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Correctional Mental Health Providers' Experiences of Forced Termination on the Working Alliance

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Correctional Mental Health Providers' Experiences

of Forced Termination on the Working Alliance

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DISSERTATION

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The undersigned have examined the dissertation entitled:

**CORRECTIONAL MENTAL HEALTH PROVIDERS' EXPERIENCES
OF FORCED TERMINATION ON THE WORKING ALLIANCE**

presented on March 15, 2017

by

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Abstract

This is a study of the experiences of forced terminations in correctional facilities, particularly their impact on the working alliance between mental health service providers and incarcerated patients. The study includes an introduction to the research problem and its context, followed by a discussion of the literature on the working alliance in psychotherapy, conditions of forced terminations in the treatment of the incarcerated, the problem of forced termination and the working alliance in the correctional settings, and the study's research methodology. The research methodology is qualitative and includes semi-structured interviews of providers in correctional settings and an analysis of these accounts using Interpretative Phenomenological Analysis (IPA). The results of this study are based on the major themes found in the interviews. In addition to supervision, participants spoke of the importance of the working alliance to help patients become motivated and "invest" in therapy. To establish a solid alliance, providers suggested using empathy, active listening, and validation as well as non-judgmental and respectful behavior, regardless of the patient's crimes. Given the unpredictable setting and short-term nature of therapy in correctional settings, providers generally moved fast in sessions and focused on their tasks. The interviewed providers also prepared their patients of the possibility of forced termination and regularly reviewed progress and achievements with them. Further, providers discussed areas of improvements with patients, which they may be able to explore with future therapists. Most providers wished they had the opportunity to help their patients find therapists when forced termination occurred and wanted to be able to contact future providers. Some also wanted to continue contact with the patient during the transition period. These ideas were seen as potential strategies to counteract the negative effect of forced termination. Given the small sample of mental health providers who were interviewed for this study, the findings presented

cannot be generalized to apply to all forced termination cases in correctional settings. However, they may enable future researchers to conduct quantitative studies on the development of the working alliance, forced termination outcomes, and their interaction in the correctional setting.

Keywords: correctional setting, forced termination, working alliance, Interpretative Phenomenological Analysis

Correctional Mental Health Providers' Experiences of Forced Termination on the Working

Alliance

The working alliance between a patient and therapist is a critical factor for the success of

any type of therapy (Horvath & Greenberg, 1994). However, maintaining a positive alliance

could be difficult in settings that do not encourage trust, such as correctional institutions

(Helfgott, 2013). There, a therapist has to navigate a system that discourages confidentiality and

privacy (Helfgott, 2013) and may work with mandated or manipulative patients. The therapist

might also have to manage a dual relationship, one with the patient and one with the institution,

which may weaken the therapeutic relationship (Brans & Lesko, 1999; Ward, 2013).

An additional obstacle to the working alliance between the therapist and the patient is the

unpredictability of this setting. There are environmentally specific interruptions to psychotherapy

with prisoners. One-on-one or group sessions can be interrupted at any time due to lockdowns or

facility recalls. Therapy may also be forcedly terminated because of the incarcerated patient's

sudden and unexpected transfer, release, or because the incarcerated patient is stopped from

attending therapy because of disruptive behavior (Sun, 2012). Furthermore, a large number of

offenders drop out of therapy (Wormith & Olver, 2002). In fact, non-completion of treatment

among offenders may be higher than it is for therapy patients outside of correctional facilities

(Wormith & Olver, 2002). Consequently, it is important to investigate how correctional mental

health providers make sense of forced termination, prepare their patients to terminate therapy,

and study how the unpredictability of therapy and possible forced termination affect a

therapeutic working alliance.

Background and Context of the Problem

According to the Human Rights Watch (HRW), the United States (U.S.) has the highest

number of incarcerated people in the world, relative to the population worldwide. At the end of

2011, more than 2.3 million people in the U.S. were incarcerated (Human Rights Watch, 2012).

That means that out of 100,000 inhabitants in the U.S., 752 individuals were imprisoned.

Furthermore, in 1998, approximately 250,000 mentally disordered offenders resided in U.S.

prisons and jails and an additional 547,000 probationers had stayed at a mental hospital or have

had a mental condition at some point in their lives (Sun, 2012). The Bureau of Justice Statistics

(Glaze & James, 2006) found that in 2005, more than half of all prison and jail inmates had a

mental health problem. Sun states that in 2000, on average one in ten state inmates received

psychotropic medication; in five states, the number was up to 20%, and at least one in eight state

inmates received mental health therapy or counseling. Most importantly, more than half of all

inmates (56% state prisoners, 45% federal prisoners, and 64% jail inmates) have had a mental

health problem within a 12-month period. Evidently, the work of mental health service providers

in those institutions is vital; however, research on the therapy processes performed in this setting

as well as important topics, such as therapy termination with inmates and forced termination, are

scarce in published research literature.

History of the problem. Although prisons were not designed to treat the mentally ill

population, mental health treatment has come to be one of their primary roles today. The

following provides a summary of the historical intersection of mentally disordered persons and

imprisonment. The Treatment Advocacy Center delineates the history of mental illness in

correctional facilities starting at colonial times, from 1820 to 1970, and from 1970 to the present

(Torrey et al., 2014).

During colonial times, while non-violent mentally ill individuals received care from their

families in their homes, violent persons would be confined in jail regardless of their mental status

(Torrey et al., 2014). At the time, many people voiced their concerns about the confinement of mentally ill people, considering this treatment inhumane. In response, the first psychiatric ward was opened in the Pennsylvania Hospital in Philadelphia in 1752, and in 1773, the first psychiatric hospital for the insane was built in Williamsburg, Virginia. In 1825, Reverend Louis Dwight founded the Boston Prison Discipline Society, which advocated for improved prison conditions and insisted that mentally ill individuals belonged in hospitals. Two years later, a committee by the Massachusetts legislature recommended that the confinement of the mentally ill in prison be made illegal. In 1833, a state psychiatric hospital for 120 patients opened in Worcester and many individuals were transferred from jails and prisons to the hospital. Dorothera Dix made further efforts to improve the situation for the mentally ill by visiting every jail in Massachusetts and publicizing her horrific findings, urging states' legislatures to build more psychiatric hospitals. By 1847, Dix had visited 300 jails and 18 prisons and by 1880, there were 75 psychiatric hospitals in existence. At the time (from 1870 until approximately 1970), the assumption was that mentally ill people did not belong in correctional institutions (Torrey et al., 2014).

However, in the 1960s, a serious movement of deinstitutionalizing asylums began in the U.S. (Torrey et al., 2014). This has been in part traced back to the introduction of psychotropic medication in the 1950s (Stall, 2013). These agents helped with the stabilization of many patients who were then discharged and were supposed to be treated on an outpatient basis. However, funding for this endeavor was never adequate, patients were being discharged from psychiatric hospitals without follow-up care, and they rapidly began relapsing. Some of these individuals committed misdemeanors, often associated with their untreated mental illness, and were arrested (Torrey et al., 2014). This, in turn, increased the number of mentally ill individuals in jails and

prisons (Torrey et al., 2014). During the 1970s and 1980s multiple studies were conducted and

Dr. H. Richard Lamb and his colleagues at the University of Southern California concluded

> Thus, by the early 1980s, three decades ago, it was clear that deinstitutionalization was
>
> resulting in a progressive increase of mentally ill individuals in the criminal justice
>
> system. Discharging individuals with serious mental illnesses without ensuring that they
>
> received proper treatment in the community was a prescription for sure disaster (Torrey,
>
> et al., 2014).

> In the 1980s, an estimated 10% of incarcerated individuals had serious mental illnesses.

In 1992, a study found that not only were people imprisoned due to minor offenses associated

with untreated mental illness, but also their psychiatric symptoms were worsening during

incarceration. Continuing deinstitutionalizations and closures of mental health hospitals

increased the number of serious mentally ill individuals to an estimated 30 to 60% in many

states' prisons and jails (Torrey et al., 2014).

The history of correctional mental health treatment. Sun (2012) divides the history of

correctional counseling into three stages, (a) 1870s to 1945, (b) 1945 to the mid-1970s, and (c)

mid-1970s to the present. During the first stage (from the 1870s to 1945), many people started to

counsel in correctional facilities, such as parole officers, clergymen, teachers, and others (Sun,

2012). This attempt was fueled by recent advances in the treatment of offenders, initiated by

concerned citizens outside of the criminal justice system. At the time, however, there was little to

no research on the needs of offenders and counseling attempts were based on "trial and error"

(Sun, 2012). In stage two (from 1945 to the mid-1970s), rehabilitation became an ideal and

individual and group counseling, behavior modification, and vocational and educational

programs were introduced in correctional facilities (Sun, 2012). Treatment in prison was widely

popular in the 1960s although research on its effectiveness was still missing.

Starting in the 1970s, the idea that "nothing works" arose following an article by

Martinson (1974) that stated, "with few and isolated exceptions, the rehabilitative efforts that

have been reported so far have had no appreciable effect on recidivism" (p. 25). This was easy to

believe, considering that correctional mental health workers usually witnessed the failures

represented by patients who stayed at or returned to prison but did not see the successes after

release (Mobley, 1999). However, research revealed that certain therapy approaches, such as

cognitive behavioral therapy (CBT), were successful in reducing aggression, personality

disorders, substance abuse, self-harm, suicide risk, criminal activities, and recidivism (French &

Gendreau, 2006; McGuire & McGuire, 2005). In addition, counseling was found to be effective

with juvenile delinquents (Kadish, Glaser, Calhoun, & Risler, 1999).

During the third stage, from the mid-1970s to the present, correctional treatment became

less valued (Sun, 2012). Phelps (2011) explains, during this period, the *rehabilitative ideal*, that

is, the idea that incarcerated persons could be reformed and could return to society as

law-abiding citizens, declined. The criminal justice system became more punitive and less

oriented toward rehabilitation. Phelps describes that the so-called "Big House" turned into a

violent "warehouse" for people who were judged irredeemable by society. The public's

perception of increase in and fear of crime led to the idea of the radicalized "super-predators"

and the increase of harder punishments. Moreover, the number of imprisoned Black and

Hispanic individuals increased during this period. Prison riots in the 1970s further discouraged

the idea of rehabilitation; thus, funding allocated toward prison programs decreased. Despite the

anti-rehabilitation movement, Phelps found that the rehabilitation in prisons appears to have

remained stable; the penal rhetoric, according to her, did not correspond to the actual practices. However, that also means that even during the 1950s and 1960s, the implementation of rehabilitative programs was quite limited and roughly comparable to that of the 1990s (Phelps, 2011). The programs offered in prisons did increase throughout the 1980s, however, as did the prisoner population.

Contexts of the problem.

Mental health care and remediation in contemporary U.S. prisons. The issue of prisons and their goals for rehabilitation has come to recent attention, due to the great increase of inmates with mental illnesses. In the past few decades, more and more people with severe mental illness have received their psychiatric care in jails and prisons (Lamb & Weinberger, 2005). This is in part due to the structural changes in the mental health system and its reduction of psychiatric inpatient treatment. Lamb and Weinberger state that in 1955, there were 339 beds per 100,000 people available, whereas in 2000 this number had dropped to 22. In 2000, there were fewer than two non-forensic state hospital beds per 100,000 people in California. The number of inmates in turn has risen from 209 per 100,000 persons in 1978 to 708 per 100,000 in 2000. The decrease in numbers of non-forensic state psychiatric hospital beds has severely limited the availability of mental health treatment for severely mentally ill people, which in turn increased the likelihood that these individuals became involved with the criminal justice system (Lamb & Weinberger, 2005).

According to Lamb and Weinberger (2005), when the police recognize the mental illness in individuals, they often either choose not to seek hospitalization for them or are unable to secure hospital care for the person. Some obstacles to hospitalization can be the rigid criteria for involuntary psychiatric hospitalization, the shortage of beds, long waiting periods in psychiatric

hospitals, the reluctance of mental health professionals to admit aggressive patients, and the premature discharge of the mentally ill individuals.

Thus, law enforcement officers may incarcerate the mentally ill offender at a jail without adequate treatment options. In a 1988 survey, Morrissey, Swanson, Goldstrom, Rudolph, and Manderscheid (1993) found that a total of 11,546 state prison inmates in various states were receiving 24-hour psychiatric inpatient or residential treatment, which represents about 25 of 1000 inmates. During the month of September, the same year, nearly 10% of the inmates received mental health counseling or therapy from a physician, nurse, psychologist, or social worker. Further, the authors found that about five percent of incarcerated individuals received monitoring or evaluation of a psychotropic medication regimen and four percent received psychiatric assessment or psychological testing. However, Pallone and LaRosa (1979), using data from 1978, found that federal institutions had a ratio of one mental health specialist to 52 inmates and state institutions had one specialist for 81 inmates. They found that mental health services, including group and individual counseling, vocational assessment, and treatment for alcoholism and substance abuse were available in all state facilities. However, inmates in 93% of all state facilities did not have access to full-time psychiatrists, 79% did not have access to full-time psychologists, 62% did not have access to full-time social workers, and 87% did not have access to full-time correctional counselors.

Even inmates with severe mental disorders often do not receive treatment. Steadman, Holohean, and Dvoskin (1991) for example, surveyed 3,684 inmates in New York State prisons in 1986, and found that 5% had severe psychiatric disabilities and 10% had significant psychiatric disabilities. The inmates were assessed with the psychiatric summary (PSYSUM) and the Community Activity Dysfunction Scale (CADS) to determine who had significant versus

severe disabilities (Steadman, Fabisiak, Dvoskin, & Holohean Jr, 1987). While those with a higher level of disability received more mental health services than those with a lower level of disability, still 45% of the severely disabled individuals received no service at all in the surveyed year.

Goals of mental health care in contemporary U.S. prisons. Today, there are two main goals of psychologists in prison. One is to help inmates understand themselves and work through their conflicts (Sun, 2012). The second goal is to reduce recidivism of offenders, which not only prevents the inmate from repeated incarceration, but also protects society from further harm by the individual (Sun 2012). In the best-case scenario, the interaction effect of therapy and law interventions should lead to a rehabilitation of the offender, help him or her change his or her maladaptive behavior, and give him or her the tools to deal with problems in the future.

Ogloff, Roesch, and Hart (1994) explain that the physical and mental wellbeing of others is ample justification for providing mental health treatments, including treatment of incarcerated individuals. The authors' three reasons for treatment in prisons are (a) the far greater prevalence of mental illnesses among incarcerated individuals compared to the general population; (b) the goal of protecting society and maintaining safety for correctional officers and inmates; and (c) legal requirements, which mandate screening inmates for mental illness to provide a minimum of services to them.

Correctional mental health professionals in contemporary U.S. prisons. Correctional mental health professionals come from diverse fields, provide a variety of services, work within multiple theoretical orientations, and serve a broad population of inmates, who often have received treatment before.

The Bureau of Justice Statistics reported that in 2000, 1,394 of the nation's 1,558 public

and private adult correctional facilities provided mental health services to inmates (Beck & Maruschak, 2000). Seventy percent of the facilities screened inmates during intake, 65% conducted psychiatric assessments, and 51% provided mental care 24 hours a day, 71% of which was provided by trained mental health professionals. Further, 73% of the facilities reportedly distributed psychotropic medications to inmates and 66% helped released offenders receive community mental health services. The study also found that one in eight state prisoners that year received mental health treatment and nearly 10% received psychotropic medications. Less than 2% of the inmates were housed in 24-hour mental health units. Boothby and Clements (2000) surveyed 800 psychologists working in correctional facilities in 2000 and found that the number of psychologists in prison systems had doubled in the past 20 years.

Morgan, Winterowd, and Ferrell (1999), surveyed 79 randomly selected state penitentiaries with 162 returned surveys and discovered that on average, mental health providers in correctional institutions spent an equal amount of time providing individual psychotherapy services and group psychotherapy. The participants who facilitated psychotherapy groups included psychologists (71%), professional therapists and counselors (52%), addiction counselors (47%), social workers (44%), master's students in training (29%), psychiatrists (19%), other professionals (13%), nonprofessionals (12%), and doctoral students in training (11%). The group therapies available focused on anger management, stress management, problem solving, recidivism, institutional adjustment, men's issues, general psychotherapy, sex offender treatment, substance abuse issues, cognitive restructuring, and other psychotherapy. The surveyed mental health providers reported that on average 20% of the male inmates received group therapy, and most of the inmates were either selected on volunteer basis or mandated.

Ferrell, Morgan, and Winterowd (2000) asked 162 participants from 78 adult male state

correctional facilities about their perceptions about job responsibilities. These mental health professionals reported satisfaction with their variety of job responsibilities, which included group and individual psychotherapy, crisis intervention, supervision, and conducting assessments. However, the participants reported less satisfaction with administrative responsibilities, their own individual supervision, and writing reports and progress notes.

Morgan, Rozycki, and Wilson (2004) asked 418 inmates to complete a survey regarding their experiences with, and attitudes and perceptions toward mental health services. Of these participants, 36% had received mental health services before adulthood. Before incarceration, 25% of the participants had received voluntary mental health treatment and during incarceration, 31% volunteered to receive mental health treatment. Mandated treatment was experienced by 18% prior to and 22% during incarceration. The majority of the inmates (66%) preferred individual therapy to group therapy, perhaps due to the perceived increase in confidentiality and therapy tailored to the inmates' needs. Further, incarcerated individuals indicated that they preferred psychologists or professional counselors to psychiatrists, addiction counselors, social workers, students, or other professionals and nonprofessionals. The authors hypothesized that inmates may prefer psychologists because they are particularly qualified to manage issues of diversity and trained to deal with issues and problems unique to the incarcerated population.

Treatment approaches in contemporary U.S. prisons. Today, there are many treatment approaches and relapse prevention programs in prisons (Aos, Miller, Drake, & Lieb, 2006). Often, these approaches target specific populations. There are special treatment programs that aim to rehabilitate prisoners with psychological problems, drug addictions, sex offences, violent offences, and organized crime offences. Some of the most important and most frequently performed approaches are cognitive therapy (Aos et al., 2006; Boothby & Clements, 2000;

Harvey & Smedley, 2012), behavioral therapy, CBT, positive psychology, group therapy, education and vocational training, and, as mentioned, crime-specific treatment, such as sex-offender and drug treatment (Clark, 2010; Sun, 2012). Cognitive-behavioral approaches are the preferred treatment options after psycho-educational and process groups (Boothby & Clements, 2000). Cognitive-behavioral approaches are considered highly effective in reducing antisocial behavior, as evidenced in post-intervention and follow-up assessments, and are particularly successful in domains on which the specific treatment focused (McGuire & McGuire, 2005).

Further, outpatient treatment services in correctional institutions that are not restricted in orientations (as some prisons may request only specific treatments) include approaches, such as assertiveness training and Zen, which claim some success, but not for the long-term (Mobley, 1999). All of these approaches have treatment programs and interventions designed to fit the client's needs while aiming to decrease the probability of relapse, and require a trusting relationship between the client and the therapist to be effective. However, the latter can be difficult to establish.

The difficulty of correctional mental health treatment. Many patients have personal life histories characterized by poor bonding, emotional neglect, negative experiences in institutions, and few if any supporting and trusting relationships (Carlson & Shafer, 2010). Weeks and Widom's (1998) study for example revealed that 68% of incarcerated males from a New York State medium-correctional facility reported some form of childhood victimization. A common experience among female inmates is trauma, which is defined as "any form of interpersonal or domestic physical, sexual or emotional abuse or neglect which is sufficiently detrimental to cause prolonged physical, psychological, or social distress to the individual" (Moloney, van den Bergh, & Moller, 2009, pp. 427). Fifty-seven percent of incarcerated females

and 16.1% of males reported abuse before entering prison, and 39% of female inmates and 5.8%

of males experienced sexual abuse before entering state prison (Sipes, 2012). In 69% of the cases

of female inmates, the abuse occurred before the age of 18 (Greenfeld & Snell, 1999). Trust,

therefore, does not come easy to most of the incarcerated patients. Weinfield, Sroufe, Egeland,

and Carlson (1999) assert that these abusive or neglectful early experiences may lead people to

develop insecure attachments and start defending themselves against the insecurity through

aggressive behaviors.

Further, Haley (2010) explains that not only disrupted attachments but also the prison

environment creates concerns with prisoners' attachment issues. Haley also suggests that the

design of buildings, promoting isolation, and the separation from one's family may create or

worsen attachment anxiety; moreover, abrupt terminations of treatment can increase this anxiety

(Haley, 2010). Prisoners may project their early traumatic attachment experiences with their

caregivers onto the prison staff (Haley, 2010) and potentially on the therapist when, leading to a

recreation of experiences of neglect when forced termination occurs.

To be more effective in building trust and rapport, Marshall and Serran (2004) suggest

that therapists model appropriate pro-social behavior, demonstrate flexibility, warmth,

genuineness, and empathy, and encourage clients to act the same way. Helping offenders identify

benefits and costs of their behaviors can be motivating. However, the authors also acknowledge

that this may be difficult with patients who behave in a resistant or hostile manner. Therapists

need to give feedback explaining that this behavior, while understandable, is inappropriate, and

this needs to be done in a non-confrontational style.

Furthermore, to establish trust, the need for a safe space in the therapeutic setting is also a

key issue (Harvey & Smedley, 2012). Incarcerated psychotherapy patients will only be willing to

talk candidly about themselves in a safe and private space. Constant therapeutic work is required to create this setting. Additionally, the stay in a prison is stressful and may cause irritability, depression, and aggressiveness. These behaviors or affects of the client will make it more difficult for the therapist to treat the client (Schnittker, Massoglia, & Uggen, 2012). Further complicating therapy with these individuals is the unpredictability of termination (Sun, 2012). To be able to achieve a positive outcome in this setting, the working alliance becomes an important factor.

Theoretical Framework

  The working alliance. According to Lambert (1992), four therapeutic factors influence the outcome of therapy. Extratherapeutic change makes up 40%, common factors 30%, techniques 15%, and expectancy (placebo effects) 15%. The extratherapeutic factors include the influences from outside of therapy that influence the outcome regardless of the patient's participation in therapy, such as events that occur during treatment (e.g., patient's ego strength) and the patient's environment (e.g., patient's social support). The expectancy (placebo effects) results from the patient's knowledge that he or she is being treated (Lambert, 1992). Technique includes the factors that are unique to the specific therapeutic approach; in the case of therapy in correctional settings, it appears to be the focused attention on a specific problem. Common factors are therapy-overarching elements within all schools of therapy. These factors may be empathy, warmth, acceptance, and encouragement. All of these common factors are considered to

    provide for a cooperative working endeavor in which the patient's increased sense of

    trust, security, and safety, along with decreases in tension, threat, and anxiety, lead to

    changes in conceptualizing his or her problems and ultimately in acting differently by

replacing fears, taking risks, and working through problems in interpersonal

relationships. (Lambert, 1992, pg. 104)

One common factor is the therapeutic alliance, also known as the working alliance

(Lambert, 1992). The working alliance between patient and therapist is a critical factor for the

success of any type of therapy (Frieswyk, Allen, Colson, Cayne, Gibbard, & Horwitz, 1986).

Therapeutic alliance: Its place as a process and outcome variable in dynamic psychotherapy

research. Journal of Consulting and Clinical Psychology, 54, 32–38.., 1986). The working

alliance is a special form of personal relationship, in which aspects of perceived support,

appreciation, and respect exert a strong influence on its development. The patient's ability to do

purposeful work in the therapy, his or her affective relationship to the therapist, the therapist's

empathic understanding of the patient, and the agreement on goals and tasks of the therapy are

important in order to establish the therapeutic relationship (Gaston, 1990).

The working alliance in the context of psychotherapy has been the subject of clinical

interest, theoretical discussion, and empirical research (Lambert, 1992). Psychoanalysis and the

resulting psychodynamic schools of therapy laid the foundation for the scientific discourse of the

working alliance. The origin of the concept lies in Freud's work (1913). While at first he

regarded transference as purely negative, he later saw the positive bond between therapist and

patient as the basis for a positive transfer (Ardito & Rabellino, 2011). In fact, he posited that

therapists should show consistent sympathy and interest in the patient in order to elicit the

positive transference (Freud, 1913). This positive transference or alliance creates the initial

safety and confidence needed by the patient for a successful analysis.

Other therapeutic schools also considered the working alliance as important. Carl Rogers

(1951) thought that the working alliance presents an inherent positive and healing function. The

therapeutic relationship in behavior therapy was not discussed for a long time; however, a good therapy relationship was considered a prerequisite for the implementation of certain techniques (Horvath & Greenberg, 1994).

A catalyst for the research leading to common factors theory, occurring in the course of early empirical psychotherapy research in the 1950s, was introduced by Eysenck's (1952) highly contested article, which concluded that psychotherapy is no more effective than a placebo condition. Over time, the consensus on a need for an overarching and pantheoretical understanding of the working alliance became clear. Bordin (1979) formulated the psychodynamic understanding of the therapeutic relationship in a more general model, valid for all professional helping processes. He emphasized a bidirectional relationship process, based on trust and acceptance with three interlocking components: (a) the agreement on the therapeutic goals, (b) the consensus on tasks in the therapy process, and (c) the interpersonal alliance or bond between the therapist and patient (Bordin, 1979).

