THE ROCK AND THE HARD PLACE: HOW THE PRISON PSYCHOTHERAPIST BALANCES TREATMENT NEEDS WITH SECURITY NEEDS

ELIJAH PAIGE RICKS

Department of Psychology

APPROVED:

Jennifer Eno Louden, Ph.D., Chair

Leanne F. Alarid, Ph.D.

Theodore V. Cooper, Ph.D.

Daniel N. Jones, Ph.D.

Osvaldo F. Morera, Ph.D.

Charles Ambler, Ph.D.
Dean of the Graduate School

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ELIJAH PAIGE RICKS, M.A.

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Abstract

Research on traditional psychotherapy suggests that the quality of the relationship between the therapist and client is the most important element of effective mental health work. In contrast, prison policies often require that staff maintain an emotional distance from offenders, and many elements of the prison environment and characteristics of the offenders may be counterproductive to the therapeutic relationship. Due to the competing demands of psychotherapy and prisons, it is important to understand how prison psychotherapists reconcile the aims of both in their work. This dissertation examined the psychometric properties of a new measure of how prison therapists balance the security and safety demands of the prison environment compared with the emotional and relational needs of the therapeutic process. The Prison Therapist Orientation Measure (PTOM) assessed therapists' views of the aims of prison therapy, offenders in general, and their level of emotional engagement during therapy. Responses appeared reliable ($\alpha = .79$, $\omega = .83$), and correlations with other measures supported construct validity. 237 prison therapists gave diverse responses in their opinions about the balance of security and treatment demands. A prison therapist's PTOM score was not well predicted by the hypothesized variables, except for the sex of the offenders on a therapist's caseload—therapists working with female offenders emphasized the rehabilitative aims more than those working with males, but this was true only for female therapists. Decisions in 2 treatment scenarios were not well predicted by orientation scores. Respondents reported role conflict, generally high satisfaction with their positions, and good working relationships with offenders. Their overall attitudes toward offenders were positive, with some reservations. Implications of the findings and future directions for the PTOM are discussed.

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Introduction

> ‘We comply with the court order and that’s all we ask you to do!’ It’s unfortunate, because it puts clinicians between a rock and a hard place… by nature we want to …facilitate therapy and do what our profession calls us to, but we can’t in a lot of ways… - Psychologist in the California Department of Corrections and Rehabilitation (Karcher, 2003, p. 120).

Psychotherapy[1] is an interpersonal approach toward assisting people with various problems—it fundamentally seeks to improve the quality of life. To accomplish this aim, a psychotherapist often encourages self-exploration and insight (Frank, 1982; Goldfried & Padawer, 1982; Strupp, 1986; Wampold, 2001, 2007), teaches about maladaptive thinking patterns and helps practice new ones (e.g., Cognitive-Behavioral Therapy; Fruzzetti & Erikson, 2009), models prosocial interactions (e.g., Social Learning Theory; Bandura, 1977), and provides a relationship that is free from judgment or prejudice while offering sincere feedback (e.g., Goldfried, Raue, & Castonguay, 1998).

In contrast to the primarily nonjudgmental and rehabilitative therapeutic environment, prisons primarily serve to isolate and punish. The criminal justice system is based on judgment—offenders are placed in prisons because their behavior has been judged as unfit for society. Whereas traditional psychotherapy seeks to empower clients, the prisons keep offenders isolated from citizens. Whereas traditional psychotherapy seeks to benefit the client (e.g., American Psychological Association, 2010), the loss of autonomy that takes place in prisons serves to punish offenders for their crimes (e.g., Fellner, 2006; U.S. Department of Justice,

[1] No opinions, findings, or interpretations presented in this document necessarily reflect the views of any of the agencies that participated in this research.

2004). Finally, although traditional psychotherapy is meant to provide a warm and inviting environment (e.g., Haigh, 2013), prisons are intended to be undesirable and even frightening places (e.g., Katz, Levitt, & Shustorovich, 2003).

The contrast between psychotherapeutic methods and correctional methods is an area of great importance, especially due to the high prevalence of mental health symptoms among offenders (Diamond, Wang, Holzer, Thomas, & Cruser, 2001; Fazel & Danesh, 2002). Whereas psychotherapeutic methods typically strive to be free of judgment and work toward empowering the client, correctional work is dependent upon judgment, and its practice is built upon limiting the offender's freedom, at least for the duration of his sentence. Therefore, there appears to be an inherent conflict in ideology between corrections and psychotherapy. This conflict has large implications for the mental health professionals who work in corrections and the offenders they treat.

This dissertation examined how correctional psychotherapists[2] reconcile this ideological conflict. More specifically, this project sought to understand if and how correctional mental health workers' attitudes about elements of their work vary depending on their characteristics and elements of their work environments. The following sections provide context for the research questions, first by describing the current state of mental illness among offenders in prisons and jails to highlight the relevance of the topic. Thereafter is an exploration of the differing ideological foundations of mental health treatment and corrections. Before describing the aims of the present study is an examination of specific prison practices and policies that

[2] Throughout this document the terms *prison therapists, correctional psychotherapists, clinicians, mental health professionals, mental health workers*, and different combinations of these are used synonymously.

apparently conflict with what research has found to be the most effective elements of psychotherapy.

Mental Illness and Incarceration

The United States incarcerates more people per capita than any other nation in the world (Hartney, 2006; also see Currie, 1998). The most recent report explains that one in every 35 people in the U.S. is under some form of supervision by the criminal justice system, and one in every 110 is behind bars (jail or prison; U.S. Department of Justice, 2014a). The reasons for these high incarceration rates is beyond the scope of this paper, but a consistent pattern accompanying the confinement of the U.S. criminal population is the high prevalence of mental illness within jails and prisons.

Trends in mental illness and corrections. People with mental illness are overrepresented in the offender population (Diamond et al., 2001). United States jails and prisons hold at least 3 times more mentally ill people than do psychiatric hospitals (Human Rights Watch, 2003). Whereas community samples find approximately 6.3% of people with a serious mental illness (i.e., bipolar disorder, major depression, schizophrenia; Kessler et al., 2005), approximately 20% of offenders in jail or prison have these same mental illnesses (American Psychiatric Association, 2000; Steadman, Osher, Robbins, Case, & Samuels, 2009; see also Torrey, Kennard, Eslinger, Lamb, & Pavle, 2010; see Fazel & Danesh, 2002, for worldwide estimates).

Many other mental disorders are also found with high prevalence in incarcerated settings. Studies of inmates have found high rates of Attention Deficit Hyperactivity Disorder (45%; Rosler et al., 2004; see also Ginsberg, Hirvikoski, & Lindefors, 2010), substance abuse and dependence (10% to 60%; Fazel, Bains, & Doll, 2006), and personality disorders (42%; Fazel &

Danesh, 2002). Additionally, dysthymia (a less severe form of depression; 8-14%; Powell, Holt, & Fondacaro, 1997; Veysey & Bichler-Robertson, 2002), posttraumatic stress disorder (4% to 21%; Goff, Rose, Rose, & Purves, 2007; see also Spitzer et al., 2001; Veysey & Bichler-Robertson, 2002), and anxiety disorders (22% to 30%; Veysey & Bichler-Robertson, 2002) appear to be relatively prominent among inmates compared to the general population (Kessler et al., 2005). Even beyond diagnosable mental illnesses, the often volatile and unforgiving prison environment certainly has an effect on the stress levels of the offenders (Mobley, 2008).

The high proportion of inmates with mental illness has made the criminal justice system the de facto provider of mental health treatment (Treatment Advocacy Center, 2009). Indeed, it has been called the largest provider of mental health services in the nation (Council of State Governments, 2002; Diamond et al., 2001; Human Rights Watch, 2003; Torrey, 1995; Torrey et al., 2010). This fact has large implications for the way prisons operate and allocate resources. For example, at the turn of this century 13% of offenders in state correctional facilities were receiving psychotherapy, and 71% of the facilities reported providing psychotherapy to offenders (U.S. Department of Justice, 2001). The overlap between treating mental illness and carrying out punishment is an area that remains important and complex, and does not appear to be dwindling.

Corrections and mental illness are intertwined. The large overlap between mental illness and incarceration is perhaps not surprising when considering how the two may influence one another. In some cases, a person may come into contact with the legal system due (at least in part) to a mental illness. Although offenders in general are arrested because their behavior is deviant and/or disruptive, it is supposed that they engage in such behavior with criminal intent. However, a person with a mental illness may display similarly deviant or disruptive behavior, but because of the mental illness this behavior may be absent of criminal intent or even awareness of

wrongdoing (Borum, Swanson, Swartz, & Hiday, 1997; Lamberti & Weisman, 2004; Reynolds, Dziegielewski, & Shapp, 2004; Teplin, 2000; Trawver, 2008). However, police officers are more likely to arrest a person with mental illness than someone without for the same behavior (Teplin, 2000), perhaps to ensure the person have at least some form of supervision (Reynolds et al., 2004).

Although instances of criminal justice involvement due directly to mental illness are thought to be relatively infrequent (Peterson, Skeem, Hart, Vidal, & Keith, 2010; Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014), people with mental illness tend to have risk factors for criminal behavior, such as higher rates of substance use and poverty (Draine, Solomon, Salzer, Culhane, & Hadley, 2003; Fischer, 1988; Fisher, Silver, & Wolff, 2006). Furthermore, a minority of offenders with mental illness may have avoided legal complications had they received adequate treatment for their mental illness before coming in contact with law enforcement (Seltzer, 2005; Skeem, Manchack, & Peterson, 2011).

In addition to factors that may funnel people with mental illness into the criminal justice system, there is evidence that the environment in prisons may exacerbate existing symptoms in some offenders, or perhaps even cause mental illness. Once incarcerated, offenders lose autonomy and privacy, have less contact with their social supports from the community, have little to no control over noise levels or room temperatures, may face sentences that are long or indeterminate, and others have no hope of release (e.g., Fellner, 2006; U.S. Department of Justice, 2004). Furthermore, prisons often are violent, aggressive environments (Silberman, 1995; U.S. Department of Justice, 2014b; Wolff, Blitz, Shi, Siegel, & Bachman, 2007), which may lead to increased anxiety or trauma. Although individuals vary considerably in levels of adaptation to the environment (Bonta & Gendreau, 1990), many offenders' mental health

symptoms may get worse in prison (Appelbaum, Hickey, & Packer, 2001; Bonta & Gendreau, 1990).

In the most severe prison environments currently allowed in the United States, offenders may be isolated from each other and prison staff. Solitary confinement has been decried by many as a detriment to the mental health of inmates. Haney (2003, p. 125), for example, wrote in reference to solitary confinement that, "There are few if any forms of imprisonment that appear to produce so much psychological trauma and in which so many symptoms of psychopathology are manifested." There are many accounts of the negative effects of solitary confinement on mental health (Benjamin & Lux, 1975, 1977; Brodsky & Scogin, 1988; Coffey, 2012; Grassian, 1983; Haney & Lynch, 1997; Jackson, 1983; Korn, 1988; Martel, 1999). Although empirical research on the effects of solitary confinement finds that these detrimental effects are not typical (e.g., O'Keefe et al., 2013; Suedfeld et al., 1982; also see Gendreau & Bonta, 1984), it does appear that confinement can have a large, negative impact on some offenders' mental health symptoms. Recognizing the ethical concerns relating to mental health treatment among offenders, the legal precedent for their proper care has been a growing concern.

Treatment is legally mandated. The 8th Amendment of the United States' Constitution is the basis for most statutes regarding the treatment of offenders. It prohibits "cruel and unusual punishments" from being inflicted. The clause has slowly led to changes in the penal system, expanding the meaning of the 8th Amendment from prohibiting tortures to ensuring the adequate medical and psychiatric care of offenders while incarcerated (see Klein, 1978, for a review). Prison officials now must be wary of "deliberate indifference" (Estelle v. Gamble, 1976), which is the failure to act on an inmate's needs, including serious medical or mental health problems (Bowring v. Godwin, 1976; Hoptowit v. Ray, 1982). For this reason, jails and prisons are legally

required to periodically screen inmates for medical and mental illness symptoms (e.g., Gibson v. County of Washoe, Nevada, 2002; U.S. Department of Justice, 2001), and must provide adequate medical and psychiatric care when such are warranted (Americans with Disabilities Act of 1990; Balla v. Idaho State Board of Corrections, 1984; Inmates of Allegheny County Jail v. Pierce, 1979; also see U.S. Department of Justice, 2005). These requirements partially led to a recent U.S. Supreme Court decision causing the state of California to release as many as 46,000 inmates from prison—the overcrowding had prevented some inmates' medical and psychiatric needs from being met in a timely manner (Brown v. Plata, 2011; Salins & Simpson, 2013).

Summary. Mental health needs within prisons are high. The legal precedent for treating offenders' mental illnesses has been growing in recent decades, especially as failure to provide treatment can have large consequences. It is, therefore, necessary and prudent that prisons address the high need for mental health care among their inmates.

Challenges of Mental Health Treatment in Corrections

The combination of high prevalence of mental illness among prisoners and legal requirements to provide treatment to them has led corrections institutions to become one of the largest employers of clinical and counseling psychologists (Dvoskin & Morgan, 2009)[3]. However, corrections and psychotherapy are historically and philosophically founded upon different principles. Although both share the common goal of behavior change, they differ in how they bring it about. Correctional practices were founded upon punishment (see below), and operate with an adversarial system of authority (e.g., Brodsky, 1982), whereas psychotherapy

[3] The author was employed as a psychotherapist for the Colorado Department of Corrections. The Curriculum Vitae at the end of this document contains more detail.

was founded upon rehabilitation, and operates on principles of cohesion, understanding, and mutual respect (e.g., Goldfried et al., 1998).

Corrections practices for punishment. Societies have always sought to intervene with criminal behavior. For the majority of history, criminals have faced many forms of punishment as a consequence for their crimes, and there has been relatively less focus on the reformation of behavior. The foundation of punishment-for-change can be traced back at least to Beccaria's (1764/1986) treatise on criminology, who argued that crime is prevented through swift, certain, and severe punishment. Indeed, the historical records are rife with accounts of miserable living conditions (e.g., Halliday, 2008), tortures (e.g., Donnelly & Diehl, 2011), and even agonizing forms of execution (e.g., Abbott, 2006) as retribution for criminal behavior. In the United States, early punishments included public whippings, or hours of confinement in a pillory, sometimes involving nailing the offender's ears into the wood (see Edge, 2009, for a review). The intention was presumably that the punishments would serve as retribution for wrongdoing, and discourage criminal behavior in general. Although early behaviorists (Estes, 1944; Skinner, 1938, 1953) initially concluded that punishments may not directly diminish problematic behaviors, other scientists have endorsed the implementation of punishment as an effective response to criminality, when done correctly. For example, Singer (1970) made several recommendations for applying findings from punishment research to corrections, such as removing policies that allow sentence reduction for good behavior, and implementing mandatory minimum sentences for certain crimes.

Punishment in modern corrections. Although corporal punishments and forced labor have been all but eradicated in modern times, the theoretical approach toward criminality arguably remains punishment- and incapacitation-oriented. Indeed, a national survey of prison

wardens found that incapacitation was ranked as the preferred aim of incarceration (Cullen, Latessa, Burton, & Lombardo, 1993). Similarly, a survey of prison and jail employees found that incapacitation and deterrence were the favored goals of corrections, with rehabilitation ranking third (Kifer, Hemmens, & Stohr, 2003). Another study of correctional officers' orientations found that the most frequently reported approach toward their work was that of a rule enforcer—a person who is inflexible, rigid, militaristic, and suspicious of offenders (Farkas, 2000).

The "correctional" system remains synonymous with the "penal" system (e.g., Cavadino & Dignan, 2007), and perhaps for good reason. Modern prisons commonly use a form of solitary confinement (known as "administrative segregation"; see Pizarro & Stenius, 2004) and utilize pepper spray to address problematic behaviors (e.g., Haney, 2008). Additionally, the relatively low quality of life in prisons has been suggested to have a greater deterrent effect on crime than does the death penalty (Katz et al., 2003). Prisons are built upon historical and ideological beliefs in punishment as the appropriate response to criminality (Boonin, 2008).

Punishment remains embedded in this nation's correctional practices, and has been a central element to the tough-on-crime era (see Greene, 2002, for a review; see also Boonin, 2008). The punishment ideal's existence is openly endorsed in many arenas. For example, punishment is explicitly named as a primary goal of the U.S. Department of Justice—its official mission statement reads in part, "…to seek just punishment for those guilty of unlawful behavior…" (U.S. Department of Justice, n.d.). This ideology stands in stark contrast to the primary aims and methods of modern psychotherapy, which are to assist people to develop new ways of thinking and behaving through a warm, cohesive relationship.

Psychotherapy founded upon rehabilitation. Most correctional therapists are trained in clinical social work, psychology, or professional counseling (Ferrell, Morgan, & Winterowd, 2000). These disciplines emphasize the use of science and practices that ultimately assist others. For example, among psychologists' primary aspirations is to benefit those with whom they work, and to do no harm (i.e., beneficence; American Psychological Association, 2010). These principles are generally shared by professional organizations that promote the practice of psychotherapy (see Bonner & Vandecreek, 2006, for an excellent review; National Association of Social Workers, 2004). Therapy is, therefore, a helping profession—at its core, rehabilitative.

Psychotherapy is also necessarily free from blame and judgment. Rogers (1957), one of the most influential figures in the development of psychotherapeutic methods, argued that elements of empathy, nonpossessive warmth, unconditional positive regard, and genuineness are absolutely necessary for people to change (Keijsers, Schaap, & Hoogduin, 2000). Rather than thinking in terms of guilt and blame, therapists are trained to frame problematic behaviors in the context of the perpetrator's environment, genetic predispositions, or simply poor life skills. Similar principles have also slowly found their way into corrections models; For example, a relatively recent model of offender rehabilitation is the Good Lives Model (Ward, 2012), which views criminal behavior merely as the perpetrator's attempt to fulfill a need, although the attempt was in an unacceptable manner. This model inherently frames offenders as people who need assistance to fulfill their needs in appropriate ways, rather than as "bad" people who are unfit to live among the civilized. Additionally, the more common model of correctional practice is the "firm but fair" approach toward offenders, which stresses the need for interpersonal relationships between staff and offenders to be respectful and free from blame (Dowden & Andrews, 2004). The latter model even bases its relationship principles on the psychotherapy literature for its

effectiveness in clients' improvement (Dowden & Andrews, 2004). These corrections models appear to recognize the importance of at least many psychotherapeutic elements in effecting offender behavior change, perhaps because correctional aims nearly always include rehabilitative efforts, and because there has been promising evidence of the value of rehabilitation-centered intervention (e.g., Gendreau & Ross, 1980, 1987). However, even with the apparently increased attention toward rehabilitation, there remain many challenges to psychotherapy within prisons.

Therapy's conflict with corrections. The highly restrictive, controlling, and adversarial prison environment clashes with psychotherapeutic values of clients' rights to self-determination, confidentiality, and working to benefit the client (American Psychological Association, 2010; Bonner & Vandecreek, 2006; Mobley, 2008). Due to these apparently conflicting aims between corrections and psychotherapy, prison therapists face challenges in meeting the demands of both (e.g., Gannon & Ward, 2014), but have little formal guidance for how to do so. Indeed, it is rare that a therapist receives training in how to appropriately apply his or her clinical skills within the correctional environment (Magaletta & Boothby, 2003).

These challenges appear to originate with the different foundations upon which corrections and psychotherapy were built—punishment verses rehabilitation. As Ward and Salmon (2009, p. 2) stated, "…punishment is embedded within a framework concerned with accountability and questions of rightness and wrongness while rehabilitation revolves around skill acquisition and well-being enhancement." Whereas psychotherapy is built upon a foundation of collaboration, trust, and support to achieve new coping skills and rehabilitation, correctional practices are founded upon principles of authority, punishment, control, and security to reach behavior compliance.

Rehabilitation as justice. The alternative to punishment as the means to justice is the notion of rehabilitation as justice. In other words, the best way to serve justice may not be to simply punish criminals for wrongdoing, but rather to turn them into productive, law-abiding citizens[4]. In a similar vein is the argument that rehabilitation efforts make a better use of resources than punishment, as they might yield beneficial returns to communities and victims (Boonin, 2008; Cullen, 1995; Simon, 1993).

Many correctional departments' mission statements and policies include an emphasis on rehabilitation (Appendix A). For example, Arizona's Department of Corrections (2014a) has a policy stating that, "…providing structured programming designed to support inmate accountability and successful community reintegration…" is among their primary goals. Additionally, many correctional agencies have increased educational and work skill programs available to offenders in recent years (Erisman & Contardo, 2005). These programs may focus on work and living skills, which are helpful toward rehabilitation, but they often fail to take advantage of the rehabilitative potential that psychotherapy offers. Rehabilitation is, in fact, the stated aim of correctional counseling (Roberts & Biswas, 2008). Therefore, psychotherapists in corrections may serve a primary role in reaching the aims of rehabilitation-as-justice. However, there are many inherent obstacles within prisons that hinder psychotherapeutic methods toward rehabilitation, which the next section addresses.

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[4] Neither the punishment-only nor the rehabilitation-ideal is free from weakness (see Raynor & Robinson, 2009). The rehabilitation model has been described as a manipulative or condescending response to illegal behavior, and has been criticized for a lack of empirical evidence and its inherent differential treatment of offenders (see Avila, 2013, for a summary of the debate). This is perhaps why the Risk-Need-Responsivity model, which is empirically supported, uses a "firm but fair" approach (Dowden & Andrews, 2004), attempting to work toward rehabilitation with the use of authority as a learning tool.

