in that they relate to the same theoretical concepts. Moreover, the MSA regions describe distinct profiles of TC leavers with de-selected residents being more covertly resistant and experiencing fewer gains and residents who asked to leave being more overtly resistant and experiencing more therapeutic gains. Thus, there are clear differences between those who were de-selected and those who asked to leave.

These findings are in line with the statistical analysis of variance that showed that de-selected residents reported more often ‘not adhering to TC rules’, ‘having felt misunderstood and not listened to’ (which falls into the same region of negative experiences) and ‘no gains’, which reflects that those who asked to leave were more
likely to gain from having been to the TC. As in the MSA, residents who asked to leave reported more often that being in the TC was a challenging experience.

The major limitation of this study is that it was dependent on secondary analysis. The subject of the research was determined by what was convenient and the research design was out of the control of the researcher. This is problematic in that research can only be as good as its tools; the quality of the data was not as high as it could have been, which was due to the fact that it was designed as a quick service user evaluation only. The study could have been improved through ‘richer’ data, which could have been achieved by a more detailed questionnaire, and the dichotomous data used in this study limited the opportunities for statistical analysis. Also, it could be interesting to include staff into a study like this, as resistance is difficult to understand and detect from the client’s point of view (because clients do not necessarily understand their leaving as resisting to the therapeutic process). How do staff make sense of inmates leaving the TC? What do they think the client’s resistance is about? Such insights could bring an extended understanding about the process of resistance to therapy. Moreover, in order to generalise findings about dropout from prison-based TCs it is important not only to investigate other TCs, as it is possible that the described processes are inherent to this particular prison, but also female TCs in order to establish whether there are gender differences in dropout and/or resistance to therapeutic change.

However, despite its limitations, this study allows for a deepened understanding of the processes that are likely to be associated with leaving the TC. The identification of these processes has theoretical and practical implications. Most importantly, the understanding of different ways of resisting therapeutic change should allow for acknowledgement and exploration of residents’ ambivalence and resistance as part of the therapeutic process. Strategies that correspond to a resident’s individual stage of change within this heterogeneous group can then be used to avoid dropout. In particular those residents who ask to leave can be seen as a target group as they did
report regretting leaving the TC and possibly could profit from interventions that focus on their resistance in the early days of being in the TC (which is naturally a time of confusion, adjustment and resistance to the new environment). For example, the concept of resistance and issues surrounding it could be presented to inmates in order to help them understand what might be going on for them. This could be combined with additional support for those who want to deal with their resistance. By allowing residents to understand and offering them the opportunity to deal with their resistance they are given a choice and might not only feel more supported and understood, but also more in control and possibly able to overcome their resistance. These findings have little implication for the selection procedure though, as most, if not all, individuals wanting to become part of a TC will have some form of resistance, whether overt or covert. However, adherence depends not on the degree or type of resistance, but on how it is dealt with and responded to on an individual level.

Through exploring leaver's experiences this investigation has started to combine process and outcome research. This is important, as it still seems that most research focuses on either process or outcome despite the growing understanding and need to combine service users' experiences and therapeutic outcome. Therefore, research studies like these are an advance in producing knowledge in a new and challenging way. Moreover, by having used the data that has been collected by a forensic researcher, this study is a product of a combined effort of forensic and counselling psychology. This is an exciting and necessary endeavour just as much as combining process and outcome research is. By working hand in hand the two professions are able to pool their resources and knowledge so as to investigate processes in prison in a more complex manner.

Further research could investigate the reasons for leaving in a more dynamic process, for example using follow-up interviews. Such research would allow for a deepened understanding about the processes involved, as it can be assumed that a short
questionnaire is not sufficient to portray such a difficult process. Therefore, it would be interesting and important to ask participants to talk more about their experiences and feelings and to use the interview between the researcher and a leaver as a dynamic and flexible tool to capture the individuals' experiences. This could be combined with a focus on particular regions, thus could lead to a 'fuller' profile of leavers. Additionally these individuals could be asked to comment on what could have helped them to deal with their difficulties (either with themselves or within the community), which would aid conceptualisation, and eventually implementation, of appropriate interventions. Finally, it is crucial to investigate the experiences of those who did not leave the Therapeutic Community. In order to understand more about the processes involved it is necessary to explore those individuals who stick to the program and those who do not. This leaves the question why those who did not leave prematurely did not respond to the questionnaire. Such an investigation could lead to findings that suggest that the described processes are happening to those who do not leave the TC prematurely in the same or at least a similar way and could lead to new ways of understanding differences between those who leave prematurely and those who do not.
References


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APPENDIX
Appendices
Details of participants' consent and assurance of anonymity (Appendix A)
Copy of Questionnaire (Appendix B)
Copy of letter to ex-residents (Appendix C)
List of variables derived from the content analysis (Appendix D)
Krukal-Wallis Output (Appendix E)
MSA profiles (Appendix F)
Copy of instructions for authors: Therapeutic Communities (Appendix G)
Self Reflection (Appendix H)
Account of the researcher's original research attempt (Appendix I)
Details of participants’ consent and need for continued anonymity

As the researcher was the secondary analyst, it was important to ensure participants’ consent and continued anonymity.