With the development of reliable measuring scales to assess the therapeutic relationship, many studies on the relationship between the working alliance and the treatment outcome were conducted. A major meta-analytic study summarized the main results (Horvath & Symonds, 1991). The researchers found that there was a small but consistent general relationship between the working alliance and psychotherapy outcome with an effect size of $r = 0.26$ in 23 primary studies (Horvath & Symonds, 1991). Horvath and Greenberg (1994) cites Safran and Wallner (1991) and Wallner and Samstag (1992) who discovered that the severity of a patient's symptoms does not affect the development of a positive therapeutic relationship. Furthermore, he cites Jones (1988) who found that the patient's expectations and preferences have little effect on the working alliance.

The working alliance and psychotherapy types. Raue, Goldfried, and Barkham (1997) compared the working alliance between clients being treated with CBT with clients who were treated with psychodynamic–interpersonal therapy. They found that CBT sessions were rated as having a higher therapeutic alliance than the psychodynamic sessions. The authors suggest that the therapists using CBT showed greater degrees of empathy, congruence, and interpersonal contact. The researchers had used the same therapists for both approaches to rule out that the differences, which could be attributed to therapist factors; however, the relative competence of therapists' command of both models was not evaluated. According to the authors, the reasons for this difference may be the aim of the CBT approach to give clients positive experience and positive coping strategies, whereas psychodynamic therapy may have some unresolved efforts in giving clients corrective experiences.

The working alliance in the correctional setting. The working alliance is an important factor in the success of mental health treatment with offenders (Huffman, 2006). A study by Witte, Gu, Nicholaichuck, and Wong (2001), for example, revealed that offenders who rated the working alliance with their therapists as poor, recidivated at a higher rate than offenders who perceived the working alliance more positively.

As mentioned, Lambert (1992) posed that 30% of improvement in psychotherapy could be attributed to common factors, including empathy, acceptance, encouragement, and positive regard for the client. Marshall et al. (2003) and Serran et al. (2003), who studied therapy outcomes with sex offenders, confirmed that certain therapist characteristics are considered important in eliciting a positive working alliance, such as warmth, genuineness, providing positive reinforcement, and appropriate self-disclosure. Similarly, Wallace (2005), researching therapeutic work with therapy mandated clients, found that a positive therapeutic relationship

with the client is an important factor in effective psychotherapy with this clientele. Rochlen, Rude, & Barón, 2005) stated that working with clients in the precontemplative stage of change presents a problem when trying to agree on goals or planning for task and that a positive therapeutic connection is necessary for the success of this stage.

Difficulties of establishing a working alliance in the correctional setting. Other factors could undermine a positive working alliance between a therapist and an inmate. One of them is the power differential. Every therapist in the correctional setting has to manage dual roles, having the institution as one's employer and the inmate as a patient and having to enforce correctional procedures in the therapeutic context (Brans & Lesko, 1999). Further, this dual relationship is problematic in that the inmate is asked to participate and be vulnerable with a therapist who is a member of the oppressing institution. Being in therapy can be especially disempowering and frustrating for an inmate. The therapist, therefore, has to find a way to use correctional procedures in ways that are empowering to the inmate.

The lack of privacy and confidentiality in the correctional setting is another issue threatening the working alliance between the therapist and an inmate (Helfgott, 2013). Any staff, visitor, or inmate is able to see who attends psychotherapy sessions by seeing or hearing the inmates' names are on a callout (Helfgott, 2013; Huffman, 2006). Emails are sent discussing inmates' health status, therapists report potential drug abuse in prison, clinical notes are available to all treatment providers, in some cases therapy conversations are audible to other inmates (Huffman, 2006), and inmates can be seen in inpatient units through windows. Interruptions and intrusions in the therapy room, loud conversations of staff in adjacent rooms, horseplay of nearby inmates, guards doing count of who is present are just a few of the difficulties therapists and clients have to deal with in this setting (Huffman, 2006). The establishment of an inmate's trust

is always precarious and tentative, if only because the inmate knows that the therapist must disclose information to authorities (Helfgott, 2013).

Another threat to the working alliance between therapists and incarcerated clients concerns the ability of the therapist to trust the patient. Due to the nature of the setting, therapists may be afraid that they will be manipulated by the inmate (Helfgott, 2013). The therapist is aware that the patient has to do whatever it takes to get his or her needs met; a sense of being objectified by the patient can impair a therapist's empathy. Hence, it is very important that therapist understand why this manipulation occurs and depersonalize it (Helfgott, 2013). A therapist may experience fear and worse when sitting with an inmate who denies or minimizes the horrible crimes he or she has committed. It such cases it is important for the therapist to work hard to remember that inmates who deny the impact of their crime probably are trying to protect their fragile personality structure by using this as a defense mechanism (Helfgott, 2013). It is understandable that therapists of the incarcerated could hesitate in sharing personal information. While some self-disclosure might be therapeutically beneficial, patients could disclose this information to cellmates or other inmates who know the therapist (Huffman, 2006).

Ross, Polaschek, and Ward's (2008) article describes in detail factors specific to the correctional setting that can affect the therapeutic alliance, such as client and therapist characteristics, client-therapist interactions, setting and contextual factors, system factors, immediate therapy context, role conflict and confusion, and program factors. The authors suggest revisions to the model of the therapeutic alliance proposed by Bordin (1979) that would consider the interactions of these factors to produce a therapeutic alliance as measured by goals, tasks, and bond.

While these obstacles to a working alliance are possible to overcome, there are other

obstacles that neither the therapist, nor the patient can change. One of such obstacles is forced termination of therapy.

Psychotherapy termination. All psychotherapeutic work must end; it is after all the most fundamental goal of therapy to make itself obsolete. There are many answers to the question of when it is the right time to end therapy; one is the absence of symptoms. The American Psychological Association (2003) guideline 10.10, for example, requires that "psychologists terminate therapy when it becomes reasonably clear the client/patient no longer needs service, is not likely to benefit, or is harmed by continued service" (p. 14). However, these guidelines do not explain the processes for how termination should happen. To have a well-rounded understanding of psychotherapy, one should be aware of the potential impact and complications of termination.

History of therapy termination. In the early days of psychoanalysis, termination was not a major concern. The main reason for this was Freud's idea of the never-ending analysis and Ferenczi's belief that truly cured patients will free themselves from analysis and will seek gratification elsewhere (Auld, & Hyman, 1991). However, Freud eventually recognized the traumatizing effect discontinuation of therapy could have on the client. Late in his career, Freud explored the question of whether there is such a thing as a natural and complete end to an analysis, or whether it is possible to conduct an analysis toward such an end (Bass, 2009).

The termination phase became a discussion point in the 1950s (Bass, 2009). At a symposium, it was acknowledged that termination evolves naturally, and that the termination phase, which should be mutually agreed-upon, includes regression, reactivation of symptoms, and a mourning process (Bass, 2009). Glover (1955) as cited by Bass stated that termination is necessary to a successful analysis, and that termination is not just the end of the analytic process,

but an analytic process. In the 1950s, discussions also involved the possibility of patients seeing therapists again after therapy had been terminated (Mendenhall, 2009). However, to this day, and despite almost 100 years of discussions on termination, theoretical and methodological considerations are still generally inconsistent (Bass, 2009; Joyce, Piper, Ogrodniczuk, & Klein, 2007; Mendenhall, 2009).

Major areas of discussion of this phase of therapy are time, date setting, methods, and problems of termination, as well as the context of the therapeutic relationship after therapy, and the therapist's and patient's reactions regarding the end of therapy (Joyce et al., 2007). Further, discussions focus on the type of therapy the termination takes place in and the reasons for termination.

Today, we know that the temporal structuring and interruptions in the regular course of therapy are part of any psychotherapy. Termination is prepared and practiced over the course of therapy. Terminations and interruptions as well as the emotional reaction to them can give important clues regarding existing dynamics clients have towards termination (Joyce et al., 2007).

Further, it is now clear that the termination of short-term therapies, often limited to around 12 sessions, could increase the requirements on the therapist because they should fit a termination phase into the time-constricted therapy. Meanwhile, therapists doing long-term therapies are faced with the disengagement from therapeutic relationships in which they have invested much time and commitment. With respect to termination, it seems to be important how the time limitation is handled, regardless of the actual length of therapy. Moreover, termination carries different emotional meanings for therapists and clients, depending on whether it is planned and carried out voluntarily or is due to external circumstances (Joyce et al., 2007).

In long-term therapy, termination is generally only considered after the patient's core problems have been resolved, whereas in short-term therapy, termination is often introduced at the outset or after a comparatively short time (Joyce et al., 2007). In CBT, which is usually short-term, less emphasis is placed on termination (Joyce et al., 2007). According to Joyce et al., more emphasis is generally placed on termination in therapy approaches that focus more on the therapeutic alliance.

The process of therapy termination. According to Joyce et al. (2007), there are two primary phases that occur toward the end of therapy: the working phase and the termination phase. The working phase includes the late working phase of therapy and the pretermination phase. In the late working phase of therapy, the patient demonstrates the attainment of therapy objectives, which can be relief from distress, mastery of problems, and the capacity to function independently. In the pretermination phase, the issue of ending is raised and criteria for termination are evaluated. The patient and the mental health provider agree that the shared goals of therapy have been fulfilled and the therapist clarifies that a shift in the patient-mental health provider relationship has occurred (i.e., there is a decrease in distortion and an increase in the quality of a real relationship). Finally, the mental health provider and the patient agree that the patient is ready to terminate (Joyce et al., 2007).

After a date for the end of therapy is set, the termination phase begins. The general objectives of this phase are a discussion of the patient's achievement of a balanced, realistic view of the therapy process and relationship, and an internalization of positive aspects of therapy. Associated tasks in this phase are a review and recapitulation of therapy course, accomplishments, and unmet goals. The mental health provider and patient address the relational meaning of ending, including issues of loss and separation, transference, and

countertransference. Furthermore, the client's internalization of the therapy process and the

mental health provider's functions are revisited. Outcomes of the termination phase should

include the reinforcement and consolidation of the therapy process, discussions of the gains from

therapy, the resolution of issues in the therapy relationship, and the preparedness for maintaining

healthy functioning outside of therapy (Joyce et al., 2007).

The separation during the termination phase is theorized to be similar to Bolwby's

grieving process (Bowlby, 1982). Although his theories on the grieving process are based solely

on grief and loss caused by death, they are valid for all separation processes. During termination,

emotions (particularly separation anxiety), the risk of resistance and pathological development,

the connection to past separation trauma, the interaction between reality, cognitions, behavior,

and the instinctive determination on the one hand, and the intrapsychic, unconscious conflicts,

processes and structures as well as environmental influences on the other are present.

Forced therapy termination. Ideally, a patient and his or her therapist realize at the same

time that the treatment goals are achieved to a sufficient degree and are ready to terminate;

however, this does not always happen. Often, either the patient or therapist will want or need to

stop treatment, while the other thinks that the time is not right. Sometimes, the reasons for the

termination are external and nonnegotiable (Mikkelsen & Gutlheil, 1979).

If the termination date is set ahead of time, the patient and the therapist can plan and

prepare for it and make the separation successful by working through the termination phase.

However, in the absence of an anticipatory termination phase and a sudden termination, the

therapy ending is considered forced termination. The therapy is finished, but not successfully

terminated.

The experience, processing, and solution of separation activities at the end of therapy, as

well as the improvement of separation abilities are major therapeutic goals of the final phase of psychotherapy (Joyce et al., 2007). Given that a not sufficiently managed separation of therapy can cause relapse or other psychological problems, the therapeutic work in the termination phase is important for the post-terminal period and the post-therapeutic long-term course. According to Joyce et al. (2007), patients may experience feelings of anger and disappointment, as well as depression associated with feelings of powerlessness and displaced grieving when faced with forced termination.

Forced therapy termination in the correctional setting. Forced termination, especially the unexpected, nonnegotiable kind, often occurs in the correctional setting. According to Wormith and Olver (2002), there are three types of therapy attrition in the correctional setting: (a) client-initiated dropout, (b) agency-initiated expulsion, and (c) administratively based exit. Client-initiated dropout occurs when the inmate refuses to continue therapy. Administratively based exit occurs when the inmate is released or transferred for reasons that have nothing to do with his or her need for treatment or performance in therapy (e.g., court overturns conviction or sentence, offender gets parole, transfer). Agency-initiated expulsion occurs when an exclusionary criterion (e.g., disruptive inmate) is invoked to disallow a referred offender from entering treatment.

Wormith and Olver (2002) reviewed the literature and found that treatment attrition among offenders is higher than it is for many other patient populations. Three quarters of noncompleters were presumably client-initiated dropouts. About one-half of the remainder was agency-based expulsions, and the other half were administratively based exits. Forced termination due to transfer may occur frequently in state facilities but are less common in federal prisons or county jails as well as women's facilities because there are fewer facilities to which the inmate can be transferred (K. Sun, personal communication, February, 25, 2014).

Given the unpredictability of these outside factors of termination, the correctional mental health provider seldom can complete the treatment as planned (Sun, 2012). Sun cites Baum (2005), who found that feelings and reactions toward termination are more positive for the client when they believe that they have attained their therapeutic goals and have a choice in termination. Conversely, patients who have no control over the termination, show more resistance, anger, rage, anxiety, and frustration regarding termination. Sun states that termination in the correctional setting is often unexpected and beyond the control of the offender. In a therapy setting outside of corrections, it is suggested that the therapist inform the client about the therapy termination as early as possible and to prepare them to handle the negative reactions. However, if the mental health provider and/or the patient are unable to give the impending termination enough consideration, the progress made during therapy may be nullified. To make some progress in the face of this unpredictability, the working alliance must be established quickly to elicit at least some change in the inmate.

The intersection between forced termination and the working alliance. There is much research on premature or unilateral termination and the working alliance. Tyron and Kane (1993), for example, asked four psychologists and six practicum trainees as well as their 103 college student patients to complete the short version of the Working Alliance Inventory. Unilateral termination was considered to have occurred when the patient failed to attend therapy for three weeks in a row. The researchers found that the counselor ratings of the working alliance were positively related to mutual termination. Kokotovic and Tracey had a different result in their 1990 study, stating that the counselor-rated working alliance was not related to the termination type. However, Kokotovic and Tracey (1990) assessed the alliance after the first

counseling session whereas Tyron and Kane assessed the alliance after the third session when they believed an adequate alliance could be established.

This research, however, is based on the issue of patient-initiated dropout. There is little, if any research on the connection of the working alliance and forced termination that is caused by outside factors and not therapist or patient initiated.

Significance of the Study

Therapy in correctional facilities has been effective in reducing recidivism (Someda, 2009). Many inmates suffer from mental disorders (Glaze & James, 2006), and the unpredictability of incarceration time makes it necessary for mental health providers to learn more about correctional therapy and how a positive working alliance may be able to help the inmate despite the unpredictability of the setting and the frequent lack of a termination phase.

With the large number of incarcerated people in the United States comes an increase of costs maintaining the facilities and the staff. Furthermore, it increases the cost for the country due to the loss of productivity of the inmates in society. The cost of incarceration in California was $27,000 per inmate per year and would have been $4,500 had the offender received treatment instead (McVay, Schiraldi, Ziedenberg, & Justice Policy Institute, 2004). Ensuring that offenders are not re-incarcerated should be a major goal and therapy has been found to play a major role in lowering recidivism (Aos et al., 2009). Without adequate treatment, inmates may return to their former lives with the high probability of re-offending.

The intent of this study was to interview a sample of mental health service providers about their perceptions of the working alliance between them and the incarcerated patients in relation to unexpected therapy termination. The working alliance is an important factor in therapy outcome in that a positive working alliance is a reliable predictor of positive therapeutic

outcome (Horvath & Symonds, 1991; Safran, Corcker, McMain & Murray, 1990). The beneficial factor of the working alliance may be robust enough to survive and contribute in less than desirable settings such as a prison and in therapies that were forcedly terminated. Consequently, it is important to research how mental health service providers perceive the working alliance established in treatment that was forced terminated.

While there is some research on the effectiveness of therapy approaches (Aos et al., 2006; Duwe & Goldman, 2009) and suggestions on how to handle the many obstacles in the treatment of offenders (Ross e al., 2010), more research is needed in this area and the influence of forced termination. Lambert's (1992) finding that 30% of improvement in psychotherapy can be attributed to common factors, such as the working alliance, brought about the question how mental health service providers can establish a positive therapeutic relationship with inmates quickly and despite the constant peril of forced termination. Mental health service providers in this setting have the duty to aid inmates overcoming their difficulties; but how do mental health service providers dismantle the many obstacles that prevent these individuals from receiving appropriate treatment?

Summary

Treatment plays a big role in helping inmates turn in the right direction, which will benefit society. Research has shown that therapy can be helpful in reducing recidivism and there is evidence that a positive working alliance between a therapist and a patient can lead to successful therapy. However, there are many obstacles to establishing a working alliance, such as forced termination. Learning about this obstacle in the correctional setting and finding ways to overcome it could play a vital role in improving treatment outcomes.

Methodology

The purpose of this research was to explore a sample of therapists' descriptions of their experiences of termination and forced termination in the correctional setting. As suggested by Olver, Stockdake, and Wormith (2011), there are many predictors of therapy attrition among inmates and awareness of these factors allows for more effective efforts to counteract premature termination. This awareness should include factors that are related to the system (i.e., the prison system). I proposed that a better understanding of how correctional mental health providers experience forced termination and the working alliance in this setting will contribute to the field of correctional psychology with the goal to improve treatment for inmates.

This chapter covers the rationale and procedures for the use of a qualitative research method, information on the sample size and type of population interviewed for this study, information on the instrumentation, procedure, qualitative material collection method, ethical considerations, and limitations of the study.

Rationale for Research Methodology

Research in psychology is used to acquire knowledge about the psychological and social reality of people. The general goal of research is the development and review of theories about this reality. I chose a qualitative approach to this research due to pragmatic reasons. Mertens (2009) describes Patton's (2002) types of research questions for which qualitative methods would be appropriate. These include questions regarding "process, implementation, or development of a program," emphasis on "individualized outcomes," "in-depth information about clients or programs," "diversity among, idiosyncrasies of, and unique qualities exhibited by individuals," or understanding "the program theory" ("that is, the staff members' (and participants') beliefs as to the nature of the problem they are addressing and how their actions

will lead to desired outcomes).” The goal of this study was to explore how correctional mental health providers handle forced termination with clients in the correctional setting, whether there are steps that can be taken to ensure a good outcome despite premature termination, how the working alliance influences the outcome of the forcedly terminated treatment, and whether there are other ideas on how to counteract negative consequences of forced termination in this setting. The research is looking at the participants' beliefs regarding the nature of the problem and how they are addressing it. Therefore, qualitative analysis of the participants' ideas and beliefs is the best method.

As a theoretical orientation, the approach of Interpretative Phenomenological Analysis presented itself to this study. This approach, developed by Jonathan Smith (Smith, Flowers, & Larkin, 2009), allows researchers to gain insight into the experiences of its subjects. The goal of IPA is to understand the experiences of participants from their point of view, recognizing that their understanding is based on a dialogical process of co-construction of meanings between a researcher and participants. According to Smith, Flowers, and Larkin, IPA is informed "by three key areas of the philosophy of knowledge: phenomenology, hermeneutics and ideography" (p. 11).

The four leading figures in phenomenological philosophy are Husserl, Heidegger, Merleau-Ponty, and Sartre (Smith, Flowers, & Larkin, 2009). Husserl's contribution to the field was the recognition that phenomenology involves focusing on people's experiences, memories, judgments, assumptions, beliefs, and perceptions. Heidegger, acknowledging the importance of Husserl's ideas, emphasized hermeneutics (Smith, Flowers, & Larkin, 2009). His assumptions are that people are "'thrown into' a world of objects, relationships, and language," and that our experiences are "perspectival, always temporal, and always 'in-relation-to' something" (Smith,

Flowers, & Larkin, 2009). This in turn led him to conclude that making sense or "meaning-

making activities" (p. 18) are the center of phenomenological inquiry in psychology. Merleau-

Ponty acknowledged that we see ourselves as different from the world (Smith, Flowers, &

Larkin, 2009). This means that we can observe and experience others but can never completely

share another person's experience. Sartre expands on these ideas by pointing out that our

experiences are understood by the presence and absence of our relationships to others (Smith,

Flowers, & Larkin, 2009).

Heidegger made the connection between phenomenology and hermeneutics (Smith,

Flowers, & Larkin, 2009). He recognized that when one attempts to understand another's

experience, one has to understand the mind-set and language of the other person. Gadamer

further added that understanding of another person always requires interpretation (Smith,

Flowers, & Larkin, 2009). That means that we have prejudices and the way we understand

experiences depends on our circumstances (e.g., the time we live in).

The third key area of the philosophy of knowledge, the ideography, refers to the in-depth

analysis of single cases, by examining perspectives and experiences of others in their context.

This way of studying experiences requires one to explore single cases before producing general

statements regarding experiences (Smith, Flowers, & Larkin, 2009).

Participants and Sampling

Seven participants volunteered to participate in this study by replying to the "request for

participation," and all of them were interviewed as they fit the requirements for participation.

The seven participants of this study were employed forensic mental health service providers who

were certified or licensed with a minimum of a Master's degree. These participants worked in

different correctional facilities (e.g., jails, state prisons, federal prisons) and in different locations

in the United States. They had worked at a correctional facility that offers individual therapy to inmates, and experienced at least one forced termination of an evidence-based practice at some point during their work at this setting. These individuals could answer questions regarding their experiences of forced termination with their incarcerated patients and efforts they made to ensure beneficial therapies despite premature termination. Forced termination criteria included administratively based exit, agency-initiated expulsion, and client-initiated dropouts. A more detailed description of the participants follows in the Results section.

Rationale for sampling methods and size. IPA requires an intensive qualitative analysis of the participants' accounts of their experiences, where meanings are the objects of interpretation (Smith & Osborn, 2003). The interpretive aspect of IPA assumes that meanings are socially constructed and thus call for an interpretive (dialogic) scientific model. The phenomenological aspect of IPA is the view that the analysis of individual meanings can provide insight into the essence of the human experience to be understood by the research -- making sense of a phenomenon. Dialogues are used to elicit an individual's meanings: in IPA, in-depth, semi-structured interviews are typically used. An IPA study is a detailed analysis of cases, rather than a statistical analysis of aggregate data. Because of this intensity of each analysis, Smith and Osborn suggest using only a small sample size of roughly six to 15, preferably nine, participants. When researching a topic in psychotherapy and counseling using IPA, six to 15 participants is the norm. Dallos and Vetere (2005) for example present a sample of nine participants. Only participants who can offer some meaningful insight to the study are invited to participate.

In this current study, seven participants shared their experiences during semi-structured interviews. The participants were selected without regard to gender. The goal was to interview six participants with one to two years of experience in the correctional setting, and at least three

participants with more than two years of experience, which was achieved. The goal of an

ethnically diverse sample was attempted by interviewing three to four minorities from the

volunteers to achieve an information rich and diverse sample of experiences. However, as it was

difficult to find enough participants, only seven were interviewed without regard for ethnic

diversity.

Data Collection Methods

The goal of a qualitative research method is to explore the subjective experiences of

participants as phenomena. Because it is not possible to directly experience another's experience,

the phenomena are studied through participants' self-reports of their experiences. By listening to

first-hand accounts of participants' experiences in a dialogical process of interpretation, or

making meaning, I could learn what participants' experiences meant to them. IPA recommends

using semi-structured interviews to access the phenomenon of interest (Smith & Osborn, 2003).

For the interview, I developed a set of questions in advance organized by the research questions

(Appendix F). A flexible, dynamic, and appropriate empathetic process was necessary for this

approach, which aimed to avoid a detached relationship between the participants and me.

Procedures. Requests for participation in the research study were emailed to members of

the American Psychology-Law Association (Division 41), which can be found in appendix A. To

include other mental health service providers in addition to those who are members of the APA,

a request was made on the LinkedIn group page of the International Association for Correctional

and Forensic Psychology; members' professional activities and interests are close in affiliation

with correctional psychology, such as PhDs, PsyDs, and LCSWs (Appendix B). Participants who

agreed to participate in the study were offered a $20 Amazon gift card.

After correctional mental health providers indicated interest in participating in the study,

emails were sent to them, which included a description of the study, length of time estimated for the interviews, insurance of interview confidentiality, methods of interviewing, and my contact information. Information about the study as well as informed consent were presented to the participants before the interview (see Appendix C).