Summary. The historical purpose of corrections was as punishment for wrongdoing. Modern prisons have largely departed from corporal methods of punishment, and there is some movement toward rehabilitating offenders so that they might be fit to reenter society. Although rehabilitation is the primary aim of psychotherapy, it still remains underemphasized in modern corrections.

Therapy Within Prison

There are essentially two reasons for providing mental health treatment to prisoners. The first is to alleviate unnecessarily cruel or unusual suffering (8th Amendment). The second is to work toward changing offenders' worldviews, beliefs, and behavior so that they may appropriately live in a civil society (e.g., Gendreau & Andrews, 1990; Saunders, 2001). The former has legal precedent (see above), but the latter does not, and carries with it the complication of quantifying rehabilitation. That is, corrections agencies or workers may be held responsible if they do not work to alleviate mental health symptoms (Estelle v. Gamble, 1976), but there are no direct consequences for corrections agencies if a prisoner is released without having made strides toward new worldviews and beliefs. Therefore, the majority of prison policies typically address steps that focus on stabilization of offenders; symptom reduction, crisis management, suicide prevention, and so on (Mobley, 2006).

For example, in Colorado's DOC policy regarding mental health, the services available for offenders includes the description of psychoeducational/skills development programs. The policy reads, "These programs are designed to assist offenders in the development of social and self-management skills that will assist in the stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting…" (Colorado Department of Corrections, 2013a, p. 5; see also Nevada Department of Corrections, 2013a; also see Appendix A). Here, the

policy states that the programs they offer are specifically designed for stabilization. Although stabilizing offenders to prevent harm to themselves or others is and should be among the aims of correctional mental health treatment (Mobley, 2006), it is perhaps only the minimum service that mental health treatment professionals can provide. It is certainly less related to psychotherapeutic principles of rehabilitation than to the apparent correctional aim of pacification.

In regards to what prison therapists actually do, there has been little research examining how much of their time is divided between activities such as assessment, crisis management, paperwork, and therapy. In one such study (Boothby & Clements, 2000), 830 prison psychologists reported spending the majority of their time with administrative tasks and assessments (48% combined), with only approximately 26% of their time spent actually treating offenders. Even so, they stated that of their treatment time, more was spent in psycho-educational groups than in "process" groups (the authors did not define process groups, but these are typically focused on discussing feelings and the establishment of trust). Based on this research, it appears that many correctional therapists spend only a small amount of their time in treatment, and that direct treatment commonly involves techniques aimed at symptom reduction and behavior management rather than rehabilitation.

Effective psychotherapy. Psychotherapeutic techniques differ in their specific techniques and theoretical bases, but share commonalities in their aims. Research on the many different styles of psychotherapy has repeatedly demonstrated that its core elements are (a) offering hope for demoralized people; (b) offering new perspective on oneself and the world; and (c) doing this through an empathic, trusting, caring relationship (Frank, 1982; Goldfried & Padawer, 1982; Strupp, 1986; Wampold, 2001, 2007). Each of these appears relevant to an

incarcerated population, but this study limits its empirical focus on the latter—the importance of an empathic, trusting, caring relationship between a prison therapist and offenders—as it is the element of psychotherapy that is often directly related to written prison policies.

Even with the elements common to all psychotherapies, the end result may be influenced by factors external to the therapy (e.g., the passage of time, situational changes), the client's expectations or motivation, and the specific techniques of therapy (i.e., the theoretical approach toward mental illness). However, research suggests that the manner through which the therapist goes about therapy is at least as important as the actual steps of therapy (see Duncan, Miller, Wampold, & Hubble, 2009). Indeed, of the factors that the professional may control, the nature of the therapeutic relationship has repeatedly been shown to be the most important (e.g., Alexander & Luborsky, 1986; Horvath & Greenberg, 1986; Horvath & Symonds, 1991; Lambert & Barley, 2001; Marmar, Horowitz, Weiss, & Marziali, 1986; Suh, Strupp, & O'Malley, 1986). By forming a warm, caring, and empathic relationship with clients, the therapist encourages them to engage in the treatment process. In effect, a strong therapeutic relationship offers a comfortable and supportive, but also motivating environment for help-seekers to work toward their goals.

Several researchers have found that the personal contribution of the therapist is just as (if not more than) important as the actual techniques or theoretical orientation of the therapy (Crits-Christoph et al., 1991; Keijsers et al., 2000; Luborsky et al., 1986; Wampold, 2001; see also Henry, 1998). In other words, the therapist's education, discipline, experience level, training, supervision, and license have a relatively small effect on the treatment outcome (Luborsky et al., 2002; Seligman, 1995; Wampold, 2007). The most effective therapists are those who are

empathic, caring, and who form a strong bond with the client (Blatt, Sanislow, Zuroff, & Pilkonis, 1996; McCabe & Priebe, 2004).

Therapeutic alliance. This relationship between the therapist and client is often referred to as the therapeutic alliance. Bordin (1979) theorized that the alliance consists of three elements: (a) agreement between client and therapist upon the goals of treatment, (b) collaboration on what must be done to achieve those treatment goals, and (c) a "bond" between the therapist and client. His theory stresses the importance of an emotionally intimate and collaborative relationship between the therapist and client in order to reach the desired outcomes of therapy.

The personalized and necessarily intimate therapeutic alliance stands in stark contrast to the historically punishing and adversarial model of corrections. When using incapacitation and isolation to control behavior, the offender's feelings or attitudes toward his treatment are inconsequential. The therapeutic alliance, however, must take the client's perceptions, feelings, and attitudes into account, and in many ways is driven by them (Safran & Muran, 2000). Without consideration of the client's feelings, the elements of the alliance cannot be formed. In prison, the offenders' trust must be skillfully sought and kept, as must an agreement on the purpose and aims of his treatment (Marshall & Serran, 2004). If the therapeutic alliance is not built and maintained, the modality of treatment may be of little consequence.

Despite the strengths of highly structured approaches toward treatment (see Andrews, 2001; Leschied, 2001; McGuire, 2001), many argue that truly effective, lasting change from therapy must involve something that cannot be gained from workbooks, education, or medications—it requires a deeply interpersonal experience (Lambert & Bergin, 1994). That is, whereas manuals provide integrity to treatment (Andrews, 2001), and consistency across

clinicians (McGuire, 2001), the procedure may still be best delivered with a process that includes a strong therapeutic alliance, built on respect, trust, and caring. However, as correctional practices are founded upon aims different from psychotherapy, and because the offender population poses inherent risks, the therapeutic relationship is faced with many obstacles within the prison setting. The next section will address the risks involved in relating to offenders. The section thereafter outlines the methods prisons use to mitigate those dangers, and the ways in which those methods hinder the therapeutic relationship.

Summary. Rehabilitative efforts within prisons tend to focus on education, work skills, and daily life skills, but not on psychotherapy. However, rehabilitation is prison psychotherapy's overarching aim. Decades of research have demonstrated that the most effective element of therapeutic methods in reaching the goals of treatment is a warm, empathic, cooperative relationship between the client and therapist. This relationship is hindered within prisons.

The Danger in Relating to Offenders

Although the therapeutic relationship is vital to therapeutic outcomes in traditional therapy, mental health treatment in incarcerated settings is not traditional therapy. Offenders are a unique population, with unique challenges. There is real risk involved with their treatment. Offenders were convicted because their behavior was judged as posing some threat to others, whether physical or otherwise. Although rare, offender-on-staff assaults occur (Light, 1991; Sorensen, Cunningham, Vigen, & Woods, 2011; Steinke, 1991; see also Arizona Department of Corrections, 2014b), and safety is a constant concern for correctional workers (Triplett, Mullings, & Scarborough, 1996). Sometimes these aggressions are brutal and severe (e.g., stabbings; Sorensen et al., 2011). Beyond physical dangers, there is also much concern surrounding the tactics that offenders might use to manipulate staff members, to form

inappropriate alliances, or to take advantage of them (Allen & Bosta, 1981). It is for these reasons that control and security are paramount within prisons, and why safety is commonly cited as the top priority by prison administrations (Appendix A).

Boundary violations. Offenders pose many threats to staff members. They may have a history of manipulative or deceitful behavior. Inmates are often found to target corrections staff members who seem vulnerable to compromise (Allen & Bosta, 1981; Marquart, Barnhill, & Balshaw-Biddle, 2001; Worley, Marquart, & Mullings, 2003). When staff members become emotionally involved with an offender, they may begin to sympathize with his situation, and give him special treatment (see Marquart et al., 2001, for an excellent review). In theory, sympathy can then be the doorway that leads a staff member to do special favors for an offender. These inmates may subtly initiate boundary violations with seemingly minor acts of exchanging small items or having overly private communications. In some cases, these eventually escalate into requests for phone calls, exchanges of prohibited materials, or even romantic relationships (see Marquart et al., 2001). The danger is further compacted in that, if at any point the staff member refuses to comply with an offender's request, the offender may threaten to expose previous favors and put the staff member at risk of losing his or her job or facing legal prosecution (Allen & Bosta, 1981; Cornelius, 2009). In fact, inappropriate relationships between staff and offenders have resulted in several staff terminations, lawsuits, and felony charges placed on corrections workers (Worley et al., 2003). Thus, the danger of becoming too personal with an offender is clear to prison administrations (e.g., U.S. Department of Justice, 2000).

There is also danger in staff members taking advantage of inmates. Staff members may initiate inappropriate relationships (e.g., a sexual predator who takes advantage of the power differential), which may leave the corrections agency liable, or at least placing it under public

scrutiny. For these reasons, it is in prisons' best interests to limit staff-offender interactions. There are real dangers to staff and offenders becoming overly familiar. The following section will address several of the ways in which this is accomplished.

Obstacles to the Therapeutic Alliance in Prison

Due to the inherent dangers of their population, prisons have adopted several approaches to reduce the chances of staff becoming overly familiar with offenders. There are policies that explicitly prohibit relationships, and other practices and policies that combine to reduce the therapist's ability to form a bond with offenders.

Prisons prohibit staff-offender relationships. Security and safety concerns involved with the offender population motivate prison administrators to establish strict policies limiting the scope and depth of staff-offender relationships. Typical prison practices and policies make clear that interactions between staff and offenders must remain respectful, but superficial. For example, Arizona's Department of Corrections' (2013, p. 3) policy states that "Employees are required at all times to maintain a professional distance from current or former inmates…" and to "avoid undue familiarity" (see also Colorado Department of Corrections, 2015a; State of Connecticut, 2014a; Nevada Department of Corrections, 2013b; and others in Appendix A). The same policy later (p. 4) explains that staff will be periodically rotated in order to avoid the formation of relationships with offenders.

The appearance is that security issues are of primary concern, whereas treatment issues are secondary (also see Cullen et al., 1993; and Farkas, 2000). Indeed, perhaps Mobley (2008, p. 384) expressed the issue best with the statement, "I am not aware of a corrections officer or administrator who was disciplined or fired for not making sure that an inmate got to therapy on time. I am aware of hundreds who were terminated for breaches of security." Safety and security

perhaps should be the priority in prison settings; However, what is concerning for rehabilitative efforts is the possibility that security aims may be sought at the expense of effective psychotherapeutic methods. Whether the two are needfully at odds is debatable (e.g., Dignam, 2003; Dvoskin & Spiers, 2004), but the issue at hand is how the current practices within prisons may presently work against the therapeutic alliance for the sake of security concerns.

Impersonalism in prison treatment. Beyond the direct prohibition of staff forming relationships with offenders, there are also other elements within the prison system that keep psychotherapists at an emotional distance from the offenders. The issue stems from several areas of policy, budget, and interpersonal concerns.

***Prioritizing resources*.** Although the correctional mental health field is growing, mental health remains understaffed in many prisons, and there is often high turnover (Borritz et al., 2006). For example, some states have as few as 24 mental health staff treating nearly 24,000 inmates (Roberts & Biswas, 2008). A survey of correctional psychologists found an average ratio of clinician to inmate of 1:750 (Boothby & Clements, 2000). This ratio certainly varies depending on the type of facility, but highlights the broader problem of clinicians having little time to dedicate to an individual offender (also see Appendix J).

With these limitations in resources, the scope of treatment in prisons is often restricted to only those offenders with the most severe needs (see Fellner, 2006). Indeed, the written policy of Colorado's Department of Corrections regarding the scope of mental health treatment states, "When mental health resources are limited, priority will be given to offenders who suffer from chronic or acute mental illnesses and those offenders who present a danger of injury to themselves or others due to mental health problems" (Colorado Department of Corrections, 2013a, p. 6). An unfortunate consequence of these limited resources is that an offender may

experience mental health symptoms, but receive little attention for them until they become a safety concern. Therefore, the average offender who does not complain of severe symptoms (e.g., suicidal thoughts) does not normally receive any contact with mental health workers outside of brief and non-private mandatory check-ins (Steadman, McCarthy, & Morrisey, 1989)[5].

Medications rather than therapy. Perhaps as a consequence of the lack of staff and those policies aimed at reducing staff-offender contact is that treatment is often limited to psychotropic medications rather than psychotherapy (Steadman et al., 1989; Thorburn, 1995; U.S. Department of Justice, 2006). A 2000 census of state prison facilities found that 73% of state prison facilities distribute psychotropic medications to offenders, and five states reported nearly 20% of inmates receive psychotropic medications (although the national average was 10%; U.S. Department of Justice, 2001).

Although medications can be highly effective for many disorders, the reliance upon them rather than therapy is problematic for several reasons. First, there is the potential to misuse many psychotropic medications (e.g., by snorting rather than ingesting them; Burns, 2009; Del Paggio, 2012; Pierre, Shnayder, Wirshing, & Wirshing, 2004; Reccoppa, Malcolm, & Ware, 2004). Because offenders have high rates of substance abuse and dependence (10% to 60%; Fazel et al., 2006), providing them mind-altering medications poses obvious problems. When offenders misuse their medication, it is clearly counterproductive to the aims of psychotherapy and rehabilitation, needlessly wasteful of prison resources, and potentially dangerous to offenders and staff. Relatedly, when offenders have valuable medications, they may benefit from selling them to offenders for whom they were not intended (see O'Keefe & Schnell, 2007; see also

[5] This effect may be exacerbated by offenders' reluctance to report symptoms (also addressed below). For example, male prisoners often avoid reporting their mental health symptoms, sometimes until they become unbearable or dangerous (Kupers, 1999, 2001).

Kalinich, 1986, for information on prison bartering). Medication selling is alarming in that the offender who apparently could benefit from the drug does not actually ingest it, and it may then be physically hazardous to the offender who abuses it.

Even when taken as prescribed, medications often have side effects. This may have a discouraging effect on compliance with medication regimens (Baillargeon, Contreras, Grady, Black, & Murray, 2000) thus leading to no relative decrease in symptoms, and serving as yet another inherent barrier between offenders and mental health treatment. For these reasons, the use of medications as the primary form of treatment is not ideal (see Burns, 2009, for further discussion).

Even when compliant offenders have symptoms that warrant medications, there are commonly delays from the time staff become aware of the symptoms to the time the offender actually receives medication. Reed (2002, p. 1) quotes a senior medical officer in a prison who summarized the problem, "I have always found it strange that a patient suffering from a medical emergency can be in the nearby general hospital within 30 minutes but if they are floridly psychotic it takes 30 days at least to find an appropriate disposal [intervention]". There appears to be conflict in the lack of interpersonal therapy available, the use of medications as the primary or only form of treatment, and the many obstacles for offenders to actually obtain or maintain medication (Hassan, Edge, Senior, & Shaw, 2014). In the worst of circumstances, an offender with non-emergency mental health concerns, even if actively seeking some form of treatment, is relatively unlikely to be seen by a clinician without some delay, and then is likely to receive little interpersonal therapy. If his symptoms are deemed severe enough, he may be scheduled to see the psychiatrist on a relatively lengthy waitlist, with long delays before actually receiving medication.

Nontherapeutic methods. In addition to staffing limitations, prison administrators are restricted by budget concerns. Therefore, they prefer cost-effective treatment options (U.S. Department of Justice, 2004; see also Bennett, Rosenbaum, & McCullough, 1978). Thus, psychoeducational or self-help groups are often implemented as treatment, rather than interpersonal psychotherapy or even group therapy (Cordess, 2002; Green, 1995; Robinson & Porporino, 2001; Trawver, 2008). Such groups involve exercises aimed at educating offenders on stress, recognizing when they are angry, understanding how a mental illness affects them, and understanding the benefits of medication. These methods allow for one or two non-licensed correctional staff members to simultaneously engage several offenders, thus saving time and resources. Psychoeducation courses are better than no treatment (Liau et al., 2004; Walters, 2003), but in spite of their cost-effectiveness, these types of groups may disregard the most essential element of therapeutic change—the therapeutic alliance. To borrow the language of Marshall and Serran (2004), they focus on procedures rather than process[6].

Similarly, there has been a continual movement for state-funded agencies to use empirically-supported treatments (Andrews, 2001; Leschied, 2001; McGuire, 2001). To establish scientific evidence for therapeutic practices, there must be proven consistency within the practices. Consistency between clinicians requires clearly outlined steps of therapy, thus leading to the use of manuals that describe a series of topics to discuss and actions in which to engage (e.g., journaling, identifying triggers; Gannon & Ward, 2014). These have the advantage of ensuring that therapists are making proper use of therapeutic time, and providing consistency between practitioners; however, some have argued that improved consistency may come at the

[6] Offenders also seem to view individual counseling as better than other forms. Morgan, Rozycki, & Wilson (2004) found that 61% of inmates they surveyed prefer individual counseling over other treatments.

reduction the therapist's personal contribution (Gannon & Ward, 2014; Henry, 1998). A common view of therapeutic manuals is that they overemphasize the steps of treatment (rather than the approach), and that this leads to rigid, mechanistic treatment (see Addis, 1997; Addis & Krasnow, 2000; Marshall, 2009; Stewart, Stirman, & Chambless, 2012). There is concern that the result of this approach is an overall reduction in the quality of treatment (Addis & Krasnow, 2000; Henry, 1998; Marshall et al., 2003; Stewart et al., 2012), because consistency among clinicians necessarily reduces the individual contribution of the therapist (e.g., Sweet, 1984; also see Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Although using manuals or psychoeducation groups does not eliminate the ability of clinicians to build a therapeutic alliance, shifting the focus of therapy away from mutual respect, cooperation, and common aims, toward covering specific topics and doing certain activities may reduce the quality of the alliance (see Addis & Krasnow, 2000; Castonguay et al., 1996; Marshall & Serran, 2004; Stewart et al., 2012).

Summary. Due to the inherent dangers of the adversarial prison environment, there is reason to limit interactions between staff and offenders. Policy prohibits the therapist from becoming emotionally invested with the offenders. Additionally, there are limitations in the number of mental health staff available and the funds to hire such, thus reducing the amount and (potentially) quality of contact between therapists and offenders. When therapists do interact with offenders, it is often using manualized treatments. The final result may be impersonal, emotionally distant treatment. These elements may help to explain the low effectiveness of prison therapy (e.g., Ortmann, 2000; Roter & Hall, 1992).

Prison Environment is Non-Therapeutic

In addition to the barriers already in place hindering the therapeutic alliance in prisons, several other elements of the prison environment may be generally counterproductive for both the offender and the therapist in treating mental health. Ortmann (2000), in a randomized experimental design, found that psychotherapy in German prisons had low success rates, even with therapists' high level of effort. He attributed the lack of effect to the environment, stating that "prison is definitely not a good place to influence the behavior of human beings in a socially positive direction" (p. 229). Indeed, there are several elements of the prison environment that appear counterproductive to treatment.

Beginning with their architecture, prisons are built for purposes of security, surveillance, and punishment (McConville, 2000). Under the goal of security, the heavy use of concrete, the high walls, lack of windows, thick metal doors, and razor wire or electrified fences have the psychological side effects of isolation and punishment. Mental health treatment is, at best, secondary to security in correctional aims (Cullen et al., 1993; also see Appendix A). Security and treatment measures therefore often collide, forcing treatment to adjust. In a qualitative study, Karcher (2003) found that security-driven disruptions to therapy sessions, and even delays for appointments, are commonly reported among correctional clinicians. Although the reason for the treatment disruptions is to maintain security (an important element; Mobley, 2008), it may have an overall detrimental effect on offender behavior. For example, Wright (1993) found a positive association between behavior problems and the amount of structure in prison, suggesting that prisons' rigidity with schedules and security may exacerbate problem behaviors.

Power differences. Physical structure and schedule conflicts aside, an inherent barrier to the therapeutic relationship is in the hierarchy of prison. Prisons have at their core a power

difference between staff and offenders: the keepers and the kept (Arboleda-Florez, 1987). Some have argued that, because of this fact alone, prisons are inherently pathological (Clements, 1999; Haney, Banks, & Zimbardo, 1973; Haney & Zimbardo, 1998). Offenders' experiences are largely based on decisions that staff make on their behalf. Thus, they may tend to adopt traits of passivity, dependency, helplessness, and loss of identity, while the staff members exert more control, and find greater social power (Haney et al., 1973). The self-perpetuating power difference between the keepers and the kept may serve to maintain order and security, but poses yet another obstacle to the therapeutic alliance by retaining emotional distance between therapist and offender.