Consent was given on a number of levels: (1) the University of Surrey Research Team has general consent on behalf of the Home Office to conduct research within this prison-based Therapeutic Community, (2) specific consent was negotiated between the University of Surrey Research Team Leader and the therapy director of the Therapeutic Community, (3) each inmate is required to sign informed consent on entering the Therapeutic Community that any material or data that is generated through their TC experience can be used by the University of Surrey Research Team, and (4) finally, the questionnaires were sent to participants who had already left the Therapeutic Community and their returning of the questionnaires can be seen as their consent to use the data.

Continued anonymity was secured through separating the demographic data from the questionnaire and keeping both sets of data in different locations.
SOUTHGATE TC LEAVERS’ QUESTIONNAIRE

We would like to get some feedback from people who have left Southgate TC. We would appreciate it if you would fill out this questionnaire. All questionnaires are dealt with in a confidential manner. This means that when the overall results are reported, no names are used. You do not have to put your name and prison number on this. However, if you would like to take part in a follow-up interview to talk about why you have left and how you are getting on then please fill these in:

Name ....................... Prison No ...... Present Establishment ...............
Age ............ Date left Southgate ......... Index Offence ...............
Current sentence length ............ Current sentence left to serve ..............
Are you a life sentence prisoner? ........ If yes, what is your tariff? ..............

In your own words, why did you leave X TC?
________________________________________________________________________
________________________________________________________________________

Looking back how would you describe your time at X TC?
________________________________________________________________________
________________________________________________________________________

Having been in a TC, are there any difficult aspects about being back in a ‘normal’ prison? If so, what are they?
________________________________________________________________________
________________________________________________________________________

Are there any aspects of being back in a ‘normal’ prison that have been made easier because you have been in a TC?
________________________________________________________________________
________________________________________________________________________

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PLEASE READ THE FOLLOWING STATEMENT AND CIRCLE ONE OF THE OPTIONS THAT BEST DESCRIBES YOU

I LEFT SOUTHGATE TC BECAUSE...

A) I was de-selected

B) I requested to leave early (put in 48-hour notice)

C) I was assessed as ready to leave by staff

If you answered A) please answer Sheet 1
If you answered B) please answer Sheet 2
If you answered C) please answer Sheet 3
Please read the following statements and circle one of the options that best describes you and your situation

1. I was in X TC for 1-2mths 2-6mths 6-12mths 12-18mths over 18mths

2. My de-selection was unfair True False
3. I do not understand why I was de-selected True False
4. I think that the others in the TC understood me True False
5. At the time I was de-selected it didn’t bother me True False
6. Looking back, I regret my de-selection True False
7. Others were wrong for de-selecting me True False
8. I still feel upset about leaving True False
9. I don’t think about the TC at all True False
10. Being in a TC just wasn’t for me True False
11. On the whole, my time in the TC was helpful True False
12. I don’t have any problems that need changing True False
13. I hope to try another type of therapy True False
14. Having been in a TC is still an important experience to me True False
15. I am much happier now that I’ve left True False
16. I would like to try this TC again True False
17. I learnt things in the TC that are still useful to me True False
18. Moving back to normal prison has been difficult True False

You have completed the questionnaire. Thank you for helping. If you are interested in the results of this study please let us know.
Please read the following statements and circle one of the options that best describes you and your situation

19. I was in X TC for 1-2mths 2-6mths 6-12mths 12-18mths over 18mths

20. At the time, my decision seemed like a good one True False

21. I do not understand why I left True False

22. I think that the others in the TC understood me True False

23. At the time I decided to leave it didn’t bother me True False

24. Looking back, I regret leaving True False

25. Others were the reason I left True False

26. I still feel upset about leaving True False

27. I don’t think about the TC at all True False

28. Being in a TC just wasn’t for me True False

29. On the whole, my time in the TC was helpful True False

30. I don’t have any problems that need changing True False

31. I hope to try another type of therapy True False

32. Having been in a TC is still an important experience to me True False

33. My leaving had nothing to do with anyone else True False

34. I am much happier now that I’ve left True False

35. I would like to try this TC again True False

36. I learnt things in the TC that are still useful to me True False

37. Moving back to normal prison has been difficult True False

You have completed the questionnaire. Thank you for helping. If you are interested in the results of this study please let us know.
**APPENDIX B**