Informed consent. A fundamental ethical commitment when doing research with human participants is the process of informed consent. Mental health service providers who had experienced forced termination with incarcerated clients were provided with this study's Informed Consent form, sent to them via email and signed and returned either by mail or email, prior to scheduling an interview appointment. Specifically, they were informed that their confidentiality was protected during and after the study. They knew that their name was given a code to hide their identity and that this code was used throughout the research study when any of their information was used in written or verbal formats. Furthermore, they were informed that any follow-up information or publication that may result from this study protects their identity. A copy of the Informed Consent form can be found in Appendix B. In addition, the participants received a Release for Recording form (Appendix D). The participants were asked to sign both forms and return them to me.

The disclosure of possible risks to participation on the Informed Consent form included a restatement that their participation was voluntary. Also mentioned was that discussing their forced therapy termination experiences could be mildly upsetting, since it involved revisiting and disclosing any manageable states of anger, frustration, or feelings of loss they might have experienced, which could rekindle similar states during the interview. The participants were informed that taking part in the study was voluntary and that they could withdraw at any time without consequences. They also knew they could choose not to answer any question. No

occasion for physical harm was associated with participation in the interview. Thus, participants were informed that there would be no more than minimal risk associated with their participation.

The possible benefits associated with participation in the study were, (a) the possibility that the mental health service providers may discover and learn new ways of understanding their experiences of forced termination and working alliance, (b) that they may have the desire to see others benefit from their experience and may help them be spared of the negative experiences, and (c) that other interview participants often report positive experiences of being interviewed. It was hoped that participants might enjoy being able to share their story, feel that they have made progress, experience a sense of closure, and may eventually feel that something good came out of their potentially negative experiences.

The participants were further informed that all relevant information regarding their participation in the study was kept in a locked filing cabinet when it was not being analyzed and only I had access to this information.

With the information provided in the email and Informed Consent form about the study, rapport and trustworthiness was introduced. Given the highly educated participants, some information on the data interpretation was provided. A level of language considered appropriate for this sample was used.

Once the signed Informed Consent and Release for Recording form were received, a demographics questionnaire was emailed to the participants, which asked questions about the participants' age, gender, ethnicity, nationality, type of education, preferred therapy approach, and years on the job site and working with the incarcerated population. This informed me of diversity of participants and differences in correctional facilities. Furthermore, the questionnaire asked the participants to provide information on their facility type, security class, approximate

number of inmates, approximate number of mental health service staff at the facility, and mental

health service types offered (see Appendix E). This information helped provide a context

(information on the conditions of the setting at which each participant was working) for greater

understanding of participants' interview responses, which was considered critical information for

a qualitative study.

Interview. In order to arrange for the interviews, I asked participants for a time that

would be convenient for them to hold the interview. The semi-structured interviews were

conducted via phone or voice-over-IP services (e.g., Skype or Google Talk). By choosing the

best available time for the interview and offering phone and voice-over-IP services, the

participants were able to create their own interview setting that provided comfort and reasonable

privacy. The semi-structured interview protocol was based on four open-ended questions

(Appendix F) covering the following topics: (a) how do correctional mental health providers

cope with forced termination? (b) how does the working alliance influence the outcome of forced

termination? (c) current support conditions and what steps can be taken to support a positive

outcome despite premature termination? and (d) what else can be done to counteract the effects

of forced termination in the correctional field? The questions were developed in advance and

follow-up questions were adapted on the spot, considering participants' responses. Furthermore,

general questions about the mental health service structure and available supervision were asked.

No hypersensitive information was asked throughout any of the interviews out of respect for

privacy. The interview was audio-recorded for easy transcription and was deleted after

transcription had finished. After conducting the semi-structured interview, the participants had

the opportunity to ask questions and voice concerns.

Methods and Procedures for Data Analyses and Synthesis

Soon after the data collection, which took approximately two months, the interviews were transcribed and identification codes were assigned to each transcript. Every detail of the interview was transcribed, including nonverbal communication, such as pauses, laughter, or interruptions. All demographic data (age, gender, institution etc.) was summarized to illustrate potential patterns.

Analytic approach. The analysis was conducted carefully in the manner consistent with IPA. Double hermeneutics as an approach was employed, which is a "two-stage interpretation process," (Smith & Osborn, 2003). Using this approach, I interpreted the participants' attempt to make sense of the phenomenon.

Transcription process. Each interview was transcribed by listening to each audio recording soon after the interview was conducted. The transcript was re-read while listening to the recording once more to assure correct transcription and add notes regarding non-verbal communication. The first step of IPA is to re-read the transcribed interviews to become immersed in the participants' experiences and begin identify significant phrases. Initial notes were taken during this time. The transcripts were then uploaded into MAXQDA 12, an electronic data analysis program that facilitated the reliable analysis of the transcripts, storage, and organization of interpretive codes and themes. Using MAXQDA, meaningful phrases in the transcripts were coded for emergent themes and organized into networks of superordinate themes. The emergent themes and superordinate themes can be seen in Appendix H, figure H1.

Finally, a rich and exhaustive description of the experience of the participants was written. All themes were represented by extracts from the original text. These extracts were chosen according to their richness.

Quality Assurance

Credibility. By providing credibility, I ensured that the study measured what it intended to measure. This was done by employing a number of strategies. To ensure the honesty of the participants, they were given the opportunity to refuse participation. Further, frequent debriefing sessions between me and my advisor helped me widen my vision and discuss alternative approaches if necessary.

Dependability. To ensure dependability, I employed techniques to show that, if the study were to be repeated in the same context and with the same method and participants, similar results would be obtained. Such techniques included a detailed description of the plan and the execution of the study, the strategies of data collection, and an evaluation of the effectiveness of the process.

Transferability. Transferability ensures that the findings of the study can be applied to other situations or a wider population. Although this qualitative study does not aim to be representative, information on the organization taking part in the study, its restrictions, the number of participants, the data collection method, the number of data collection sessions, and the period of the data collection was provided.

Confirmability. Steps were taken to ensure that the findings of the study were the result of the experiences of the participants and not my ideas and biases. Examples of the analysis can be found in Appendix G.

Summary

This section provided a detailed description of the methodology employed for the research. The study attempted to explore how correctional mental health providers handle forced termination with clients in the correctional setting, whether there are steps that can be taken to ensure a good outcome despite premature termination, how the working alliance influences the

outcome of the forcedly terminated treatment, and whether there are other ideas on how to counteract negative consequences of forced termination in this setting. I used the IPA approach and addressed issues such as credibility, dependability, transferability, conformability, and ethical concerns during the research.

Results

Participants

Seven participants agreed to participate in this study: five women and two men. They all had worked with incarcerated patients and had experienced forced termination. A brief description of each participant follows in the order in which interviews were conducted and a table with the demographics can be found in Appendix I.

Participant 1. Participant 1 was a Caucasian woman who chose not to state her age. She had worked with the incarcerated population for half a year and practiced at a correctional site for the past three months as a Licensed Clinical Social Worker. At her correctional site, a juvenile detention center, 11 inmates were served by 10 mental staff members. Individual and group psychotherapy were available and assessments were conducted at this site. Participant 1's preferred model of treatment was CBT, Dialectical Behavior Therapy, Motivational Interviewing, and attachment theory.

Participant 2. Participant 2 was a 28-year-old Asian American female with a doctoral degree in psychology. She had been working at a county jail and with incarcerated individuals for one year. This county jail housed inmates of minimum, medium, and maximum security classes. Eight inmates were being served by nine mental staff members at a time with individual psychotherapy. Participant 2's preferred therapy method was Motivational Interviewing and CBT.

Participant 3. Participant 3 was a 45-year-old Caucasian woman working as a neuropsychologist with a private practice. In addition to assessments, she provided individual and group therapy at multiple sites, including jails, prisons, and juvenile sex offender treatment facilities. At the time of conduction of this study, she had worked with the incarcerated population for 13 years. Participant 3 focused her discussion mainly on the juvenile sex offender site, which employed eight mental health staff who serve one adult and over 200 adolescents. Participant 3 has employed multiple models of treatment, including CBT, Solution Focused Therapy, Rational Emotive Behavior Therapy, Insight-Oriented Therapy, Psychoeducation, Psychodynamic Therapy, Supportive Interpersonal Therapy, Time-line treatment, Hypnosis, EMDR, Multi-Modal Therapy, and Sexual Recovery Therapy.

Participant 4. Participant 4 was a 45-year-old Caucasian woman who worked as a Licensed Clinical Social worker. She has worked with the incarcerated and in a jail/prison setting for 10 years. The levels of security in those settings have been minimum, medium, and maximum. Her focus was on her most recent employment at a very large correctional facility. At this facility, individual, group, and assessments are available. Participant 4's preferred orientation was CBT.

Participant 5. Participant 5 was a 29-year-old Caucasian woman who worked as a social worker and is now attaining her doctorate in psychology. She had worked in a jail for one year. The number of inmates served in that setting is 90 and there are six mental health staff employed who provide individual psychotherapy. Participant 5 has been providing CBT and DBT.

Participant 6. Participant 6 was a Caucasian man who chose not to disclose his age. He worked as a Licensed Clinical Mental Health Clinician providing primarily CBT at his private

practice to individuals who are incarcerated. He has been working in this capacity for 30 years

and has been providing individual and group therapy and conducts assessments.

      Participant 7. Participant 7 was a 58-year-old Hispanic man who works as a

psychologist at a federal prison. He has worked with the incarcerated for 14 years and at this

specific site for three years. Around 1200 inmates are being served by 20 mental health staff

members who provide individual and group psychotherapy. Participant 7 prefers providing CBT.

Results

      The analysis of the data from the responses to the open-ended questions are represented

based on emergent themes. These themes gave insight into the participants' experiences

regarding forced termination, the effects of the working alliance on forced termination, steps

taken to ensure good outcomes, and ways to counteract negative effects of forced termination.

The themes are listed and supported with evidence from the responses given by the participants.

A graphic map (Figure H1 in Appendix H) shows the emerging themes that occurred based on

each research question. The numbers behind each subordinate theme represent the frequency in

which each theme occurred throughout all of the interviews (e.g., 15 means the theme was

mentioned 15 times throughout the seven interviews). In the presentation of the findings below,

some branches will be included under different research questions, depending on which question

they may answer.

      Support on site. To start, the participants were asked about the supervision they receive

or had received at their correctional sites and whether this was a place for discussing termination.
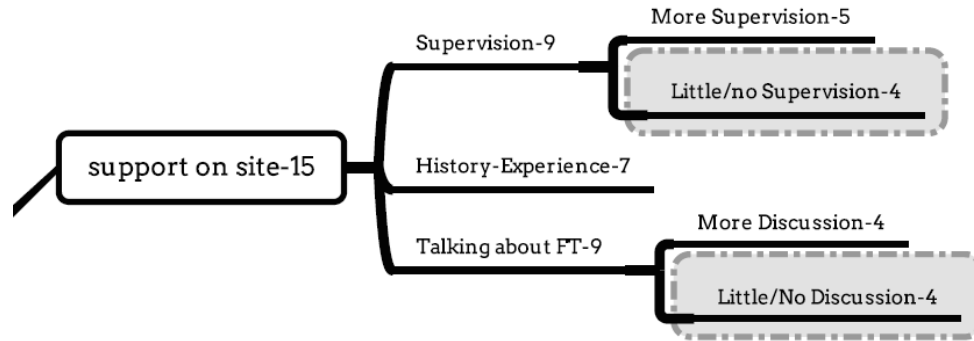
Figure 1. Support at correctional facility.

More supervision. Some participants had more supervision than others. Participant 2 and 4, for example, experienced an adequate amount of supervision, stating, they were supervised not only by their individual supervisors but also by other professionals, such as social workers, psychiatrists, and medical staff. Other, more experienced mental health professionals (Participants 6 and 7) still took advantage of supervision by attending weekly group supervision within their agencies or received supervision through national trainings, online conferences, and peer support.

Little/no supervision. Not all participants were satisfied with the amount of supervision they received. Often it appeared that staff was unable to provide the needed supervision of the mental health providers. Participant 5, for example, received supervision, but she felt it was insufficient for her setting.

> …in general it seems like there is a lack of support in terms of supervision in working
>
> with the incarcerated population. There doesn't seem to be a real expert. (Participant 5)

While some participants struggled to receive supervision, one participant chose not to seek it out because she was a licensed psychologist. However, she saw the value of supervision for therapists who experience difficult counter-transference problems with patients, often experienced in forced termination. She stated,

Like, if the therapist has become attached to the client and they get moved and are forced to stop and how the therapist is reacting? Yeah, absolutely they need help. They should not have transference issues. That should not be happening. They obviously need to have a supervisor or someone talking with them about those issues and helping them work through them because that's not healthy at all. (Participant 3)

Talking about their forced terminations. The participants were asked whether time in supervision was used to discuss forced terminations.

Discussion during supervision. Some participants did have the chance to discuss their experiences of forced termination during supervision, but not all found it helpful. For example, Participant 1 had the chance to discuss her forced termination experiences during supervision but perceived it as less helpful as the loss of her patient had already occurred and she felt unprepared for this situation. Other therapists, however, found supervision more helpful (Participant 6 and 7), discussing how to prepare their patients for possible termination with peers and other colleagues.

Little/no discussion. Discussions regarding forced termination did not occur in all cases. Participant 5, for example did not have the opportunity to discuss termination with her supervisor, however, she sought out supervision from other staff members, such as the patient's case manager. With him, she was able to discuss "how quickly things can go and what we need

to do to wrap up a session. Uhmm, but other than that it's just a conversation but it can be incredibly helpful."

The Importance of Discussing Forced Termination
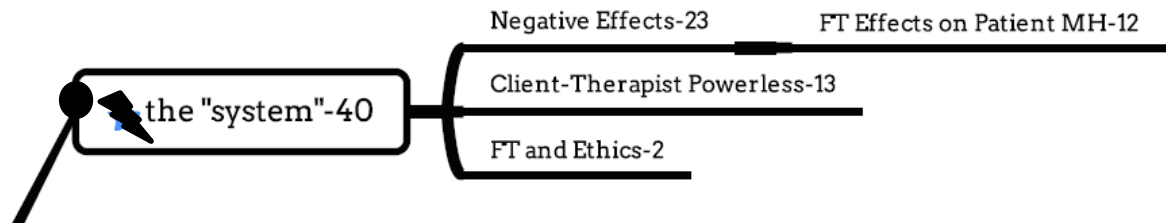
Figure 2. Importance of discussing forced termination.

The participants were asked about their views on how forced terminations affected their patients. Unless termination was initiated by the patient him or herself (Participant 6), nearly all participants agreed that forced terminations had a negative effect on their patients' mental health. For example, Participant 1 stated that not only is forced termination damaging to the patient, but also patients may hesitate to re-engage in therapy in the future because they do not want to form another connection that yet again will abruptly end.

Participant 2 worried about the support inmates will have in society after release but considered that patients may have other worries besides finding another therapist, that therapy may not be their priority. Conversely, Participant 3 recognized that patients might become upset when they lose their therapist. She advocated for a continuum of care with the same therapist and reported she was fortunate to have once been able to continue therapy with a patient who was moved. She advocated to continue seeing this patient on the basis of his severe increase of anxiety, depression, and suicidal intent when termination became imminent. Similarly,

Participant 5 reported that some patients suffer from forced termination because of their attachment problems. Participant 6 added,

> … particularly if they form a bond with the clinician or they are making improvements. Particularly with people who are seriously mentally ill, you know stress exacerbates symptoms. You know when you have someone who is uhmm somewhat normalizing uhmm or functioning well and then they are just abruptly terminating and pulled out of treatment with someone that, you know things are going well with; I don't think there is anything positive. (Participant 6)

Further, Participant 7 introduced the concern that the patients will not continue to get treatment once they are back in their communities because,

> [patients] generally have difficulties grasping the notion that their mental health problems are with them once they are released. So, I think the willingness of them to seek out treatment or to engage in treatment once they get released may be diminished because they have the perception that problems will no longer be present. (Participant 7)

In addition to discussing the negative effects that forced termination may have on patients, Participant 4 stated that she is "working on a project about ethics and with health clinicians and health care in prisons. This topic made her think of the ethical violation that forced termination inside prisons presents. She explained that

> Really, like looking at APA guidelines, it's not ethical what we do to these clients inside of jails. Uhmm, there is (sic) so many things that happen inside of jails and prisons and I think when you work inside, it's kind of like, it's so normalized and when you step away from it and kind of look inside, you're like "what are we really doing?"

Research Question 1: How do correctional mental health providers experience forced terminations?

  Participants' feelings when forced termination occurred. Participants were asked about their feelings regarding experienced forced terminations.
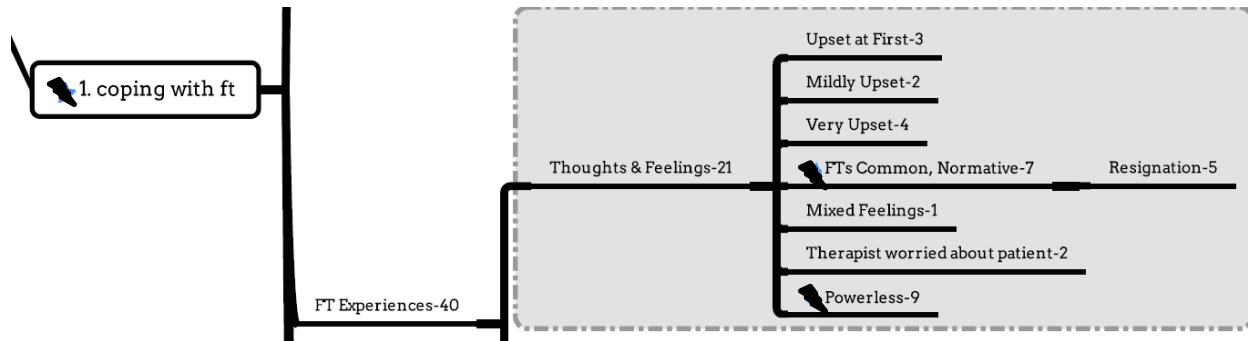
Figure 3. Forced termination experiences.

  Very upset. Participants 1 and 2 were very upset when they experienced forced termination as they struggled with not being able to say "goodbye" to their patients and were concerned about their patients' treatment in the future in correctional settings.

  Upset. Participant 2, 4, and 5 said they were upset at first. Participant 4 specifically experienced these feelings with patients with whom she felt progress was being made or a good connection had been established. Participant 7 pointed out that forced termination, as well as the limited scope of psychotherapy in prisons, can have an effect on a mental health provider's morale, stating "in terms of seeing positive outcomes it's very narrow and very limited. So of course that affects how uhmm, how challenging it is to work in the prison environment."

Not Upset. Some participants saw forced termination as a common occurrence that they

had to manage. Both Participant 2 and 4 were used to forced termination, stating for example,

"In the jail setting, forced termination was almost like a daily occurrence." Further, explaining,

> It becomes normalized for the clinician and for the inmate. It's kind of like, it's almost a
>
> given that they know that you're not going to be their clinician for the long term. And if
>
> you do get placed in a unit for months at a time, it's positive, but on the inmate site they
>
> don't expect it either. (Participant 4)

Regarding the experience of forced termination, Participant 5 stated, "It's a fleeting

thought; it goes away, and it's just something you think about for a day or two."

Resignation. Participant 2 and 4 said they felt a sense of resignation when discussing

forced termination. Participant 2 stated, "…I think I accepted that it's just one of those things

like I can't control." Similarly, Participant 4 felt that even the patients did not expect to see their

therapist for a long time.

> … some of the guys get moved around so much it becomes normalized for the clinician
>
> and for the inmate.[…] when they were released I don't think I had any feelings, like
>
> "this is a bad or good thing," it's just like "well ok, they are not coming back."
>
> (Participant 4)

In addition to resignation, Participant 4 experienced sadness and a sense of loss and

Participant 5 was worried about the wellbeing of her patients.

Powerlessness. Most participants said they felt powerless when they experienced forced

terminations especially as they do not know what happened to their patient once forced

termination occurred. Participant 5 felt that she was "always kind of semi-terminating in every

session because you never know." She provided an example:

Like the current client I have is looking at three to seven years but she could be moved to

a different county in the process of something, because she keeps on getting in trouble at

this facility. So she could be moved at any second. Uhmm, so it's always on my mind and

it's always something I think about…

Feeling positive. Participant 2 saw a positive aspect regarding the unpredictability of

forced termination, recognizing her patients' resilience and strength. Forced terminations "made

[her] realize how much stronger the people that [she is] working with are than [she] had

originally thought" and patients were "able to go through these experiences and be able to just

take it better."

Coping with forced terminations. The participants had the opportunity to discuss how

they generally managed the experiences of forced termination in the correctional setting.
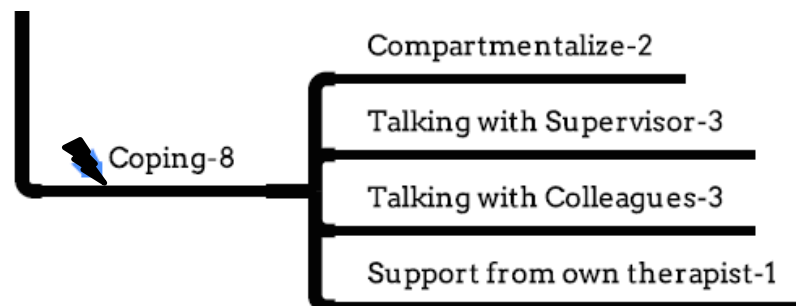
Figure 4. Coping with forced termination.

Compartmentalization. Participants 5 and 6 both coped by using compartmentalization in

order to not worry about every single patient.

Talking in supervision and with colleagues. Participant 5, 6, and 7 found that talking

about forced termination during supervision with psychologists, peers, or other staff helped them

cope. Additionally, Participant 3 sought out help outside of her work place with her own

individual therapist.

 Forced termination's effects on practice. Participants were asked how forced

termination affected how they practiced psychotherapy in the correctional setting.
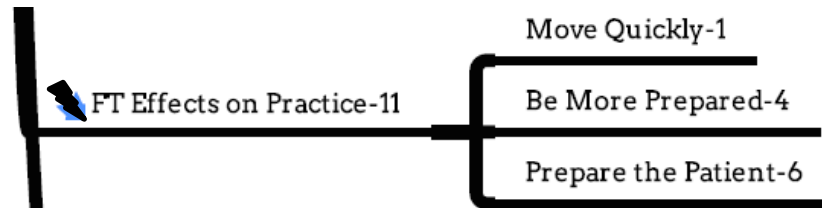
Figure 5. Forced termination effects on practice.

 Move quickly. Participant 3 suggested to move fast in therapy:

 I try to move as quickly as I can. I try to push them to their limits[…] I may give them 10

 minutes to catch me up but after that I make them work [laughs] […] And I hear a lot of

 other people say that therapists that they work with let them talk about whatever they

 want. Well, that works to a certain extent but you don't always end doing the progress of

 the trauma work that you need to do to help these people. (Participant 3)

 Prepare clients. Participants 1 and 2 felt that they had to be more prepared due to the

unpredictability of forced termination. Participant 1 said that she had to "[plan] better for the

unknown for both me and the client." Almost all participants prepared their patients for the

possibility of a forced termination. For example, Participant 4 reported,

 I mean when I would start with a client, especially when I knew they had a court date

 coming up or it was kind of like at the end, it was kind of like "If I see you again, we will

 work on this." There was never like a guarantee so I think when ending the session, was

almost like "well I'm not quite sure if we're going to be continuing this next time, but if I

see you, we'll keep doing this." I did that often, especially if there's a court date coming

up. (Participant 4)

Similarly, Participant 5 said that she ended every session by preparing her patient for the

possibility of forced termination.

So, it was always kind of trying to terminate and end sessions on this like "so this might

be the last time that we see each other. How are you feeling? Are you going to seek

therapy elsewhere?" But when you see her the next time, that just feels like it was a false

alarm and you're always kind of semi-terminating in every session because you never

know. (Participant 5)

Effects on morale and stress. Participants were asked whether forced termination had

affected their morale and stress level.
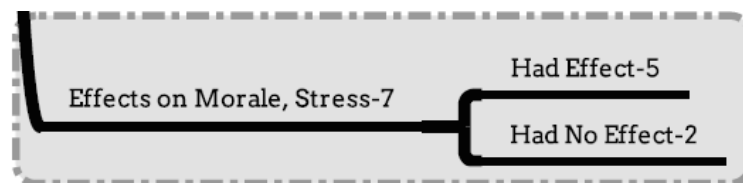
Figure 6. Forced termination effects on morale and stress level.

Had effect. Most participants felt that forced termination had an effect on their morale

and stress level. Participant 4 felt the effect primarily because she knew that forced terminations

were counterproductive for the patients, stating

I think when I was working in inpatient and the inmates were being moved around not for

any type of treatment reasons but because of space considerations or because of the

inmates not getting along and they want to keep people separated. Yeah, I mean I

particularly felt that was bad for treatment and so I didn't like that. I wish there was a

different way to handle that. (Participant 4)

Participant 6 specifically felt the impact of forced termination when he worked with

patients who had committed heinous crimes, presumably because of the danger that arises from

these individuals not continuing therapy. Participant 7 was primarily affected by forced

termination because he could not see if his therapy with patients had positive outcomes, such as

whether his patients were "applying themselves in order to function."