Offenders are punished by governmental agencies, the embodiment of which is the prison staff, including the treatment personnel[7]. This inherently adversarial system may have large implications on the offenders' willingness to engage in therapy and disclose information to personnel they view as being their keepers (Arboleda-Florez, 1987). As offenders often perceive treatment staff and security staff to be the same (Mobley, 2006), there is a clear power differential. Additionally, the therapist is the authority figure in therapy. This is particularly true in the most common form of therapy in prison—group therapy. Due to her title, expertise, and role in creating and enforcing the rules and exchanges during group sessions, the therapist holds the power (Berman, 1982; Douglas, 1985). This power over offenders can have large consequences for the therapeutic relationship and outcome. For example, De Varis (1994) explains that traditional therapy places a great deal of power in the hands of the client, and states

[7] During the author's employment as a prison therapist, he was trained to be a "correctional officer first, treatment provider second." For example, all mental health personnel were required to take part in searching offenders' cells for contraband. This and other similar practices lead offenders to view mental health staff as just another type of guard, rather than a treatment provider (see Bonner & Vandecreek, 2006; and Weinberger & Screenivasan, 1994).

that the therapeutic process eventually demonstrates that the therapist is fallible. In this way, it works to empower the client, making him equal to the therapist. This process of equalization may be explicitly disrupted by prison policies that prohibit self-disclosure and staff-offender relationships. Security concerns discourage any showing of staff vulnerability because it may be exploited by the offenders[8]. Therefore, it perpetuates the difference in power.

At best, it appears that such a high degree of control is detrimental to the aims of psychotherapy. Therapists' degree of control exercised in treatment can often have negative effects on outcome. For example, clinicians who exercise very high control, or use their influence in a hostile manner, also face poorer relationships and outcomes with their clientele (Coady & Marziali, 1994; Harrist, Quintana, Strupp, & Henry, 1994; Najavits & Strupp, 1994). These therapeutic outcomes may be worse within a prison, where offenders are already subject to high institutional control, and often have inherent distrust of mental health practitioners (Howerton et al., 2007).

Malingering. There are several barriers to a prison clinician developing trust in an offender. One common challenge is that many prisoners feign mental health symptoms in an attempt to obtain potentially mind-altering medications that may be abused (Burns, 2009). In some cases, the offender may believe that a label of mental illness will allow him to escape work assignments (Flanagan & Flanagan, 2001), or be housed in a more comfortable environment (Flanagan & Flanagan, 2002; also see Mobley, 2008). Potential malingering can negatively affect how correctional mental health workers approach their clientele. In a qualitative interview

[8] Early on in the author's internship within corrections, a sergeant on the security staff gave the advice, "Never apologize to an offender. You are never wrong."

with prison clinicians (Karcher, 2003) a psychologist related the distrust a mental health worker may have for prisoners:

> Most of the time I'd be dealing with malingerers and manipulators, people who lie, and they *want* to be labeled as seriously mentally ill. So, at that time, I evolved into a little different kind of psychologist, who, along with diagnostic evaluations, I do a little bit of detective work: What is the motive of this inmate coming to me, what does he want from me? (p. 193)

In the correctional system, staff must be wary of offender requests, and must constantly work to detect hidden motives that may place him or her in a compromised position. This inherent distrust is counterproductive to the therapeutic alliance.

Inmates may be reluctant to receive treatment. In addition to the many barriers to quality psychotherapy that stem from the prison structure and staff distrust, there are several reasons that offenders may be reluctant to engage with mental health services while incarcerated (Morgan, Steffan, Shaw, & Wilson, 2007). Offenders express concern over how their mental health information will be shared, or how other inmates would view them (Morgan et al., 2004). Within prisons, survival is the focus of the behavior code (Gilligan, 1996; Toch, 1992), therefore making it potentially dangerous to reveal a mental illness. Offenders may fear that the label of mental illness will be interpreted by other offenders as a weakness that could be exploited (Mobley, 2008), or that having a mental diagnosis will be a liability for parole reviews or otherwise affect their progress through the system (Kupers, 2001; Mobley, 2006). It may also be risky for an offender to display the potentially painful emotions evoked through the therapeutic process. To many, the risk of displaying vulnerabilities may not be worth whatever benefit comes with treatment, especially when considering that the offender spends all of his time,

perhaps for years at a time, among other offenders, and only a fraction of the time with the treatment provider (see Mobley, 2008 for more discussion).

Offenders are not typical consumers of psychotherapy. There are other reasons that offenders would be reluctant to engage in therapy. Offenders differ in several ways from clients seeking treatment in the community. People who are incarcerated are inherently different in some ways than those who are not (otherwise, they would not be incarcerated), and some of these differences may influence how or whether they seek mental health treatment. For example, offenders often come from households where abuse was present (Freyd et al., 2005; Kempe & Kempe, 1978; Kendall-Tackett, Williams, & Finkelhor, 1993; Lewis et al., 1988). Abuse during childhood can have permanent effects on a person, and how he or she interacts with the world. Indeed, Teicher (2000) stated that abuse during childhood wires a child to approach the world as if it is malevolent—that the individual becomes irritable, impulsive, suspicious, and defensive. In addition to abuse, many offenders come from homes that faced marital instability, parental illness, poor caretaking of children, overcrowding, and financial problems (Kolvin, Miller, Fleeting, & Kolvin, 1988). These experiences during development likely negatively influence how offenders approach relationships.

Offender obstacles to the therapeutic alliance. According to attachment theory, these adverse conditions during an offender's development may lead him or her to form unhealthy patterns of interacting with others. Levinson and Fonagy (2004) explored how attachment differed between offenders and controls, and found that offenders had not only experienced more abuse and neglect than controls, but that they were also more dismissive in their attachment patterns. Similarly, Ross and Pfäfflin (2007) found that a sample of German prisoners had less-

secure attachment styles and less emotional attachment to others compared to community samples (also see Hudson & Ward, 1997; Marshall, 1989; Smallbone & Dadds, 1998).

If offenders tend to have more severe problems with relating to others, this presents a large challenge to clinicians who attempt to form a therapeutic alliance with them. Ross, Polaschek, and Ward (2008) suggest that the therapeutic alliance involves many elements of attachment, and that an offender's attachment style will likely affect the bond formed with the therapist. Offenders who, whether by nature or through their experiences with the legal system, are distrustful of authority figures, dismissive in their relationships, and pessimistic about therapy, prove a daunting challenge to the clinician.

Facility barriers to treatment. Offenders' likelihood to seek out or engage in mental health treatment may also be hindered by practices within the facility. Prisons frequently move offenders and staff to different units or even facilities for any number of reasons. For example, Arizona's Department of Corrections (2013, p. 4) has a policy declaring that "Periodic rotation of employees…may occur to prevent over-familiarity with individual inmates or offenders." Thus, the stated reason for this Arizona policy is to disrupt relationship formation. This is particularly problematic when considering research on the course of the therapeutic relationship—Johansson and Jansson (2010) found that, although measures of the therapeutic alliance at the beginning of treatment had no correlation with the outcomes of psychiatric outpatients, the alliance nearing the end of treatment was an important predictor of therapeutic outcome. Disrupting the therapeutic alliance, therefore, appears likely to negatively affect outcome.

Prisoners are aware that they have little to no say in where they may be placed, and they must become accustomed to such changes that are out of their control. For this reason, they may

be reluctant to become emotionally engaged with a correctional mental health worker. It may be particularly difficult for an offender to invest emotionally in a therapeutic alliance when administrative decisions may disrupt the therapeutic process at virtually any time. One prison clinician in a previous study expressed the problem by stating

> …if I'm doing psychotherapy with somebody and all of a sudden he's pulled [moved to another unit], that's abandonment… I don't like how you have a group of patients and then it changes, and they just pull [move] them… One morning, [a clinician] came in, and they'd moved every single person and disseminated them all around the institution. Some of these people she had been seeing for 5 years. She had to run around and terminate with them all and make sure they weren't freaking out. (Karcher, 2003, p. 164)

The therapist's and inmate's inability to control or even predict correctional practices such as placement may lead either or both to avoid building a therapeutic alliance rather than to invest in it only to have it disrupted. When relationships have been formed and are interrupted, they can be detrimental to the outcomes of therapy.

The barriers to therapy and the therapeutic relationship are clearly numerous and pervasive in prison. Perhaps more important is the consequence of these "ruptures" (Safran, Crocker, McMain, & Murray, 1990). When there is a fluctuation in the quality of the therapeutic relationship, it generally leads to poorer outcomes for the client unless resolved (Aguirre McLaughlin, Keller, Feeny, Youngstrom, & Zoellner, 2013; Safran et al., 1990). Therefore, due to the many elements of the prison environment that are counterproductive to psychotherapeutic methods, therapy may be made less effective.

Summary. In addition to policy barriers to the therapeutic alliance, there are several additional obstacles to the alliance inherent to the prison environment; (a) Offenders are often

reluctant to disclose symptoms; (b) Those who do disclose symptoms often face delays before receiving treatment; (c) When they do receive treatment, they are often treated with medication alone; (d) If they do see a psychotherapist, there are several barriers to emotionally investing in a therapeutic relationship, such as power differences, and real or imagined fears of harm or abandonment; (e) Even if the offender will invest in a relationship, therapists must be wary of malingering and other manipulation from offenders; and (f) prison policies tend to focus on impersonal interventions that disregard or prohibit the power and necessity of an engaged and dedicated therapist. These correctional elements, practices, and policies combine to make the prison therapist's work a difficult task.

Dual Roles

Due to legal statutes and ethical principles, prison therapists must care for those under their treatment. However, due to prison policies (and other practices), they must simultaneously remain unattached to those they treat. These roles appear incompatible, thus leading to the question of how the correctional mental health worker views his or her role.

The dual role was defined by Robertson and Walter (2008, p. 229) as a situation in which a mental health worker faces "conflicting expectations or responsibilities, between the therapeutic relationship on the one hand and the interests of third parties on the other." In the case of the prison therapist, he or she faces this conflict in the responsibility to establish a therapeutic relationship with the offender while working in the interest and expectations of his or her employer, the corrections department (Ward, 2013)[9]. The state has sanctioned the therapist's employer to carry out a punishment. However, the therapist's role is to provide some manner of

[9] Not all corrections departments employ their own mental health staff. Many use contract workers to carry out treatment, which may alleviate some of the conflict (see Weinberger & Screenivasan, 1994, for more).

alleviation of symptoms which may be exacerbated by the environment. Thus, the tasks of corrections and therapy are theoretically at odds (Weinberger & Screenivasan, 1994; see also Ward, 2013, for a more in-depth review; also see Arboleda-Florez, 1987).

Further compounding the prison therapist's role conflict, there is a quandary between the therapeutic relationship and a clientele that is potentially manipulative, dangerous, or resistant to treatment. In such instances, the therapist's helping role must be reconciled with his or her role as a control or custody agent. In other words, the therapist must approach the offender as an individual who needs help to improve his quality of life, but who may also be looking for someone to victimize. In this way, prison therapists may face pressures from three sides: (a) an institution charged with carrying out punishment, (b) the aims of psychotherapy to enhance well-being, and (c) the offender's potentially manipulative or destructive objectives.

When dual (or triple) roles exist, the professional must either differentially emphasize the demands of his or her role or find methods to ethically meet the standards of each simultaneously. This fact has important ethical implications for the correctional mental health worker. If he emphasizes treatment demands above security demands, he may become compromised and overly attached to the offender, turning into an advocate or potential victim rather than an unbiased treatment provider. If, on the other hand, he emphasizes security above treatment needs, he remains an emotionally distant therapist, working only towards the aims of decreasing symptoms through methods other than a therapeutic relationship. Without the most important element of effective psychotherapy, the offender's symptoms may not meaningfully improve, or may be exacerbated, thus violating ethical codes and responsibilities, as well as failing to follow legal statutes requiring that treatment be provided.

In other contexts, therapists who face dual roles must actively work to keep the conflict from influencing the therapeutic alliance. For example, in a court-ordered mental health treatment program, therapists must frequently work with clients who have difficulty following treatment recommendations and who are resistant to treatment. For this reason, therapists in such treatment environments may find it necessary to exert pressure on clients (Angell, 2006). Although higher therapist control is then associated with more submissive clients, this does not necessarily come at the expense of the quality of the therapeutic alliance (Manchak, Skeem, & Rook, 2013). In such circumstances, it appears that the therapists are assertive and clear in their expectations, but also largely empathic and caring. That is, even if the client may not agree with the aims of treatment, resistance to change may be overcome through a supportive and encouraging therapeutic relationship. When the therapeutic setting allows for a warm and empathic relationship, in which positive behavior is rewarded, then client resistance may be replaced with shared aims toward personal improvement (Marshall & Serran, 2004). However, due to the policies in prison that specifically prohibit empathic and caring relationships between staff and offender, this approach may not be possible in the prison environment.

Reconciling role duality in prison. Early studies of how general correctional employees (i.e., prison guards) cope with their difficult positions indicate that many workers adopt a stance of emotional distance from the offenders (e.g., Jacobs & Retsky, 1975; Regoli, Poole, & Schrink, 1979). Cruser and Diamond (2000) more recently found that new correctional personnel in a prison hospital approach mentally ill offenders in different ways, depending on their role. In their sample, security staff viewed treatment as solvable through incarceration and security, whereas treatment staff preferred habilitation, in which treatment is accomplished through interaction and integration. However, Cruser and Diamond (2000) focused on a hospital

environment, where the institutional aim is primarily on mental health rather than security. It is not clear how mental health staff approach their role when they work in a prison where treatment is not the primary goal.

Although the majority of the arguments about prison therapy suggest that they are largely incompatible, this view is not universal. Dignam (2003), a service administrator in corrections argued for a different point of view of correctional mental health work. He wrote that the ethics of corrections and treatment need not be at odds, but rather that, in practice, their aims are largely complementary. For example, Dignam suggests that the primary purpose of security within the corrections environment is for the inmates' safety from each other and themselves. He writes that both security staff and mental health staff can and should simultaneously work toward reinforcing prosocial behavior through modeling, structure, and consistency (Dignam, 2003). Indeed, this ideal of prison practice appears in line with the core correctional practices (CCP; Dowden & Andrews, 2004) outlined for the Risk-Need-Responsivity model of correctional supervision (RNR; Andrews, Zinger et al., 1990; Andrews, Bonta, & Hoge, 1990). These principles include dimensions of (a) effectively using authority as a teaching tool, (b) modeling appropriate behavior and encouraging compliance through positive reinforcement, and (c) maintaining open, warm, enthusiastic, and solution-focused communication between staff and offenders. This view of the compatibility of mental health and correctional aims is perhaps the ideal, and serves as the direction for correctional mental health work, however, the evidence suggests that in reality the ideal has not yet been reached.

Lack of training for correctional mental health work. Prison therapists are faced with conflicting roles (Crespi, 1990; Karcher, 2003; Sweet, 1973; see also commentaries by Arboleda-Florez, 1987; Gannon & Ward, 2014; Osofsky, 1996; Weinberger & Sreenivasan,

1994). They must treat offenders in a nontherapeutic environment. The mental health profession appears largely unprepared for this sort of ethical dilemma. Clinicians who are employed in corrections often come unprepared to face the competing demands. In graduate schools, curricula focus on clinical practice and effective therapeutic techniques—rarely are students trained on how to merge the aims of corrections with the aims of psychotherapy (Magaletta & Boothby, 2003; also see Huffman, 2005). There are relatively few graduate programs in the United States that focus on the subspecialty of correctional mental health (the American Psychology-Law Society lists 26 clinical doctoral programs with forensic specialties, with 17 additional clinical masters programs with forensic specialties). Although some offer emphasis on legal issues, these focus less on the treatment of mental health within a correctional setting, and more on clinical assessment of witnesses, competency to stand trial, and other clinical issues that are relevant before incarceration (Magaletta & Boothby, 2003). There is little specific training that considers the marriage of correctional and mental health goals (Huffman, 2005). In a survey of correctional mental health workers, respondents frequently cited graduate school as the source of their clinical knowledge, but issues more related to the correctional environment were learned once the clinician has entered the field (Magaletta, Patry, Dietz, & Ax, 2007)[10].

Without clearer trainings or policies, prison therapists are often left to wrestle with the competing demands of treatment and safety. They must find their own balance of treatment and security, trust and mistrust. As such, this project seeks to understand how prison therapists' approaches toward therapy are affected by their role duality. This project intends to discover

[10] The author took part in a 4-week training by the Colorado Department of Corrections before beginning his employment as a therapist in prison. Only 3 days of this time were specific to the position, and focused on mental health screenings, suicide watches, the use of restraints to prevent self-harm, and the like. There was no instruction on effective use of the therapeutic alliance.

more about the actual perceptions correctional mental health workers have of their roles, and aims to apply findings to inform best practices and better understand the possibilities of the ideal of cooperation and mutual goals between mental health and corrections. Therefore, the first step toward the ideal is to understand the current state of mental health work within corrections.

Summary. Prison therapists face competing demands from correctional policies, their ethical principles, and the offenders' aims. At best, these are out of sync with one another. There is evidence that role reconciliation can be reached without violating the needs and expectations of the agency or the offender, but whether and how this is accomplished among prison therapists is not yet known. They receive little to no formal guidance on how to ethically treat offenders while also following strict prison policies, and thus may use different approaches. It is important to understand how prison therapists perceive their roles in terms of the therapeutic alliance and security concerns.

Direction of the Literature

Where corrections and mental health overlap, past research has focused largely on the prevalence of mental illness among offenders and effectiveness of interventions. Relatively less research has been concerned with correctional staff, and when so, has nearly always focused on security staff (e.g., Farkas, 2000; Kifer et al., 2003). The few studies that have focused on mental health staff in corrections typically have examined job satisfaction or staff burnout with specialty populations such as sex offenders (e.g., Farrenkopf, 1992; Kadambi & Truscott, 2003; Scheela, 2001). There is a sizable gap in the literature concerning how correctional mental health workers balance the opposing demands of the prison environment (i.e., prison policies and offender motives) with the goals of their profession (Huffman, 2005).

Although many commentaries and opinions have been published, to the author's knowledge, the only study that has included some indication of how competing demands influence a correctional mental health worker's approach toward treatment is a qualitative doctoral dissertation involving 16 prison psychologists (Karcher, 2003). The general themes from that section of the dissertation reflect the relevance of competing demands and how they might affect a prison clinician's job performance. Namely, the themes that emerged are that professionals felt a need to (a) remain wary of environmental dangers, (b) consciously resist the environment's negativity from turning into apathy and cynicism, (c) be flexible about what constitutes therapy, (d) keep expectations about treatment outcome realistic, (e) choose to have a positive attitude toward the work, and (f) balance interpersonal boundaries. In brief, Karcher (2003) found role conflict and its potential impact on the psychologists to be a constant and important element in the clinicians' work. The psychologists acknowledged that the competing demands inherent in their role could lead staff to emphasize one over the other, or even to pretend that the conflict does not exist.

Karcher (2003) also found that the psychologists reported feeling more similar to offenders than they had expected, and that this could be a potential role conflict as they realized that they could easily be in the offenders' position. This finding highlights the inherent incompatibility of the clinician's motivation to relate to offenders and being discouraged to do so at an institutional level. Indeed, Karcher writes (pp. 214-215), "…the correctional culture works assiduously to instill a strong sense of 'us' vs. 'them,' with an uncrossable divide between them." These emerging themes lead toward several questions not answered in the literature that the present study more deeply addresses in a quantitative manner. These questions are described in the next section.

Current Study: Prison Therapists' Role Emphasis

There is reason to believe that when professionals face competing and perhaps irreconcilable demands, they may choose a manner in which to respond to those demands that also emphasizes them differently. This behavior has important implications for correctional mental health, yet the differential emphasis of roles in prison therapy has never been explicitly and quantitatively examined. The current study addressed this gap in the literature.

Different Emphases

Therapists can be differentiated by their theoretical orientations toward mental illness and treatment, but the ways in which they approach the therapeutic relationship specifically have not been widely explored. Although it is clear that the approach is important, there is scant research on whether therapists actually differ in terms of their approach to the therapeutic relationship. One early study concerning therapists who treat patients of schizophrenia found that the attitudes and approach of the therapist in terms of participation had some effect on the patients' improvement (Betz & Whitehorn, 1956; see also Whitehorn & Betz, 1960; but also see McNair, Callahan, & Lorr, 1962). A later study examined therapists who worked with patients of schizophrenia or those with neurosis, and suggested that some therapists approach clientele with more empathy than others, depending on the client's diagnosis (Beutler, Johnson, Neville, Workman, & Elkins, 1973). These findings imply that not all therapists share the same emphases in terms of the therapeutic alliance.

A more recent study compared a sample of court-ordered mental health treatment recipients with others who had voluntarily sought treatment (Manchak et al., 2013). The researchers found that court-ordered clients perceived their therapists as exerting more control than did voluntary clients of their therapists. Their data could not determine whether therapists

actually differed in how controlling they were, but their analyses support the idea that not all therapists approach the therapeutic relationship in the same manner.

Another study found that therapist trainees had different approaches to their clients. In light of research on the therapeutic alliance's importance in therapy, it is perhaps not surprising that less effective therapists regarded therapy as a largely verbal and conceptual interchange, rather than involving something more emotional and nonverbal (Lafferty, 1987). In terms of the alliance, therapists who approached their clients with less emphasis on the emotional bond between them approached therapy without the most effective element of treatment.