**SHEET 3**

Please read the following statements and circle one of the options that best describes you and your situation

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>38. I had been in the TC for 1-2mths 2-6mths 6-12mths 12-18mths over 18mths</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. At the time, my decision seemed like a good one</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>40. I do not understand why I was assessed as ready to leave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. I think that the others in the TC understood me</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>42. At the time I left it didn’t bother me</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>43. Looking back, I regret leaving</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>44. Others were wrong in thinking that I was ready to leave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45. I still feel upset about leaving</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>46. I don’t think about the TC at all</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>47. I regret my time in the TC</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>48. On the whole, my time in the TC was helpful</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>49. I don’t have any problems that need changing</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>50. I hope to try another type of therapy</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>51. Having been in a TC is still an important experience to me</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>52. Now I am finding it difficult to cope</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>53. I am much happier now that I’ve left</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>54. I would like to go back to the TC again</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>55. I learnt things in the TC that are still useful to me</td>
<td>True</td>
<td>False</td>
</tr>
<tr>
<td>56. Moving back to normal prison has been difficult</td>
<td>True</td>
<td>False</td>
</tr>
</tbody>
</table>

You have completed the questionnaire. Thank you for helping. If you are interested in the results of this study please let us know.
September 03

Dear Ex Resident

Re: Experience of HMP Southgate Therapeutic Community

I am writing to you as somebody who has passed through part or all of the Therapeutic Community process within the last two years. I am reviewing people's experience of their time at the TC in order that we can continue to develop and offer a more effective service to people wishing to change their lives through therapy. It would be extremely useful if you would be prepared to complete the enclosed questionnaire regarding your experience at the Therapeutic Community. Any suggestion that you have that would enable us to improve what we do would be most appreciated. You will note that the questionnaires are anonymous; therefore any information that you give will not be attributable to you.

I hope that, whatever the circumstances of your leaving the TC were, you found the time, be it short or long, a useful one.

I look forward to receiving your responses in the pre-paid envelope provided.

Yours sincerely,

Director of Therapy – HMP Southgate
Complete list of variables

1. reason for leaving: 1=de-selected; 2=48 hour notice; 3=graduate [reason]

LEAVING attributions
2. L: not adhering to TC rules (misuse of drugs, violence) [lnarules]
3. L: failure to deal with problems [lfailprb]
4. L: timing (wrong time for me) [ltiming]
5. L: failure to adjust to environment/system (not fitting in, not liking groups, prison politics, lack of work) [lfailenv]
6. L: felt misunderstood & not listened to [lfeltmis]
7. L: staff issues (incompetence, lack of control, staff shortage) [lstaffiss]
8. L: non-acceptance of others (they just want an easy life, other’s drug misuse) [lononacc]
9. L: others’ pressure (grassing, backstabbing, non-acceptance) [lopress]
10. L: personal reasons (parole issues, repatriation, court appearances) [lperson]

DOVEGATE experiences
11. D: positive experience (rewarding, learning experience) [dposex]
12. D: opened up old wounds [dwounds]
13. D: challenging, hard work, most difficult experience ever [dchallng]
14. D: gained something (I’m a better person now, I have an idea of what I need to work on) [dgainsth]
15. D: having dealt with difficult issues [ddiffiss],
16. D: overanalysed [doanaly]
17. D: strange & uncomfortable experience [duncomfex]
18. D: no help experienced (dealing with difficult stuff) [dnohelp]
19. D: negative experience (disgraceful, haunting, unproductive) [dnegex]
20. D: frustrating [dfrust]
21. D: not given a chance & non-acceptance [dnochanc]

ADJUSTMENT to mainstream prison
22. A: no impact [anoimp]
23. A: lack of help, difficulty to talk to others [alckhelp]
24. A: difficulty fitting back in & being different [adifffit]
25. A: feeling vulnerable (after having been stripped down) [afeelvul]
26. A increased defences (guards, shields up) [aincerdef]
27. A: easier (bottle things up, less stressful to cope) [aeasier]
28. A: environment seems harsher (officers are strict & unhelpful) [aenvhrsh]