Despite the negative effects on their morale, the participants still chose to continue

working with this population and the correctional settings. "… [I]t was stressful, yes, but it just

made me feel like … uhhh, like there was more to the work. It was more purposeful to me to be

in that field and to work with that population. (Participant 2)

Had no effect. Participants 3 and 5 did not think that forced terminations had any effect

on their morale or stress level. They accepted the situation, believed that their patients would be

able to find care elsewhere, and found pleasure in their work in other settings (e.g., different

jobs).

Circumstances when forced termination occurred. Most participants chose to speak

about the circumstances of the setting, which appeared to have a big influence on whether forced

termination occurred.

Conditions. Participant 1, for example, stated, "I think half the battle is the setting. Like

how do you give someone skills in a chaotic stressful environment?" Participant 3 found some

aspects of the setting helpful when treating inmates, such as the police officers and guards.

Conditions-11

Short-term-6

Length of TX-11

Long-term-5

Circumstances-29

No Plan-4

Goals Rarely Met-11   Reason for Not Meeting goals-7

Goals Met-6
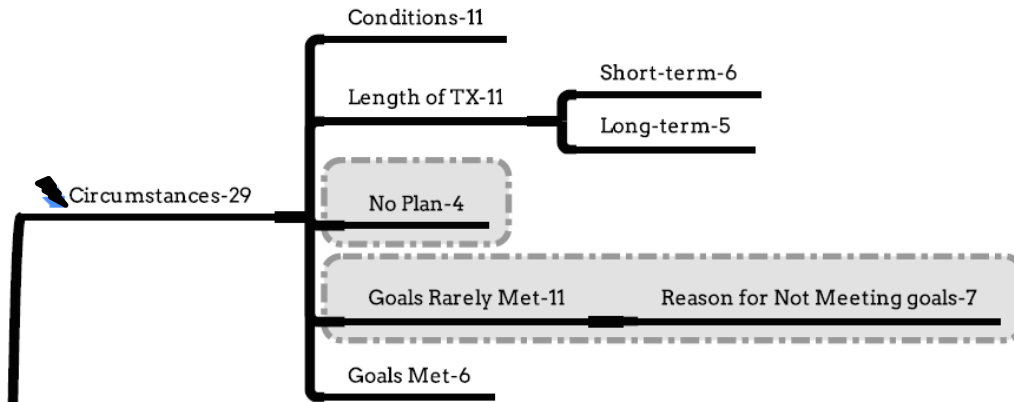
Figure 7. Circumstances of forced termination.

Further, she recognized that there were other circumstances that made forced termination more or less likely to occur, such as in cases when patients' discharges were contingent upon their successful completion of therapy. In those cases, both the system and the patients were invested in therapy. However, she also stated that in some cases, the therapist is not the right fit for the patient, which speaks to a lack of mental health providers specialized in certain mental health issues with the correctional population.

Participant 4 said she thought that the major cause of forced terminations was the setting. She explained, "I don't think there was anything at the jail setting itself that helped treatment." The jail setting specifically caused terminations early on, as she experienced terminations that sometimes occurred after only one or two sessions.

According to Participant 6, forced termination was less of an issue when psychologists were able to take on multiple roles, to guarantee a continuity of care for the inmate. "… [W]hen clinicians like myself are allowed to do both case management, in terms of helping people get jobs, housing, and cars all with the psychotherapy pieces with it, uhmm, it seems to work out much better."

Length of treatment. Some participants planned on using short-term therapies given their knowledge that forced termination occurred frequently. In session, they focused on "stabilization rather than […] intensive therapy" and psychoeducation (Participant 1). Similarly, due to the expectations at his setting, Participant 7 only saw patients for a short period of time: "…a limited period of time only varying degrees of frequency depending on their clinical needs. […] It's more like sustaining them on a day to day basis as opposed to trying to make changes for the long-term."

Participant 2 had the opportunity to see patients for a longer time, which also depended on the setting. Some patients had trial dates that were farther in the future, which enabled her to see her patients for longer. She believed that the relationship in instances of longer term therapy was better as she had time to "…establish rapport and for them to get to know me and for me to get to know them, because it was really hard to get past their barriers and for them to trust uhmm anybody outside or anybody they didn't know to open up to."

Participant 3 also had the opportunity to see patients for a longer time, specifically those with significant mental health issues, bipolar disorder, and schizophrenia, as they may spent more time in the correctional setting. Long-term therapy was also possible for Participant 6, as he was able to see patients during and after their incarceration in his private practice.

However, not every participant made plans for the length of therapy. Participant 2, for example, stated, "I didn't have any plans because I didn't know how long everybody was gonna stay or anyone could say how long I was gonna be with them." Similarly, Participant 4 did not make plans regarding length of therapy due to the unpredictability of the setting, saying, "[Y]ou just really never know."

Meeting goals. Some participants did not achieve the goals that were set at the beginning of therapy. In correctional settings, the participants were able to help their patients regulate their emotions, teach coping strategies (Participant 2), adjust to the correctional setting, or manage current stressors, such as grief (Participant 4), but did not feel that they reached many goals beyond that as compared to their outpatient experiences (Participant 3).

When participants stated that they were unable to meet goals, they were asked to specify the reasons for not meeting them. Some participants recognized that their patients did not always consider therapy their priority, given they had many other issues or a lack of insight into their mental health problems. However, most participants considered the prison system as the main barrier to reaching therapy goals. Reaching therapy goals in the correctional setting became easier when pre-screening of therapy patients occurred, which speaks to the goal directed short-term therapy approach which was preferred by most participants.

> When that has usually happened / when the treatment goals have been met is generally when inmates have been selected for therapy because they have a specific uhmm, mental health core symptoms, whether that is specific anxiety disorders, where they come to see us willingly, voluntarily, and when we see them on a regular basis for a specific time, usually without any self-harm history or psychotic disorder. (Participant 7)

Research Question 2: How Does the Working Alliance Influence the Effects of Forced Terminations?
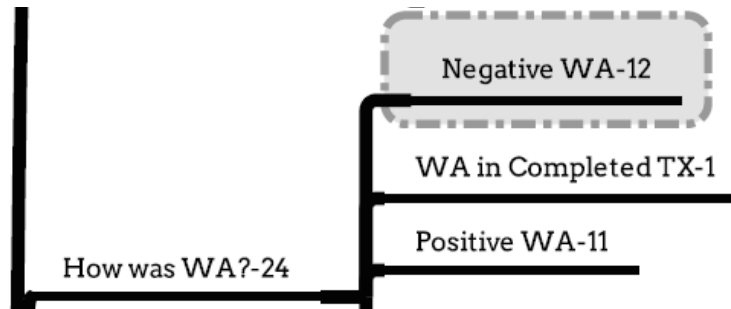
Figure 8. Experience of the working alliance.

Completed therapies. Only one participant (Participant 7) was able to speak about the working alliance in therapies that were completed as most participants experienced only forced terminations in correctional settings. He (Participant 7) stated that the working alliance "was good. I mean afterwards they eventually are grateful and very appreciative. And they tend to have a good possible outcome of the relationship and after that they are able to seek out the needed services."

Working alliance. Generally, all seven participants had experienced positive working alliances with their patients before forced terminations occurred. Patients saw therapy as "an outlet during their day and someone they can talk to" (Participant 1). Further, good working alliances were established with patients who agreed with their therapists on short-term goals (e.g., working on specific mental health symptoms), as long-term goals were often something the patients could not focus on while incarcerated (Participant 2 and 7).

Developing the working alliance. The participants had many ideas on how to develop the working alliance.
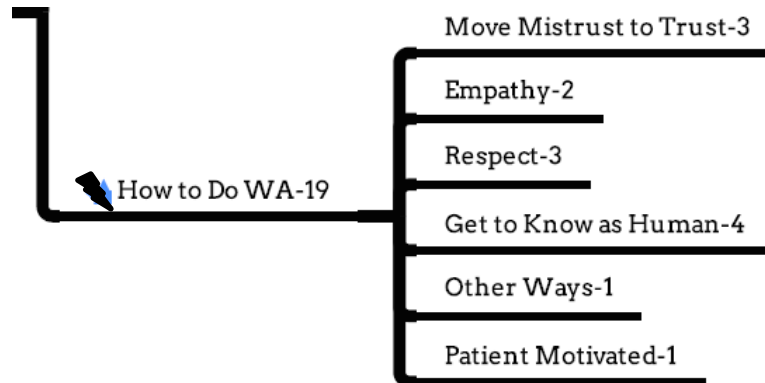
Figure 9. How to develop the working alliance.

Moving mistrust to trust. Participant 2, for example worked on moving mistrust to trust, stating, "It was really hard to get past their barriers and for them to trust uhmm anybody outside or anybody they didn't know to open up to." Similarly, Participant 5 discussed the concept of trust: "Uhmm, I think it's initially really difficult to establish a working alliance because there is this automatic mistrust. You know you are working as part of this system that has incarcerated them. So there is this automatic mistrust that you have to work through." Participant 6 had the same experience. "Uhmm, early on, the incarcerated patients are very mistrustful, uhh, they have no reason to believe that the system will be helpful because of their past experience."

Empathy. Empathy was a helpful tool for establishing the working alliance. Participant 1 "[tried] to understand what they were going through." Participant 4 used empathy as well, stating,

> Their feelings of sadness and anxiety aren't, aren't validated because they feel more
>
> punitive. Like "well you're here, that's how you're supposed to feel." So validating
>
> those feelings, that it's difficult regardless of what brought them in, it's a very difficult
>
> setting to be in. (Participant 1)

Respect. Another way to establish the working alliance was treating the incarcerated patients in a respectful manner (Participants 4 and 6).

Getting to know the patient. Getting to know the patient was seen as a helpful way of improving the working alliance: "Well, I feel like the therapeutic alliance is based on the relationship I have with them. If they experience me as a human being trying to support them as a human being." (Participant 6)

Weekly therapy goals. Participant 2 recognized "when we did go over like treatment goals, we did something like a week-by-week goal" and then "create a short-term goal and it would be agreed upon or we would do it." Establishing weekly therapy goals, therefore, was used to help establish the working alliance.

Research Question 3: What steps could be taken to ensure a good outcome despite premature terminations?

Barriers to Improvements.

The participants were asked about barriers that made reaching therapy goals difficult when forced termination occurred.

Can't follow up. One of those barriers was that participants were unable to follow up with the patient. Only one participant (Participant 3) had the opportunity to follow one case due to the patient's severe anxiety, depression, and suicidal intent. However, in most cases, this was not possible. Participant 7 added to this topic, "With no follow-up support, with no supervision, with no mental health services, that just sets them up for more likelihood of failures."

The setting. The setting was seen as a major barrier to improvements in the patients' mental health. Specifically the lack of continuity of care was a barrier to a successful outcome (Participant 5) and the dual role of the mental health provider:

It makes sense to me that they wouldn't trust the system. We set them up in a system and

then bring therapists in that are part of the system and uhmm they are like 'wait, you are

working for the system that incarcerated me. Why would I tell you my story?' It just, it

doesn't make sense. (Participant 1)
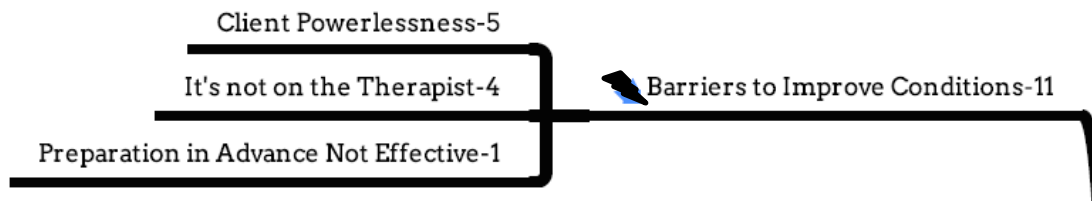
Figure 10. Barriers to improve conditions

Client's powerlessness. Many of the barriers to improve patients' well-being contributed

to the patients' powerlessness. Participant 1 stated, "I would ask if they've been to therapy

before and what they really didn't like about it and they said like 'we are constantly switched.'"

Further, Participant 3 explained, that not knowing about continuity of care was difficult for

patients.

It's not the therapist's fault. Most participants agreed that when therapy did not have a

positive outcome, or goals were not achieved, it was not the therapist's fault. Some patients may

not consider therapy as their priority during their incarceration (Participant 2 and 4) or may cause

the termination themselves due to behavioral issue (Participant 6). Further, Participant 7

recognized that incarcerated patients may have little insight into their mental health problems

and "have the perception that their problems exist because of the fact that they are incarcerated.

They generally have difficulties grasping the notion that their mental health problems are with

them once they are released."

Seeing Some Improvements. Despite barriers, some participants saw improvements despite forced termination. Participant 1 found that "small coping skills can help people a long way." Participant 2 "did see a few of them less anxious and less uhmm emotional in session."

Have seen Some-4

None-4

Improvements In Spite of FT
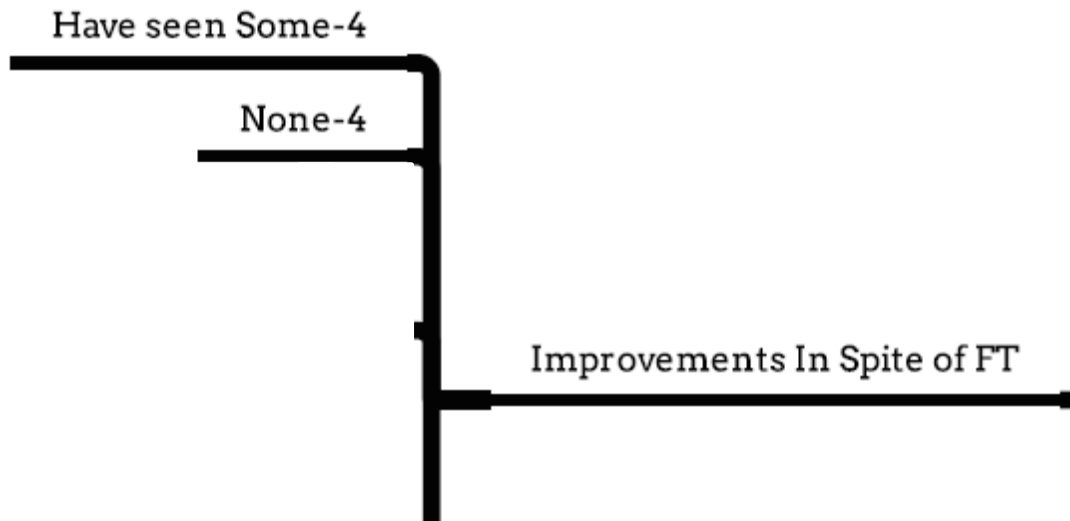
Figure 11. Seeing improvements.

Some participants, however, did not feel very confident about these improvements and some hardly ever or never saw improvements. However, partially, this may be because therapists will seldom see patients' success after termination. Participant 7 for example stated, "…the fact of the matter is a lot of times and frequently working in positions you don't get to see uhmm, successful outcomes. They don't see people actually reintegrating relationships or people reentering society. "

What contributed to improvements? The participants were asked what had contributed to improvements in patients' symptoms, if they had noticed any.
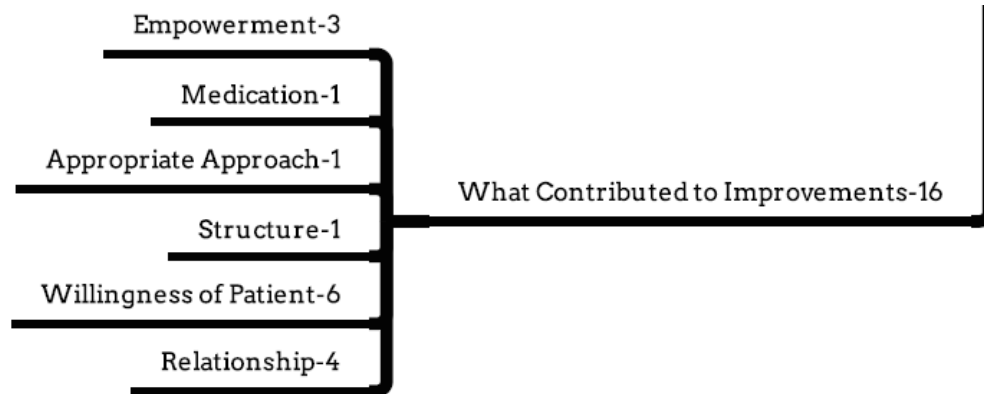
Figure 12. What contributed to improvements?

Empowerment. Some felt that empowerment of the patient played a large role. Participant 5, for example, explained,

> But I also kind of work from a feminist perspective where it's really up to them to establish these goals. If they don't want to get clean that doesn't need to be one of the goals we will be working on. If they want to use, I'd rather have them talk to me about their plans to go out and use if they do that in a safe manner, uhmm in the safest manner possible versus me telling them "well the goals are you're clean and you're sober and you do this, this, and that, x, y, and z." So helping them establish treatment goals that mean something to them as opposed to the prison necessarily, or the corrections officers, or to, you know, the judge. (Participant 5)

> Participant 6 also used empowerment and reminded patients of what they had

accomplished as a strategy to improve his patients' well-being. Participant 7 acknowledged that empowerment will help improve the patients' symptoms because "the patient is much more involved in their own uhmm treatment course."

Patients' motivation. Furthermore, the willingness of the patient to work toward their goals played a large role in improvements in the patients' wellbeing. Participant 3 explained,

Investment, self-investment. They have to honestly want to change. A lot of them think "if I just go through what they tell me to do, then I go home and then I'm done. So, ok, I'll listen to you for an hour." And that's not what the therapy there is about.

Other ways. Another ways of achieving improvement was the use of medication (Participant 6). Also using the appropriate therapy approach will lead to improvements, according to Participant 4:

And I was using a lot of motivational interviewing on my end and CBT which is my orientation. But I think just working with them on their level and starting with what they thought was important was very helpful. And then maybe kind of moving on to other symptoms. (Participant 4)

Finally, the "Structure, it was a structured, like, hour of just having this relationship" was helpful, according to Participant 2.

Relationship. The relationship between the therapist and the patient was seen as a tool for improvement by Participant 2 and 6 as the therapist was a person who was non-judgmental and "not part of you know the inmate population" (Participant 2). Further, relationships with other correctional staff could be helpful (Participant 6) in improvement of patients' symptoms.

Minimizing negative consequences of forced termination. When asked how to minimize the negative consequences of forced termination, the participants had many ideas.
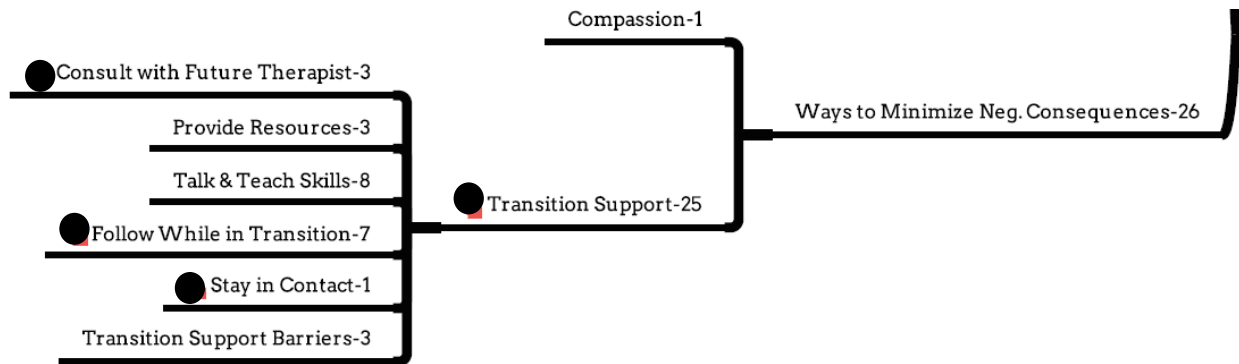
Figure 13. Ways to minimize negative consequences of forced termination.

Compassion. Participant 6, who was able to continue working with patients in an outpatient setting, felt that compassion is helpful, stating, "compassion can be a cup of coffee, a granola bar, letting them charge up their phone, uhhh, laughing with them, sitting outside so they can smoke a cigarette while talking to you."

Transition support. Further, participants felt that transition support will help patients when forced termination occurs. Participants 1 and 3 for example suggested consulting with the patient's future therapist.

> And it would be nice if they would allow this new therapist to talk to for example me so that we can make sure that everybody knows where they've ended in therapy, so not basically starting over with someone new. (Participant 3)

Providing the patient with resources was also seen as a helpful tool in minimizing negative consequences of forced termination. Participant 2, for example was able to refer patients to other coworkers when she had to leave the facility. However, referrals to other therapists or contact with future therapists was rare in this setting.

Talk about and teach skills. Talking about and teaching skills was a strategy employed by most participants. Participant 5 suggested discussing the patients' treatment plan with the patient and Participant 6 and 7 discussed with the patient his or her achievements and what he or she may want to continue to work on with the next therapist.

Follow while in transition. Most participants believed that a helpful strategy would be to be able to follow up with the patient during the transitional period. However, staying in contact was not allowed for most participants given the setting. The lack of follow up was perceived as problematic by Participant 7, who stated "with no follow-up support, with no supervision, with no mental health services, that just sets them up for more likelihood of failures."

Research question 4: What Else Could Be Done to Counteract the Effects of Forced Terminations in the Field of Corrections?

Other interventions to counteract forced termination effects. The participants were asked what else could be done to counteract the negative effects of forced termination.
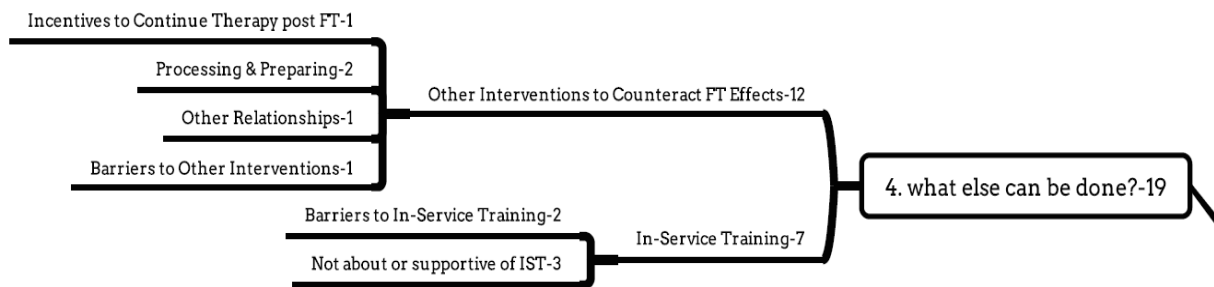
Figure 14. What else can be done?

Participant 6 suggested incentives to continue therapy, such as receiving parole with completed psychotherapy. Participant 2 and 5 felt that processing upcoming terminations and helping the patient prepare for the end of therapy would be helpful.

Further, Participant 5 suggested that additional attachments and relationships may be beneficial for patients:

We just need a new system and we need to increase the type of treatment and not just therapy, talk-therapy. I think there needs to be other ways to form attachments, to form bonds. So there could be animal-assisted therapy or uhmm, you know, just creating resilience in different ways not just in this therapeutic alliance. (Participant 5)

In-Service training. When discussing other ways to counteract the negative effects of forced termination, participants were asked whether an in-service training may be helpful. Most participants were not in favor of such an approach. Participant 1, for example, stated, "Like I'm all for training but if you don't have like the advantage, so if the whole mental health department is not engaged in it it's really hard." Participant 2 wondered, "I'm thinking like you could have more training but then it's just like everybody's experience working with the incarcerated people are different so what would you preparing them for?" Conversely, more in favor of in-service training, Participant 4 stated,

I feel like if there are evidence-based models for forced termination, or evidence-based, you know, research that's showing what's most helpful in terms of that kind of stuff. [inaudible] I don't think it's talked about enough in terms of that specific population.

Discussion

In this section, the findings of the previous chapter are summarized and discussed with reference to the literature reviewed in the Theoretical Framework section (pages 23-34) and other considerations. The four research questions organize this discussion, with a focus on the prison system's influences on the phenomenon of forced termination. From these questions, I

derived the clinical implications, recommendations for the prison system, and future research suggestions.

Research Question 1: How did Correctional Mental Health Providers' Experience/Cope with Forced Terminations

The participants of this study discussed when they experienced forced termination in their work with incarcerated patients and what precipitated these terminations.

Types of therapy attrition. As mentioned in the section on the research literature, Wormith and Olver (2002) listed three types of therapy attrition in the correctional setting: client-initiated dropout, agency-initiated expulsion, and administratively based exit. Three quarters of noncompleters were presumably client-initiated dropouts, about one half of the remainder was agency-based expulsions, and the other half were administratively based exits (Wormith and Olver, 2002).