Emphases in prison therapy. As discussed above, the therapeutic alliance is expressly challenged in the prison environment. What is not yet known is the actual effect of these challenges on how therapists emphasize the therapeutic alliance in relation to the safety and security measures of the position, and whether those different emphases influence the quality of treatment that offenders receive. It appears likely that the therapeutic alliance would be negatively affected by the many obstacles in prison, and that the restricted alliance would then lead to less effective treatment. Indeed, in writing about his experiences with prison therapists, Toch (1995) describes some who appeared to do more harm than good to the offenders (see Appendix J for similar sentiments from this study's sample); yet the majority of the therapists in Karcher's (2003) study indicated a desire to overcome many obstacles to treatment quality. In light of these contrasting therapist role emphases, this study aims to systematically explore how prison therapists weigh the opposing demands of their position, how that changes their approach toward the therapeutic alliance, and how that, in turn, may influence their treatment decisions for offenders.

At present, there is no extant psychological measure of how a prison therapist balances the opposing roles of his or her position, and it is therefore not possible to determine how the emphases influence decisions in treatment. Although some similar measures exist, they are focused on correctional workers such as administration, prison guards, probation officers, or the offenders (e.g., Cullen et al., 1993; O'Leary & Duffee, 1971; Skeem, Eno Louden, Polaschek, & Camp, 2007). This project aimed to fill this gap in the literature by first constructing a psychometrically sound measure of how prison therapists differently emphasize the demands of their work, and then analyzing what elements account for variance in scale scores. Finally, this project explored the effect of role emphasis on treatment decisions.

Correctional mental health work emphases. Based on previous research, as well as on the sources of competing demands placed on them (and the author's own experience), there is reason to expect that correctional mental health workers vary in how they differentially emphasize their dual roles. Some clinicians likely stress safety and security measures differently than the rehabilitative, interpersonal elements of psychotherapy. Specifically, three general orientations of mental health workers likely exist: (a) those whose primary concerns are of safety, institutional security, and symptom reduction; (b) those whose primary concerns are of engaging and motivating offenders to make lasting changes; and (c), therapists who balance these aims (Figure 1). Below, each of these conceptualizations of role emphasis is described in more detail.

Stabilization emphasis. There is reason to believe that some therapists endorse an orientation towards their work that emphasizes security and safety above rehabilitation efforts. First, prison policies appear to encourage such an orientation; the policies written specifically for mental health within many states' correctional institutions largely focus on stabilization

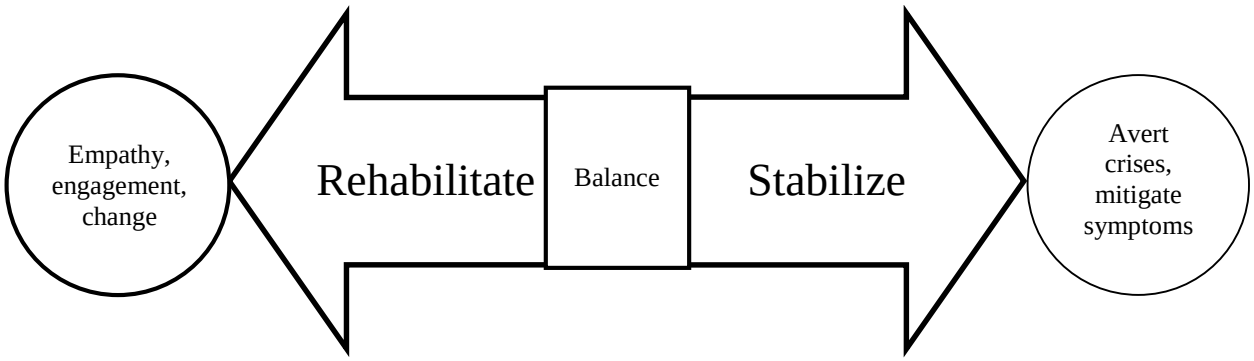

Figure 1. Conceptualization of the different role emphases of prison therapists.

measures, such as assessing for suicidality or aggression, ensuring compliance with prescribed psychotropic medications, guidelines for restricting offenders' access to certain materials (e.g., many sex offenders are prevented from possessing pornographic materials, offenders with a history of self-harm may be prevented from using blade razors for shaving), and the proper use of physical restraints to prevent self-harm (Arizona Department of Corrections, 2012; Colorado Department of Corrections, 2013a, 2013b; also see Appendix A). Treatments such as individual or group therapy are mentioned, but the scope and manner in which these are carried out are not outlined in the policy. This is often true of corrections departments' written mental health policies, and handbooks on mental health treatment in corrections (e.g., Mobley, 2006).

Furthermore, mental health policies in prison may perpetuate a dehumanizing approach toward offenders. For example, offenders often use behavioral outbursts as a means to achieve secondary gain (Mobley, 2008), thus several prison policies respond to purported mental health crises in ways that appear intended to discourage such disruptions. A prisoner who reports suicidal thoughts or intent may face a number of unpleasant and even degrading practices; The offender may have his clothing confiscated and replaced with a "smock, wrap, or blanket," may be directly and continuously observed for several hours at a time, sometimes while also restrained (Colorado Department of Corrections, 2013b, pp. 2-3; see also Arizona Department of

Corrections, 2012). Such practices may prevent crises through direct physical intervention, but they do virtually nothing to solve the underlying emotional causes of suicidality (e.g., Mandracchia & Smith, 2014). One clinician in a California prison acknowledged the stabilization-rather-than-rehabilitation policies when stating, "When the court [monitor] comes, he's going to ask the patients, how are they treated? And they look at the chart and they see if we meet the requirements… Anything that you do outside of these is unnecessary" (Karcher, 2003, p. 166; see similar sentiments from this study's sample in Appendix J). If this view of policies is shared among therapists, then it is further evidence of institutional pressure to adhere to a stabilization and security-focused orientation, that may come at the expense of therapeutic quality.

An additional concern is the relatively high burnout rates among mental health workers within prisons. Psychotherapists as a group have high rates of job burnout (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2011), and corrections workers are prone to such also (Brodsky, 1982; Schaufeli & Peeters, 2000). Thus, it is not surprising to find that psychotherapists who work within corrections have the highest rates of client-related burnout among all human service positions (Borritz et al., 2006). Because burnout is associated with emotional exhaustion (e.g., Leiter & Harvie, 1996), it is likely that many prison therapists facing the stressors that lead to burnout are also emotionally disengaged.

Therefore, although they are typically educated in fields that place little to no emphasis on security or incarceration, there is likely a meaningful proportion of correctional mental health workers who endorse a "stabilization" approach toward therapy. Clinicians who emphasize safety and security above psychotherapeutic elements likely stress safety and security while avoiding compromising situations and relationships—they view their work more as that of

behavior management, pacification, or stabilization. They see their role as primarily to keep offenders lucid and calm, and are less concerned with or even hesitant to form relationships with offenders. These therapists have relatively less concern or desire to help offenders make lasting changes in their worldviews or thought patterns. Therefore, the therapeutic alliance is not a priority to therapists who focus primarily on security and stabilization. The archetypal therapist who places high emphasis on the security and stabilization aspects of her job with far less concern about rehabilitation might say about it, "My role is to keep the offenders from hurting themselves and others, to intervene in and reduce crises, and encourage their compliance with medication so that they can get through their time in prison" (see Appendix J for similar statements).

Mental health workers with attitudes in this direction likely admit that some offenders are sincere in their desire to make lasting behavior changes, but are less willing to risk becoming emotionally involved, or cite a lack of time or resources to dedicate to such offenders. The stabilization-emphasizing therapist focuses on interventions that benefit the institution rather than the individual offender. She also is less concerned about input from offenders in the treatment process. In sum, the power placed with therapists, combined with the institutional restrictions, is expected to lead many to adopt attitudes about their work that reflect an emotionally disengaged, directive, and stabilization-focused form of treatment.

Rehabilitation emphasis. In contrast to the correctional therapist who places relatively little emphasis on (or even avoids) relationship building with offenders, there are likely correctional mental health workers who emphasize their role as helpers above institutional security measures. Workers on this end of the spectrum acknowledge stabilization as an important step toward behavior change, but they see that as perhaps only the beginning of their

role. Although they recognize the necessity of security measures to keep the offenders and staff safe, they view these measures as secondary to the importance of motivating offenders to adopt new worldviews, learn new interpersonal skills, and develop trust. They place their emphasis on being agents of change in the offenders' levels of insight and worldviews, and work to achieve this through warm and engaged relationships with the offenders. They strive to be accepting and empathic in their interactions with offenders, separating the person from his behavior. They believe that the therapeutic relationship is a necessary and effective tool of psychotherapy, and that offenders can become better people if they have a nourishing therapeutic relationship in which to thrive. The archetypal therapist who focuses primarily on rehabilitation may say about his work, "Treating people like criminals reinforces criminality. Through a supportive, accepting, and nonjudgmental relationship, I can foster offenders' belief that they can make lasting changes and be productive people."

One example of this rehabilitation orientation, as conceptualized here, is noted in an interview with a prison therapist (Bertrand-Godfrey & Loewenthal, 2011). This therapist witnessed an officer making fun of an offender on his caseload, and felt compelled to step in and protect the offender. Such strong feelings to serve offenders even at the risk of being accused of breaching boundaries may be common, and a reflection of therapists' approaches toward their professional duties.

There is reason to believe that some therapists possess this rehabilitation orientation toward their role, in part because prison therapists likely chose their professions in order to be agents of positive change. Norcross and Farber (2005) found that the most frequent reason psychotherapists give for why they chose their profession is the desire to help others. In their education of therapeutic techniques, students are introduced to several therapeutic methods that

emphasize warmth and respect for clients (e.g., Frank, 1982; Goldfried & Padawer, 1982; Rogers, 1951; Strupp, 1986; Wampold, 2001, 2007). As such attitudes are central to therapeutic practice, it is expected that many therapists, including those who practice in prisons, adopt attitudes of a caring and helpful change agent. Indeed, one survey of correctional psychologists found that 19% of respondents endorsed a humanistic orientation (Boothby & Clements, 2000), which focuses on human potential, among other things. Additionally, interest in the positive psychology of the Good Lives Model of offender rehabilitation reflects the view some share that offenders are generally normal people who did inappropriate things, but deserve the same respect and care as any people (Ward, 2012).

The balanced approach. Beyond those who emphasize stabilization and rehabilitation differently, the majority of correctional mental health workers are expected to report a balanced approach toward treatment. These therapists view their role as a combination of symptom reduction and therapeutic guidance for offenders who want to change. Therapists who endorse this balanced role are moderately emotionally engaged in therapy, but also mindful of professional boundaries. They acknowledge both the potential of the changes they can make with offenders, and their high-risk nature. The archetypal correctional mental health worker with this balanced view of her work may say, "Offenders are potentially dangerous and manipulative. Some really want to change. I can do a great deal of good with this population, but I mustn't forget the risks."

This ability to adapt to the prison environment as a therapist has been reported in previous qualitative research (Bertrand-Godfrey & Loewenthal, 2011), and is presented by some as the proper approach toward mental health work within corrections (Dignam, 2003; also see Dowden & Andrews, 2004). It is likely that many therapists in prisons are able to see where

mental health's treatment goals can be in line with the goals of corrections, and that they work to serve both simultaneously through balancing the safety and security demands with elements of the therapeutic alliance.

Emphases and Decision-Making

Due to the expected differences in how prison therapists weigh the demands of their work, the author also expects that their work-related decisions will vary. Decision-making is a psychological process wherein the decider must, among other things, identify and prioritize aims, evaluate actions and alternatives, take the action deemed most appropriate, and evaluate the consequences. Making treatment decisions for offenders can be a difficult task, given that the aims of therapy and corrections often conflict, the consequences of decisions are not easily predictable, and appropriate outcomes may be defined differently depending on who is concerned (i.e., the aims of therapy vs. the aims of corrections).

Though making decisions is a complex process between many variables, some important elements that are the focus of this project are the decider's beliefs, opinions, understanding of goals, and the options available (Zeleny, 1982). Furthermore, within an organization such as a prison, when an ethical dilemma arises, the decider may need to evaluate his or her role in context of authority figures, and several sources of pressure (Trevino, 1986).

As this project intends to examine prison therapists' attitudes and how they perceive the goals of the environment in which they make their decisions, weighing opposing systems, it is appropriate to explore how these constructs may relate to the decisions they make. Additionally, understanding how their decisions are affected by their attitudes and approaches will shed light on the actual impact the different role orientations may have on the offenders' treatment.

Although the current project did not directly explore what actions prison therapists take, using hypothetical situations provided some basis for future study of such.

As prison therapists have a range of duties (Boothby & Clements, 2000), and are regarded as the authorities on mental health related decisions, it is also important to gauge how their decisions may align with recommended practices. The empirically-supported Risk-Need-Responsivity model (RNR; Andrews, Zinger et al., 1990; Andrews, Bonta et al., 1990) outlines recommended practices to achieve the desired outcome of lower recidivism. These practices focus on officers, but can also be applied to the prison therapist (see Marshall & Serran, 2004). In the case of the correctional therapist, a confrontational or authoritarian approach is unlikely to succeed, as is one that looks past problematic behaviors (e.g., Marshall, 1996). It is likely that the most effective therapist is one who reinforces offenders' positive behaviors, models prosocial behavior, being flexible, warm, and empathic, and encourages the offenders to do the same (Marshall & Serran, 2004). This appears to generally reflect the conceptualization of the balanced approach toward prison therapy, but it is useful to examine if the balanced orientation also relates to decisions that are in line with the RNR model. Therefore, this project included a section that was intended to assess the decisions that prison therapists believe they would be likely to make when given a realistic scenario.

Hypotheses

This study seeks to understand prison mental health workers' attitudes toward their roles, and how these attitudes may be explained by therapist characteristics or elements of the prison. To work toward this end, several hypotheses were formulated, which fall into three categories: (a) exploring the psychometric properties of a new measure of prison therapists' role emphases, (b) determining the sources and sizes of variance in emphasis and some of the other constructs of

interest, and (c) examining the relationship between role emphasis and prison therapists' treatment decisions.

Role emphasis measure's psychometric properties. As mentioned above, a novel measure was constructed (also see Materials section below) to assess how prison therapists emphasize their competing roles. In addition to calculating indices of average inter-item association, factor saturation (i.e., reliability), and factor structure, the scale scores from this new measure were contrasted with scale scores from other empirically tested psychological scales (to support construct validity). The author expected that responses on the novel measure of role emphasis would meaningfully correlate with those on a measure of the relationship quality between a therapist and an offender, and a measure of the therapist's attitudes towards offenders in general.

Predictors and correlates of emphases. Some therapist characteristics and elements of the prisons in which they work were expected to covary with the therapists' role emphases. Others were expected not to relate with role emphases. Staff members who work primarily in facilities with lower security levels were thought likely to also emphasize rehabilitation above stabilization and security than do staff members who work in medium or higher security facilities. As the security level of a facility increases, the therapists' emphasis on rehabilitation was expected to diminish while their emphasis on security and stabilization were expected to increase. Similarly, offenders within facilities often differ in their personal restrictions (custody levels), and these restrictive levels were expected to also have some influence on a prison therapist's emphases, with lower restrictions associating with more emphasis on rehabilitation.

As female offenders are typically less violent and kept at lower security levels than are male offenders (see Farr, 2000), the sex[11] of the offenders whom the prison therapist primarily treats was expected to associate with role emphasis. Namely, primarily or exclusively female caseloads were expected to associate with more role emphasis on rehabilitation and less security/stabilization emphasis from the therapists.

Some prison therapists have specialized caseloads, primarily treating sex offenders or offenders with mood disorders, and so on. Survey materials included questions about these specializations in order to examine any relationship to role emphasis. Those treating sex offenders and offenders with personality disorders were expected to have higher emphases on stabilization rather than rehabilitation, due largely to the relative difficulty of treatment and high burnout in treatment providers working with these groups (Farrenkopf, 1992; Linehan, Cochran, Mar, Levensky, & Comtois, 2000), but differences between other specializations were not expected.

Therapists' theoretical orientations toward psychotherapy were expected to associate with their relative emphases on security/stabilization and the therapeutic alliance. Client-centered therapists were expected to have a large emphasis on therapeutic alliance, whereas Gestalt, Cognitive-Behavioral, and Behavioral-oriented therapists were expected to have less emphasis on the alliance. Other orientations were not expected to show meaningful patterns of difference on emphases.

The author hypothesized no meaningful differences in emphases based on a therapist's race, gender, or major area of study for their highest degree (i.e., no differences between

[11] In the majority of cases, corrections departments categorize offenders by their anatomical sex, rather than the psychological construct of gender (e.g., Sumner & Jenness, 2014).

counseling majors, social work majors, and psychology majors). This hypothesis is based primarily on past research suggesting that these same therapist characteristics are unimportant to the therapeutic alliance (Luborsky et al., 2002; Seligman, 1995; Wampold, 2007). As the emphasis on the therapeutic alliance is represented within the role orientation measure, these therapist characteristics are not expected to account for significant differences in either the role orientation measure or a measure of the quality of the therapeutic relationship.

Difference with experience. As people generally adapt to their situations, the author hypothesized that a therapist's relative emphases would correlate with the number of years he or she has worked in corrections (Kifer et al., 2003). Specifically, the expected pattern was that correctional mental health workers initially enter the field with an emphasis on rehabilitation and the therapeutic relationship, but after experiencing the challenges of the environment and difficult population their endorsement of stabilization and security needs would increase. This hypothesis is based on cognitive dissonance theory (e.g., Festinger, 1957), which states that when a person's beliefs and attitudes are incompatible with his actions, he will shift his attitudes and beliefs to be more in line with his behaviors. In the case of correctional mental health workers, the author expects that most enter correctional work hoping to be involved in offenders' processes of personal growth, but after being organizationally restricted from, and witnessing the potential pitfalls of, engaging emotionally in therapy with their clientele, workers' attitudes may shift toward the stabilization and security aspects of their roles. However, although the direction of the change is thought to generally shift more in favor of stabilization and security, it is expected that the majority of therapists will likely settle near balanced roles after the initial years of their position, as they learn through experience how to reconcile the correctional and therapeutic aims.

Furthermore, this pattern is expected because past research finds that correctional therapists have high rates of burnout compared to other positions in human services (Borritz et al., 2006; Schaufeli & Peeters, 2000). Therefore, there are likely to be more therapists with security and safety emphases after many years of experience than there are with rehabilitative orientations (also see Kifer et al., 2003).

An additional basis for this hypothesis is past evidence that therapists working with sex offenders often experience attitude shifts over the course of their employment (Farrenkopf, 1992). The research suggests that many correctional therapists entered their work with feelings of vulnerability and shock, which were often followed by a more idealistic stance of non-judgment and empathy. Following the time of idealism often was cynicism and disenchantment. Other researchers have also found a pattern of increasing disillusionment among jail workers who emphasized rehabilitation as their careers continued (Poole & Pogrebin, 1988). The author hypothesized a similar pattern in shifting perceptions of offenders among clinicians—that the direction of change in emphasis over time would be more toward stabilization and security with less effort toward relationship building.

Different role emphases in different facilities. Because the security level of a facility likely impacts the practices and flexibility of therapy, it was expected that mental health workers working in facilities with lower security levels would be more oriented toward the rehabilitation/alliance emphasis, whereas workers in higher security levels would emphasize stabilization and safety. This hypothesis is based on the fact that offenders at lower custody levels (and therefore typically lower security levels) also have less violent records, better behavior, and fewer instances of facility disruption than offenders at higher custody levels (e.g., Colorado Department of Corrections, 2015b). Lower security levels likely also have fewer

instances of mental health crises, such as suicidality and threats of harm. There is also less physical separation of mental health staff from the offenders in lower security facilities (e.g., fewer bars, doors, and restraints), removing some of the barriers to an emotionally engaged therapeutic relationship.

Employment and role emphasis. An additional hypothesis originates from an article by Weinberger and Screenivasan (1994), in which the authors suggest that many ethical dilemmas in correctional mental health work may be avoided when the mental health providers are not directly employed by a department of corrections. The authors argue that this model reduces the therapists' role conflict by keeping their role entirely that of mental health, rather than divided between clinical and nonclinical activities[12] (also see an excellent review of the dilemma by Bonner & Vandecreek, 2006). The recommendation does not appear to be based on empirical data, but is a reasonable expectation. Therefore, the current project expects that the mental health workers who are contracted to work for the department of corrections will generally report attitudes more in line with the rehabilitation role emphasis than those who are employed directly by a corrections department.

Correctional mental health workers' conflict of roles. Robertson's and Walter's (2008) definition of role duality was adapted to the current study, and is conceptualized as when a mental health worker faces "conflicting expectations or responsibilities, between the therapeutic relationship on the one hand and the interests of [the prison institution] on the other" (p. 229). Namely, the conflict is that therapists' most effective tool is a caring, empathic relationship with

[12] Often, institutions make clear that even clinical staff is expected to participate in security-related work (e.g., Arkansas' policies in Appendix A). While the author worked in the Colorado Department of Corrections, he was expected to participate in cell searches, which involved going through all of an offender's belongings, searching for contraband.

their clientele, but the prison prohibits such. In line with past research on prison employees in other capacities (Grusky, 1959; Hepburn & Albonetti, 1980; Schaufeli & Peeters, 2000), correctional mental health workers were expected to perceive role conflict in their positions (also see Borritz et al., 2006). Therapists' levels of role conflict were expected to vary with other measures, as discussed below.

***Role conflict and orientation*.** No direct relationship between role orientation and role conflict is expected, but a nonlinear relationship may exist, or role conflict may act as a moderator between role orientation and job satisfaction. For example, among correctional therapists who report low role conflict, the author expected a higher emphasis on stabilization and security than rehabilitation and therapeutic relationship. These workers were thought to see their therapeutic aims as in sync with the policies of the prison, and therefore find little to no conflict. Such a mental health worker likely views her position as preventing and dealing with crises through screening techniques and compliance with prison regulations, as well as through encouraging adherence to medication interventions. She may view this stabilization or pacification of offenders as the primary methods by which safety and security are achieved. This appears to be in line with Dignam's (2003) argument that mental health aims in corrections are complementary to security aims (also see Bonner & Vandecreek, 2006, for further discussion).