GAINS/ LACK OF GAINS from being in TC
29. G: no gains [gnone]
30. G: regrets [gregrets]
31. G: improved communication skills [gimpcomm]
32. G: improved behaviour (better person, no nickings) [gimpbehv]
33. G: able to deal with difficulties & solve problems (confrontations, frustrations, asking for help) [gdealdif]
34. G: able to avoid violence [gavdvio]
35. G: increased awareness & reflection of self and others & utilise defences [gincawa]
36. G: ability to control emotions [gcontremo]
37. G: increase in positive feelings (confidence, like oneself) [gincposf]
38. G: greater tolerance [gtoleran]
39. G: remain drug free [gdrugfre]
40. G: being more determined, follow things through, being self-disciplined [gdeterm]
<table>
<thead>
<tr>
<th>Reason for Leaving</th>
<th>N</th>
<th>Mean Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>28.88</td>
</tr>
<tr>
<td>48-hour notice</td>
<td>28</td>
<td>29.13</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Sentence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>28.12</td>
</tr>
<tr>
<td>48-hour notice</td>
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<td>29.91</td>
</tr>
<tr>
<td>Total</td>
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<tr>
<td>Time at TC</td>
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<tr>
<td>De-selected</td>
<td>29</td>
<td>26.34</td>
</tr>
<tr>
<td>48-hour notice</td>
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<td>31.75</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Not adhering to TC rules</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>31.86</td>
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<tr>
<td>48-hour notice</td>
<td>28</td>
<td>26.04</td>
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<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Failure to deal with problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>25.90</td>
</tr>
<tr>
<td>48-hour notice</td>
<td>28</td>
<td>32.21</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Timing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
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<td>27.41</td>
</tr>
<tr>
<td>48-hour notice</td>
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<td>30.64</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Failure to adjust to environment/system (not fitting in, disliking groups, prison politics)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>27.31</td>
</tr>
<tr>
<td>48-hour notice</td>
<td>28</td>
<td>30.75</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Felt misunderstood &amp; not listened to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>31.90</td>
</tr>
<tr>
<td>48-hour notice</td>
<td>28</td>
<td>26.00</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Staff issues (incompetence, lack of control, staff shortage)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>31.33</td>
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<tr>
<td>48-hour notice</td>
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<td>26.59</td>
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<tr>
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<td>57</td>
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<tr>
<td>L: Non-acceptance of others (they want an easy life, other's drug misuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
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<td>29.41</td>
</tr>
<tr>
<td>48-hour notice</td>
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<td>28.57</td>
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<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Others' pressure (grassing, backstabbing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>27.48</td>
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<td>30.57</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>L: Personal reasons (parole issues, repatriation, court appearance)</td>
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<td></td>
</tr>
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<td>De-selected</td>
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<td>29.47</td>
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<td>28.52</td>
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</tr>
<tr>
<td>D: Positive experience (rewarding, learning experience)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>De-selected</td>
<td>29</td>
<td>27.21</td>
</tr>
<tr>
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<td>30.86</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>D: Opened up old wounds</td>
<td></td>
<td></td>
</tr>
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<td>D: Challenging hard work, most difficult experience</td>
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<td>D: Gained something (I'm a better person now, I have an idea of what to work on)</td>
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<td>Mean Rank</td>
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<tr>
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<tr>
<td>D: having dealt with difficult issues</td>
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<td>D: overanalysed</td>
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<td>26.59</td>
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<tr>
<td>A: lack of help &amp; difficulty to talk to others</td>
<td>28</td>
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<td>29.00</td>
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<td>27.00</td>
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<td>56</td>
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<tr>
<td>A: increased defences (guards, shields up)</td>
<td>28</td>
<td>28.00</td>
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<td>28</td>
<td>29.00</td>
</tr>
<tr>
<td></td>
<td>56</td>
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<tr>
<td>A: easier (bottle things up, less stressful to cope)</td>
<td>28</td>
<td>28.00</td>
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<td>28</td>
<td>29.00</td>
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<td>A: environment seems harsher (officers are strict &amp; unhelpful)</td>
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<td>26.50</td>
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<td>30.50</td>
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<tr>
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<td>G: improved behaviour (better person, no nickings)</td>
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<td>27.64</td>
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<tr>
<td>G: remain drug free de-selected</td>
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<td>29.97</td>
</tr>
<tr>
<td>48-hour notice</td>
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<td>28.00</td>
</tr>
<tr>
<td>Total</td>
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<tr>
<td>G: being more determined, follow things through, being self-disciplined de-selected</td>
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<td>29.47</td>
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### Test Statistics

#### Chi-Square

<table>
<thead>
<tr>
<th>Test Statistics (a,b)</th>
<th>age</th>
<th>sentence</th>
<th>time at TC</th>
<th>L: not adhering to TC rules</th>
<th>L: failure to deal with problems</th>
<th>L: timing</th>
<th>L: failure to adjust to environment/system (not fitting in, disliking groups, prison politics)</th>
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<tbody>
<tr>
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<td>.170</td>
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<td>.363</td>
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#### Test Statistics