Client-initiated dropouts. The client-initiated dropout occurs when the inmate refuses to continue therapy. Participant 3 reported that for her this occurred more often with adult offenders; the youth sex offenders seemed to be less likely to drop out of therapy due, she believed, to their motivation to return to their home. Such motivated patients could be those who would be able to return to their community after therapy completion, along with those who hope for more leniency from a parole board that values mental health treatment.

Sometimes the reason for dropping out can be due to systemic problems, such as underfunding of the treatment program at a site. This same participant noted that in some correctional settings, only a small number of therapists are on staff, and cannot accommodate transfers to another therapist when the fit between the therapist and patient is not adequate, and can lead to client-initiated dropout.

In a similar vein, an insufficient number of staff therapists might be trained to treat certain populations, such as sex offenders, and this could also lead to client-initiated terminations. For example, a psychologist would not agree to work with a client who requires competencies she does not have, for ethical reasons. Psychology's Ethical Principles include, "Psychologists provide services, teach, and conduct research with populations and in areas only within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional experience" (American Psychological Association, 2002).

Given these factors that lead to client-initiated dropouts, it can be argued that therapeutic programs in correctional programs which promise a more lenient sentence or sooner parole would lead to fewer client-initiated dropouts and completed therapy programs. Further, hiring professionals who will provide specialized treatment and/or testing procedures to treat and diagnose this very diverse population should be at the forefront of the criminal justice system to ensure proper treatment and lead to "correction" and "rehabilitation" of these offenders.

Agency-initiated expulsion. Only one participant (Participant 6) spoke about his client, for whom an exclusionary criterion (i.e., disruptive inmate) was invoked to disallow a referred offender from entering treatment. He said he had treated inmates who became verbally aggressive during sessions, which led to forced termination. Although, as previously mentioned, the majority of terminations occur when patients decide to drop out of treatment, the agency-initiated expulsions are still troublesome. In these cases, inmates are not allowed to attend therapy groups and individual sessions after disruptive behavior. Instead, they have to stay on their unit, or worse, are sent to solitary confinement for disruptive behavior. Some may reason that this form of discipline is appropriate from a safety standpoint, however, arguably many

times when inmates are put in isolation, it is for low-level infractions. At this point, it is

important to balance the safety issue and the mental health issue when deciding how to proceed

with a disruptive inmate. It is also important to consider that most inmates who are in a

therapeutic program are struggling with their emotional outbursts and aggressive behaviors

which they are supposed to work on by attending therapeutic programming. Punishing these

individuals by disallowing them from attending programming or putting them in solitary

confinement, a place that can induce anxiety and depression, is counterintuitive.

Administratively based exits. Most of the participants described instances when

administratively based exits occurred: when the inmate is released or transferred for reasons that

have nothing to do with his or her need for treatment or performance in it (e.g., court overturns

conviction or sentence, offender gets parole, transfer, bailout). Participants discussed experiences

of lack of funding, clinicians being moved from facilities to facilities, and patients being moved

to different housing units, all of which resulted in forced terminations.

To my knowledge, the only instance in which therapy trumps administratively based

exits, occurs in states which have "Sexually Violent Predator" laws that allows for civil

commitment of offenders who are deemed too dangerous to be released to society. While in no

way I would propose extended commitment for inmates who have mental health problems,

follow-up services are an absolutely necessary in the community to ensure safety of the

individual and safety of others.

The Prison System and Forced Termination

For the participants, the correctional system appeared to be the root of many barriers that

therapists face when working with the incarcerated as seen in the Figure H2, Appendix H. This

figure was created by analyzing the results of the research questions and focusing on those

themes that are specifically connected to the prison system, as indicated in the gray shaded

subthemes in Figure H1. The different arms of figure will be discussed below.

Support on site for therapists experiencing forced termination. An important factor of

therapy in the correctional system is the supervision available to mental health providers as

forced termination not only affects patients, but also therapists who have a great influence on the

outcome of therapy. Zuckerman and Mitchell (2004) describe the symptoms that may result

when patients must accept the loss of the therapist, which include defensive maneuvers to

alleviate anxiety resulting from object loss. Similarly, therapists may experience anxiety and

some may use the defense of denial of importance of their patients and the loss of objectivity in

their evaluation of patients' progresses. Further, the authors describe countertransference issues,

such as guilt and delay in informing their patients about termination. Supervision was therefore

assumed to be a valuable tool to manage forced termination and explored with the participants.
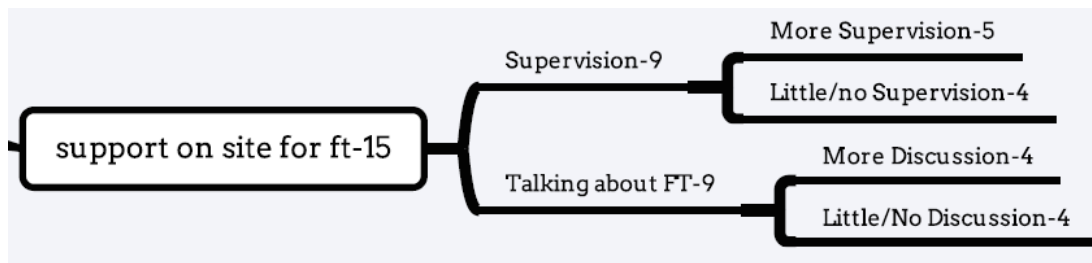
Figure 15. Support on site regarding forced termination.

Some participants enjoyed ample supervision while working in the correctional setting.

They worked with psychologists, nurses, medical doctors, psychiatrists, and social workers.

While one licensed psychologists (Participant 3) who was interviewed for this study stated that

she did not receive supervision, she did see the value in supervised work for novice therapists.

Two other licensed psychologists (Participants 6 and 7) took advantage of weekly supervision at their settings and consulted with other psychologists. Participant 7 also attended national trainings and conferences online and conversed with peers there. Some participants had the opportunity to discuss their experiences of forced termination during supervision, although not all found it helpful. For example, one participant (Participant 1) felt that supervision could not prepare her for forced termination. But other participants (Participants 6 and 7) were able to discuss how to go about termination and how to prepare patients during sessions.

Unfortunately, not every participant experienced a sufficient amount of supervision. Sometimes supervisors were very busy at their sites and did not have enough time for their supervisees. One participant (Participant 5) did receive supervision but felt a general lack of support regarding working with the incarcerated population and its specific problems. Further, even participants who received supervision did not always have the opportunity to discuss forced termination. Some were able to seek out consultation with social workers or other staff who were involved with patients' discharge (Participants 2 and 3), but were not able to discuss termination with their licensed supervisor (Participant 5).

The lack of supervision experienced by some participants again speaks to the need to hire more mental health professionals at correctional settings. This will not only ensure that there are enough staff to treat the large number of mentally ill offenders but more staff will help provide sufficient supervision for new and seasoned staff which in turn will increase effectiveness of treatment and decrease burnout among staff.

Circumstances/conditions of forced terminations. Participant 1 stated, "I think half the battle is the setting. Like how do you give someone skills in a chaotic stressful environment?" The conditions of forced termination were indeed often caused by the correctional system. While

one participant (Participant 3) found that parts of the setting were beneficial (e.g., helpful guards or police officers), most participants found fault with the system. Issues, such as bad fit between patient and therapist due to the lack of trained therapists available (Participant 3), sudden reassignments of therapists to other buildings or facilities, and sudden releases, bail outs, and moves (Participant 4 and 7) were experienced frequently and caused forced terminations.

Length of treatment. Consequently, the length of treatment was often influenced by the prison setting. Participants who worked in jails for example generally had to do short-term therapies with their patients, which predominantly focused on stabilization, psychoeducation, and adjustment to the prison setting. Therapy sometimes focused solely on "sustaining [the patient] on a day to day basis as opposed to trying to make changes for the long-term" (Participant 7). Further, the focus of therapy was frequently on specific symptoms, such as anxiety or depression. Even with such a specific focus and the short-term nature of therapy, patients were seen with varying frequency, such as twice a week to once a month (Participant 7). Due to the unpredictability of the setting, some participants chose to not even plan for a specific treatment length (Participants 2, 4, and 5) and were often not able to see positive outcomes of their therapy cases. Conversely, some participants did have the opportunity to see their patients for a longer period, such as when the trial date of the inmate was farther in the future or the patient served more time in prison. The length of treatment was, therefore, heavily influenced by the length of stay determined by the criminal justice system, not by the patients' therapeutic needs.

The participants' experiences reflected what the literature says about the treatment approaches in contemporary correctional settings. Short-term therapy is frequently used, such as cognitive therapy, behavioral therapy, cognitive behavioral therapy, positive psychology, group

therapy, and education and vocational training (Aos et al., 2006; Boothby & Clements, 2000; Harvey & Smedley, 2012). These short-term approaches may be more viable in settings were length of treatment tends to be short or unpredictable. Aos et al.stated that treatment approaches in prisons are also often targeted for different populations with special treatment programs that aim to rehabilitate special types of prisoners, such as those with psychological problems, drug addictions, and sex, violence, and organized crime offenses.

Meeting treatment goals. To adapt to the unpredictability of their context, some participants chose to help their patients acquire skills in regulating their emotions or coping strategies, considering that these goals were feasible in short-term psychotherapy. One participant (Participant 4) related, when a patient was able to adjust to the setting and cope with their current stressors, such as the death of a family member, they could meet their therapy goals.

When therapists knew that the termination date was approaching, it was easier for them to reach goals because they adapted their methods to match the time they had left with the patient (Participant 2). In some cases, when courts required the completion of therapy goals before release, goals were generally met (Participant 3). Goal achievement was also supported when therapists could see their patients for a longer time (Participant 6), or when they pre-screened patients to treat specific symptoms (Participant 7) during the short time they had with the patient.

At this point, it may be important to restate Bordin's (1979) three interlocking components of the working alliance: the agreement on therapeutic goals, the consensus on task in the therapy process, and the interpersonal alliance or bong between the therapist and patient. Adapting to the unpredictability of time a therapist has with a patient may actually be a helpful tool in establishing a working alliance quickly. Therapists who know that their therapeutic relationship could end at any time may be more focused on the patient's short-term goals, which

in turn helps the patient "buy into" therapy and help establish the alliance. It can be argued that quick successes, such as fewer symptoms of anxiety or depression, and a positive therapy experience may also make it more likely that a patient will seek therapy in the future elsewhere.

Therapists' thoughts and feelings. The fact that many therapists are unable to see the positive impact they have had on their patients due to the forced termination may have led to the generally negative emotions felt when forced termination occurred.
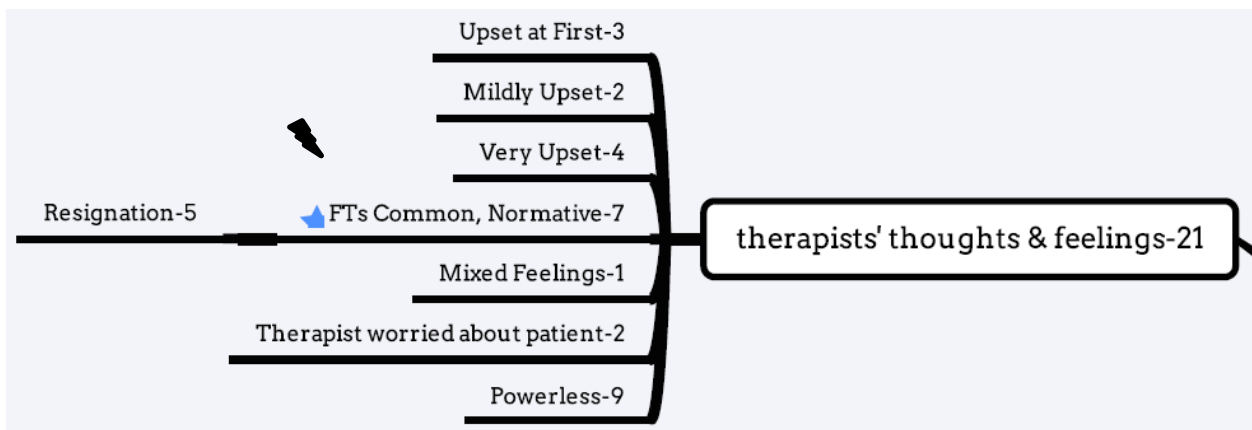
Figure 16. Therapist's thoughts and feelings regarding forced termination experiences.

Forced terminations upset therapists. Some of the participants were upset and struggled with forced termination, especially when a solid relationship with the patient had already been established. This appears to be a common experience, according to Penn (1990) who notes that therapists often experience "feelings of anger, anxiety and loss, self-blame, and reluctance to express feelings." These feelings could be exacerbated by the fact that therapists' lack information about the effect treatment might have had on the patient later. Other participants felt some sadness, regret, and self-doubt, as they wondered whether they could have done anything differently during treatment. One participant even worried about the wellbeing of her patients after forced terminations. Further, levels of morale and stress were negatively affected in most of

these participants. While this experience was not a deterrent to work in this setting, many

participants found forced termination to be stressful and also counterproductive in the recovery

of their patients. Some participants worried that forced terminations could contribute to

recidivism.

Even when participants did not feel upset, they experienced feelings of powerlessness

brought on by forced terminations. Participants 2 and 4 who had were upset by forced

terminations explained that this was because forced terminations were very common, "almost a

given" (Participant 4). Participant 5 said she was so used to it, she did not generally think about it

for very long, and Participants 2 and 4 claimed they experienced forced terminations so

frequently, it became normative. It appears that the absence of unpleasant feelings could be

suggestive of numbing, which eventually could cause feelings of resignation and powerlessness.

One participant (Participant 2) stands out in how she rationalized forced terminations'

possible effects. She said in these instances she recognized that her patients were often much

"stronger" than she had originally thought. She described strength as inmates' capacity to adapt

to the unpredictability of the setting as a sign of their resilience. Similarly, Siebold (2012)

describes the adaption and growth that can occur during therapy termination, explaining:

> When a forced termination occurs the therapeutic process may be incomplete, yet healing
>
> processes may have occurred that encourage a reduction of separation anxiety, support
>
> improved relationships with family and friends, or help the client develop better coping
>
> mechanisms for abandonment fears (p. 329).

Further, Siebold cautions therapists that "overemphasizing the grim aspects of forced

termination may impair the departing therapist's ability to sustain a belief in the client's ability to

survive loss, use the process productively, and, when indicated, transfer to another therapist."

Seibold (2012) summarizes,

In other words, letting go can be as difficult for the therapist as it is for the client. The

therapist may fear that he or she has failed some clients, or that someone else can do a better job.

Conversely, omnipotent feelings may encourage a belief that he or she is the only one who

understands and tolerates this client, which may affect the effort to find a transfer therapist. For

the unsupervised therapist, this may be a time to seek consultation (p. 331).It is notable that only

one participant (Participant 2) recognized her patients' resilience whereas the other participants

experienced negative feelings regarding forced termination or resignation and numbness. This is

not to say that forced termination does not have any negative implications, however, the negative

feelings invoked by forced termination reinforce the importance of supervision for therapists

who experience these frequent terminations as they may struggle seeing the benefits their

sessions have had, are second-guessing themselves, and may experience feelings of omnipotence

(e.g., the patient cannot succeed without the therapist's support). Figure 17 shows the general

progression of mental health provider's thoughts and feelings regarding forced termination and

the two paths to managing these emotions. One path is colored by resignation and feelings of

powerlessness, which lead to normalizing and compartmentalizing of the experience as a coping

strategy. While this path may lead to temporary relief, it is likely that it eventually leads to

emotional exhaustion and burnout in the therapist. The other path leads to seeking of supervision

to cope with the forced termination and helps therapists avoid self-questioning, guilt, feelings of

failure, and helplessness in a more adaptive way.
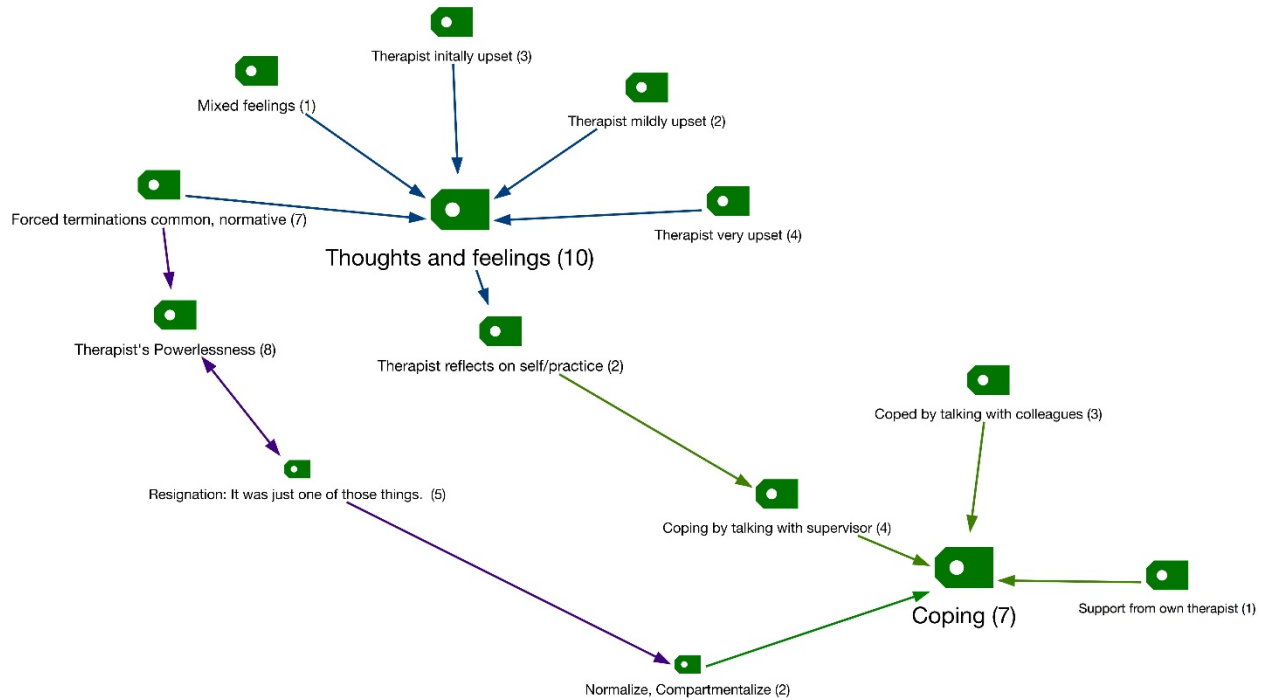
Figure 17. Participants' thoughts and feelings regarding forced termination with coping

strategies

Negative effects of forced termination. According to Joyce et al. (2007), at the end of a

therapeutic relationship, patients may experience feelings of anger and disappointment, as well

as depression associated with feelings of powerlessness and displaced grieving. Therefore, the

final phase of therapy usually has a focus on processing and improving skills regarding

separation. However, forced termination often prevents this very important phase of therapy to

occur. Sun (2012), citing Baum (2005), states that patients who have no control over the

termination can present with more resistance, anger, rage, anxiety, and frustration. Nearly all of

the participants believed that forced termination had negative effects on their patients' mental

health. The examples they gave were that: (a) patients could be discouraged from engaging in

therapy in the future, (b) patients with attachment disorders could in the face of yet another

relationship ending, re-experience attachment traumas, and (c) patients' symptoms could be exacerbated due to the added stress of the termination.

Forced termination and ethics. One participant (Participant 4) brought up ethical issues raised in the context of forced termination. This is a topic worthy of consideration as the American Psychological Association's Ethical Principles of Psychologists and Code of Conduct (2002) specifies, "Psychologists terminate therapy when it becomes reasonably clear that the client/patient no longer needs the service, is not likely to benefit, or is being harmed by continued service." This means that therapists shall not abandon their patients and must plan in advance for scenarios in which termination is unavoidable and premature. Psychologists are required to "make reasonable efforts to plan for facilitating care in the event that psychological services are interrupted," and provide an "appropriate resolution of responsibility for patient or client care in the event that the employment or contractual relationship ends." The participants of this study did indeed make these reasonable efforts by discussing the possibility of termination early with their patients and, when possible, prepared them for their next step.

Participant 7 added another issue that might fit under the topic of ethics. He recognized that the correctional system not only causes forced terminations that therapists must manage, it also can lead to failed treatments. Specifically, he criticized the length of incarceration which often impedes the patients' ability to readjust to society after release. According to him, patients who are incarcerated five years or less, may have less difficulty reintegrating because their support system may still in place. However, those who have been incarcerated for a longer time, may find it difficult to return to their community regardless of beneficial psychotherapy. Further, those who get released into the community may not have an appropriate treatment system in place. As most of these participants recognized, wrap-around services and follow-up

opportunities were often not available for their patients, and they complained of the lack of

continued outpatient psychiatric treatment for those with significant mental health problems.

Question 2: How does the working alliance influence the effects of forced terminations?

Most research regarding termination and the working alliance was based on the issue of

patient-initiated dropout. No research was found that explored how the working alliance

influences the effects of forced termination caused by other factors. Regarding planned

termination, Tryon and Kane (1993) discovered that the working alliance was positively related

to mutual termination. It is conceivable, based on this finding, that the working alliance also has

a positive effect on the outcome of therapy, even when forced termination occurred.

The reason for the lack of research on this topic is likely the difficulty determining

whether a good alliance had a positive influence on the outcome when therapy was forcedly

terminated because generally no follow-up can occur. Most participants chose to speak about

their experiences of positive alliances in therapies before forced termination occurred. In many

ways, the participants were able to establish their alliances in the way Bordin (1979) suggested:

by agreeing with patients on goals, on the tasks to accomplish those goals, and the interpersonal

bond. Participant 1, for example, specifically stated that she focused on the goals that her patients

wanted to accomplish. Participant 2 experienced good relationships with long-term therapies and

patients with whom she was able to establish short-term goals early on. Similarly, Participant 7

felt that working alliances were strong with patients who came to therapy with specific mental

health symptoms; presumably, these cases made it easier to establish and agree on goals.

Besides establishing goals and agreeing on tasks, most participants focused a lot of their

attention on the interpersonal bond between them and their patients. The way to establish

interpersonal bonds was achieved by moving mistrust to trust. This mistrust can be understood

by looking at the patients' background. Carlson & Shafer (2010), for example stated that many incarcerated patients have personal life histories characterized by poor bonding, emotional neglect, negative experiences in institutions, and few if any supporting and trusting relationships. Abusive or neglectful early experience may have led patients to develop insecure attachments and these individuals start defending themselves against the insecurity through aggressive behaviors (Weinfield et al., 1999), which may partly be the reason for their incarceration. Haley (2010) added that not only disrupted early attachments but also the prison environment can create prisoners' attachment issues by causing separation from one's family and abrupt therapy terminations.

    In addition to maladaptive attachment patters experienced by many incarcerated individuals, they may also experiences a particular mistrust toward members of the correctional system, as illustrated by Participants 2 and 6. Brans and Lesko (1999) describe the power differential, meaning that every therapist in the correctional setting has to balance dual roles, having the institution as one's employer and the inmate as a client and having to enforce correctional procedures in the therapeutic context. As explained in the literature review, dual relationships present the issue of asking the inmate to participate and be vulnerable with a therapist who is a member of the oppressing institution which can feel disempowering and frustrating to the inmate. Participant 4 used empathy as a tool to establish the working alliance by validating the patients and their feelings about the setting. Participant 4 and 6 also stressed the importance of being respectful toward their patients and "not treating them like an inmate." Finally, Participant 1, 2, and 4 felt that getting to know their patients and the patients to know them on a "human level" helped them to establish the alliance.

The question of how the working alliance influences the outcome of forced termination remains difficulty to answer. It appears that most participants employed strategies to bond with the patient, which in turn may have led to improvements in patients' conditions before forced termination occurred, however, more research is necessary to explore the effects a positive working alliance has on therapeutic outcomes of forcedly terminated therapy cases.

Question 3: What steps could be taken to ensure a good outcome despite premature terminations?

Joyce et al. (2007) listed the objectives of the termination phase, which included discussions regarding achievements, unmet goals, loss and separation, reinforcement of the therapy process, and preparing for functioning outside of therapy. The discussion regarding separation is especially important considering that therapy termination can evoke similar feelings to those of grief, including resistance and reminders of past separation trauma (Bowlby, 1982).

Given that the termination phase likely does not occur in forced terminations, the participants discussed what strategies led to improvement in their patients' well-being before therapy was terminated. These strategies likely also helped the participants manage negative feelings regarding forced terminations as these strategies kept them in control to some extent. Some participants 1, 2, and 5 decided to prepare their patients for termination or at least thought about the possibility of termination throughout their entire time with the patient. Participants used strategies, such as empowerment (Participant 5), for example allowing the patient to choose their own goals and establish plans themselves, and reminding them what they have already accomplished and how to continue improving themselves (Participant 6). Empowerment was considered a helpful approach because patients will be more involved in their own treatment, according to Participant 7. The relationship between the therapist and the patient was also

considered a tool to improve the patients' well-being. It was helpful for patients to have someone

to talk to who is non-judgmental but also not an inmate (Participant 2), as well as someone who

is committed to helping them (Participant 6). Further, medication (Participant 6) and appropriate

therapy approaches for the patients' level of need were considered helpful. Specifically highly

structured therapy approaches, such as motivational interviewing and CBT were named

(Participant 4, 2); again approaches that are short in nature, more focused on short-term goals,

and may be more fitting in an unpredictable setting.