However, for therapists who see their role as primarily one of rehabilitation, some may also believe that this aim is in line with the facility's mission and may not perceive role conflict, thus leading to higher job satisfaction. Some therapists who see their role as primarily that of rehabilitation, if they also perceive high role conflict, are likely to feel that they are working against the facility's aims and therefore experience lower job satisfaction. However, due to their higher concern for helping offender, many were also expected to find their work rewarding (see

Karcher, 2003, for basis), thus increasing levels of job satisfaction. A therapist emphasizing stabilization and security is unlikely to experience role conflict, but may be less satisfied with his position.

Covariates of other constructs. As this study's data are also equipped to examine predictors and correlates of issues related to staff retention, an important issue for prison administrators, some hypotheses were formed regarding the covariates of role conflict and job satisfaction.

Predicting role conflict. As noted above, therapists' role emphases were expected to also correlate with their experience levels within the correctional environment. This is thought to partially be explained by their levels of role conflict at different experience levels. Namely, therapists with less experience within corrections were expected to report higher role conflict than the more experienced therapists.

Predicting job satisfaction. To further inform agencies wishing to retain their employees, the sources of job satisfaction (or dissatisfaction) were examined. Because workers are kept within the restrictive environments during their work hours, the security level of the facility was thought to also have some influence on a therapist's job satisfaction. Similarly, an offender's custody level is typically a reflection of that offender's need for restraint or additional security measures, thus a therapist's job satisfaction was thought to be affected by the typical risk level of the offenders with whom he or she works. Additionally, because the offenders can be a source of job discomfort, the number of hours an employee spends with offenders was expected to also relate to job satisfaction. In a similar vein, therapists with more administrative roles and less treatment-oriented tasks may be less satisfied with their positions (Karcher, 2003).

Role conflict and job satisfaction. Role conflict and job satisfaction were also thought to be related to one another. Because correctional mental health workers were expected to generally report high role conflict, it was expected that they would also have moderate to low ratings of job satisfaction. If mental health workers face dual roles in their daily work, meaning competing pressures, this is likely to cause discomfort with their position. It was hypothesized that therapists reporting high role conflict would also report lower job satisfaction (see Acker, 2004). Those who report low role conflict were expected to report higher job satisfaction.

Relation of role emphasis to treatment decisions. As the relative role emphases of a prison therapist are expected to differ, perhaps the most important question to follow is how differing emphases may influence treatment decisions. The author expects that therapists who report a higher emphasis on rehabilitation and the therapeutic relationship will also report being more likely to engage in relationship-building behaviors in their interactions with offenders, whereas those with a higher emphasis on security and safety would be less likely to do so. In contrast, the author hypothesizes that a rehabilitation and relationship emphasis will not necessarily correspond to a therapist being less likely to act in accordance with security and stabilization.

Methods

As this research involved the development of a novel measure of prison therapist role orientation, it was necessary to pilot test the materials. Using the recruitment and testing procedures described in this section, all survey materials were first administered to a pilot sample of prison therapists. Following minor revisions to the materials (described below), the novel measure and several other psychological measures were administered to a larger sample of therapists who treat adult prisoners in the United States. Data from these measures were then used to address the study's aims.

Recruitment

Several avenues of recruitment were explored, including through government agencies, private companies, and professional organizations. Twenty-nine state corrections departments were contacted regarding this project, as was the United States Bureau of Prisons. Initial inquiries were made to their respective mental health departments to (a) determine whether mental health staff members were employed by the department of corrections or another company, (b) estimate the number of potential participants, and (c) explore the departments' receptiveness to the research.

All departments that reported employing their own mental health workers were solicited to participate in this project, regardless of the number of potential participants. Six state corrections departments approved the project and assisted with the distribution of survey materials (Arkansas, Idaho, Nebraska, Pennsylvania, Washington State, and a department wishing to remain anonymous). The remaining departments that were contacted either did not employ their own mental health staff, declined to participate for various reasons (six state

departments), or did not review the research proposal by the end of the data collection period (February 11, 2015).

Three state corrections departments that declined to participate or refused to review the project permitted access to contact information for their mental health staff so that the survey could be advertised to them (Colorado, Illinois, and South Carolina). In those cases, potential participants were asked to complete survey materials on their own time (not at work or using agency resources).

If a department's mental health workers were contracted through another company, the author attempted to communicate with the contractor about participating in the research. Four private companies that are contracted to provide mental health services to offenders were contacted about this research. One company declined to participate due to undisclosed legal concerns. Another declined to participate for unknown reasons. The remaining two contracted companies agreed to participate. One was a university hospital that has 86 employees working in the state's prisons (University of Connecticut Health Center). The other is a large company with employees in various capacities across 38 states (Correct Care Solutions), which distributed the survey to mental health workers at two of its sites (in Arkansas and Maine).

Two additional private prison companies and five professional organizations whose memberships include prison therapists all received initial inquiries about participation in this project. The private prison companies did not complete their review process by the end date of the data collection period. Two professional organizations approved and assisted with the distribution of the survey materials (the International Association for Correctional and Forensic Psychology, and the Forensic Mental Health Association of California). Only one of the

professional organizations declined to participate with the survey distribution. The remaining two did not respond to inquiries.

Participants. Potential recruits were eligible to participate in this research if they were at least 18 years of age, could read English, and practiced some form of mental health treatment with offenders in a U.S. prison. Psychiatrists and psychiatric nurses were excluded, as their duties are typically focused on pharmaceutical treatments, with no interpersonal psychotherapy. The pilot study included 24 prison therapists, and the main study included 315 surveys that had been started, 244 of which had also been submitted by the user to the online database.

The dataset was reduced to 237 participants after removal of some cases. Twenty-five of the surveys had been started but no data had been entered, thus these were unusable. Another 36 sets of responses were excluded from all data preparation (see below) and analyses because the participants had not completed any section beyond the demographic questions (Appendix B). Fourteen participants were excluded from analyses because they did not fit the target population (psychiatrists, treat only juvenile offenders, or work in jail rather than prison). Two others were excluded after reporting duties that do not include any mental health treatment (assessment only). One additional participant's responses were excluded from analyses because this person incorrectly responded to the attention check. All participants who completed at least a portion of questions after the demographic section were retained in analyses. After case removal resulted in 237 usable response sets, all missing data were multiply imputed (details below). Unless otherwise stated, all results reported are pooled from the multiple imputations.

Participants averaged 45.74 years old (SD = 12.2). The majority was female (64.3%). This sample reported a range of security levels and average offender custody levels. The majority reported working primarily within maximum security facilities (n = 85; 35.9%); 65

(27.4%) reported working in medium security facilities; 34 (14.3%) reported working in minimum security facilities; and the remaining 51 respondents (21.5%) reported working in facilities with mixed security levels where they work equally with offenders at all levels.

The sample included 49 therapists contracted to treat offenders at prison facilities, and 184 who are employed by a state department of corrections. The remaining four respondents did not fit well into either category—some were employed through another government agency, such as a sheriff's department, to do mental health treatment in the state prison, for example.

Participants were asked to estimate the proportions of their caseloads that are at each custody level. Therapists as a group estimated a mean percentage of 25.6% of the offenders they treat were at the lowest restriction level, that 32.6% were at a moderate or medium restriction level, 15.3% were at close or high restrictions, and that 26.6% were at the highest level of restriction possible. Additionally, 16 therapists (6.8%) stated that they were not sure of the custody levels they treat, and 28 (11.8%) stated that their offenders are equally at all custody levels. Most of the respondents reported treating offenders at some custody levels more than others, thus these therapists were categorized according to the typical custody level of their caseloads. In this way, 47 (19.8%) of therapists work primarily with offenders at the lowest level of restrictions, 54 (22.8%) treat offenders primarily at medium levels of restrictions, 25 (10.5%) treat primarily offenders at high ("close") levels of restrictions, and 53 (22.4%) treat primarily offenders who are at the highest levels of restrictions. The remaining 58 therapists could not be categorized. Those respondents who did not fit into one of these categories were excluded from analyses that included custody level as a variable. Table 1 presents other descriptive information about the respondents.

Table 1

Characteristics of Sample

Race/Ethnicity	***n***	**%**
African American	15	6.3
European American	195	82.3
Latino	8	3.4
Other	19	8.0
Education	***n***	**%**
Some college	1	0.4
Bachelor's	7	3.0
Master's	173	73.3
Doctoral	55	23.3
College Major	***n***	**%**
Counseling	68	28.7
Social Work	58	24.5
Psychology	100	42.2
Other	11	4.6
Experience	**Median**	**Mode**
Years in Corrections	6.9	0.0
Years Community Mental Health	6.0	0.0

Procedure

Participants were contacted using three media: (a) direct email, (b) direct physical mail, and (c) targeted advertisement. The majority of participants were contacted via their professional email through departmental or facility listservs, with a brief description of the project and whatever incentive their organization permitted (example text in Appendix C). Following recommendations to improve response rates (Roth & BeVier, 1998), two to three reminder emails were sent to all potential participants for whom email addresses were available. Colorado participants received either these same advertisements in print form (n = 87) or an entire copy of the survey materials in print form (n = 25) via the United States Postal Service (i.e., Colorado pool received no emails). For those who received paper surveys, they were asked

to complete the materials and then return them through a provided envelope that was stamped and addressed to the researcher. The physical surveys also included the web address for the survey, and an offer for interested persons to complete the materials online should they prefer. The third method of recruitment was through advertisement on the professional organizations' websites or in their newsletters. A brief description of the project was followed by the author's contact information and/or link to the online survey. A summary of the participating organizations is in Table 2. More information on each organization's policies is given in Appendix A.

Table 2

Summary of Recruitment

Organization	**Type**	**Recruitment Method**	**Incentive Offered**
Anonymous DOC*	State DOC	Email sent by agency	None
Arkansas DOC	State DOC	Email sent by agency	$10 gift code
Colorado DOC	State DOC	Letters or surveys mailed	$10 gift code
University of Connecticut Health Center	Contracted	Email sent by agency	$10 gift code
Idaho DOC	State DOC	Email sent by agency	$10 gift code
Illinois DOC	State DOC	Email to staff to complete outside of work	$10 gift code
Nebraska DOC	State DOC	Email sent by agency	Pen
Pennsylvania DOC	State DOC	Email sent by agency	None
South Carolina DOC	State DOC	Email to staff to complete outside of work	$10 gift code
Washington State DOC	State DOC	Email sent by agency	None
International Association for Correctional and Forensic Psychology	Professional Organization	Ad in newsletter	$10 gift code
Forensic Mental Health Association of California	Professional Organization	Ad on website	$10 gift code
Correct Care Solutions	Contracted	Email sent by agency	$10 gift code

*This agency agreed to participate under the condition of anonymity.

Precise response rates are impossible to calculate as the survey was advertised in a newsletter and on an agency website and it is not knowable how many qualified persons actually saw the advertisements. However, response rates for those who were contacted by email range

from 14.0% to 68.6%, with a mean of 33.8% (*SD* = 15.7%). The Colorado sample (which received letters or surveys through the mail) had a response rate of 11.7%, although it cannot be known how many of the intended recipients received, opened, and read the materials.

The majority of potential participants were offered a gift code worth $10 toward any purchase through a popular online retailer. However, many organizations have policies in place that do not allow employees to receive compensation for research participation. In such instances, the author attempted to arrange an offer of a ball point pen with the logo of the author's university to each participant. The pen incentive was accepted by only one organization, and the remaining two organizations that participated did not permit any incentive to be offered. Ninety-six (40.5%) participants accepted the $10 gift code, 15 (6.3%) accepted the pen incentive, and the remaining participants either declined these incentives or received no offer per their employer policies.

Materials

This study required a measure of correctional mental health workers' role emphases regarding safety concerns and therapeutic concerns, but none was extant at the time of the study design. Therefore, the author created such a measure based on a conceptually similar one of community corrections officer role orientation (Dembo, 1972; see also Ricks & Eno Louden, 2014, for a revision). The remaining measures included in this research were chosen because they reflected the constructs that were expected to covary (or not) with role emphasis. Two of these also provided a basis for assessing the novel measure's construct validity.

Prison Therapist Orientation Measure. The Prison Therapist Orientation Measure (PTOM; Appendix D) was designed to be a unidimensional measure of a prison therapist's general approach toward the role's competing demands of the interpersonal elements of

psychotherapy with the institutional security and stabilization aims. It was intended to also consist of three correlated subscales to assist with more detailed exploration of role emphasis. Its 15 items were constructed following McDonald's (1999) guidelines for scale development. Item content was based largely on the author's own experiences as a prison therapist, and on qualitative data collected previously. For example, Broderick (2007), Hinshelwood (1994), and Huffman (2005) all provided experiences of role duality as prison therapists. Huffman (p. 321) explains that "prison mental health is a hybrid of coercion and compassion." This statement eloquently describes the duality of interest in this project, and the items included in the PTOM were intended to reflect these competing demands. Themes from Karcher's (2003) research were also included in the scale's construction.

The three subscales of the PTOM were constructed to assess three elements of therapist approach toward treatment in the prison environment (Figure 2). The first set of items was intended to assess a clinician's views of the aims of prison therapy; whether its main purpose is to keep offenders calm and stable or to change their thought patterns to be more productive (items 1-3, 5, & 10). The second set of items intended to explore a clinician's attitudes about offenders; whether they view offenders as dangerous and manipulative, or more as victims of circumstance who are capable of change (items 6, 12-15). A third set of items was constructed to examine the level of emotional engagement the clinician uses in her approach toward therapy; whether disengaged and distant, or empathic and caring (items 4, 7-9, & 11).

The PTOM was designed with a semantic differential format, allowing respondents to mark their orientation as some point between two opposing statements. One of these statements supports the emotionally distant, security-driven role emphasis (marked with "+3"). The other statement supports the emotionally engaged, client-driven, interpersonal elements of a

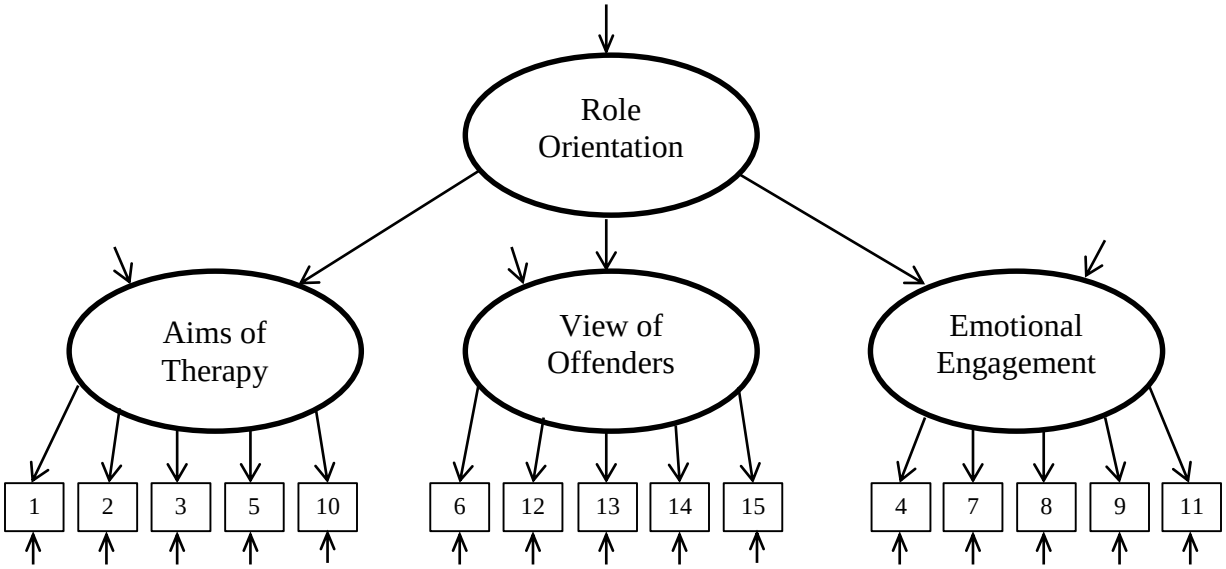

Figure 2. Hypothesized model of prison therapist role orientation. The numbered boxes represent corresponding scale items from the Prison Therapist Orientation Measure.

therapeutic alliance (marked as "-3"). Respondents were asked to weigh both opposing statements simultaneously before responding, directly assessing which they emphasize more. The semantic differential technique has generally been supported as an appropriate method for assessing attitudes (see Heise, 1970, 2010). Responses to the items are summarized in Appendix D following the measure. Reliability indices for this measure are presented in the Results section.

The PTOM has a minimum scale score of 15 and a maximum scale score of 105. The observed scores were between 23 and 88, with a mean of 53.9 (SD = 10.9). A histogram of the untransformed scores appears reasonably normally distributed (Figure 3), and Anderson and Darling's (1954) normality test also suggested that the distribution did not differ significantly from a normal one, $A^2 = 1.33$, $p > .05$. This test was chosen because it weights the distribution tails more heavily than the Kolmogorov-Smirnov test of normality (Farrel & Stewart, 2006), and has demonstrated more power (Razali & Wah, 2011). The remaining analyses were computed using untransformed PTOM scale scores.

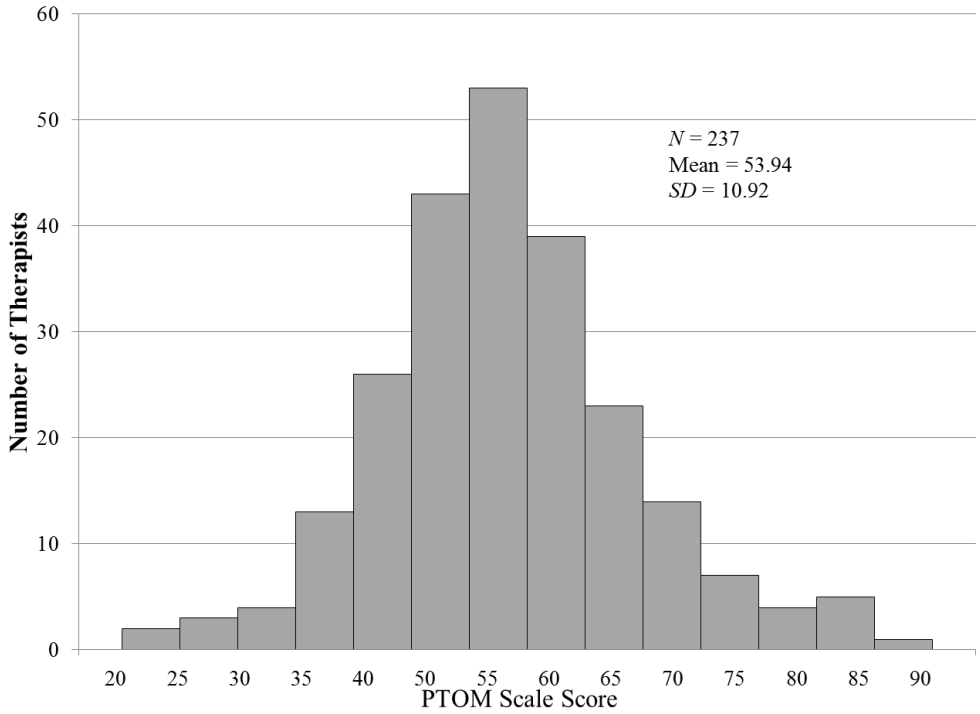

Figure 3. Distribution of Prison Therapist Orientation (PTOM) scale scores.

Attitudes Toward Prisoners scale. Survey materials also included a measure of how participants think about offenders. Melvin, Gramling, and Gardner (1985) constructed a 36-item Likert-type scale of general attitudes toward prisoners (Appendix E). Low scores reflect attitudes that offenders are dangerous, untrustworthy, and unlikely to change, whereas high scores reflect attitudes that offenders are normal people who made poor choices, deserve to be well-treated, and have potential to change. The Attitudes Toward Prisoners (ATP) scale has received acceptably reliable responses in the past (split-half r = .84, test-retest r = .82). The present study found similar results, α = .82, 95% CI [.78, .85]. Melvin et al. also found evidence that the scale measures what it purports to measure; The researchers found that groups who were self-defined as dedicated to prisoner rehabilitation and reform scored significantly higher on scale items than did prison security staff members.

Due to the career choices of the correctional mental health workers sought for this research, the author expected to find less variability than Melvin and colleagues (1985) found in their total sample, with participants of the current project generally scoring high (positive attitudes toward prisoners) on the ATP, but with the expectation that scores from this scale would correlate with scores on the PTOM. The ATP's wording was modified slightly to better reflect the population of interest.

Following the pilot stage of this research, the ATP was reduced to 19 items (more detail in Results). In its reduced form, the ATP had a possible range of scores from 19 to 95. The observed scores with this sample ranged between 34 and 87, with a mean score of 62.9 (*SD* = 8.6). Response summaries appear after the scale items in Appendix E.

