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The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change?

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ABSTRACT

The nature and quality of the relationship that forms between clinicians and participants in an offending behavior program is considered by some to have a profound influence on treatment outcomes. This paper aims to offer a critical examination of the current evidence relevant to the effects of what has been termed the therapeutic alliance on violent offender treatment. It is concluded that there is currently an insufficient evidence base to support the view that the therapeutic alliance impacts either directly or indirectly on treatment outcomes and that other factors, such as offender motivation, treatment readiness, offender personality characteristics, and the way in which clinicians' attend to participant problems, are also likely to be important. Nonetheless, it is concluded there are strong theoretical and practice grounds for clinicians to attend to the development and maintenance of strong alliances in offending behavior programs, and some recommendations for clinical practice in this area are offered.

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1. Introduction

In recent years correctional practitioners and researchers alike have become increasingly interested in how rehabilitation programs for violent offenders should be delivered. Questions around who to rehabilitate (risk assessment) and what to change (the identification of criminogenic needs) have been supplemented with those which ask how rehabilitation providers should deliver treatment, and which types of relationship between program providers and offenders are most likely to lead to behavior change (Marshall & Serran, 2004; Ward & Brown, 2004). Such questions are timely in the context of a growing commitment by many correctional agencies to deliver rehabilitation programs that have high levels of program integrity (e.g., Heseltine, Day, & Sarre, 2011) and concerns expressed by some that offender treatment has become so structured that clinicians are unable to respond to

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individual participant needs as they arise (e.g., Serran, Fernandez, Marshall, & Mann, 2003) or even act in ways that may be experienced as punitive (e.g., Glaser, 2003). The aim of this paper then is to review the available evidence pertaining to the way in which clinicians should relate to participants in offender rehabilitation programs. A critical examination of this type has not previously been published, despite the assertions that are sometimes made by clinicians and researchers that the therapeutic relationship is a necessary, if not sufficient, condition for behavior change to occur.

2. Perspectives on therapeutic practice and the therapeutic alliance

A number of different views have been expressed about the interpersonal approach that clinicians should adopt in their work with offenders, particularly in relation to the treatment of those with personality disorders. These range from those who suggest that it is important to develop a strong bond with offenders, to those who suggest that the clinician should remain emotionally detached. Livesley (2007), for example, suggests that a generic component of treatment with high-risk offenders who demonstrate personality disorder has two parts: the treatment relationship and the therapeutic frame—the latter determining the therapeutic tasks required. Livesley acknowledges that problems in trust and cooperation are defining features of personality disorder, but suggests that these can be built over time and develop as a result of effective treatment. A somewhat different position is offered by Milkman and Wanberg (2007) who, in their review of cognitive behavioral treatments within correctional environments, advise that "the provider must approve (reinforce) the client's anticriminal expressions and disapprove (punish) the client's pro-criminal expressions" (p.13). Milkman and Wanberg further specify the need for clinicians to articulate their disapproval and report violations to correctional providers. This implies that a particular manner and tone is required from those who deliver offending behavior programs. Finally, Wong and Hare (2005) have suggested that what they term a 'functional working alliance' should be developed when working with clients who have psychopathic tendencies. This places more emphasis on the tasks and goals of the program and less on the development of an emotional relationship. In their view this is because characteristics such as being manipulative, and lying impede their ability to form a close bond. Downplaying this element of the therapeutic relationship is also regarded as a means of safeguarding clinicians from exploitation.