Many participants also chose to discuss how to minimize the negative consequences of

forced termination. Participant 6 for example recognized compassion as a tool to avoid negative

consequences of forced termination. Further, participants felt that teaching and reviewing skills

with patients throughout their sessions can be helpful. Participants, for example, encouraged

patients to seek further treatment when they leave (Participant 3) and reviewed their treatment

plans with the patient to enable patients to pick up where they left off (Participant 5). Participant

6 discussed patients' achievements and Participant 7 explored areas that patients may want to

continue working on with the next therapist. These strategies can be used at any time with

patients and may be a key strategy in helping patients manage forced terminations.

When therapist and patient are aware that forced termination is about to occur,

participants suggested that therapists may be able to contact future therapists to discuss the

patient or they may help the patient find another therapist at the new facility or in the

community. This strategy may reduce the drop-out rate of transferred patients, which has been

found to double, compared to non-transferred patients (Tantam, & Klerman, 1979). Siebold

(1992) states,

Whether disguised or overt, clients are likely to express grief for the departed therapist and distrust of the new therapist. Being discounted and tested out by clients who expect that transfer therapists, too, will abandon them is not uncommon under these circumstances. A transfer therapist may find herself wanting to reject a client, thus gratifying the client's expectations.

Further, Siebold notes that therapists who contact future therapists and have a discussion with the patient about the future therapist, aid in the process of separation and reattachment, and a discussion about the patient's fears and resistances regarding the future therapist can be initiated. It is, therefore, conceivable that a discussion between the past and future therapist can be helpful because patients likely have not worked through the loss of the past therapist when they begin sessions with their new therapists.

Very few therapists in correctional settings may have the opportunity to follow up with their patients after termination. Only one participant (Participant 3) was able to continue therapy after forced termination had occurred by seeing the patient at the new facility. Another participant (Participant 5) worked in an outpatient setting while simultaneously working at a correctional facility, which enabled patients to see her post-release, should they choose to do so. Such opportunities, although rare, can be beneficial when helping a patient transition to a new setting and a new therapist.

Again it is important to discuss the correctional system a bit more in depth in relation to forced termination. As shown in Figure 18, correctional mental health providers interviewed for this study attempted to solve the systemic problem of forced termination in correctional settings by employing individualistic solutions. These solutions helped the participants in managing their feelings of powerlessness. However, these solutions also highlight the participant's underlying

wish to prolong the connection with the patient (e.g., following patients during transition, consulting with future therapist). This makes sense as intuitively, as therapists know that a transfer to a new therapists may be difficulty for a patient and helping the patient with a smooth transition will help diminish negative experiences. Given the frequent transfer of patients in correctional settings, therapists on the "receiving" end may need to keep certain considerations in mind. Firstly, the therapist should inquire whether the patient has had a therapist before and if so, needs to recognize that the relationship with the prior therapist likely influences the patient's expectations about the current therapeutic relationship. Further, the receiving therapist should be able to discuss this relationship with the patient and possibly work on grieving the loss of the old therapist. Finally, frequent check-ins regarding how things are going between the new therapist and his or her patient may be necessary, including encouraging the patient share prior therapy experiences.
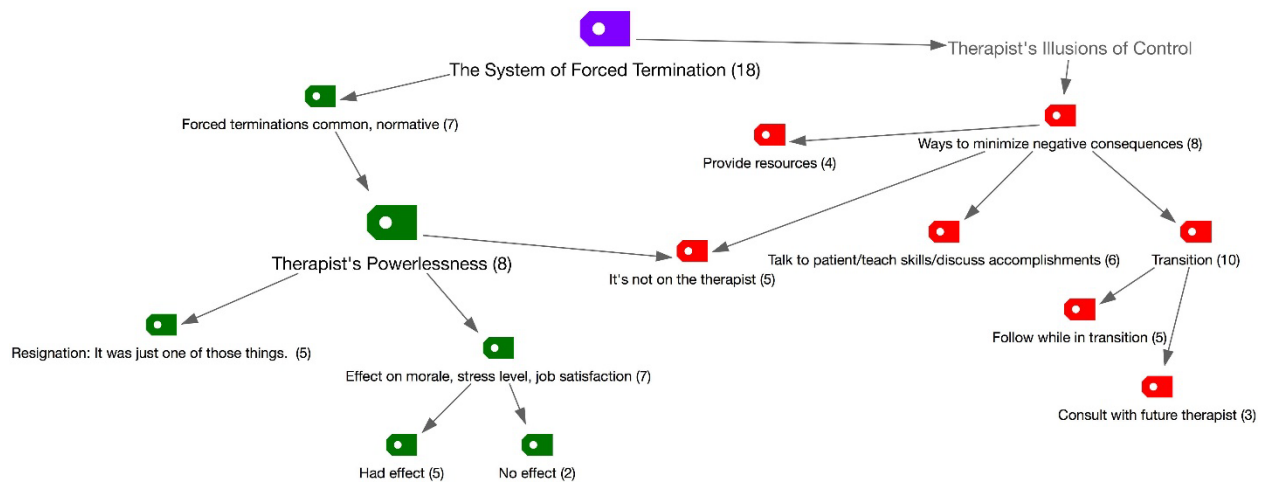
Figure 18. Changing the systemic problem of forced termination in correctional settings with individualistic solutions.

Question 4: What else could be done to counteract the effects of forced terminations in the correctional field?

The participants discussed additional strategies to counteract the effects of forced termination with a specific focus on in-service training regarding termination. The assumption was that therapists should be made aware of the ever present possibility of forced termination and may benefit from strategies to prevent negative effects on their patients or on themselves. However, the participants largely did not agree that this would be beneficial. Reasons for this could be that the staff may not be as engaged in such training (Participant 1) or that mental health professionals may not experience forced terminations the same way and it would be unclear on how they could be prepared for forced termination (Participant 2). Participant 4 did think that it was important for therapists to acknowledge that terminations happen and negative consequences may arise and Participant 5 even suggested training in evidence-based models for forced termination. However, while she believed that therapists need to learn about termination, she felt that there were other, more urgent issues regarding forced termination, such as the lack of wrap-around services. Participant 6 had similar concerns, focusing on discussing how to incite individuals to continue therapy at their new placement, rather than how therapists can learn about termination.

However, it is of my opinion that therapists in the correctional setting still may profit from a specific training based on forced termination. I propose that the following "clinical implications" guide such a training to help correctional mental health providers offer better care and support to the incarcerated patients.

Clinical Implications

The findings of the current study have implications surrounding each of the superordinate themes. Although this research is based on the experiences of a small number of correctional mental health providers, it has highlighted several implications for people working with incarcerated patients.

Coping with forced termination. For correctional mental health professionals, supervision can be a great help when coping with therapeutic relationships that were forcibly terminated. Speaking with a supervisor may lower the therapist' anxiety, guilt, countertransference issues, and burn-out and is therefore a valuable tool to managing forced termination. Further, supervision can help mental health providers explore achievements they have had with patients, even with those whom they were only able to see for a short while. Supervision may also remind practitioners of their patients' resilience, that a forced termination will not "break" their patient.

Correctional mental health providers may seek supervision or peer-supervision among other professions, such as nursing, medicine, or with psychiatrists or social workers. Similarly, correctional mental health providers can find supervision with peers from other locations, such as through forensic professionals' networks, during conferences, or by participating in online training programs. Ideally, professional mental health providers would receive appropriate supervision by supervisors in their field, such as a psychologist being supervised by other psychologists. This is important as supervisors who work in the field of their supervisees will have the competence in the foundational and functional competency domains of that specific field. Especially mental health providers in training need to have sufficient supervision to be able to manage providing therapy in such a challenging environment.

Practice in settings with frequent forced terminations. One of the earliest steps in therapy has to be the development of the working alliance. Developing a good working alliance may help the patient become motivated in therapy, and it may help them learn to "invest" in their own treatment. However, the working alliance can be difficult to establish as incarcerated patients may have mistrust toward a therapist who works for the correctional institution. Developing the working alliance can be achieved through empathy, active listening, and validation of the patient's feelings regardless of what brought them into the correctional setting. Similarly, patients benefit from therapists who try to get to know them and support them as a patient, non-judgmentally and respectfully.

Once the working alliance is established, the therapist should move quickly, stay focused and on task, given the often short-term nature of therapy in correctional facilities. Further, the therapist has to be prepared for the unpredictability of number of therapy sessions to be able to plan for sudden terminations. It may also be helpful to prepare the patient of the possibility of forced termination early and throughout the sessions. Discussing progress throughout all sessions and reviewing goals that have been achieved may help the patient feel more confident finding help elsewhere after forced termination occurred.

To ensure a good outcome of therapy, an appropriate therapy approach should be chosen for the patient. Motivational interviewing, CBT, time-limited dynamic therapy, solution focused therapy, and other short-term approaches appear to be successful as they are short-term, move quickly, and may be fitting in an unpredictable setting. The therapist may let the patient choose their own goals and establish plans themselves. Throughout sessions, the therapist can remind the patient what he or she has already accomplished, and how to continue improving him or herself. Teaching and reviewing skills and reviewing the treatment plan with the patient regularly

will be helpful in the case of a forced termination. That way patients can explore areas that they may still want to work on in the future.

Once forced termination is about to occur or has occurred already, the therapist may help the patient find another therapist at the new facility or in the community, follow the patient during the transition period, or may even continue to stay in contact, given that the benefits would outweigh the drawbacks of such a continued contact. If possible, the therapists may choose to contact future therapists to discuss the patient. Therapists who contact future therapists and have a discussion with the patient about the future therapist, can aid in the process of separation and reattachment, and a discussion about the patient's fears and resistances regarding the future therapist can be initiated.

Therapists in correctional settings also need to be prepared to work with patients who have had therapists before and therefore need to discuss this relationship with their patients, processing the grief of the old therapist with the patient, and encouraging the patient to share their current and prior therapy experiences.

System Specific Recommendations

Although this study focused on forced termination and the working alliance between therapists and patients in correctional settings, some systemic issues were uncovered that need to be addressed. As mentioned previously, correctional mental health providers' strategies to manage forced termination are individualistic solutions to a systemic problem. Although this is an important factor, there are recommendations to be made to change the system to become more therapeutic.

Firstly, there appears to be a lack of mental health service providers in the correctional setting. This issue is "sandwiched between" a mental health system that fails to treat people long

before they enter the criminal justice system and one that fails to help them reintegrate into society. Focusing just on the treatment provided in prisons, it appears that mental health staff in correctional settings have unreasonably heavy caseloads which simply limits the care each inmate gets and stifles the work of specialized treatment providers as they may have to do work that is below their training. In a similar vein, mental health staff may be forced to do work that is beyond their competence (e.g., providing sex offender treatment). Therefore, the first suggestion is to hire more mental health staff for correctional facilities.

Hiring more staff will also mediate the apparent lack of supervision experienced by mental health staff. Ensuring there is sufficient supervision will enhance positive outcomes of therapy and lessen burnout of staff, which in turn lowers staff turnover. Further, additional staff can ensure that patients are screened before therapy even begins to assign appropriately skilled therapists and establish achievable goals.

Another factor that needs to be changed to make correctional settings more therapeutic is the punitive measures within the prison. Inmates are in therapy for a variety of reasons, often to do with their maladaptive thoughts, feelings, and behaviors. However, maladaptive behaviors are often punished by isolating the inmate, effectively preventing him or her from attending programming that is supposed to help them with this behavior. Further, instead of teaching inmates to not behave in the same way again, isolation may induce anxiety and depression, in turn making it more likely for another behavioral outburst.

Finally, a topic that came up multiple times during the interviews was the lack of follow-up and wrap-around services. When inmates leave prisons, they are often faced with an unstable housing situation and experience difficulty finding employment. Further, their mental health issues may still be an obstacle to reintegration. New programs and resources for this population

need to be created in order to help former inmates become psychologically stable and prevent

incarceration, effectively making crime and homelessness in communities less likely to occur.

Limitations of this Research

Given that this study entered new territory and explored a particular phenomenon that has

not been studied to my knowledge, it is not without its limitations. These limitations should be

addressed in future research. Firstly, the study is limited by its small sample of qualitative

interviews, which means the findings cannot be generalized to apply to all forced termination

cases in correctional settings. However, while the sample is limited, the issues discussed in this

study are likely similar across most correctional settings and are validated by the similarities of

experiences the seven participants discussed.

Another limitation is my bias regarding the topic of forced termination. It is

acknowledged that I had my own knowledge, beliefs, and experiences of forced termination and

has therefore played an active role in the co-construction of the results of this research. Although

this researcher made efforts to minimize the potential limitation by consulting with her advisor

and re-reading the transcripts, the generating of themes was still subjective.

Suggestions for Future Research

Exploratory studies like this one can inform larger sample survey research projects. For

example, to answer questions related to construct validity and generalization of themes identified

here, or to examine relationships between demographic variables and themes. Considering the

difficulties recruiting participants for this dissertation, a brief survey consisting of clear and

concise questions and anonymous participation would likely improve sample size.

Psychotherapist burnout could be examined in relationship to forced termination and

other factors likely to affect job satisfaction in prison settings. There appears to be much

dissatisfaction among the correctional mental health providers who were interviewed for this study. Future research may focus on how correctional systems can improve therapists' and patients' morale and satisfaction with treatment as well as explore what makes it possible for therapists to work in such a setting. Perhaps investigating whether increasing supervision requirements or trainings specifically with this population or regarding forced termination may mediate the less than ideal circumstances in prisons.

A quantitative longitudinal study regarding patient recidivism or general mental health may be valuable in order to see whether therapeutic contact was beneficial even if forced termination occurred. As such, the working alliance may need to be assessed as well, by measuring how both the patient and therapist perceived the therapeutic relationship.

Interviews could be conducted with inmates who experienced forced termination to gain insight into their perspectives about how termination affected their well-being, their willingness to continue therapy elsewhere, and obstacles that they may experience receiving continued treatment. Quantitative methods could also be utilized to identify the numbers of patients who received follow-up care after their initial forced termination experience.

Conclusion

The study focused on the experience of correctional mental health providers related to forced terminations and their working alliance with incarcerated patients. The purpose of this qualitative study, completed with an interpretative phenomenological analysis, was to gain insight into the experiences of seven participants who had experienced forced termination with incarcerated patients. The results of this study are based on the major themes found in the interviews. The themes include the suggestion of seeking supervision among professional peers (e.g., psychologists, psychiatrists, social workers, nurses, etc.) and face to face or through

distance communication, especially when forced termination has or is occurring. Supervision is a very important factor in the work with incarcerated patients as many providers may struggle with forced terminations by doubting the success of their work. Further, the mental health professionals spoke of the importance of the working alliance to help patients become motivated and invest in therapy. To establish a solid alliance, providers suggested using empathy, active listening, and validation as well as non-judgmental and respectful behavior, regardless of the patient's crimes. Given the unpredictable setting and short-term nature of therapy in correctional settings, providers generally moved fast in sessions and focused on their tasks. The interviewed providers also prepared their patients of the possibility of forced termination and regularly reviewed progress and achievements with them. Further, providers discussed areas of improvements with patients, which they may be able to explore with future therapists. Most providers wished they had the opportunity to help their patients find therapists when forced termination occurred and wanted to be able to contact future providers. Some also wanted to continue contact with the patient during the transition period. These ideas were seen as potential strategies to counteract the negative effects of forced termination. Overall, this showed that correctional mental health providers were attempting to dismantle the obstacles to mental health treatment created by the correctional system by applying individualistic solutions, which likely played a vital role in improving treatment outcomes.

Final Thoughts

This study was motivated by several factors. The first motivation came from my own experiences as a psychology practicum student providing psychotherapy in a correctional institution for female inmates. Like this study's participants, I experienced numerous forced terminations with patients and wondered whether I had made any impact during my very limited

time with the inmates. After initial experiences of forced termination, I began to expect this to

occur frequently and began preparing my patients that forced termination may happen.

Furthermore, I attempted to focus on smaller goals that could be achieved with short-term

therapy approaches to help the patients "get something out of therapy." I also frequently

reminded patients of the unpredictability of the setting, such as "Unless there is a lock-down, I

will see you on [date]," or "If I see you next week, what would you like to work on?"

Following my practicum at the prison, I have continued working in settings that are

connected to the criminal justice system, such as a competency restoration unit, a hospital with a

large forensic population, and a forensic center. While I still experience forced termination and

the population often presents with the same issues and with similar attachment problems, I know

that they generally continue to receive treatment within the institution or in other settings. I

perceive the issue of forced termination in correctional facilities as uniquely challenging because

prisons and jails are not focused on treatment and there appears to be very limited continuity of

care within the prison and in the community. I am aware that my experiences shaped how I

conducted the study and I attended to this impact by listening to, reading the interviews

repeatedly, and analyzing the transcripts carefully, as well as consulting with my advisor

throughout this process.

Further, my novice approach to IPA in itself presents a limitation to this research.

However, I found it fascinating to learn about this approach and apply some creativity to the

interpretation. Further, being able to speak to other correctional mental health providers about

issues that I wanted to know more about as I had experienced them myself was incredibly helpful

for my development as a clinician.

With this study, I was able to explore a topic that I had been curious about in the past. I was able to find out more about the experiences that others in similar positions (providing psychotherapy to inmates that were forcedly terminated) and I believe I have achieved this goal. This was an affirming and enriching experience and I am thankful I had the chance to explore this topic with IPA.

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Appendix A

Participant Recruiting Email (AP-LS)

Email Subject Line: "Request for participation in a research project"

Disclaimer: This email does not describe a request made by the American Psychology-Law Society (AP-LS). AP-LS is neither conducting nor endorsing this research. Instead, AP-LS is sending this on behalf of a member(s) to use the email list to recruit research participants (see policy at: http://www.apadivisions.org/division-41/about/resources/email-list.aspx). Any specific questions regarding the participation request should be directed to xxxxx@antioch.edu.

Help Us to Learn More About Forced Termination With Inmates

My name is Karin Gepp. I am inviting correctional mental health providers who have had experience with forced termination to participate in a study as part of my dissertation research. My study explores the connection between the working alliance between mental health service providers and their incarcerated clients in face of forced termination. Participation will require that you fill out a questionnaire regarding basic demographics, participate in a semi-structured interview via video call, and a follow-up interview based on your availability. It is expected that this will take about 30 to 40 minutes. If selected for participation in the interview, you will be eligible for a $20 Amazon gift card, even if you decide to end participation before the data collection session is finished.

If interested, please call or email

Karin Gepp

███████

███████**@antioch.edu**

Appendix B

Participant Recruiting Posting (IACFP)

Help Us to Learn More About Forced Termination With Inmates

A Call for Research Participants

My name is Karin Gepp. I am inviting correctional mental health providers who have had experience with forced termination to participate in a study as part of my dissertation research. My study explores the connection between the working alliance between mental health service providers and their incarcerated clients in face of forced termination. Participation will require that you fill out a questionnaire regarding basic demographics, participate in a semi-structured interview via video call, and a follow-up interview based on your availability. It is expected that this will take about 30 to 40 minutes. If selected for participation in the interview, you will be eligible for a $20 Amazon gift card, even if you decide to end participation before the data collection session is finished.

If interested, please call or email, or comment on this post.

Karin Gepp

@antioch.edu

Appendix C

Informed Consent Form

You are invited to take part in a research study regarding your experience with unexpected endings of treatment with inmates. Principle investigator is Karin Gepp, who is a doctoral student at the department of clinical psychology at Antioch University New England.

What the study is about: This study is designed to gain a better understanding of your perceptions of the working alliance between yourself and patients in relation to unpredictable therapy termination in the correctional setting.

What you will be asked to do: As a participant, you will be asked to fill out a questionnaire regarding basic demographics and information about your work environment, and participate in a semi-structured interview. If you agree, I will schedule an interview time, and location that is convenient for you. We will conduct the interview via video chat (you can opt for audio only). The interview will be audiotaped, and will take approximately 20-30 minutes.

Risks and Benefits: The risks in participation are expected to be minimal. The topic of therapy termination could be uncomfortable on professional grounds, but the interview questions are unlikely to be personally upsetting. Results from this study will be used to expand on the literature and knowledge of forced termination of therapy in the correctional setting. While participating in this study, you may discover and learn new ways of understanding your experiences. You may have the desire to see others benefit from your experience and may help them be spared of the negative experiences. You may enjoy being able to share your story, feel that you have made progress, experience a sense of closure, and may eventually feel that something good came out of your potentially negative experiences.

Taking part is voluntary: Taking part in this study is voluntary. If you choose to be in the study, you can withdraw at any time without consequences of any kind. You may choose to not answer a particular question. Participating in this study does not mean that you are giving up any of your legal rights.

Your answers will be confidential: The records of this study will be kept private. Data and interview materials, coded with numbers for anonymity, will be kept in a locked box and the data added to a database on a computer – to which only the researcher has access – will be password protected. The audio recordings will have no identifying information except your voice and will be destroyed at the end of the completion of the study. With your signed permission below, we may abstract quotes from your interview for inclusion in research reports and formal presentations. Any report of this research that is made available to the public will not include your name or any other individual information by which you could be identified.

If you have questions or want a copy or summary of the study results: Contact the researcher at █████@antioch.edu or 603-283-2183 (Clinical Psychology Department), or the researcher's dissertation chair Dr. Susan Hawes at shawes@anatioch.edu or 603-283-2192.

If you have any questions about whether you have been treated in an illegal or unethical way, contact Dr. Kevin Lyness, Chair of the Antioch University New England Institutional Research Board at klyness@antioch.edu or Dr. Melinda Treadwell, Vice President for Academic Affairs at mtreadwell@antioch.edu or 603-283-2444.

Statement of Consent: I have read the above information and have received answers to any questions. I consent to take part in the research study of experience with termination and forced termination.

Participant's Name (Printed)   Date

Participant's Signature   Date

Appendix D

Release for Recording

I, _____ give my consent to _____to record the

interview process for her dissertation research.

_____
Participant's Name (Printed)

_____   _____
Participant's Signature   Date

Appendix E

Questionnaire for Demographic Data

Thank you for agreeing to participate in this study. Please complete the questionnaire below and return it in the attached, self-addressed, stamped envelope. The information in this questionnaire is completely confidential and will only be used for the purposes of this research study.

Demographic Information Sheet

Gender:

☐ male
☐ female

Age: _____

Ethnicity:
☐ White
☐ African American
☐ Asian
☐ Hispanic
☐ Native American
☐ Other _____

Education:
☐ Psy.D./Ph.D.
☐ L.C.S.W
☐ Other _____

Your model(s) of treatment:_____

#of years of working with the incarcerated:_____

# of years at current site:_____

Type of facility (e.g., jail, state prison, federal prison):_____

Security Class (e.g., minimum, medium, maximum):_____

Approximate # of Inmate:_____

Approximate # of Mental Health Service Staff: _____

Mental Health Service Types:
☐ Individual
☐ Group

☐   Assessment

Thank you for completing this questionnaire.

Appendix F

Interview Protocol

Participant Code:_____

Today's Date: _____

Type of contact:
☐   Phone/ Online Conference
☐   In person

General Questions:

- Opening question
    - Would you please tell me, **briefly**, your history of [the story of] your work providing psychotherapy for incarcerated people?

    - Would you tell me about the kinds of supports currently available to the psychotherapists at your facility?
        - If you are part of a team with other professionals, are regular meetings to discuss treatments for patients (as a group and individually), and for therapists to present cases scheduled? [1. When the response is "no," ask for clarification on their understanding of the institution's rationale for this absence; 2.When the response is "yes," follow up by asking about their experiences of this meeting, including their assessment of its strengths and weaknesses].
            - How is this meeting organized: hierarchically, collaboratively, or otherwise? How is the purpose of this meeting explained to the mental health staff?
            - Is this a place where discussions about terminating with patients could occur? In your time there, have terminations been discussed? [If "yes" to the latter, ask about the participant's experience of this].
        - Does your setting provide individual supervision?
        - What opportunities for peer consultation [other than the above] are available to you?

I)   Research Question 1: [*How do correctional mental health providers cope with forced termination?*]
    A) When you begin working with an incarcerated patient, based on your treatment model, what are your typical plans/assumptions for the length of treatment?
        1) Have there been instances when you have been able to end therapy with the treatment goals met?
            (a) How common has this been for your patients?
            (b) What conditions at your site contributed to this?
    B) I am using Bordin's definition for "working alliance," which says that the working alliance is a collaborative feature of the treatment relationship, composed of goals of the treatment, agreement on the tasks, and a personal bond between the patient and the therapist made up of reciprocal positive feelings (Bordin, 1979, p. 12).