Measure of role conflict. This study hypothesized that perceived role conflict is related to a prison therapist's relative emphases on security and relationship aspects of his or her job. To assess perceived role conflict, items from the Role Conflict and Role Ambiguity Scales (Rizzo, House, & Lirtzman, 1970) were adapted to the current population of interest, focusing primarily on role conflict items (due to the relevance to the research questions; Appendix F). The scale authors originally used a 7-point Likert-type response scale with anchors of "very false" to "very true." The current study followed revisions from Tang and Chang (2010) who used a 6-point scale, and changed the anchors to "strongly disagree" to "strongly agree." Low scores are indicative of little to no perceived conflict in the expectations of one's job, whereas high scores reflect a perception of largely incompatible expectations between two or more aspects of one's job. The original scales consisted of 29 items total, and the adapted scale used in the current project contained 16 items (focused more on role conflict rather than role ambiguity, due to the relevance to the research questions). Thus, the possible range of scores was from 16 to 96. The

observed scores ranged between 26 and 80. The mean role conflict score was 52.4 with this sample (*SD* = 9.5). Additional summaries of the item responses is presented in Appendix F after the scale items.

Responses to the original role conflict and role ambiguity scales demonstrated Kuder-Richardson ratings of .82 and .78, respectively (Tang & Chang obtained α = .86 and .89 for the role ambiguity and role conflict scales, respectively), indicating reliable responses. The sample for the present study demonstrated similarly reliable responses, α = .80, 95% CI [.76, .83]. Rizzo and colleagues established evidence of construct validity through correlations with measures of need fulfillment, leader interactions with subordinates, and anxiety and propensity to leave the organization.

Job satisfaction scale. It was necessary to include a measure of job satisfaction to test predictions related to how a prison therapist's approach toward his or her work may associate with his or her contentment in work. The Minnesota Satisfaction Questionnaire (Weiss, Dawis, England, & Lofquist, 1967) Short-Form (Hirschfeld, 2000; Appendix G) was selected for this purpose. This is a 20-item scale that assesses workers' satisfaction about the nature of their work as well as aspects about the work environment that are unrelated to the work itself (e.g., "The way my co-workers get along with each other"). Based on past revisions to the scale, the 17-item version examined by Hirschfeld (2000) was selected for this research. The short form has been used widely in job satisfaction research (Spector, 1997), and responses correlate highly with those to the original form (*r* = .96; Hirschfeld, 2000). This study's responses appeared reliable, α = .88, 95% CI [.85, .90].

The job satisfaction measure has possible scores ranging from 17 to 85, where high scores indicate high satisfaction. The sample in this study had scores ranging from 29 to 84,

with a mean score of 57.8 (*SD* = 11.5). A summary of the items responses is presented after the scale items in Appendix G.

Working Alliance Inventory. To provide evidence of the PTOM's construct validity, and to further understand how perceived role conflict may influence a therapist's perceptions of his or her relationship quality with offenders, this study included an adapted version of the Working Alliance Inventory (see Horvath & Greenberg, 1986). This measure was constructed to assess the quality of the working relationship between a therapist and client. It includes items based on Bordin's (1979) model of the therapeutic alliance (discussed above), which involves dimensions of the therapeutic bond, therapeutic goals, and tasks in therapy.

Several versions of the scale exist. The present project utilized the short form version (Hatcher & Gillaspy, 2006; Appendix H) that is completed by the therapist. This version consists of 10 items that are answered on a 5-point Likert-type scale, where low scores indicate that the therapist perceives his or her relationship with the offender as discordant, detached, and even disrespectful; High scores indicate a perception of their relationship as congruous, cooperative, and mutually respectful. Because this study did not intend to match therapist responses with their clients' responses, the instructions asked the therapist to imagine that the items refer to a typical offender they might treat. The scale does not appear to have been used in this way previously, but it hypothetically provides a reasonable basis for a general sense of how the respondents view the quality of their relationships with offenders. Other scales have asked participants to think of their caseloads "on average" with good results (e.g., the revised Dual-Role Relationship Inventory; Skeem et al., 2007), so this is likely a reasonable approach to answer the research question. Hatcher and Gillaspy (2006) obtained high reliability coefficients (.88 with their first sample, and .92 with their second sample). This study's sample found similar

results, α = .90, 95% CI [.88, .92]. Hatcher and Gillaspy cross-validated responses to the short form version with those for the original, as well as other scales that examine the contributions of the therapist and client to the strategies and goals of therapy.

The Working Alliance Inventory has a range of possible scores between 10 and 50. The observed scores ranged between 16 and 49. The mean from this sample was 34.3 (*SD* = 6.5).

Vignettes. To explore how therapists' role orientations may influence their decisions, the survey materials included a pair of vignettes (Appendix I) that present realistic scenarios prison therapists may face in their work. The scenarios were constructed based on common duties in which mental health professionals are asked to take part. The first scenario is directly related to mental health, whereas the second is behavioral in nature, but mental health staff members are often involved. Accompanying each vignette were response options reflecting the different possible reactions that allow calculations of composite scores on two dimensions. One dimension was aimed at assessing the respondent's concern for security or symptom reduction (referred to as the Security scale), and the other was aimed at assessing the respondent's concern for the therapeutic alliance (referred to as the Alliance scale). In this case the two were not treated as mutually exclusive—a therapist could have demonstrated high likelihood to engage in the therapeutic alliance and measures of security (and/or symptom reduction), low likelihood to work towards either, or could have indicated different likelihoods of doing either. This was an important step to include in the study, as the PTOM assesses attitudes, but the vignettes assess what therapists believe they would actually do in the given situations.

Participants rated how likely they were to do each of the options given, on a scale from 1, "very unlikely" to 5, "very likely". The items corresponding to the therapeutic alliance were

then summed into a scale score (Alliance), as were the items corresponding to the safety, security, and stabilization emphasis (Stabilization).

In addition to the actions that were presented, both vignettes offered a free response item, where therapists could type in any additional actions they would take. For the first vignette, 73 therapists gave a free response; 50 gave a free response for the second vignette. Responses that simply clarified one of their previous responses or repeated one of the steps they already rated were removed. The remaining free responses were then independently coded by two trained raters on whether they reflected an action that was more related to the therapeutic alliance, or safety, security, and stabilization of symptoms. Raters could also conclude that the free response reflected neither role emphasis. For example, the first vignette describes an offender who expresses suicidal thoughts after learning his daughter has dropped out of high school (Appendix I). One respondent wrote in regards to this scenario, "I would ask him more about his own high school experience. I would ask him what he would hope his parents would do if he dropped out of high school…." Both raters agreed that this statement most reflects the therapist's concern for the offender as an individual, and fosters a cooperative and empathic relationship while working with the offender. Therefore, this free response appeared most related to the therapeutic alliance, and was coded as such. Another respondent wrote in regards to the same vignette, "Reassess in 24 hours, protective 'watch' cell w[ith] only mattress, safety smock or safety blanket, boxer/no t-shirt, and finger foods." Both raters agreed that this response was more focused on safety and security, and therefore this item was coded as such. Many free responses did not appear to clearly fit into either category. For example, one respondent wrote, "Contact the unit team to let them know about the offender's situation, my assessment, and my suggestions." Both raters found this statement to be unrelated to either the therapeutic alliance or the safety and security

emphases, and thus it was not coded. The interrater agreement for the free responses were κ = .92, and κ = .87 for the first and second vignettes, respectively, indicating high agreement. In cases where the two raters disagreed on how an item should be coded, the author assessed the free response item blind to the other scorers' ratings, and then coded it based on that rating. For the first vignette free responses, 27 therapists gave a response that was coded as focusing more on the security and stabilization role of prison therapy, and 21 therapists' responses were coded as focused more on elements of effective psychotherapy. For the second vignette, 11 therapists' responses were coded as leading more toward safety and security, whereas 23 gave responses that were coded as emphasizing the therapeutic relationship.

Both the Alliance and Stabilization scores for the first vignette had a minimum possible score of 4 and a maximum possible score of 20. The average Alliance score was 15.6 (*SD* = 1.9), and the average Stabilization score was 15.8 (*SD* = 2.2). For the second vignette, the minimum possible Alliance score was 4, with a maximum of 20, and the Stabilization score had a minimum possible of 5, with a maximum of 25. The average Alliance score was 14.3 (*SD* = 2.6), and the average Stabilization score was 18.0 (*SD* = 2.9). The free-responses were analyzed separately from the scores that were summed on the response scale.

Data preparation. After exclusion of the cases mentioned above, but before analyses, several steps were taken to ensure a complete and unbiased dataset. The data from the retained 237 response sets were first assessed for missing responses, as simply deleting cases with missing data may lead to biased conclusions (Rubin, 1987). In some cases, missing data could be accurately replaced by the researcher. For example, one respondent did not answer the item asking the sex of the offenders he or she treats, but this person did answer the name of his or her work facility in a later item. According the corresponding state's department of corrections

webpage, that facility serves only male offenders, thus the value regarding the sex of offenders for that respondent could be accurately entered. Similarly, the item with the most missing data (11.3%) asked the participants to specify whether they typically see offenders in group or individual therapy. Because all respondents had completed the section describing their most frequent work duties, including how much time they spend in individual or group therapy, these responses were used to determine the most appropriate value for the setting in which they typically treat offenders. After all steps could be taken to accurately enter such missing data, analyses showed that 79.51% of the remaining variables had at least one missing value, and 27.85% of all respondents had left at least one value unanswered. Overall, however, only 2.55% of the entire dataset was missing.

There was no discernable pattern to the missing data aside from there being more responses missing from items near the end of the survey. Little's (1988) test of data-missing-completely-at-random found that the pattern of missing data does not appear systematic, $\chi^2(4737) = 4853.62$, $p = .116$. These missing data were dealt with using multiple imputation methods (Rubin, 1987; Schafer, 1997), which replace missing values multiple times with values that are plausible based on probabilities taken from the completed data. These imputations are then pooled to provide a reasonable estimate of what the dataset would look like had there been no missing values.

Although the current recommendations are to make 20 imputations (e.g., Graham, Olchowski, & Gilreath, 2007), these were recommended for datasets with more than 10% missing data. Previous authors found little benefit to doing more than five, especially with datasets with relatively little missing data (Rubin, 1987; see also Schafer, 1999). Therefore, due to the low percentage of data missing overall in this dataset, only five imputations were made.

These were completed using the Markov chain Monte Carlo methods (Gilks, Richardson, & Spiegelhalter, 1996) available through IBM's (2012) SPSS version 21. These methods involve creating predictive distributions from the completed data, and then randomly drawing plausible entries to be imputed into the dataset. The multiple imputation method is a generally accepted method for handling missing data (Schafer, 1999). In general, there was little variation between the imputations in the results of analyses, and none of the conclusions made in this document would change based on the results of one imputation over another. Unless otherwise noted, all reported results are pooled from the imputations.

Results

There were two stages to this research: a pilot stage to test the measures and the web-based survey for unforeseen problems, and the main stage of the study after any necessary revisions to the survey materials. The pilot results and following revisions will first be described before the main stage of the research.

Pilot

Because the first aim of this project was the development of a novel psychological measure (the PTOM), it was necessary to first complete a pilot study of its performance. A sample of 24 prison therapists completed all survey materials in their entirety and successfully responded to an attention check. Several analyses were conducted to determine whether any revisions were appropriate. The first revision was to the PTOM—two items (10 and 15) contributed relatively low information about the respective attributes they were intended to assess (as indicated by their respective ratios of squared loading to unique variance; McDonald, 1999) and were revised to clarify wording. The items in Appendix D reflect only the revisions.

Also following the pilot study, the number of items included on the Attitudes Toward Prisoners scale (ATP) was reduced from 36 to 19. The primary purpose of this revision was to reduce the time the survey materials required to complete—the ATP was the longest of the measures in the survey. The 17 items that were removed were chosen due to their relatively low variance in responses. For example, the original item "In general, prisoners are basically bad people" received virtually uniform disagreement from the pilot sample, with a standard deviation of only .55 on the 1 to 5 scale. Each item from the ATP whose responses had standard deviations of .80 or below was not included in the abbreviated version for the main stage of the study (Appendix E). This criterion was chosen because the number of items that it would

actually exclude was not so low as to make the exclusion irrelevant, and not so high as to reduce the scale to too few items.

Following the pilot stage, the revised survey materials were distributed to a new sample of respondents. The remaining sections of this dissertation concern the results from only the new sample, described in the Participants section above.

Psychometric Properties of the PTOM

The analyses for the main stage of the project served three broad purposes reflecting the study's aims to (a) assess the PTOM's psychometric properties, (b) explore which therapist or facility characteristics explain the variation within PTOM scores, and (c) to assess how the PTOM relates to therapists' treatment decisions.

To address the first aim of this project, the psychometric properties of the measure of therapists' role emphases, several analyses were conducted. Following descriptive statistics for the responses, indices of reliability, factorability, and evidence of validity were all explored.

The mathematical midpoint of the PTOM is 60, whereas the observed mean of responses was approximately 54. This pattern indicates that respondents tended to lean toward the lower end of the scale, which reflects attitudes that emphasize treatment above security. However, the average responses to individual items offered more insight into how these therapists view their work. Each PTOM item was answered on a 1 to 7 scale (although the scale was displayed from "-3" to "+3"), and responses to each item covered the full range, except for item 2, whose responses ranged from 1 to 6. Responses were not normally distributed on several of the scale items. For example, the most common response to item 1 regarding whom should primarily benefit from prison therapy was "-2," reflecting a belief that prison therapy should primarily benefit the offenders, with only secondary benefit to the facility. Indeed, of the 237 respondents,

186 (78.5%) responded to that item with more agreement toward therapy benefiting the offenders than the facility (see Appendix D for remaining item response summaries).

Reliability. Two estimates of reliability were calculated: Cronbach's (1951) alpha (also see Peterson, 1994, for a discussion of the use of alpha with a semantic differential scale) and McDonald's (1999) omega. Alpha is a measure of the average inter-item association and, therefore, reliability. However, although alpha is one of the most commonly used estimates of reliability, it has faced much criticism for its shortcomings, such as its inflation with the addition of items (see Dunn & Baguley, 2014, for a review). Omega is becoming a popular alternative to alpha, as it appears to have several advantages (Dunn & Baguley, 2014). It has been described as an estimate of the general factor saturation of a test, which is another conceptualization of reliability (Zinbarg, Revelle, Yovel, & Li, 2005).

Using all completed responses on the PTOM for 15 items, the scale's alpha was .79, 95% CI [.75, .83], and its omega was .83. The alpha suggests a relatively high average inter-item correlation for PTOM items, and the omega suggests high factor saturation. These provide evidence that the respondents answered the measure in a reliable manner[13].

Regarding the hypothesized subscales, the therapists' attitudes about the purpose of prison therapy had an alpha of .55, 95% CI [.45, .63]. The subscale regarding therapists' views of the offenders had an alpha of .56, 95% CI [.46, .64]. Finally, the subscale addressing the level of emotional engagement with offenders had an alpha of .74, 95% CI [.68, .79]. Each subscale consists of five items, and all 237 participants' responses were included in these analyses.

[13] However, it must be noted that these estimates were based upon the entire dataset, whereas current recommendations are that reliability estimates be calculated at each level of clustering (Geldhof, Preacher, & Zyphur, 2014). Because there were no systematic effects of clustering found upon the PTOM scores (as will be discussed in following sections), reliability estimates were not thought to be different in the different clusters, but should be examined in the future.

Factor analysis. To examine the underlying factors the PTOM appears to assess, factor analysis methods were used. The scale was constructed around three themes, which were expected to correspond to underlying factors—how therapists view the aims of prison therapy (Aims subscale), view the offenders (Views subscale), and the level of emotional engagement they put into treatment (Emotion subscale).

Recommendations regarding sample size for factor analysis suggest that factor analysis is appropriate for this dataset, as the sample to item ratio was relatively high (237:15, or about 16:1; Costello & Osborne, 2005; also see MacCallum, Widaman, Zhang, & Hong, 1999; and MacCallum, Widaman, Preacher, & Hong, 2001). Bartlett's (1937) test of sphericity first demonstrated that the correlations between the scale items were significantly different from zero, $\chi^2(105, N = 237) = 872.95, p < .001$. This finding further indicates that factor analysis is appropriate for these data as some of the items appear to be meaningfully correlated with one another.

An exploratory factor analysis first offered some evidence of whether the hypothesized three-factor model was appropriate for these data. Kaiser's (1960) criterion for the number of factors (eigenvalues of 1 or higher) extracted five factors. With maximum likelihood extraction, these five factors explained a total of 41.78% of the variance in PTOM scores. As the factors were expected to correlate, the factor loadings were examined using direct oblimin rotation (Costello & Osborne, 2005). After rotation, one of the five factors had only one item that loaded at the criterion of .40 or above, and another of the factors had only two items loading at .40 or above, suggesting that these two factors were not well represented with the scale items. The items' loadings were generally grouped together as they had been intended for the three-factor

model, except for items 5 and 9, which each loaded primarily onto separate factors. The patterns of loadings for these two factors were below .40 for all other items.

Restricting the analysis to extracting only three factors with direct oblimin rotation, the model explained 46.87% of the variance in scores (an improvement upon the five-factor solution). The items loaded in the pattern that was expected (Figure 2) with the exception of items 5 and 9, which did not load as highly as expected on their intended factors. Item 5 addressed attitudes regarding how the prison environment may work against or with mental health treatment. Item 9 provided two items that explored how much the therapist thinks about offenders when not at work. Item 5 was intended to load on the factor regarding the therapist's views of the aims of prison therapy, and item 9 was designed to load onto the factor regarding the therapist's level of emotional engagement, however, both loaded slightly lower than the .32 criterion recommended by Tabachnick and Fidell (2001). Additionally, these items had the lowest information of the entire scale (.18 and .07, respectively), suggesting that they may not be adding much information to the measure, and were not well captured by the retained factors (see Discussion section).

As a final analysis of the appropriate number of factors to retain, a parallel analysis was done (Horn, 1965). This is a method of generating a random correlation matrix from the same number of observations and number of variables as the actual dataset, and producing eigenvalues from the randomly generated dataset (Patil, Singh, Mishra, & Donovan, 2008). The eigenvalues obtained from the actual dataset that exceed those generated with the random data are interpreted as meaningful, and thus the corresponding number of factors are retained. Eigenvalues were generated from a random data generator (Patil, Singh, Mishra, & Donovan, 2007), and compared

to the obtained eigenvalues from the participants' responses. This method concluded that 3 factors be retained. These analyses support the use of the three factor-model to explain the data.

Confirmatory factor analysis. Following the exploration of the scale factors, a confirmatory factor analysis was used to further examine whether the hypothesized three-factor model fit these data. Confirmatory factor analysis allows for more constraints to be placed on the model, in essence forcing the model to fit the theory (Jöreskog, 1967), and then several indices of the model's fit allow evaluation of whether the proposed model adequately reproduces the data. After setting the constraints for which items should load onto which factors (Figure 2), the confirmatory factor analysis found that each item loaded significantly onto its intended factor. The analysis also produced several indices of model fit. These indices each depend in part on the chi-square statistic. Due to the potential violation of normality in this dataset, the Satorra-Bentler scaled chi-square is reported rather than the conventional chi-square test of global fit. This statistic adjusts the chi-square and the estimate of its standard error based on a scaling factor of non-normality (Satorra & Bentler, 1994). The Satorra-Bentler scaled chi-square for this dataset was significant, χ^2 (87, N = 237) = 185.2, p < .001. Following recommendations of Hu and Bentler (1999), the standardized root mean squared residual (SRMR), comparative fit index (CFI), and root mean squared error of approximation (RMSEA) are also reported. Power analyses concluded that this study has .96, and .91 power for detecting an RMSEA of .08 and .01, respectively (using software from Preacher & Coffman, 2006). The results and comparative standards are presented in Table 3.

Although the Satorra-Bentler chi-square test for these data was statistically significant, it is well known that the size of the chi-square statistic can increase as a function of sample size (Kenny & McCoach, 2003). Additionally, the RMSEA was slightly larger than desired (.075,

Table 3

Model Fit Indices and Comparison Values

Model Fit Index	Good Fit	Obtained Fit
S-B χ^2	$p > .05$	$p < .001$
SRMR	$\leq .08$	.069
CFI	$\geq .90$	.931
RMSEA	$\leq .06$	.075

Note. Values were obtained using LISREL software (Jöreskog & Sörbom, 2013). Criteria for good fit were taken from Hu and Bentler (1999), and MacCallum, Browne, and Sugawara (1996).

90% CI [.061, .088]), but still falls within the acceptable limits of fit; MacCallum, Browne, and Sugawara (1996), recommend an RMSEA no larger than .08; still others suggest as high as .10 for the cutoff (Browne & Cudeck, 1993; see also Hooper, Coughlan, & Mullen, 2008). The RMSEA may also decrease with the addition of parameters to be estimated that add to the model and increase with the reduction of degrees of freedom in the model (Breivik & Olsson, 2001). The standardized root mean square residual (SRMR) is calculated by standardizing the difference between the observed correlation and predicted correlation. It is positively biased with datasets of small sample sizes and few degrees of freedom (Hooper et al., 2008). As such, it appears to be an appropriate index of model fit for this dataset, given the size of the sample. The comparative fit index (CFI) is calculated by subtracting the chi-square statistic (minus the model's degrees of freedom) of the proposed model from that of a hypothetical null model and then removing the effects of the null model. The remaining value is an index of the fit of the model to the data, where 1 indicates perfect fit and zero equals the worst possible fit. Hu and Bentler (1999) suggest that using joint criteria of CFI below .96 and SRMR above .09 for rejecting a model is most preferable for sample sizes below 250 (also see Sivo, Fan, Witta, &

Willse, 2006). Similarly, they recommend rejecting models that have both RMSEA above .06 and SRMR greater than .09 to reduce the chance of both Type I and II errors. As such, the proposed model appears to be a reasonable fit to the data.