3. The therapeutic alliance

It is generally accepted that not only do clinicians need to have an extensive knowledge of both offending (criminology) and offenders (psychology) if they are to deliver effective rehabilitation programs, but they must also have the ability to relate well with offenders. Just what relating 'well' or 'poorly' means in this context is, however, somewhat unclear. It might, for example, be argued that relating well can be confused with 'befriending', and that this is likely to be unhelpful in so far as it has the potential to increase client dependence and reduce self-efficacy, let alone reinforce antisocial beliefs and attitudes. Conversely, a lack of emotional connectedness or an aggressive and intimidating interpersonal style may lead to client antipathy, increased rates of program attrition, and disengagement from program content. Taft and Murphy (2007), in writing about effective rehabilitation programs for perpetrators of intimate partner violence, have suggested that the use of overly confrontational treatment techniques can limit therapeutic effectiveness by failing to acknowledge issues related to victimisation or by modeling ways of behaving that are abusive. It would appear that a balance must be set between being personable and being purposeful.

The notion of the therapeutic alliance (TA) has been widely used to understand some of the most important features of the relationship that forms between a client and a clinician. The TA comprises three interrelated elements: tasks, or the specific activities that need to be undertaken to facilitate change in psychological therapy; goal, the aspect of the alliance that most centrally relates to achieving therapeutic change; and bond, the development of trust and an ability to negotiate within the therapeutic relationship (Bordin, 1979). According to Bordin (1994), the TA is the critical factor that fosters psychological and behavioral change—it concerns the development of a collaborative and purposeful relationship that engages the client, the process of identifying and striving for pertinent change goals, the negotiation of tasks to achieve this, and the evolution of a therapeutic relationship that is based on trust. A number of meta-analytic reviews have summarized the results of what is now a large number of studies that have investigated the influence of the therapeutic alliance. These studies have found evidence for a moderate, but robust, association between the TA and treatment outcome across a wide range of individual psychotherapeutic interventions (e.g., Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). In other words, the TA appears to be an important element in the process of change for clients who attend a variety of individual therapeutic interventions.

What is less clear is the extent to which these conclusions can be applied to the correctional setting in which offender treatment is typically offered. There are a number of important differences between the forensic environment and those in which mental health treatment is typically offered. First, in correctional programs the goals and tasks of intervention are generally not determined by the individual client but by a range of other considerations related to improving community safety. Client well-being is often considered important, but secondary, to this goal. Second, offenders are often aware of the enormous amount of social control that treatment providers have over their lives—this may be in the form of information that they provide to parole boards or prison authorities about their behavior in programs (which is then used to inform parole conditions and classification decisions), or to community correctional case managers (who are responsible for implementing conditions of community-based dispositions, and therefore breach proceedings). In effect a dual relationship of care and control characterizes much of the work that is undertaken in the correctional environment (see Skeem, Eno Louden, Polaschek, & Camp, 2007).

A further complicating factor is that correctional programs are almost always delivered in a group rather than individual format. For the most part existing theory and research on the TA has examined dyadic therapy, and there may be some fundamental differences in the way in which therapeutic relationships develop in group settings (Horvath & Symonds, 1991). For example, it is widely accepted that effective group work should aim to develop positive relationships between group members (Jennings & Swayer, 2003) given that difficulties between two or more participants (or a group member and a clinician) can create an anti-therapeutic environment for all group members. Clinicians within offending behavior programs, therefore, need to be concerned with not only the progress of individuals within a group, but also with how the group is functioning as a whole. Group cohesion is a term used to refer to the relationship between group members and their ability to function as a whole within a treatment context rather than between the individual and a treatment provider.

The differences that exist between psychological treatment in the forensic and the mental health context suggest that clinicians will need to continue developing and testing theories of change that are specific to the context in which they work (Magaletta & Verdeyen, 2005). There is much to do in this respect—it is even difficult to identify appropriate terminology to describe the role of corrections-based rehabilitation providers. Terms such as 'therapist', 'clinician', 'counsellor', 'forensic psychotherapist', and 'program facilitator' are all used to describe rehabilitation providers, and yet each has different connotations around the nature of the relationship that is formed with the offender. For example, implicit in the use of the term 'therapist' or 'clinician' is the idea that the development of a therapeutic relationship is relevant to the process of change, whereas the term 'program facilitator' suggests that a greater emphasis should be placed on client knowledge and skill acquisition.