In your experience, what have the working alliances been like when you have treating incarcerated patients?
1) How have the alliances typically developed with your patients?
2) From your experience, how would you describe the working alliances in those completed psychotherapies with incarcerated patients?

C) How have you experienced forced terminations in your therapeutic work with prisoners in the correctional setting?
1) Please describe one or two of these instances of forced termination you have experienced, leaving out any information about your clients and their actual therapy sessions, to preserve the ethics of client confidentiality. You may give examples of the termination processes.
  (a) What were your thoughts and feelings at the time?
  (b) How did you manage or cope with these experiences?
  (c) What did you do afterwards?
2) What, if any impact have forced terminations had upon your how practice with these patients?
  (a) Have forced terminations affected your morale, stress level, and job satisfaction? If so, how? [Probe for all 3]

II) Research Question 2: [*How does the working alliance influence the outcome of forced termination?*]
A) Have you seen improvements in patients over the course of treatments, which were then forcibly terminated?
1) If so, what do you think contributed to those improvements?
2) [If they say "the relationship": How does your relationship with the patient have a positive influence on the therapy outcome despite forced termination?]

III) Research Question 3: [*Current support conditions and what steps can be taken to support a positive outcome despite premature termination?*]
A) What are your thoughts about how forced termination of therapy affects the patient's mental health and potential future psychotherapies?
B) Have you found ways to help minimize negative consequences of forced termination on patients' mental health?
1) If so, what are these, and how do you think they helped?
C) What actions would you recommend be taken to support a positive outcome despite premature termination?

IV) Research Question 4: [*What else can be done to counteract the effects of forced termination in the correctional field*?]
A) Besides your own efforts, what other measures could be taken to counteract the negative effects of forced termination on some patients?
B) How might in-service training help/not help counteract the negative effects of forced termination on therapists? On patients?
C) Are there other questions about this issue that you think I should have asked?

• Closing
  o What was the experience of this interview like for you?
    ▪ [Content, process & suggestions]

Appendix G

Record of Interpretive Phenomenological Analysis

Sample of Stage 1, Stage 2: Emergent Themes, Original Transcript, Nonverbal Cues, Exploratory Comments, with 1 participant

Emergent Themes	Original Transcript	Nonverbal Cues	Exploratory Comments
	Participant 1		
	Would you please tell me, **briefly**, your history of [the story of] your work providing psychotherapy for incarcerated people?		Juvenile detention center
	Uhh, I worked in a juvenile detention center. I was in graduate school for social work and I interned there twice or three times a week. And I did intakes and individual therapy.		
Lack of supervision	Would you tell me about the kinds of supports currently available to the psychotherapists at your facility?	False start	Not much supervision
	Yeah, so, I had a supervisor who worked at; so in New York City there are two juvenile detention centers, one in the Bronx and one in Brooklyn, and there was a director who oversaw both of them but uhh, she wasn't there often. So I, / There was a research grant going on through ACS, that's Administration Children Services and there were these psychologists there who would help me but they weren't really assigned to me. I guess I had a supervisor but she wasn't that present.		
	If you are part of a team with other professionals, are regular meetings to discuss treatments for patients (as a group and individually), and for therapists to present cases scheduled?	Pause	No case presentations
	(pause) We had a crisis meeting maybe when there were like problems going on about uhh juvenile, like some of the kids, the residents were having a really hard time, but I wasn't there every day so I don't know. There weren't any on the days I was there but I don't know if		

	that's because I wasn't there every day.		
Many forced terminations but no discussion about it	Is this a place where discussions about terminating with patients could occur? In your time there, have terminations been discussed? *Uhmm, we didn't discuss termination because I / So what ended up happening is I was there September and I had to leave by the end of December because uhmm, the jail was really unsafe and they were just having a lot of problems. And I found myself in very unsafe situations so I had to leave. I didn't terminate with any of my clients, I was just not able to return. So we didn't really talk about it.*	False start	No talk about termination; Forced termination with all patients because therapist left
Varying lengths are planned	When you begin working with an incarcerated patient, based on your treatment model, what are your typical plans/assumptions for the length of treatment? *Yeah, (pause) holding cell…uhmm, so not a holding cell but they were on trial so it would be from like two weeks to two years was the longest kind of. My assumption was that it was really short-term… days uhmmunless they had a lot of court issues but really temporary and really about like stabilization rather than like intensive therapy. A lot of psychoeducation I guess.* *So what I was saying was the therapy uhmm / The jail that I was in they weren't supposed to be there permanently so the shortest stay was two weeks I think and the longest stay was like two years. Uhmm so we were very temporary based therapy which was much more psychoeducation and uhmm behavior plans and like becoming, like adjustment, becoming stable.*	Pause False start	2 weeks to 2 years; short term
No goals met	Have there been instances when you have been able to end therapy with the treatment goals met? *No. (pause) And even if you wanted to it was very hard to predict.*	Pause	No goals met
Some good alliances, bad when	I am using Bordin's definition for "working alliance," which says that the working alliance is a collaborative feature of the treatment relationship, composed of goals of the treatment, agreement on the	Multiple pauses False start	Some had a strong alliance;

mandatory	tasks, and a personal bond between the patient and the therapist made up of reciprocal positive feelings. In your experience, what have the working alliances been like when you have treating incarcerated patients?		some who had to meet here did not
	I think there's a strong connection with the (pause) / with the kids and me because it's like an outlet during their day and someone they can talk to (pause) uhmm (pause) I think it depends on the person. I think there some kids I really formed an alliance we really talked about like goals and what they wanted out of this and there were others who (pause) were in serious trouble and had to meet with me and they didn't wanna be there.		
Get to know patient and their problems, advocate and support	How have the alliances typically developed with your patients? *Uhmm...I just like really tried to get to know them and try to understand what they were going through uhmm especially people who haven't been to jail before I think those are the kids who most connected because it was their first experience uhmm and is like, ya, really trying to see what they are going through and trying to support them and advocate for what they need.*		Get to know them Understand what they are going through Support and advocate for them
Some sudden terminations, some predictable	How have you experienced forced terminations in your therapeutic work with prisoners in the correctional setting? *There were days when I would come in and I wouldn't expect someone to leave and then they would be gone. So we would always like ... we talked about it in the beginning.*		Sometimes sudden terminations Sometimes predictable
struggle	What were your thoughts and feelings at the time? *Me personally? Uhmm, I struggle with termination in general so it was hard for me and when the last incident happened I was really badly [inaudible] and I couldn't say goodbye I really struggled with it.*		Struggled in general

Seeking own therapy	How did you manage or cope with these experiences? *I just went through it my own. I have my own therapist so I used her as a guide to help me.*		Uses own therapist
Discuss termination with patient Patient may not like termination which leads to difficulty making connection with next therapist damaging	What, if any impact have forced terminations had upon your how practice with these patients? *Uhmm (pause) I think I'm more aware that things can happen and to always be like… / to discuss it earlier on there even if you don't know the outcome. That's what I learned from it but it's still hard for me and… / I don't know how much good it does, I guess I'd have to research it, but how good it is for the kids and the patients because I would ask if they've been to therapy before and what they really didn't like about it and they said like "we are constantly switched." So I don't (pause) know. I mean, (pause) I just think it's really hard to form a connection with someone and allowing people in such an unsafe place so if they are able to do that I think it's damaging to be like "see you later." Or like if you're doing like response, like exposure therapy, you have to commit to a certain time so they can be unsafe. And I think some of the kids reveal a lot and it's a lot for them to handle and they have someone to go to.*	Multiple pauses and false starts	Discuss termination earlier Not sure if that is helpful Patients did not like getting new therapists Hard to make connection in this setting Damaging if therapist leaves
Had effect	Have forced terminations affected your morale, stress level, and job satisfaction? If so, how? *Mine? Oh yeah, 100%.*		Affected morale, stress level, and job satisfaction
Difficult since cannot follow-up Give coping skills for later Difficult for patient to use	Have you seen improvements in patients over the course of treatments, which were then forcibly terminated? *I can't follow up with them so I don't know how they are doing. While I was with them, I think (pause) well I don't know how affective it is now, I'm sure like (pause) I think that small coping skills can help people along way. So like giving the kids ice when they wanna murder / like beat someone up … like give small things can have an effect on them. It's just like being able to practice it in such a restricted place is*	Pauses, false start	Can't follow up Can give some coping skills that can be used later Setting makes it hard for

them in setting	*very hard. But I think that some / I think that some of the kids have had experiences with therapists in a facility that has made an impact. I don't / I think half the battle is the setting. Like how do you give someone skills in a chaotic stressful environment and ... I don't know how helpful it is but think that… I don't know what they took away from it. My individual therapy or group or what they were going through but I think some of them took some of it. Maybe they weren't able to vocalize that. For sure they were… if it was more… uhmm routine and like incorporated, I think it would make a big difference.*		patients to use the skills
damaging	What are your thoughts about how forced termination of therapy affects the patient's mental health and potential future psychotherapies? *I think it can be really damaging. I think it can hinder, uhh well I only work with kids but their experience and their willingness to engage because it's very hard for them to talk about and know if someone's gonna be there for them. I think it definitely has an impact.*		Damaging
Talking doesn't prepare Remember that patient can make new relationships	Have you found ways to help minimize negative consequences of forced termination on patients' mental health? *Yeah, I mean I think talking about it doesn't really prepare you for what happens when you just don't see someone ever again. Uhmm, so ... I think like trying to understand that just because I don't see the patient that like we still have a relationship or that we still uhmm have some sense of like place in my life I think that helps me a little bit. And understanding that they can make the attachment with another therapist maybe would help more. (pause) I'm not sure ... I don't know how to fix that problem.*	pause	Talking about termination does not prepare Relationship is still there even after termination Patient can attach to another therapist
Talk to future therapist Stay in	Besides your own efforts, what other measures could be taken to counteract the negative effects of forced termination on some patients? *Oh, it would be great if there was a transition, so if a kid was moved*	Pause False start	Transition Talk to future therapist

contact with patient Help patient find future services	*to a / so what would happen with us was they would move upstate if they were found guilty so if there was a way to like transition and like… uhmm have a conversation with all the therapist that were going to be in their lives and maybe be able to send a letter. (pause) I don't know what actually is ethical or allowed. But I think it would be helpful if we could / Especially if they are transitioning to another jail to keep in contact. So they can transition to a new therapist. And if they are leaving to like help them with services in the community.*		Able to send a letter Services in the community
Training for the entire facility is necessary	How might in-service training help/not help counteract the negative effects of forced termination on therapists? On patients? *Yeah, I just think you really need buy-ins from everybody. Like I'm all for training but if you don't have like the advantage, so if the whole mental health department is not engaged in it it's really hard. So not only mental health but also the facility and understand why it's important.*		Whole facility needs to understand the importance Just a few trained individuals won't help
Termination may affect therapist more than patient	Are there other questions about this issue that you think I should have asked? *Uhmm, I don't know. I think also how termination may have affected me more as the therapist than the kids. So I don't know. I think getting perspective from them, I don't know if you are or if you can, but (pause) that would be really interesting to see what they think about it.*	pause	Therapists may be more affected by termination than patient

Stage 3: Comparison of themes emerging from the six participant interviews

	Questions	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5	Participant 6	Participant 7

	History							
	Supervision	Lack of supervision	Had supervision	Support from prison staff (mainly logistics and safety) She supervises but used to be supervised	Supervision with psychologist, unit chief, psychiatrist	No expert supervision at the jail Seeks supervision in other setting	Group and individual supervision	Supervision from psychologist, chief psychologist, team, online conferences
	Termination discussion	Many forced terminations but no discussion about it	No discussion		Discussion about termination	No supervision Unable to prepare Unpredictable terminations	Discussion, helpful	Discussion about how to terminate Also discuss situation with patient
1	**Length of treatment**	Varying lengths are planned	No plan because of unpredictability	Short-term, some long-term in severe cases	Some long-term but mostly unpredictable (see them twice)	Treatment is over when patient leaves prison Short-term treatment	longer assessment period, presumably longer therapy	Limited time, twice a week to once a month
	Goals met	No goals met	Only with long-term patients	Has met treatment goals	Rarely meet goals unless they were short-term	No goals met	Some goals met and some just changed	Rarely meets goals
	How common			Many did not meet goals Those who wanted to do therapy, met them Terminations occur because they get moved or don't want to continue Setting prevents goal achievement				
	Conditions at site			Therapy works better when guards are compassionate	Jail is not helpful		Respectful toward patients Therapists help patients with	Reach goals when symptoms are specific and patient wants to

			Therapy doesn't work well when medication is not given			jobs, housing, cars	meet; no SMI
Working alliances	Some good alliances, bad when mandatory	Good working alliance with long-term patients Initial mistrust, took some time to establish rapport Short-term goals	Alliance was better with juveniles who want to go home	Had good alliances	Difficult to establish alliance Mistrust Patient needs to establish own goals	Work through mistrust and earlier negative therapy experiences	Alliance better when patient has short sentence Difficulty with patients with SMI or mandated
How developed	Get to know patient and their problems, advocate and support	Initial mistrust, took some time to establish rapport Short-term goals	Better alliance when patient wants to work and don't just do it to appease parole Better when they don't want to be reincarcerated	Respect, active listening, validation		Exposure to therapist, treat them respectfully	Ask for their goals, discuss past therapy
WA in completed therapies				Good alliance			Positive, Grateful and appreciative
Describe instance	Some sudden terminations, some predictable	Mostly forced terminations Sudden terminations Therapist had strong reaction, received comfort from patient Used supervision	Can't follow-up Saw some patients again and that was a good experience	Forced termination happen frequently Sometimes it's known sometimes it's not	Termination not difficult with patients who are not invested Harder for those who were invested	Experienced forced termination Termination because patient became aggressive or violated parole	Experienced them Patients got moved within facility, can't see them then In those units, they can't get long-term therapy
Thoughts and feelings	Struggle	Had strong reaction (cried in session)	Tells patients to get new therapist Did she do enough? Sometimes fit is	Neutral feeling Sadness when connected to patient, not knowing what	Was difficult worries	Sadness, loss Could have done things differently?	Difficult Relationship suffers and patient may not want other

				not good	happens to patient			relationships
	Coping	Seeking own therapy	Adjusted Has no control over it		Talk to colleagues Didn't actually think about it	Peer support, supervision Compartmentaliz ation exercise	Supervision	Supervision and discussion with colleagues Discuss it with patient
	Impact on practice	Discuss termination with patient Patient may not like termination which leads to difficulty making connection with next therapist Damaging	Be prepared, plan Patients can take it Expect that there may be forced termination Talk honestly about it	Does not waste time, works fast, especially when termination is imminent	Talk about plans for when they are able to continue	Semi-terminating Have to always think about possible termination	Remembers that patients deal with a lot	Awareness that therapy can end any time Prepares patient
	Effect on morale, stress level, job satisfaction	Had effect	Stressful but work is worth it	Accepts it Patient may not be ready, can get therapy elsewhere	Didn't like it Affected morale	Not much of an effect	Has affect If patient gets in trouble again, that can feel bad for therapist	Has affected him Won't see positive outcomes Can often not do long-term therapy
2	**Improveme nts**	Difficult since cannot follow-up Give coping skills for later Difficult for patient to use them in setting	Can't follow up Talk about achievements Patients do better	Was able to continue therapy via video conference Saw one patient years later	Saw improvements	Some improvements Slow and look different because of mistrust	Has seen improvements	No improvements
	What contributed		Relationship, structure	Improves when they want, not when it's mandatory	Willingness of patient Appropriate approach regarding patient level and symptoms	System is mistrusted	Relationships, mediation, not taking substances	
	Relationshi p		Non-judgmental, give hope				Treat people humanely	

3	**Forced termination effect on patient**	Damaging	Patients saw new therapists Some may not have more support Treatment may not be as important to patient	Patients get attached and have trouble when they don't get a therapist Hard terminating when patient is invested Video conferences cold help	Termination is negative especially if patient is attached and has improved Termination is stressful for patient and leads to worse outcome	Reinforces poor attachment retraumatization	May affect them if it is outside reasons	Patient thinks problems are related to incarceration and may not seek out therapy later
	Minimize negative consequences	Talking doesn't prepare Remember that patient can make new relationships		Consulting with future therapist	Work through loss with patient Establish rapport Continuity of treatment goals Talk about termination Acknowledge that patient has seen experienced termination before	No follow-up Provide resources	Honesty and talk about patient's accomplishments	Teach skills they can continue to use Remind them what they have accomplished
4	**Other measures**	Talk to future therapist Stay in contact with patient Help patient find future services			Education therapists about termination and effects on patients Protocol on how to terminate	Increase patient resilience Encourage other bonds	Community needs to catch patient	Need appropriate housing and services Continuity of care Incentives for therapy after release
	In-service training	Training for the entire facility is necessary	More support needed Didactics may help	Therapists need supervision when they experience transference	Train therapists how to prepare patients for termination	Evidence-based model of termination Prepare students more Provide immediate wrap-around services	Therapists should talk about their feelings May experience shame and guilt Need to learn not to feel responsible	Training for therapists to understand patient's resistance and difficulty with reintegration

					(clinicians need to know about those resources too)		
Other questions	Termination may affect therapist more than patient		Set up future therapy for patient	Ethics of forced termination			Easier reintegration with people incarcerated short-term Outcome depends on pathology and services available outside Many need not be incarcerated; just need treatment

Stage 4:

Theme clusters #1 and #2:
Finding titles and concepts by using abstraction (merging themes and giving them a new overarching title), subsumption (where one theme is incorporated into another) and polarisation, where seemingly opposite themes are combined under a more abstract title

Supervision

Theme Cluster 1	**Little/no supervision**
Theme 1	Lack of supervision
Theme 2	No expert supervision at the jail Seeks supervision in other setting
Theme Cluster 2	**More supervision**
Theme 1	Had supervision
Theme 2	Support from prison staff (mainly logistics and safety) She supervises but used to be supervised
Theme 3	Supervision with psychologist, unit chief, psychiatrist
Theme 4	Group and individual supervision

Theme 5	Supervision from psychologist, chief psychologist, team, online conferences
Theme Category 1	**More discussion**
Theme Cluster 1	Discussion about termination
Theme Cluster 2	Discussion, helpful
Theme Cluster 3	Discussion about how to terminate Also discuss situation with patient
Theme Category 2	**Little/no discussion**
Theme Cluster 1	Many forced terminations but no discussion about it
Theme Cluster 2	No discussion
Theme Cluster 3	No supervision Unable to prepare Unpredictable terminations

Appendix H

Visualization of Themes

Figure H1. The Research Questions (zoomed in portions of the figure can be found on the next pages).

Incentives to Continue Therapy post FT-1

Processing & Preparing-2

Other Relationships-1   Other Interventions to Counteract FT Effects-12

Barriers to Other Interventions-1

Barriers to In-Service Training-2   In-Service Training-7

Not about or supportive of IST-3

4. what else can be done?-19

Client Powerlessness-5

It's not on the Therapist-4   Barriers to Improve Conditions-11

Preparation in Advance Not Effective-1

Compassion-1   3. current support conditions-37

Consult with Future Therapist-3

Provide Resources-3   Ways to Minimize Neg. Consequences-26

Talk & Teach Skills-8

Follow While in Transition-7   Transition Support-25

Stay in Contact-1

Transition Support Barriers-3

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Figure H1a. Zoom of the Research Questions.

Figure H1b. Zoom of the Research Questions.

Negative Effects-23   FT Effects on Patient MH-12

the "system"-40

Client-Therapist Powerless-13

FT and Ethics-2

Supervision-9

More Supervision-5

Little/no Supervision-4

support on site-15

History-Experience-7

Talking about FT-9

More Discussion-4

Little/No Discussion-4

Figure H1c. Zoom of the Research Questions.