In the confirmatory factor analysis, each of the item's factor loadings produced a Wald statistic that exceeded 1.96, indicating that each item's loading was statistically significant at least at the .05 level. However, five items had relatively low squared multiple correlations (items 5, 9, 12, 13, and 14 were below .10), indicating that less than 10% of the variance of each of these items was explained by its corresponding factor.

Because the PTOM's three factors were thought to estimate the underlying latent construct of a prison therapist's emphasis between rehabilitation and safety/security, the three-factor model was compared to a single-factor model. The three-factor model did significantly improve the CFI index of model fit (by .03), suggesting that the model fit of the three-factor model improvement is worth the cost in degrees of freedom (Cheung & Rensvold, 2002). The three-factor model is, therefore, retained. However, the hypothesized model structure included the latent higher-order factor of therapist orientation (Figure 2), which requires some consideration.

Dimensionality. As noted above, the PTOM was constructed to be a unidimensional measure of prison therapists' role orientation, and that dimension was thought to be composed of three factors. To assess the dimensionality of the PTOM, each of the factor correlations was calculated. The three PTOM factors were significantly correlated with one another, as indicated by the matrix produced by LISREL (Table 4). The scale scores corresponding to each of the factors were also significantly correlated (Table 4).

Table 4

Correlations of PTOM Factors and Corresponding Subscale Scores

Factor	Aims	Views
Aims	—	—
Views	.61 (.36)	—
Emotion	.63 (.44)	.99 (.53)

Note. All correlations from 237 pairs were significant at $p < .001$. Factor correlations are the main display, and correlations in parentheses are the subscale score correlations.

The higher-order factor model cannot be appropriately tested against the three-factor model regarding the model's fit, because the same number of parameters would be estimated between them, thus producing identical values for the model fit indices. In other words, both the three-factor and the higher-order factor models appear equally valid for these data. However, LISREL's exploration of the higher-order factor model demonstrated that each of the three lower-order factors had a significant loading onto the higher-order factor. Therefore, based on the model's theoretical structure, these scale correlations, and the factor loadings onto the higher-order factor of role orientation, the PTOM will be treated as a unidimensional measure, with some attention on the subscales that correspond to the 3 factors.

Validity. To examine whether participants' responses to the PTOM items followed what would be expected if it measured its intended construct, correlations between respondents' PTOM scores and their scores on the other measures included in the study were computed. PTOM scores were expected to correlate with measures of related constructs (convergent validity), but not with measures of constructs that should not be related. Specifically, the hypothesis was that the PTOM would correlate negatively with both the Attitudes Toward Prisoners scale (ATP) and the Working Alliance Inventory (WAI), and have no linear relationship with either the measure of role conflict or the job satisfaction items. In other words,

therapists who emphasize stabilization and security above rehabilitation (high PTOM scores) were expected to also have worse opinions of offenders (low ATP scores), and worse working relationships with offenders (low WAI scores). However, role conflict and job satisfaction were thought to be related more to other constructs than the emphasis orientation of the therapists.

Both the ATP and the WAI were negatively correlated with the PTOM; respectively with 237 participants, $r = -.55$, $p < .001$; and $r = -.37$, $p < .001$. These statistics suggest that the construct measured by the PTOM has some relation to the constructs of a prison therapist's views toward offenders and perceptions of the quality of their therapeutic relationships. As these constructs were hypothesized to be related to how a prison therapist emphasizes treatment needs and security needs, these analyses provide evidence that the construct measured by the PTOM is, at a minimum, related to the intended construct.

Properties of Included Scales

Attitudes Toward Prisoners. The arithmetic midpoint of the ATP (Melvin et al., 1985), as it was adapted to this research, is 57. The obtained mean of 62.9 indicates that this sample had generally positive attitudes toward offenders, one-sample $t(236) = 10.61$, $p < .001$, 95% CI of mean difference [4.77, 6.94], $d = .68$. However, there was heterogeneity in many item responses. Each item on the Attitudes Toward Prisoners scale (Melvin et al., 1985) received a full range of responses—the highest possible and lowest possible responses were endorsed at least once for each item. Perhaps not surprisingly given the sample, the item with the lowest variance was the item, "Trying to rehabilitate prisoners is a waste of time and money." All but seven of the respondents (97.0%) disagreed with this statement to some degree. A similarly one-sided response was found on item 5, which reads, "Prisoners have feelings like the rest of us." Only 8 (3.4%) therapists disagreed to some degree with that statement. The remaining items had

a larger spread of responses. Response summaries are included below the original scale in Appendix E.

Role conflict. The measure of role conflict (Rizzo et al., 1970; Tang & Chang, 2010) used in this research was adapted for prison therapists. The response scale has no midpoint, and thus respondents either disagreed or agreed with each item to some degree. The only items that did not receive the full range of responses were items 13 and 15. To test the hypothesis that therapists generally experience role conflict, the sample's scale scores were compared with the computed sum score had all responses been "somewhat disagree" (score = 48). That is, if each item had been responded to with "somewhat disagree," it would indicate that participants perceive relatively little role conflict, but not so little that they would "strongly disagree" with each item. Thus, this serves as a conservative criterion for assessing role conflict. The one-sample test was significant, $t(236) = 7.16$, $p < .001$, 95% CI for mean difference [3.20, 5.62], $d = .46$. The effect size index suggests that the therapists' mean role conflict score is nearly half of a standard deviation higher than the score we would expect if there was at least a minimal level of disagreement with the scale items (or agreement with the reverse-scored items). This is a medium effect, and using a more liberal criterion for role conflict would necessarily increase the size of the effect. To further illustrate the manner in which participants answered these items, response summaries are presented in Appendix F.

Working Alliance Inventory. Before completing the Working Alliance Inventory (Hatcher & Gillaspy, 2006; see also Horvath & Greenberg, 1986), participants were asked to indicate in which setting they usually treat offenders: group or individual therapy. One-hundred and forty (59.1%) therapists stated that they usually see offenders in an individual therapy setting, whereas 29 (12.2%) stated that they usually see offenders in group therapy. The

remaining 68 (28.7%) stated that they see offenders in both settings equally. There were no mean differences on the WAI scores depending upon which setting they typically see offenders, $F(2, 234) = .89$, $p = .41$.

The mean scaled score on the Working Alliance Inventory suggests that therapists in this study generally rate their therapeutic relationships with a "typical" offender as positive, cooperative, and respectful, although there was noteworthy variability. Each of the scale's 10 items received the full range of possible responses. Appendix H contains a summary of the responses, after the original scale.

Job satisfaction. The measure of job satisfaction (Weiss et al., 1967) had a minimum possible scale score of 17 (completely dissatisfied with job), and a maximum possible score of 85 (completely satisfied). The respondents' mean score was 57.8 (SD = 11.50) which, compared to the mathematical midpoint of 51 indicates relatively high job satisfaction, one-sample $t(236) = 9.16$, $p < .001$, $d = .59$, 95% CI for mean difference [5.37, 8.31]. Most of the aspects of the job received ratings reflecting satisfaction. However, a few items suggested areas of dissatisfaction. These are described further in the Discussion section below, and summaries of the responses are provided in Appendix G following the original measure.

It appears that the therapists as a group were more satisfied than not with most aspects of the work, and yet a few items indicate general dissatisfaction with how prison policies are implemented, the work load, and the opportunity for advancement. Other areas with relatively high dissatisfaction were perceptions of supervisors, recognition for doing good work, and the working conditions. Naturally, these elements vary according to the facility and, therefore, require additional analysis. These are described below.

Vignette responses. Responses to the vignettes generally were highly endorsed. Although each item received the full range of possible responses, nine of the 17 items had mean scores of 4 or above, suggesting that the therapists believed that they were at least "Somewhat likely" to do each of these actions. For example, virtually every therapist said he or she would be "very likely" to assess the offender from the first vignette for suicidality (M = 4.94; SD = .32). An initial factor analysis of the response options for the vignettes revealed that the items loaded in unexpected patterns regarding their intended factors of security- and therapeutic-alliance-related actions. This is perhaps due to therapists' likelihood to endorse certain elements of both relationship building and security. Because the loading patterns could not be easily interpreted in any way, assigning each response to its intended scale (Alliance or Security) appeared to be the most appropriate for this study's aims. However, the limitations of the vignettes and their responses are addressed in detail in the Discussion section below.

Independence of observations. As the participants in this research often share environments such as facilities and states, and because state policies and facility security levels share commonalities, it was necessary to determine whether these shared environments had a meaningful influence on PTOM scores. The therapists who completed the survey reported working at 104 distinct prison facilities throughout 12 states. As many as 19 responding therapists shared a prison complex, although the majority of respondents were the only clinician at their facility who completed the survey.

The custody levels of the prisoners are also generally sorted into three to four categories—low or minimum, medium, close, and maximum (although precise terms vary by state). Because offenders at these custody levels typically share characteristics such as history of institutional violence, seriousness of convictions, age, and so on (Champion, 1994), it appears

reasonable to suspect some similarities among offenders at the same custody level. As the therapists in this sample tended to work with offenders at one or few custody levels, there was reason to suspect similarities among therapists who work with offenders at the same custody level. One section of the survey materials asked therapists to estimate the proportions of offenders on their caseloads who are at each custody level. The average response was 25.6% (*SD* = 34.6) of their caseloads being under minimum restrictions, 32.6% (*SD* = 35.0) being at medium or moderate restrictions, 15.3% (*SD* = 27.9) at close or high restrictions, and 26.6% (*SD* = 38.5) at maximum or highest restrictions. Naturally, in many cases the facility an offender may be housed in is restricted by his or her custody level, and thus therapists tend to work primarily with one or two custody levels more than others. Therapists were therefore categorized according to the custody level with whom they primarily work.

Assessment of independence was completed using a three-level mixed linear model with clustered data (West, Welch, & Gałecki, 2007). The first level included characteristics of the therapist—sex, and their years of experience in corrections. The second level included covariates of the custody levels of the offenders with whom the therapists work—the average standardized scale score of risk that determines an offender's custody level within each state. Each state's custody assessment tool was reviewed for the scale score required for an offender to be placed at a certain custody level, and then the scores were standardized for comparison. These scores were then made the covariate of the custody level with which the therapists primarily work. The third level included a covariate of the states in which the therapists work—the percentage of the state's population that is incarcerated (U.S. Department of Justice, 2014a).

No centering technique was implemented for the covariates in the models, as each already had meaningful zero points, and the dummy-coded gender of the therapist would not

have had any influence on the significance tests had it been coded differently (e.g., effect coding; Enders & Tofighi, 2007).

Model comparisons. The first step of this multilevel model sought to assess for the random effects of the offender custody level on PTOM scores. Using SPSS (IBM, 2012), a model of PTOM scores with random intercepts for the states in which the therapists work and the custody levels within which they primarily work was compared to a model without the random intercepts for custody levels within states. The resulting chi-square statistic was not statistically significant, indicating that the nested random custody level effects within the initial model are not necessary to retain in the remaining comparisons, $\chi^2(1) = 2.27$, $p > .05$ (see West et al., 2007). The random effects associated with the states are retained in the remaining models as this reflects the hierarchical structure of the data in these models (West et al., 2007).

The second comparison was that of the model retaining only the random effects of the states to a model that included the fixed effects of the therapist-level covariates (sex and years of experience). The model comparison concluded that the fixed effects associated with the therapist covariates were not statistically significant: for years of experience, $t(237) = -0.42$, $p = .67$, 95% CI for mean difference [-0.24, -0.16]; for therapist sex, $t(237) = -0.30$, $p = .77$, 95% CI for mean difference [-3.46, 2.54]. In other words, the fixed effects of the therapists' sex and years of experience do not appear to explain a meaningful amount of variance at the therapist level. These effects are not retained for the model.

The next comparison added the offenders' custody level covariate (mean standardized risk score) to the model, and compared it to the model that included only the random effects associated with the states, as that was still the preferred model. Results suggest that the mean risk score's fixed effects were not statistically significant, $t(235) = 1.01$, $p = .32$, 95% CI for

mean difference [-.09, .29]. It appears that mean risk score of the offenders with whom the therapist works does not account for variation in PTOM scores.

The final model comparison was between the model containing only the random effects associated with the therapists' states, and a model including the fixed effects of the state covariate—the proportion of the state's residents that is imprisoned inside the state correctional facilities. The results suggest that there was no meaningful influence of the fixed effects of the state, $t(235) = .64$, $p = .53$, 95% CI for the mean difference [-6.24, 12.19]. According to these model comparisons, therapists' increases in PTOM scores do not appear to be meaningfully related to their sex, years of experience, the custody level of the offenders they treat, or the state within which they work. In other words, the PTOM score intercepts and slope do not appear to differ according to offender custody level or the state in which the therapist works. These analyses suggest that the nested variables do not have a systematic influence on a therapist's PTOM scores. The remaining analyses were carried out accordingly.

Accounting for Variance in Role Emphasis Scores

The second broad aim of this research was to explore how role emphasis may be related to characteristics of the therapist or the facility in which the therapist works. Several variables were assessed for their influence on role emphasis.

State and role emphasis. Idiosyncrasies of each state may have influenced how the therapists perceive their roles, therefore, an examination of whether PTOM scores differed by state of employment was conducted. PTOM means from each state were compared. These scores ranged between 50.2 and 58.8. An analysis of variance indicated no meaningful differences in PTOM scores based on the state in which the therapist works, $F(11, 225) = .44$, $p = .94$. However, because some states had far too few participants to be appropriately compared

to the others, states were combined into regions of the United States; the South, West Coast, Eastern states, and the West (based on Cullen et al., 1993). Again, no meaningful differences in PTOM scores were found between the regions, $F(3, 233) = .29$, $p = .83$.

Employer and role emphasis. In line with statements from Weinberger and Screenivasan (1994; also see Bonner and Vandecreek, 2006) suggesting that ethical dilemmas would be less prevalent for clinicians if they were more independent of prison policies, one hypothesis was that psychotherapists who are contracted through other companies to do treatment would experience less role conflict, higher job satisfaction, and have role orientations generally directed more toward rehabilitation and therapeutic elements than security elements. These hypotheses were examined by first using an independent samples *t* test of the mean PTOM scale scores between the contracted therapists and those employed by a department of corrections.

The test found that PTOM scores did not differ between the groups, $t(231) = -.75$, $p = .46$, 95% CI for mean difference [-.4.77, 2.18]. These analyses found no evidence to support the hypothesis that being contracted to do prison therapy would lead to different role perceptions or emphases than being employed by a department of corrections. There were also no differences between contracted workers and employees on attitudes toward prisoners, $t(231) = .25$, $p = .80$; role conflict, $t(231) = .98$, $p = .33$; working alliance, $t(231) = -.82$, $p = .42$; or job satisfaction, $t(231) = .-.96$, $p = .42$.

Security level, custody level, and role emphasis. Role emphasis scores were expected to differ based on the security level of the facility where the therapist works; specifically, higher security levels were expected to associate with more emphasis on security and safety than the therapeutic alliance and rehabilitation. Additionally, as each offender is placed at a certain level

of personal restriction based on his or her behavior and risk characteristics, the average custody level of a therapist's caseload was thought to also have some bearing on his or her role emphasis—offenders at higher restrictions were thought to associate with therapist role emphasis on security and safety.

The mean PTOM scores based on security level ranged between 50.1 and 55.7. An analysis of variance found that the means between these security levels differed, $F(3, 233) = 3.0$, $p = .03$, $\eta = .20$, but the mean difference was significant only between the maximum security therapists ($M = 55.7$, $SD = 11.7$) and the therapists at mixed security levels ($M = 50.1$, $SD = 9.6$), *HSD* mean difference = 5.6, $p = .02$, 95% CI for mean difference [.70, 10.6]. Because the mixed-security levels contain maximum security sections, this finding is difficult to interpret. Security level will be explored further in regression analyses when including additional predictors.

Using these categories of offender custody levels presented above (Participants section), the PTOM means ranged between 53.5 and 56.0. Mean comparisons found no differences based on offender custody level, $F(3, 175) = .43$, $p = .73$. Offender custody level was, therefore, not included in any further analyses as a possible predictor of PTOM scores.

Theoretical orientation and role emphasis. It was hypothesized that a therapist's theoretical orientation would relate to his or her PTOM scores. Specifically, therapists endorsing a behavioral, cognitive-behavioral, or gestalt orientation toward psychotherapy were expected to have generally higher PTOM scores, indicating less emphasis on the therapeutic alliance and more emphasis toward security and stabilization measures. There were diverse responses regarding theoretical orientations, but a clear pattern emerged; the most common orientation endorsed was cognitive-behavioral, followed by an eclectic approach. Each of the remaining

orientation options was endorsed at least twice (Table 5). Due to the relative infrequency of most of the remaining orientations, those who endorsed behavioral orientations were combined with those who endorsed cognitive-behavioral orientations, and were then compared to therapists endorsing an eclectic approach. An independent samples *t* test found no meaningful difference between the orientations' mean PTOM scores, $t(205) = 1.60$, $p = .11$, 95% CI for mean difference [-.56, 5.57].

Table 5

Respondents' Theoretical Orientations and Mean Emphasis Scores (PTOM)

		PTOM Score	
Orientation	***n* (% of Total)**	**Mean**	***SD***
Cognitive-Behavioral	95 (40.1)	55.2	11.8
Eclectic	92 (38.8)	52.6	10.4
Dialectical Behavior	12 (5.1)	57.1	7.3
Other	8 (3.4)	49.1	7.3
Behavioral	6 (2.5)	55.8	10.4
Motivational Interviewing	6 (2.5)	54.5	18.5
Client-Centered	4 (1.7)	47.8	1.5
Psychoanalytic	4 (1.7)	46.8	5.9
Group Therapy	3 (1.3)	56.7	13.2
Undecided	3 (1.3)	62.7	3.1
Existential	2 (0.8)	62.0	11.3
Gestalt	2 (0.8)	53.0	1.4

Specialized caseloads and role emphasis. Among the hypotheses relating to the PTOM was that the types of offenders on a therapist's caseload may have an influence on his or her relative role emphases. Specifically, the hypothesis was that therapists working primarily with sex offenders and offenders with personality disorders would have PTOM scores reflecting a stabilization emphasis, due to the difficult nature of these populations. No other specializations were expected to differ from one another in the therapist's PTOM scores.

Nearly three quarters of respondents (n = 174, 73.4%) reported no specializations on their caseloads. The remaining therapists stated that their caseloads are specialized (Table 6). To evaluate the hypothesis, therapists who treat primarily sex offenders or offenders with personality disorders were combined into a single group and their PTOM score mean was compared to that of therapists without specialized caseloads. No significant difference in PTOM scores was found, $t(203) = .03$, $p = .98$, 95% CI for mean difference [-4.1, 4.2]. There appears to be no difference in role emphases based on caseload specialization within this sample.

Table 6

Specialized Caseloads by Mean Role Emphasis (PTOM) Score

		PTOM Score	
Specialization	***n* (% of Total)**	**Mean**	***SD***
None	174 (73.4)	54.1	10.8
Sex Offenders	19 (8.0)	52.8	9.3
Psychotic Disorders	15 (6.3)	52.7	11.2
Personality Disorders	12 (5.1)	56.2	13.5
Substance Abuse	8 (3.4)	55.6	16.6
Mood Disorders	7 (3.0)	52.7	7.7
Intellectual Disabilities	1 (0.4)	57.0	—
Other – Trauma and Substance Abuse	1 (0.4)	35.0	—

Additional predictors of role emphasis. The scale PTOM score was separately regressed on several variables in order to discover what accounts for the most variance in therapist role emphasis. A series of hierarchical linear regressions was conducted to assess whether demographic and education variables accounted for a significant amount of variance in subscale scores, before examining the variables of interest. In the first block, the PTOM scale score was regressed on therapist's gender (dummy coded), race (dummy coded), and age. The second block included the therapist's college major (dummy coded), level of education, and

licensure status. Neither block accounted for a significant amount of variance in the PTOM, as was predicted; for the first block, $F(4, 227) = 1.14$, $p = .35$; for the second block, $\Delta F(4, 223) = .62$, $p = .65$. A third block added to the model a therapist's years of experience working in corrections, security level of the facility, whether they are employed by a department of corrections or contracted through another institution, and the sex of the offenders with whom therapists primarily work (dummy coded). The addition of these variables did account for a significant change in the R^2 statistic, meaning that the best linear combination of these variables accounts for a meaningful amount of variance (in addition to the first two blocks) in PTOM scores, $\Delta F(4, 219) = 3.37$, $p = .01$. Although the combination of these variables was significant, virtually all of the variance within the third block of the analysis was attributable to the sex of the offenders, and was therefore further explored independently of the other predictors. Age of the therapist approached significance in the third block, and was also assessed further independently (see below).

Sex of offenders predicts PTOM scores. An analysis of variance found that mean scores on the PTOM did differ according to the sex of the offenders that the therapists primarily treat, $F(2, 234) = 6.23$, $p = .002$, $\eta = .05$. Tukey's post hoc tests indicated that prison therapists who treat female offenders primarily ($n = 27$) had significantly lower PTOM scores ($M = 47.5$, $SD = 12.3$) than did therapists who treat male offenders primarily ($n = 200$; $M = 54.9$, $SD = 10.5$), $p = .001$, 95% CI for mean difference [-12.5, -2.36]. Neither group was significantly different from the prison therapists who treat both males and females in equal rates ($n = 7$; $M = 51.0$, $SD = 8.9$). This relationship supports the hypothesis that the sex of the offenders a therapist treats would have an effect on his or her role emphasis.