<table>
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<tr>
<th>L: felt misunderstood &amp; not listened to</th>
<th>L: staff issues (incompetence, lack of control, staff shortage)</th>
<th>L: non-acceptance of others (they want an easy life, other's drug misuse)</th>
<th>L: others' pressure (grassing, backstabbing)</th>
<th>L: personal reasons (parole issues, repatriation, court appearance)</th>
<th>D: positive experience (rewarding, learning experience)</th>
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<tr>
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<td>.152</td>
<td>.577</td>
<td>.315</td>
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#### Test Statistics

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<th>D: opened up old wounds</th>
<th>D: challenging, hard work, most difficult experience</th>
<th>D: gained something (I'm a better person now, I have an idea of what to work on)</th>
<th>D: having dealt with difficult issues</th>
<th>D: overanalysed</th>
<th>D: strange &amp; uncomfortable experience</th>
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<td>.691</td>
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## Test Statistics\(^{a,b}\)

<table>
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<th></th>
<th>D: no help experienced (dealing with difficult issues)</th>
<th>D: negative experience (disgraceful, haunting, unproductive)</th>
<th>D: frustrating</th>
<th>D: not given a chance &amp; non-acceptance</th>
<th>A: no impact</th>
<th>A: lack of help &amp; difficulty to talk to others</th>
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## Test Statistics\(^{a,b}\)

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<th>A: difficulty fitting back in &amp; being different</th>
<th>A: feeling vulnerable (after having been stripped down)</th>
<th>A: increased defences (guards, shields up)</th>
<th>A: easier (bottle things up, less stressful to cope)</th>
<th>A: environment seems harsher (officers are strict &amp; unhelpful)</th>
<th>G: no gains</th>
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## Test Statistics\(^{a,b}\)

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<th></th>
<th>G: regrets</th>
<th>G: improved communicatio n skills</th>
<th>G: improved behaviour (better person, no nickings)</th>
<th>G:able to deal with difficulties and solve problems (confrontation s, frustrations, asking for help)</th>
<th>G: able to avoid violence</th>
<th>G: increased awareness &amp; reflection of self and others &amp; utilise defences</th>
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<td>G: ability to control emotions</td>
<td>G: increase in positive feelings (confidence, like oneself)</td>
<td>G: greater tolerance</td>
<td>G: remain drug free</td>
<td>G: being more determined, follow things through, being self-disciplined</td>
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a. Kruskal Wallis Test
b. Grouping Variable: reason for leaving
MSA PROFILES

Profile 1 = cases 4, 5, 7, 9, 16, 20, 21, 24, 28, 31, 32, 33, 34, 35, 37, 38, 44, 46, 47, 50, 51, 53, 55, 56
Profile 2 = case 2
Profile 3 = case 3
Profile 4 = cases 6, 19, 27, 36
Profile 5 = cases 8, 10, 18, 25, 57, 58
Profile 6 = case 11
Profile 7 = case 12
Profile 8 = case 13
Profile 9 = cases 14, 17, 45
Profile 10 = case 15
Profile 11 = cases 22, 26, 40
Profile 12 = cases 23, 29
Profile 13 = case 30
Profile 14 = case 39
Profile 15 = case 41
Profile 16 = cases 42, 48, 54
Profile 17 = case 43
Profile 18 = cases 49, 59
Profile 19 = case 52
Copy of instructions for authors: Therapeutic Communities

Guidelines for Contributors

Therapeutic Communities were born out of the radical and creative forces that established alternative forms of mental health care, from the 1950s to the present day. Therapeutic environments, influenced by the ideas developed by this movement, exist for psychiatric, social work or penal institutions, in community schemes, in projects for the homeless, drug and alcohol field, educational and industrial settings. The Journal aims to build upon this creative legacy by stimulating a continual critical re-thinking of the possibilities for developing therapeutic and relational potential, in whatever communities readers work and live within. It aims to provide a forum in which those engaged in developing, managing and sustaining therapeutic cultures can communicate their experiences, the effects of political and social policy on their own settings; their ideas developments and findings; disseminate good practice and explore what happens when things go wrong.

The Journal publishes academic papers, case studies, empirical research and opinion. The Journal is interested in publishing papers that critically creatively engage with ideas drawn from a range of discourses: the therapeutic community movement and other related professional practice, psychoanalysis, art, literature, poetry, music, architecture, culture, education, philosophy, religion and environmental studies. It will be of value to those who work in health services, social services, voluntary and charitable organisations, and for all professionals involved with staff teams in therapeutic and supportive organisations.