Conditions-11

Short-term-6

Length of TX-11

Long-term-5

Circumstances-29

No Plan-4

Goals Rarely Met-11   Reason for Not Meeting goals-7

Goals Met-6

Negative WA-12

WA in Completed TX-1

Positive WA-11

How was WA?-24

Move Mistrust to Trust-3

Empathy-2

Respect-3

How to Do WA-19

Get to Know as Human-4

Other Ways-1

Patient Motivated-1

Upset at First-3

Mildly Upset-2

1. coping with ft

Very Upset-4

Thoughts & Feelings-21   FT's Common, Normative-7   Resignation-5

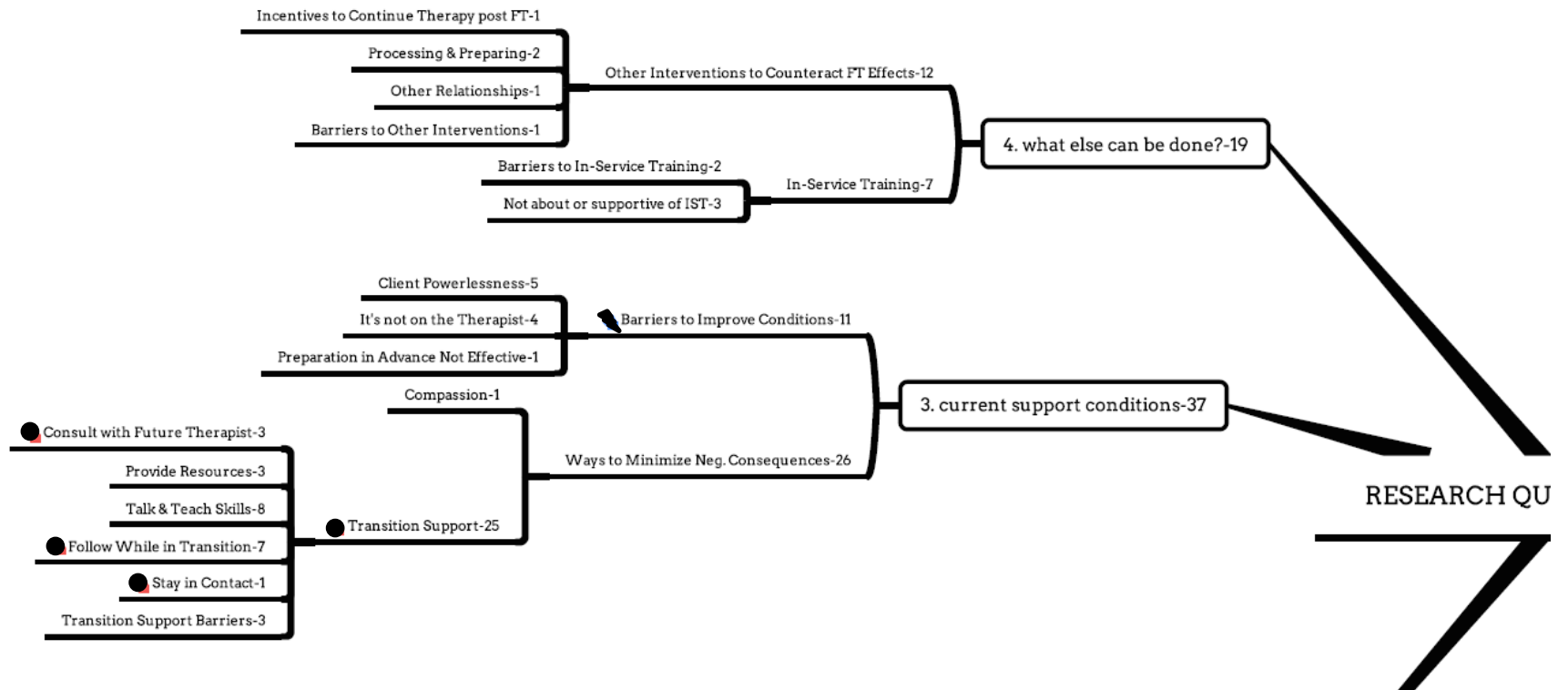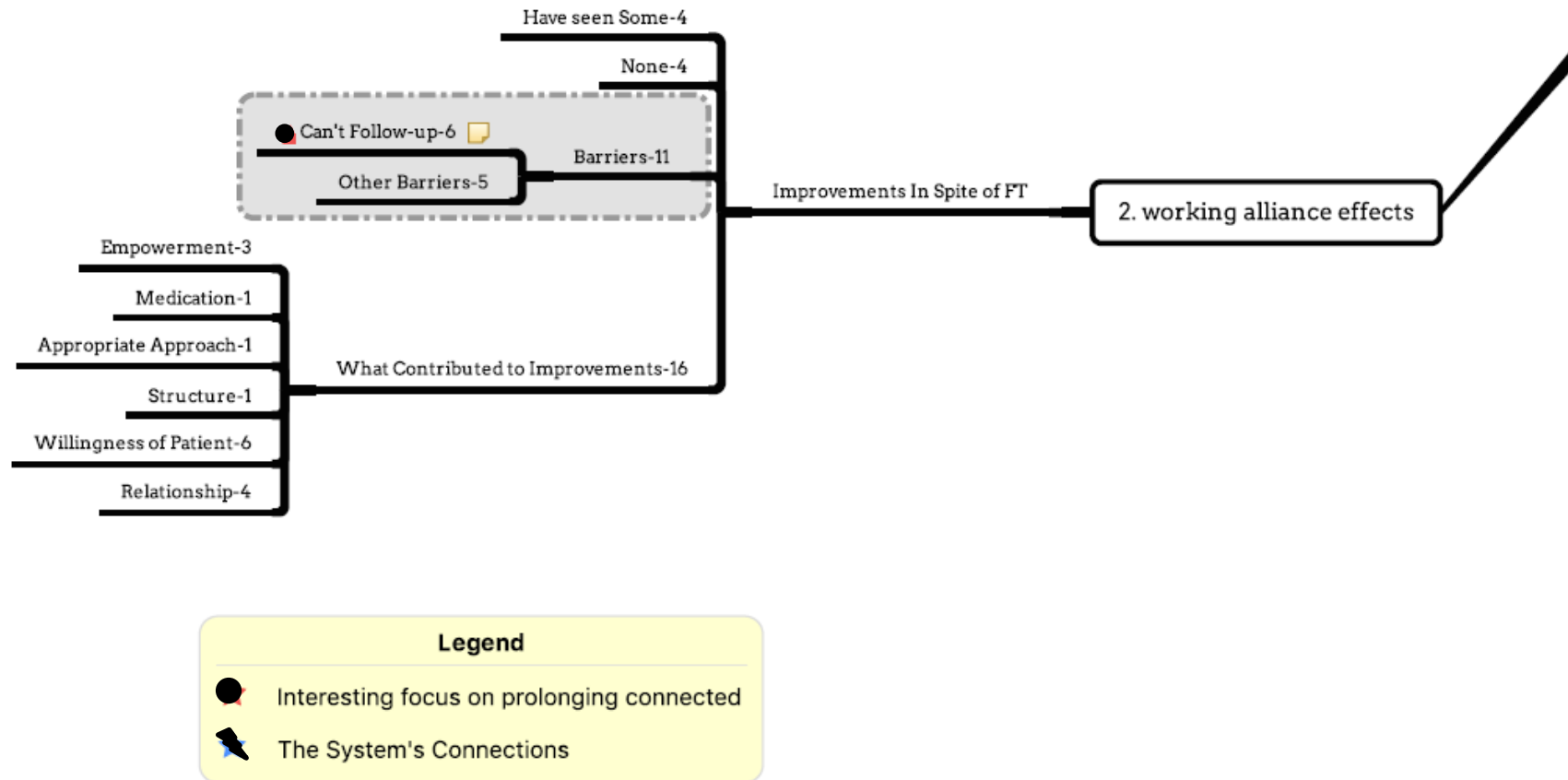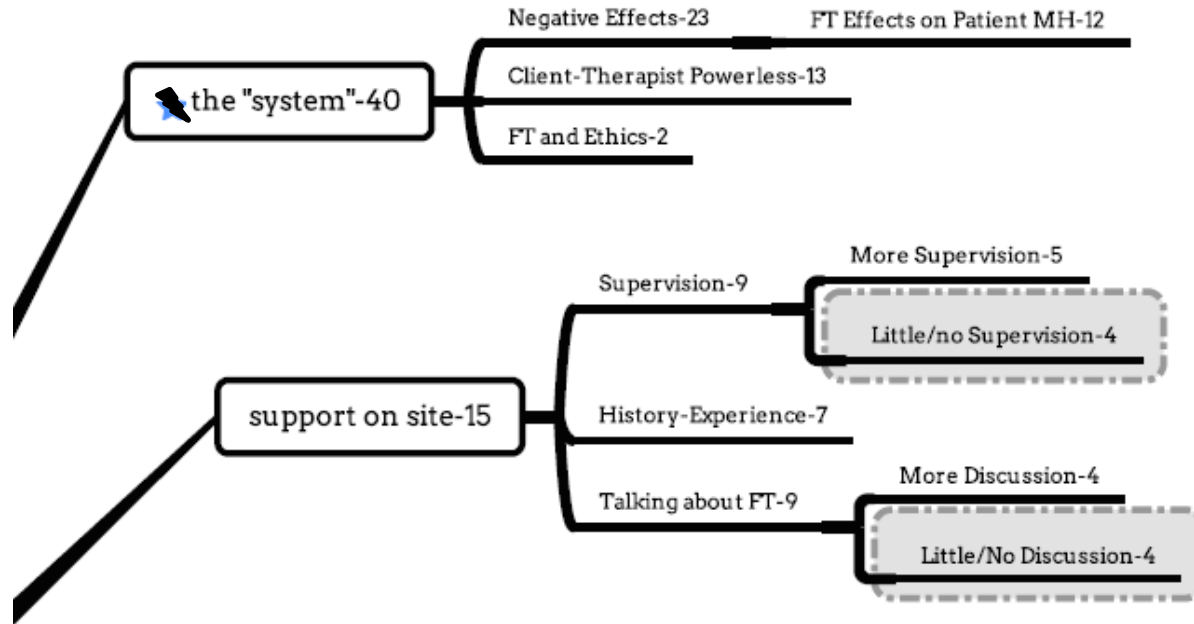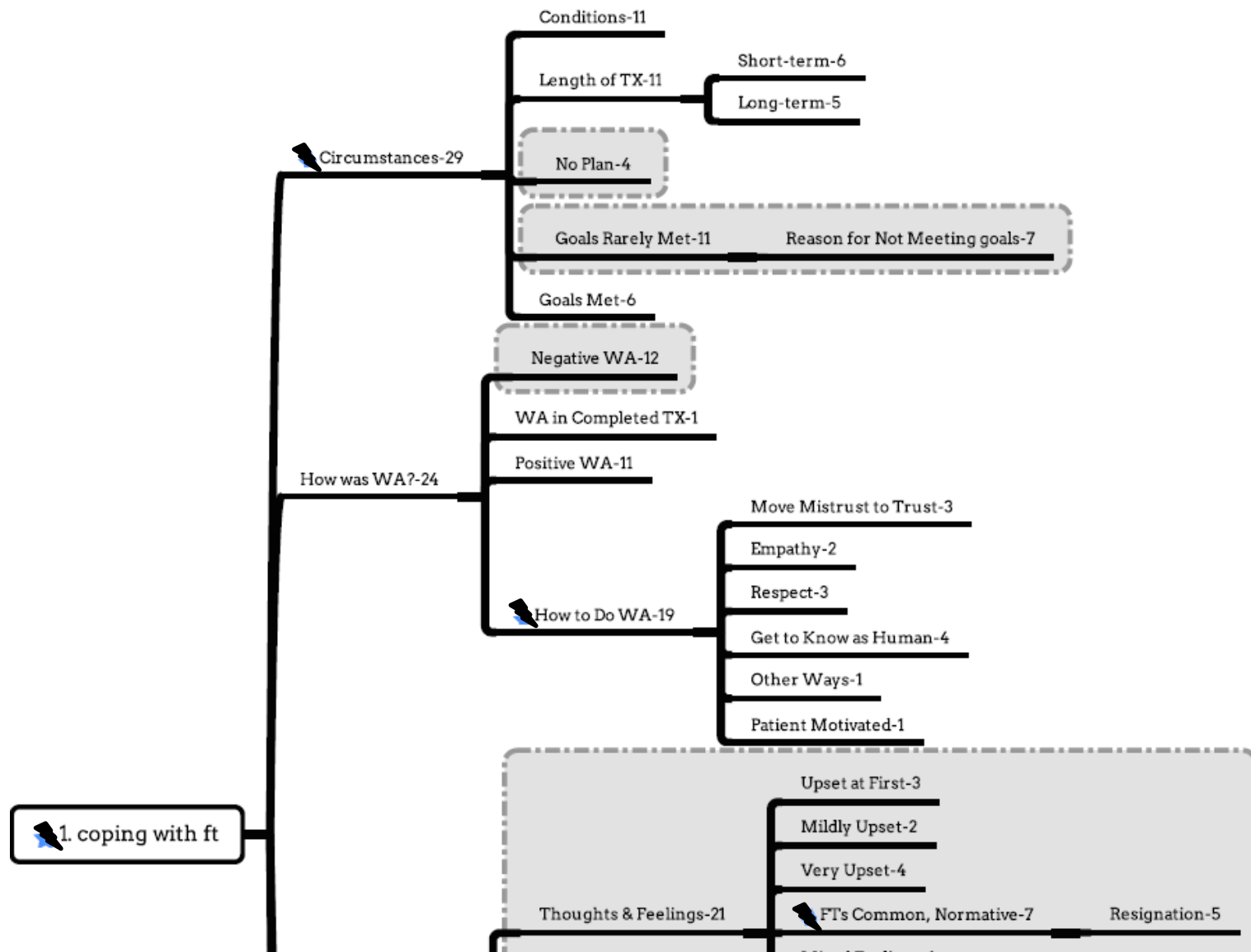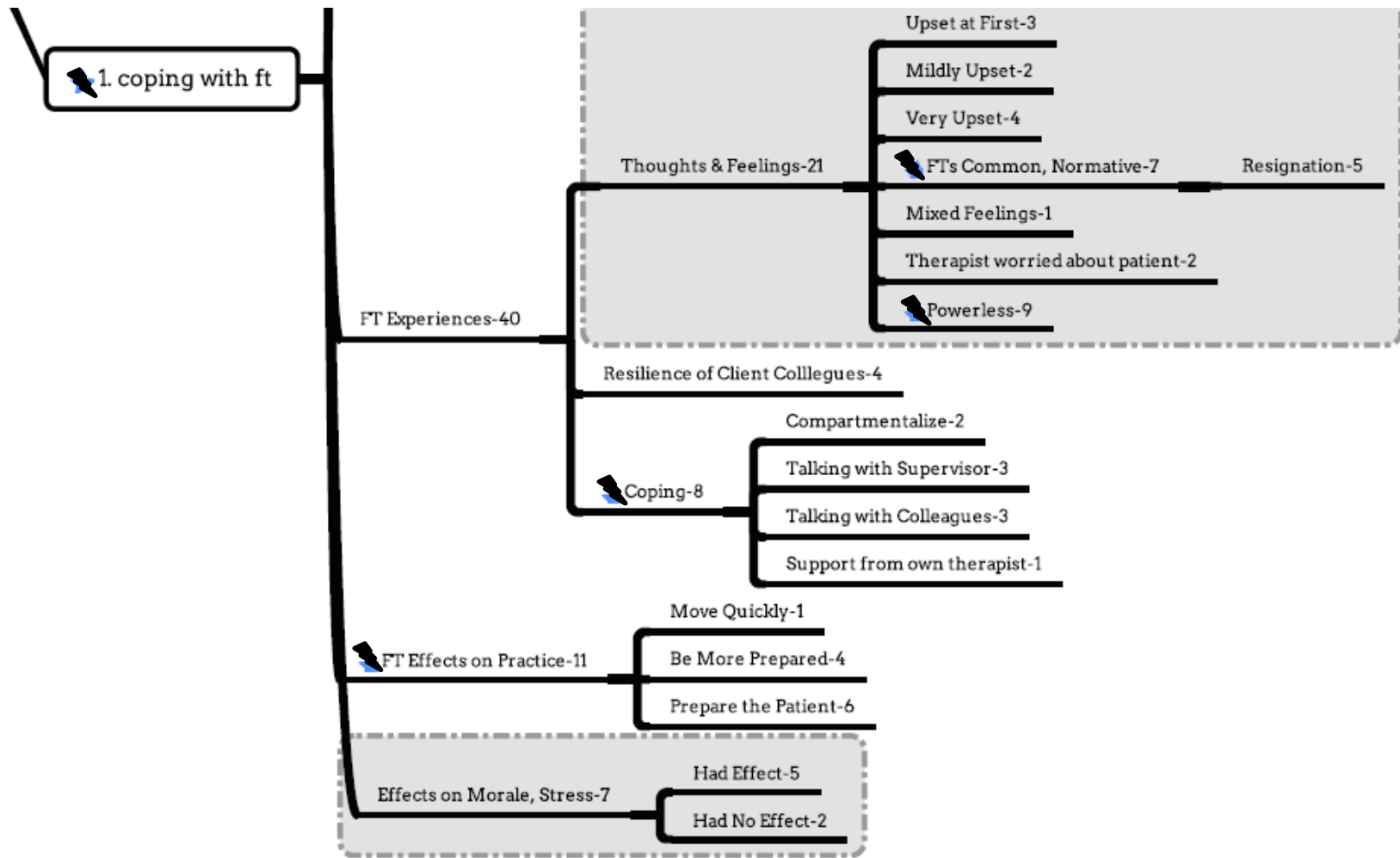*Figure H1d.* Zoom of the Research Questions.

Figure H1d. Zoom of the Research Questions.
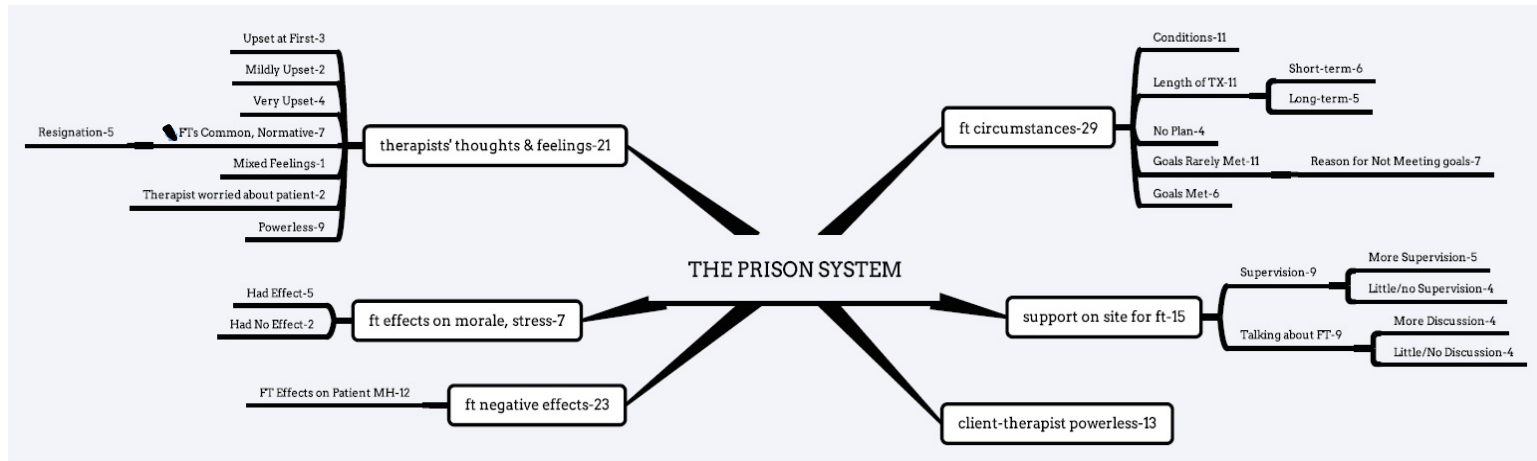
Figure H2. The Prison System (zoomed in portions of the figure can be found on the next pages)..

Upset at First-3

Mildly Upset-2

Very Upset-4

Resignation-5   FTs Common, Normative-7

therapists' thoughts & feelings-21

Mixed Feelings-1

Therapist worried about patient-2

Powerless-9

THE PRISC

Had Effect-5

Had No Effect-2

ft effects on morale, stress-7

FT Effects on Patient MH-12

ft negative effects-23
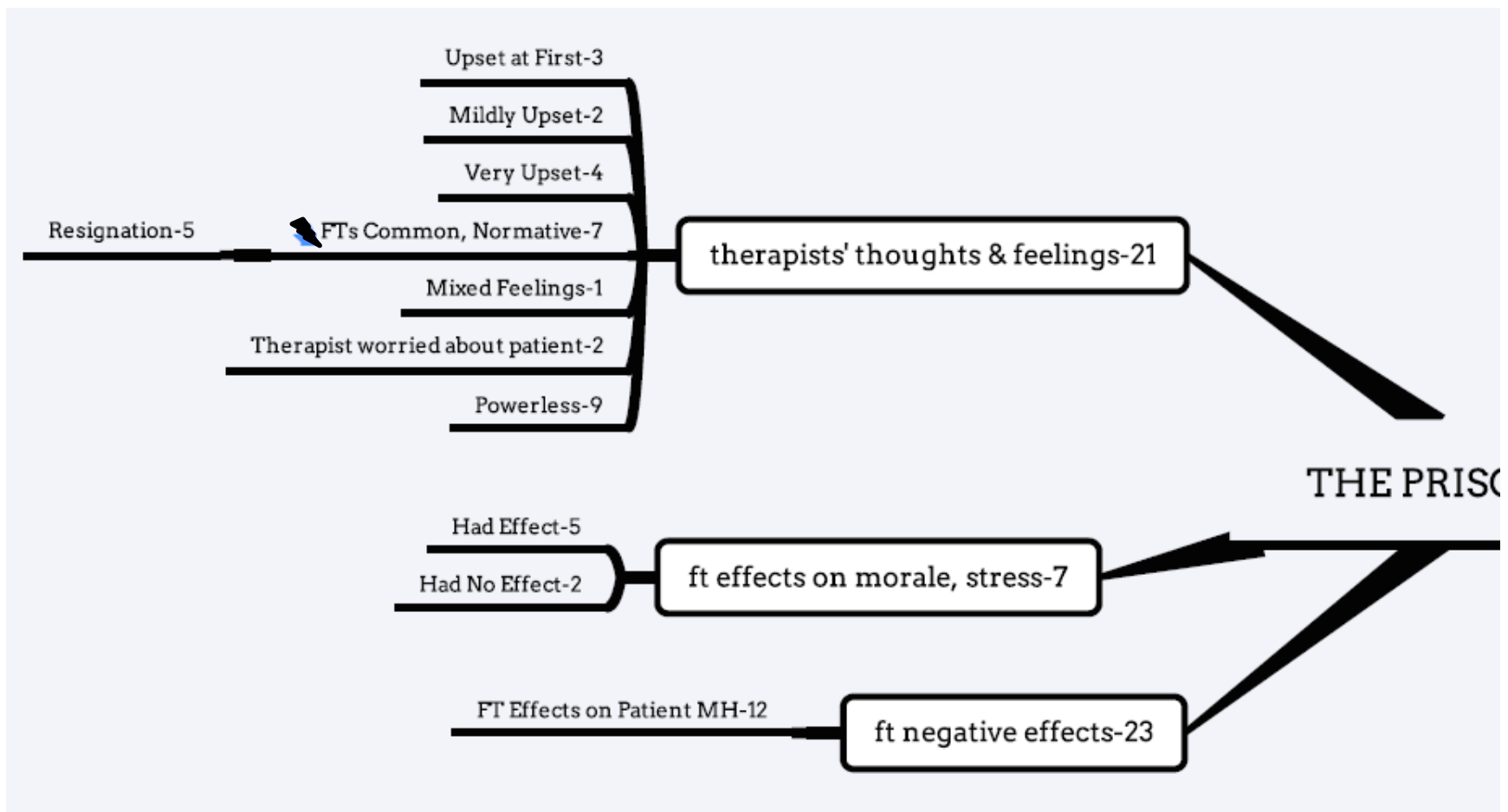
Figure H2a. Zoom of the Prison System.

Conditions-11

Length of TX-11

Short-term-6

Long-term-5

ft circumstances-29

No Plan-4

Goals Rarely Met-11 — Reason for Not Meeting goals-7

Goals Met-6

ON SYSTEM

Supervision-9

More Supervision-5

Little/no Supervision-4

support on site for ft-15

Talking about FT-9

More Discussion-4

Little/No Discussion-4

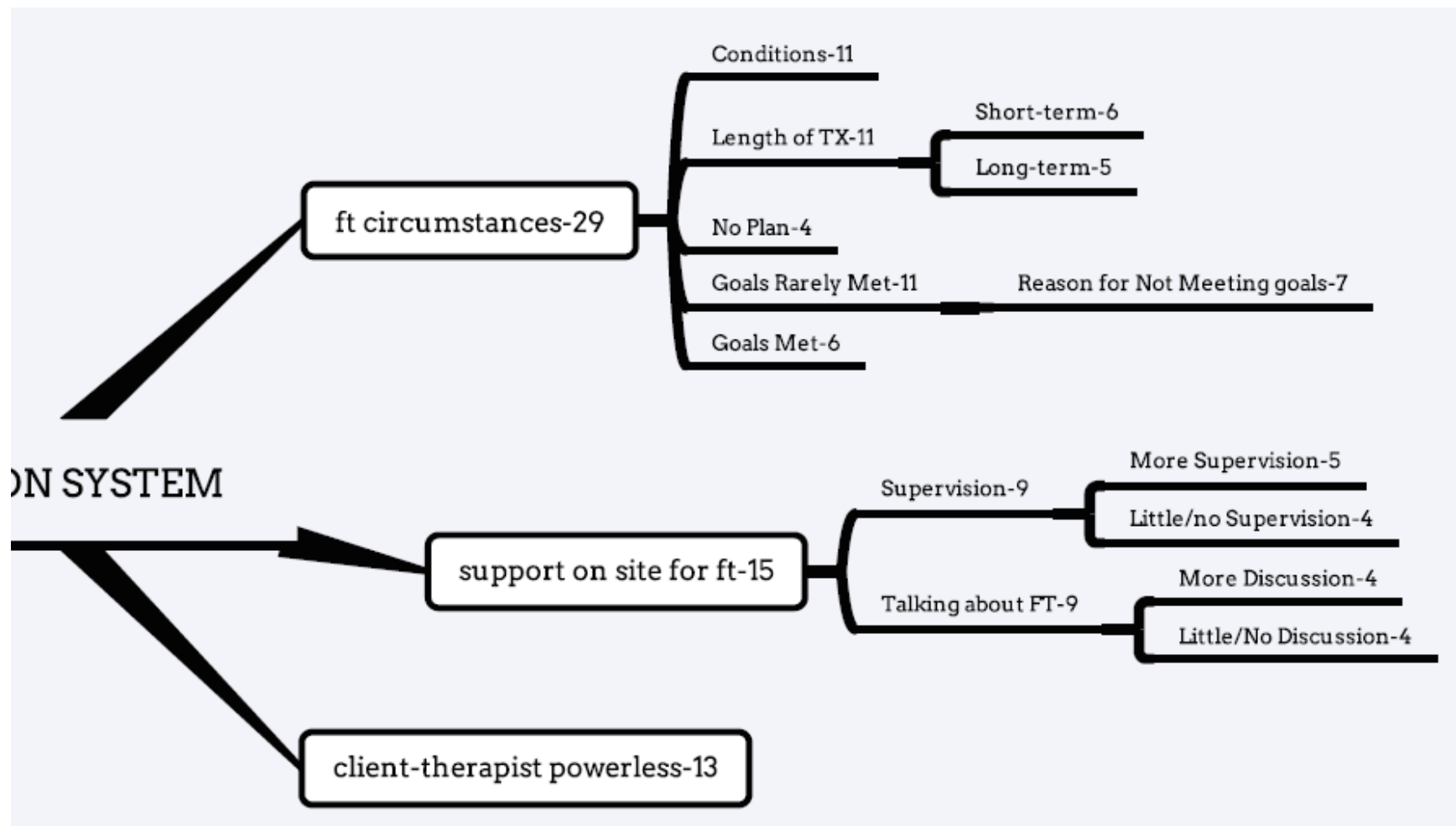client-therapist powerless-13

Figure H2b. Zoom of the Prison System.

Appendix I

Participant Demographics

P #	Gender	Age	Ethnicity	Education	Model of Treatment	# of years working with incarcerated	# of years at correctional site	Type of Facility	Security Class	# of inmates	# of mental health care staff	Mental Health Service Types
1	female	N/A	White	L.C.S.W	CBT/DBT, MI, attachment theory	0.5	3 months	Juvenile Detention Center	N/A	11	10	Individual, Group, Assessment
2	female	28	Asian	Psy.D./ Ph.D.	MI, CBT	1	1	County Jail	Minimum, Medium, Maximum	8	9	Individual
3	female	45	White	Psy.D./Ph.D.	CBT, Solution Focused Therapy, REBT, Insight-Oriented Therapy, Psychoed, Psychodynamic Therapy, Supportive Interpersonal Therapy, Time-line treatment, Hypnosis, EMDR, Multi-Modal Therapy, Sexual Recovery Therapy	13	offsite	N/A	N/A	1 adult, 200+ adolescents	8	Individual, Group, Assessment
4	female	45	White	L.C.S.W	CBT	10	10	Jail/Prison	Minimum,	N/A	N/A	Individual,

									Medium, Maximum			Group, Assessment
5	female	29	White	L.C.S.W.	CBT/DBT	1	1	Jail	N/A	90	6-Mar	Individual
6	male	N/A	White	L.C.M.H.C.	CBT	30	offsite	Private Practice	N/A	N/A	1	Individual, Group, Assessment
7	Male	58	Hispanic	Ph.D.	CBT	14	3	Federal Prison	Administrative	1200	20	Individual, Group