General Guidelines

Original contributions that fall within the scope of the journal are welcomed, including articles on current issues, practice and research (academic papers), case studies of particular communities or organisations, and personal contributions arising from the experience of the author. The Editorial group uses different criteria to assess contributions in these categories, and the following guidelines are provided. It will assist us in assessing papers if authors indicate which guidelines they have followed.

Final articles for publication should be typed in double spacing and submitted as an email attachment where possible, to the Editor’s Assistant (c.thoday@uea.ac.uk). Articles should be anonymised, with author contact details (name(s), e-mail and mailing address(es)) provided on a separate sheet. All articles are submitted for ‘blind’ review by assessors drawn from the Editorial Board of the journal, and the International Advisory Panel. Authors will be acknowledged when sending in papers for review upon receipt. Note: For authors submitting an article where English is a second language, it is recommended that the article be proof read by a fluent interpreter prior to sending, in order that intended meanings can be checked in the translated article.

Academic Papers

These can include reports of original research, papers developing original links between theory and practice, review articles and critiques of current practice. The normal conventions of academic papers should be observed, with a brief abstract (up to 150 words), followed by a review of the relevant literature, statement of the problem, method, findings, discussion and conclusion. References should follow the style of the journal. Academic papers should normally not exceed 5000 words excluding references.

Case Studies from Practitioners

These describe examples of practice, innovation, action research or evaluation in the practitioners own unit. They should include: a brief description of the setting, of the piece of work undertaken and the reasons for doing it; a clear account of the process and findings with relevant data in easy to read tables or graphics; a brief conclusion with discussion of the findings and their implications for practice within the unit and perhaps more widely. A small number of relevant references may be included, following the style of the journal, but no literature review is needed. Case studies should normally not exceed 2500 words.

Commentary/Response

The Journal would welcome short papers (up to 2000 words), which address topical issues. These issues may arise from recent themes or views addressed within the papers in the journal, from within therapeutic communities, they may emanate from strategic developments within the Association of Therapeutic Communities (for example the issue of accreditation of communities and training), or be generated by national and international policy initiatives that have an effect on therapeutic practice, the way in which it is thought about or conducted. We are seeking relevant commentaries which are reflective and thoughtful, yet critical and perhaps at times controversial; views and opinions which will stimulate debate, provoke thoughtfulness and hopefully new ideas, with which to approach contemporary issues.

Letters

We would welcome short letters (up to 200 words) from readers picking up on issues raised within the Commentary/Response section, that develop and debate issues further.

Personal Contributions

Readers are invited to send in personal accounts of some aspect of their work that may be of interest to others. The intention of such contributions is to share experience and problems, raise questions and encourage discussion. These may describe an event or situation involving the writer, occurring at the individual, group or organisational level. Contributions from experienced practitioners as well as novices are welcomed. The account should begin with a brief description of the setting, participants and background, followed by details of the particular event or situation and, if appropriate, the responses of the writer and others involved. No literature review, theoretical exposition or references are needed. Confidentiality should be maintained by disguising the identities of individuals or organisations, and authors may request that contributions are published without attribution. Personal contributions should normally be limited to 1500 words. With the author’s permission comments may be sought from practitioners with relevant experience to appear alongside personal contributions.
Self Reflection

Adopting data
In a way it felt like adopting someone else's child, which comes with pros and cons: in this case adoption was the only way of obtaining data in the time frame provided, and although I was very grateful for having obtained this data, I definitely experienced a sense of loss for my original plans. Giving up on my own research project was painful, not only because I believed in the importance of it, but also because I invested a lot of time, cost and energy in it. It felt frustrating and demoralising to abandon it unfinished.

Difficulties with secondary analysis
When I finally had the data I was to use for the analysis in my hands I felt relieved and a bit more positive. I was eager to make a good start and a real effort to get to grips with the data, as I felt I was a long way behind my fellow trainees. During the early familiarisation with the data I became alive again and my enthusiasm for research returned, as I was able to 'connect' with the data and the research idea (which was mainly due to working in a prison setting while getting a sense of the participants' experiences when reading their accounts). I started off by reading all accounts and content analysing them, which was quite straightforward, partly because I knew from previous research how to do it, but also because the accounts were relatively short.

Another set-back
The creation of the database presented me with another obstacle. When I was ready to install SPSS on my computer and it did not work I initially thought I must have tried to install the wrong version. After a lot of running around and seeing technical staff at University it seemed that no one could help me to install the program. I was devastated. After everything I had been through I expected myself to have a nervous breakdown, but instead I persevered with what I had to do as if I was on a mission.
However, I was still upset that I was presented with these obstacles. Although there was not much that the course team could help me with I felt supported by staff. One member of the course team commented:

'You must have been cursed at birth by the evil research fairy'

This is what I had come to feel, as everything I worked on did not materialise. This so-far disastrous research project taught me about my strengths though: I learned that even when things go terribly wrong ... I am able to go on and do my best. I felt determined not to let anything stop me and came to see that it is easy to do things when everything goes as planned. I made it my challenge to overcome all the obstacles that seemed to stand in my way. By the time I had organised a second computer a friend invited himself to have a look at the laptop. To my surprise he turned out to be a lovely computer 'geek' who was as determined to find this problem as I was not to give up. After hours deconstructing my computer software he managed to delete a virus and install SPSS. I felt blessed and happy, but also extremely tired and the real work hadn't even started yet.

*Back on track – but where to go from here?*

After the creation of the database I was eager to do something with the data, but did not know what. It felt like working backwards, I started with the data and had to move from there towards thinking about hypotheses. At the same time I had to learn what could be done with the data. I consulted different people with confusing results. One person would tell me that there was nothing quantitatively that could be done with the data, as it was dichotomous. We spent hours thinking about options. The next person would suggest more qualitative methods. Although I had several people I could draw upon I felt a bit lost as to how to proceed. I also spent time talking to those who designed the questionnaire and collected the data. I felt in-between and slightly lost, as it was not clear who could supervise me through this project. Here, it was really helpful for me to be able to rely on myself and on my own judgement.
Speaking to many people and hearing many different opinions was only helpful if I was able to decide what would be best for me in this particular situation. Finally, after having played around with the database on SPSS for days and having tried different ways of looking at the data, I decided to analyse the data qualitatively. Simultaneously I was placed in the capable and caring hands of a forensic psychologist as my supervisor. We had regular meetings and I felt supported and guided ever since.

Analysis
I went on to do the SSA and the MSA, which was both exciting and initially complex. I had to learn to visualise the variables within the three-dimensional matrix and how they related to each other. Multidimensional Scaling seemed like a research hybrid, being partly quantitative (in terms of using dichotomous data that are processed with the help of computer programs) and partly qualitative (in terms of interpreting the results and coming up with links and regions between the variables). Once I got to grips with that I found Multidimensional Scaling a very good research technique, in particular as it allowed me to use my understanding of therapeutic processes; my clinical experience of therapy in prisons helped me to make sense of the data. At the same time I was worried about being too speculative with the way I interpreted the data and thought that there is a right way of doing so. Thinking rather rigidly, I assumed that I must be able to account for every single variable or profile in each region. This insecurity mirrored my early clinical practice, in which I assumed that there was a ‘right way’ of working with clients. Admittedly, there is a lot that can be done in the ‘wrong way’ when doing research. Initially I was lacking confidence in how to interpret the plots and it took me some time to see that there was no “wrong way” of doing so. I was using my own clinical experience and understanding to interpret the matrices. In many ways the analysis reminded me of clinical practice as well; for example, there are some ‘hard facts’ about a client and then the therapist (depending on my view of the world and previous experiences) makes ‘hypotheses’ and ‘interpretations’ of what might be going on. Similarly, I
received data, but had to hypothesise and interpret how these variables come together. As with clinical work, there are different ways of interpreting what is going on and over time I learned to be more confident about how I ‘saw’ the data.

Looking back
I thoroughly enjoyed making sense of the data that had been given to me and in hindsight this was quite an exciting experience. Although I was limited due to being the secondary analyst I realised that research is not necessarily dependent on the actual data, but rather what you do with it. Collecting data is a difficult procedure, which is hardly ever straightforward, and at times researchers must be prepared and flexible enough to deal with unforeseen circumstances, just as much as in clinical practice.
Account of and reflections of the initial research project

The original idea
After having completed research on a prison-based therapeutic community in my second year, I was very keen to investigate offenders in the mainstream prison in my final year. I was impressed with the concept and the reality of the therapeutic community and I felt relief that there are places where offenders are treated in a helpful and thoughtful way. However, I was also aware that the average offender was unlikely to have the privilege of becoming a member of a prison-based therapeutic community. So, I wondered: what happens to those offenders who have no chance of being in a TC or even those who do not fit into the other typical prison-based group programs offered in mainstream prison?

Experiences during the early stages
Working in an all-male mainstream prison during my final year, I was aware that individual counselling/therapy for offenders was a rarity and that research into this domain would be challenging. However, with my high enthusiasm, motivation and perseverance I did not entertain the thought of not getting there. My first task was to find out which establishments offer what kind of counselling/therapy to their inmates. Already, at this early stage, I developed negative emotions such as anger and frustration towards the system. This was mainly due to the fact that many institutions did not offer any form of psychological intervention (other than outcome-oriented, structured group programs) to their incarcerated individuals. I had dozens of phone conversations with health care staff voicing frustrations and disagreement about the lack of individual psychological interventions. What stayed with me was the real need for individual counselling/therapy as staff consistently pointed out that many inmates asked specifically for these services. However, what actually filled me with confusion and resentment was not that these services were needed to a great extent, but that some of them had existed and were shut down. Some institutions had established counselling/therapy services with a dozen –often voluntary- counsellors.
under one 'pro-therapy' governor, which was then closed down by the next 'anti-therapy governor'. I was in disbelief: how could something that seemed so important and fundamental be dependent on the opinion of one single (minded) individual?

**Difficulties in 'getting in'**

After months of tracking down institutional services, talking to health care staff over the phone and sending letters on a daily basis, my frustration seemed to rise to a level of anxiety. I started to feel powerless and helpless and to collude with some of my clients (who are inmates) in terms of transference to the institution. One difficulty was that I needed permission from several 'gatekeepers' (Arber, 1993; page 37): the governor, health care staff and the area psychologist. The reality of doing research did not fit into the idealised accounts of research reported in the literature. The 'closed access' group (Hornsby-Smith, 1993; page 53) I was interested in was protected by discouraging barriers against me, the intrusive outsider. Other researchers have described difficulties in penetrating ‘closed access’ groups and reported negotiations that lasted well over a year (Cassel, 1988). Often, after extensive negotiation, I got permission from one 'gatekeeper' and not from the other, which left me, after months of trying, not only empty-handed but also demoralised, frustrated and scared.

**'Getting in'**

I came to see that I had to change my tactic; sending polite letters simply wasn’t good enough. I started to become more persistent, phoning governors who had rejected my research idea and questioned them as to why. Additionally I became more forceful in pursuing my goal; instead of sending my research proposal I would ask to come to the institution to discuss my research directly. Although this was often denied I finally got lucky with a female prison establishment in the south east of England. I drove over a hundred kilometres just to talk to the governor face-to-face and to explain my research in the hope that it would be harder to reject me this way. I was not disappointed. This governor was happy for me to do this study, under
the provision that the area psychologist agreed. I immediately spoke to the area psychologist, who sounded positive over the phone. I had to fill out another special application form to undertake research in an HMP institution (which I had done a dozen times by then). Finally I was allowed into the institution to undertake my research project. I felt relieved to have come this far and my enthusiasm returned.

Difficulties in ‘getting on’

However, I had underestimated the impact of the two-stage process. Cassel (1988) described the difficulty in ‘getting in’ (achieving physical access) and ‘getting on’ (achieving social access). Once I had physical access, I travelled several times to meet the health care manager, to identify potential participants and to send out information sheets. Initially two female inmates came forward to be interviewed. I interviewed both of them on the same day and was ecstatic that I had managed to ‘get my hands on’ some data. The interviews were interesting. This was my first time in a female establishment, and it felt different as compared to a male prison. The two women gave accounts of their experiences of receiving counselling in prison. One participant gave an overly positive account whereas the other gave an overly negative account, which is not unusual in service evaluations in that only those who are either very happy or very unhappy with the service come forward to be interviewed.

The week after these interviews no one else had come forward. I was in constant communication with the health care manager, who tried to be helpful, but seemed so overburdened that I was unclear whether she did actually help to recruit participants. I always felt like I was an extra burden to her and to the system. However, I did not give up and designed another information letter that was more eye-catching without sounding too desperate. But even after that had been sent out, nothing happened.

My general experience of inmates is that they have a great desire to talk to anyone who is not an inmate. However, trying to make sense of this experience, I came to
believe that the lack of participants was something institutional in that it seemed to be a rather unusual culture in this particular prison, possibly being one of the differences between the male and female prison culture.

Letting go of my research
After another period of frustration and feeling demoralised, I decided that it would not make sense to pursue the research any further. I came to the point where I had to seriously consider alternatives and, after talking to my research supervisor, I looked into how to obtain data for the purpose of secondary analysis. I asked people whom I had got to know through previous research whether they had data that needed analysis and also looked at national databases. When I finally learned that there was data suitable for my purposes that could be made available to me, I was relieved. I had seriously questioned whether I would be able to finish my degree this year and went through the consequences of what that would mean and whether I would be able to financially afford extending my time of study.
References
‘This is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.’

Sir Winston Churchill (1942)