This relationship was further examined to determine if it were specific to male or female therapists. The relationship was found only among the female therapists, $F(2, 147) = 5.72$, $p = .004$, $\eta = .27$; those who treat male offenders primarily ($n = 130$) had higher PTOM scores ($M = 55.32$, $SD = 10.94$) than did those who treat female offenders primarily ($n = 17$; $M = 46.2$, $SD = 9.43$), 95% CI for the mean difference [.26, 15.6]. These PTOM means were not different from the female therapists' who treat male and female offenders with equal frequency (though there were only five in the sample). No difference was found among male therapists' PTOM scores by their clientele's sex, $F(2, 79) = .96$, $p = .39$, but this must be interpreted with some caution as only 11 male therapists reported primarily treating female offenders, compared to the 71 who primarily treat male offenders. It appears that female therapists who work primarily with female offenders tend to have role emphases that are aimed more at the rehabilitative aims of therapy than are the female therapists who work primarily with male offenders.

Relating to the hypotheses, these analyses support the hypothesis that race, age, gender, education level, major, and licensure would not be related to a therapist's PTOM scores. However, the regression did not support the hypothesis that PTOM scores would be related to a therapist's years of experience, the security level of the facility, and whether the therapist was contracted or employed by the department of corrections. The hypothesis regarding offenders' sex having an effect on role emphases was supported, but only for female therapists. Male therapists do not appear to differ in role emphasis based on the sex of the offenders they treat.

Age and role emphasis. Although a therapist's age trended toward significance in the regression analysis, further examination found that the correlation between age and PTOM scores was weak, and not quite significant at the conventional level, $r(N = 237) = -.12$, $p = .09$. Age was not included in any further analyses of the PTOM scale scores.

Years of experience and role emphasis. Because the therapists' years of experience were relatively low, and because people adapt to their positions differently, it was possible that a curvilinear relationship existed between role emphasis and PTOM scores—for example, the tendency toward balance may exist only for therapists with more than 5 years of experience. To assess for this possibility, a scatterplot between the two variables was generated to visually inspect their relationship (Figure 4). There is no discernable pattern to the scatterplot that would suggest a curvilinear relationship. Additionally, a Pearson correlation between the two variables found no covariation, $r(N = 237) = -.03$, $p = .62$. Based on these results, there does not appear to be a relationship between the therapist's corrections experience and his or her role emphasis.

Figure 4. Scatterplot of therapists' years of experience and role emphasis scores.

Predicting Therapeutic Alliance

It was hypothesized that the PTOM would relate to the importance of the therapeutic alliance to a therapist, and that other characteristics of the therapist would not. Specifically, past

research suggests that the therapists' sex, race, education level, college major, and years of experience should have no substantial bearing on the quality of therapy (Luborsky et al., 2002; Seligman, 1995; Wampold, 2007). The Working Alliance Inventory is a measure of the quality of therapy, and was therefore treated as an estimate of the therapists' perceptions of their therapeutic alliance with the typical offender. The WAI scores were regressed on the abovementioned characteristics of the facility and therapist in a hierarchical regression, with the PTOM scale scores then being added in the second block. Results indicate that, as predicted, the demographic variables did not account for a significant amount of variation in the WAI scores, but the PTOM did (Table 7).

The regression suggests that the facility and therapist characteristics predict only 3% of variation in the Working Alliance Inventory scores, but that the addition of the PTOM to the model accounts for an additional 12% of the variance. The first model's predictive ability is negligible and likely to be due to chance, but the second model's predictive ability is unlikely to be due to chance. The analysis found that for each point increase in the Working Alliance Inventory scale score, there was about one fifth of a point drop in PTOM score; that is, as a therapist's perception of the quality of his or her relationships with the typical offender improved, he or she also reported emphasizing the rehabilitative role of the work over the security elements of the role.

Because it was thought likely that the therapeutic relationship would be affected by the restrictions of the prison environment, the Working Alliance Inventory scores were regressed on both the PTOM scores with the role conflict measure to determine which better accounted for a therapist's perceptions of the relationship quality with offenders. Both predictors together accounted for a significant amount of variance in the WAI, $\Delta F(2, 234) = 22.9$, $p < .001$.

Table 7

Hierarchical Regression Results Predicting Working Alliance Inventory

	Model 1			Model 2		
Variable	***b***	***SE B***	**β**	***b***	***SE B***	**β**
Therapist sex	-1.22	.95	-.09	-1.39	.89	-.09
Race						
African American	2.80	2.63	.10	1.11	2.53	.05
European American	2.75	1.86	.15	1.53	1.75	.08
Latino	1.98	2.09	.07	1.23	1.96	.05
Education Level	0.53	2.15	.03	.02	.91	.01
College Major						
Psychology	.01	2.15	.01	.80	2.02	.05
Counseling	.92	2.21	.07	1.17	2.08	.07
Social work	-.47	2.22	-.02	.12	2.08	.01
Experience	.04	.06	.04	.03	.06	.03
PTOM	—	—	—	-.22	.04	-.36
R^2		.03			.15	
ΔF in R^2		.74			33.36*	

Note. Therapist sex, race, and college major were dummy coded.
*$p < .001$.

The adjusted R^2 statistic was .16, indicating that the two predictors together explain about 16% of the variance in the working alliance inventory. When examined individually, the PTOM scores explain more variance in the WAI than do the role conflict scores (Table 8)

Table 8

Regression Predicting Therapeutic Relationship From Role Conflict and Emphasis

Predictor	***b***	***SE***	**β**	***t***	**95% CI**	***p***
Role Conflict	-.12	.04	-.17	-2.80	-.20, -.03	= .007
Role Emphasis (PTOM)	-.23	.04	-.38	-6.39	-.30, -.16	< .001

For every 1-point increase on the role conflict measure, there is a predicted decrease of .12 points on the Working Alliance Inventory scale. The predicted decrease is nearly double

when predicting from the PTOM. In other words, more role conflict combined with role emphases that are focused on safety, security, and stabilization, are associated with therapeutic relationships that are less respectful, less cooperative, and less collaborative.

Predicting Other Constructs

Predicting role conflict. One of the hypothesized relationships was that prison therapists who are relatively new to the position would experience higher role conflict than more experienced therapists. A Pearson correlation indicated a weak, but statistically significant negative association between a therapist's years of experience within corrections and his or her perceived role conflict, $r(N = 237) = -.15$, $p = .02$. That is, with more time spent within corrections, perception of role conflict appears to decline slightly. However, because the years of experience data were positively skewed, and it cannot be stated which variable influences the other, this finding must be interpreted with some caution (see Discussion section).

Role orientation and role conflict. Role conflict was hypothesized to have a nonlinear relationship to role orientation. To examine this, PTOM scores were first regressed on role conflict scores, and then upon the role conflict scores squared (representing the nonlinear effect) in a hierarchical regression. The first step of the regression was not quite significant, $F(2, 225) = 3.79$, $p = .053$. Adding the nonlinear effect of role conflict in the second step did not produce a significant change in the statistic, $\Delta F(1, 224) = 2.04$, $p = .15$. Additionally, a scatterplot of the two variables was observed with no discernable pattern. These results suggest that, although there may be a trend in the relationship between role orientation and role conflict, the difference may be due to chance, and there is no reason to believe that the relationship, if any, is nonlinear.

Predicting job satisfaction. It was hypothesized that higher role conflict would associate with lower job satisfaction. A Pearson correlation supports this, $r(N = 237) = -.49$, $p <$

.001. It appears that as a therapist's perception of role conflict increases, his or her satisfaction with the position decreases.

Other facility and therapist characteristics that might reasonably influence one's satisfaction with his or her job were explored to determine which may explain the variation within job satisfaction scores. Specifically, the security level of the facility, the years of experience within corrections, the average hours per day spent with offenders, the custody level of the offenders with whom they work, and the percentage of time spent doing paperwork were all thought to have some influence upon job satisfaction. Because role conflict was correlated with job satisfaction, these other variables were entered into a hierarchical linear regression model after role conflict to determine whether they accounted for a significant amount of additional variance in job satisfaction scores. The regression indicated no significant change in the F statistic with the addition of the second block of variables[14], ΔF (5, 178) = 1.52, p = .19. The best predictor of a therapist's level of job satisfaction appears to be his or her perceived role conflict. With each 1-point increase in the role conflict measure, there was a decrease of .6 points in the job satisfaction measure, SE = .07, β = -.50, p < .001, 95% CI for b [-.75, -.47].

Role orientation and job satisfaction. One of the hypotheses was that PTOM scores would have a nonlinear relationship with job satisfaction, and that it would possibly be moderated by role conflict. To explore a nonlinear relationship between a therapist's role orientation and job satisfaction, the same methods in the exploration of role orientation were used with role conflict. The first step in the linear regression found a nonsignificant effect of job satisfaction on role orientation, F(1, 235) = 0.11, p = .77. Adding the nonlinear effect of job

[14] This regression included fewer than 237 individuals because responses to the percentage of time spent doing paperwork were not imputed.

satisfaction into the model resulted in a nonsignificant change, $\Delta F(1, 234) = .02$, $p = .90$. Additionally, a visual inspection of a scatterplot found no discernable pattern. There was no apparent relationship between role orientation and job satisfaction. As this is also the first step in a test for moderation, and it was nonsignificant, there is no reason to continue to test for moderation.

Predicting Actions in Treatment

To assess the utility of the PTOM and its subscales in predicting the actions that prison therapists are likely to take during their work, scale scores were first calculated for the Alliance and Security scales from the vignette responses (see Materials). These scale scores were then each individually regressed on the facility security level and years of experience in corrections in a first model, and then the PTOM scores were entered. The PTOM did not explain a significant amount of variance in either the Alliance or Security scales, nor did any of the PTOM's subscales.

Because the two vignettes differed in the nature of the scenario, some comparisons were made between therapists' Alliance and Security scale scores for the individual scenarios. Paired samples *t* tests indicated that therapists' responses to the second vignette were significantly different from their responses to the first vignette on both their Alliance and Security scores. Specifically, therapists had significantly higher Security ratings on the second vignette than the first, $t(236) = -11.87$, $p < .001$, 95% CI for the difference [-2.56, -1.83], $r = .61$. They also had significantly lower Alliance scores on the second vignette than the first, $t(236) = 7.89$, $p < .001$, 95% CI for the difference [1.00, 1.67], $r = .46$. The first vignette relates a scenario of an offender who is reportedly suicidal after learning of a troubling family event, whereas the second vignette involves behavior that is destructive and potentially dangerous. These findings suggest

that therapists were less concerned with the therapeutic alliance in the scenario with destruction of property, and more concerned with security and safety measures.

Regressing PTOM subscale scores on the Alliance and Security scales separated by vignette offered some insight into what may be important about the approach. Results found that none of the subscales predicted a significant amount of variance on the Security scale for either vignette, but the Emotional Engagement subscale of the PTOM predicted a small but statistically significant amount of variance in the Alliance score for the first vignette, b = -.08, SE = .03, β = -.23, p = .006, 95% CI for b [-.13, -.02]. This pattern was not seen for the second vignette. It appears that in the scenario where the offender had no behavioral disruption, as a therapist's self-rated level of emotional engagement decreased by a single point (reflecting more emphasis on emotional engagement), his or her likelihood of acting in a manner emphasizing the therapeutic alliance increased by a fraction of a point for a scenario without a behavioral issue. This finding was unlikely to be due to chance, but with such a small change in score based on the vignette, its utility is limited. It will be further addressed in the Discussion section.

In addition to the analyses using the quantified data from the vignette responses, the coded free-response answers were entered into separate logistic regressions. The regressions assessed whether the type of role emphasis indicated in the free-response to a vignette could be predicted by the therapists' PTOM subscale scores with any accuracy. None of the PTOM subscale scores was able to predict the therapists' free-responses to the first vignette (the subscale scores were able to correctly predict only 68.8% of the free-responses from 48 participants), but the Aims subscale was able to predict the free-response type for the second vignette, b = -.53, SE = .20, β = -.59, p = .006, 95% CI for β [.40, .86]. It appears that, in response to the scenario involving an offender destroying his television set and then refusing to

comply with restraining procedures, therapists who believe that the purpose of prison therapy is more for the benefit of the offenders than the institution were more likely to respond with an action that would build the therapeutic alliance with the offender. This finding was unlikely to be due to chance, and using the PTOM subscale scores combined correctly predicted the free responses 79.4% of the time (p = .005). However, it should be noted that only 34 participants gave a response that could be categorized for the second vignette.

Qualitative Data

The final section of the survey materials included a free response item asking for any comments about the respondents' answers. Many participants left comments regarding how they interpreted certain sections of the survey, or clarifying responses, as the section was intended. However, many respondents used this item to offer insights about their position, and some were relevant to this project's overarching topics. As there appeared to be emerging themes from these comments, selections are presented in Appendix J with discussion.

Discussion

This research was the first to empirically and quantitatively examine how psychotherapists who work in prison facilities view and approach their work. Given the primarily interpersonal and emotionally engaged methods of most psychotherapies, as well as the overarching aims of psychotherapy, there is reason to suspect that prison therapists face many challenges in doing their work inside institutions that are designed to be emotionally cold, deterring, and highly controlling. The aims of this research were to (a) develop a psychometrically sound tool to assess how psychotherapists approach their work, (b) account for the variance in the scores on that instrument, and (c) determine the utility of the tool in predicting actions that the therapists believe they would take in two realistic scenarios. After addressing the limitations of this research, each of these aims will be further discussed regarding what conclusions may be drawn, their implications for correctional mental health work, and directions for future research.

Limitations

As with any research, this project has limitations to its generalizability and conclusions. First, because the survey materials were completed on a voluntary basis, it is possible that the therapists who completed the materials systematically differ from those therapists who did not complete the survey (e.g., larger workloads, different duties). All ranges of attitudes appear to be represented within these data, however, whether this sample truly represents correctional therapists cannot be said with certainty.

Similarly, this research surveyed only therapists who work in adult prisons. These findings may not be applicable to therapists who work in other corrections environments such as

jails, involuntary psychiatric hospitals, or juvenile facilities, where the treatment populations and the facilities' purposes differ.

Furthermore, this sample consisted of relatively inexperienced psychotherapists, thus it cannot be known if those therapists who completed the survey tended to have less experience in corrections than those who did not respond to the survey. For example, it may be that more-experienced therapists are more likely to leave the position, which likely relates to job satisfaction and perceptions of role conflict. No association was found between a therapist's years of experience and his or her role emphases or job satisfaction within this sample, which may indicate that there was no systematic bias with the relatively inexperienced therapists. Additionally, the sample included many therapists with more than 10 years of experience, and there was no evidence of bias in their role emphasis or job satisfaction scores.

Another notable limitation is in the comparability of states and facilities. This sample included therapists from several states and more than 100 facilities throughout the nation. Each state and facility has unique policies and practices that may not be appropriate to compare with others. Indeed, other research suggests that even wardens' emphases regarding their correctional orientation are somewhat influenced by organizational variables such as the geographical location of the facility, the sex of the offenders housed in the facility, and some others (Cullen et al., 1993). No geographically based differences in attitudes were found in this research, but issues such as the proportion of state funding set aside for prisons or mental health treatment within prisons may be important. There may also be many idiosyncrasies of each facility that could not be taken into account for this research[15]. However, because there was fairly even

[15] For example, the author worked for a time in a medium/high security facility where the offenders' cells had no air conditioning, and they were confined to their cells for approximately 20 hours per day. It is conceivable that such a

representation of security levels among these facilities and custody levels of the offenders, these characteristics unique to the facility and offenders' custody levels should not have systematically influenced therapist's responses.

On a similar note, the confirmatory factor analyses in this research were done without regard to the clustered nature of the data. This is generally discouraged as it may lead to increased values for the badness of model fit indices (Pornprasertmanit, Lee, & Preacher, 2014). Although this is an important issue to consider for future analyses of the PTOM, there were no effects of clustering found in these data, thus it is suspected that the conclusions from the confirmatory factor analyses presented above are valid.

Finally, the Working Alliance Inventory (WAI) was completed by only the therapists, when forms are ideally completed by both the therapist and the client to assess agreement. Given past research suggesting that offenders have generally distrustful views of mental health personnel (Howerton et al., 2007), and that therapists and clients tend to have different views of what elements of the therapeutic alliance are important (Bachelor, 2013), it may be that had offenders completed a version of the WAI, they would have disagreed with the therapists' perceptions of their relationships.

With these limitations noted, the results of this research must be interpreted with some caution. Replication and further examination of the topic are necessary for continued understanding of how the constructs of interest influence one another. Below, the major findings of this research will be interpreted and their implications discussed, after which some secondary findings and future directions will be detailed.

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fact would affect offender behavior and, therefore, therapist perceptions of offenders during at least the summer months.

Prison Therapist Orientation Measure

The first aim of this project was to create a self-report measure of a prison psychotherapist's perceptions of his or her balance of therapeutic emphasis with safety, security, and symptom stabilization emphasis. In brief, the PTOM appears to have acceptable psychometric properties as a general assessment tool of prison therapists' role emphases, but it has room for improvement in its future use[16].

Its limitations notwithstanding, the overall scale score appears to be an appropriate reference of a prison therapist's general orientation toward his or her role ($\omega = .83$). The PTOM scale score likely reflects the actual construct of a therapist's role emphases. Future research may further consider whether the PTOM should be considered as only a measure of a single factor, however the analyses used here found that the three-factor model was more appropriate than a single-factor model (as indicated by the change in fit indices). Barring sufficient evidence to the contrary, the hypothesized model structure appears appropriate.

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[16] Specifically, items 5 and 9 were not well captured by their corresponding factors. Item 5 was intended to load onto the factor regarding therapists' perceptions of the purpose of prison therapy, but may have been assessing some other factor such as how the prison environment may influence the therapeutic process. Revising the statements to "Mental health treatment in prison should focus on offenders' strengths, with little attention on past mistakes" and "Mental health treatment in prison should focus on the thoughts and behaviors that got offenders in trouble so that they know what needs to change" may better capture respondents' perceptions of the purpose of therapy in the prison environment than item 5 does as it is currently written.

For item 9 the majority of respondents agreed more with the statement "It is easy for me to leave my work at work," than the statement "I sometimes think about how offenders are doing when I'm not at work." This item was intended to load onto the factor regarding a therapist's level of emotional engagement in treatment, but showed the opposite pattern from the other items on this subscale. This suggests that prison therapists perceive themselves as generally caring about the offenders with whom they work, and working toward having good relationships with them, but emotional engagement may be independent of emotional involvement. Skilled therapists must have the ability to be present and focused on treatment during sessions, but to avoid over-involvement in a client's situation and progress, lest they risk burnout (Lee, Lim, Yang, & Lee, 2011). It may be that this item is indicative of this sample's ability to avoid over-involvement, or may be capturing a factor such as a therapist's level of work involvement or work centrality (Paullay, Alliger, & Stone-Romero, 1994), attachment, or burnout, rather than emotional engagement. For the item to better capture its intended factor, perhaps the statements should be excluded or revised to read "A prison therapist must be invested in offenders' rehabilitation," and "A prison therapist can be effective simply by modeling prosocial behavior and teaching new skills."

Use of the Prison Therapist Orientation Measure. Although the measure may benefit from more refinement, the current version of the Prison Therapist Orientation Measure (PTOM), at a minimum, allows a quick assessment of a prison therapist's priorities in mental health treatment. Used as such, it may be a valuable tool for corrections departments and contracted companies during hiring. Although no recommendations for cutoff scores are yet established (as the most effective role emphases are unknown at this time), the PTOM items provide a useful reference point for employers to begin a dialogue with applicants about what may appear to be divergent aims of the position. Applicants may complete the PTOM as part of the application process, and at some point during or after the hiring process may use the responses to introduce how each facility operates regarding mental health issues, and provide guidance as to how to balance the issues addressed in the measure.

Furthermore, an immediate application for correctional institutions is in surveying current psychotherapists with the PTOM to assess the staff's attitudes toward the aims of treatment and security. Administrators and mental health supervisors may then identify areas where they believe the staff could benefit from trainings on these issues. Holding trainings on how to balance the roles may provide much-needed discussion about where mental health fits in to the overall mission of corrections within each specific facility.

Therapists Differ in What Role They Emphasize

The fact that therapists emphasize the aims of correctional therapy differently is perhaps the most important finding of this research. Many therapists emphasize security demands over therapeutic needs or vice versa, and the majority report a balance of the two. Although this study was unable to describe precise differences in how therapists with these differing emphases are likely to respond to crisis scenarios, other evidence suggests that therapists who see treatment as

a largely verbal and less emotional interchange are also less effective (Lafferty, 1987). Indeed, as this study found that the quality of the therapeutic relationship was meaningfully associated with role emphases, it is likely that therapists who are less emotionally engaged, have more negative views of offenders, and view their purpose as largely that of stabilization also have lower quality relationships with the offenders they treat. Whether the lower quality relationships are also associated with worse outcomes is not yet clear, but appears likely given the past research on the necessity of warm, cooperative, and respectful relationships with clients in therapy, and with offenders in general (Blatt et al., 1996; Dowden & Andrews, 2004; McCabe & Priebe, 2004). In a typical therapeutic scenario within a prison (i.e., not a crisis situation), an offender may be less likely to share emotions such as guilt or distress with a therapist who forecasts less emotional engagement. Therefore, emotionally disengaged therapists may miss opportunities to demonstrate prosocial skills such as active listening and validation, appropriate empathy, and then to process those emotions and help the offender to better cope or to resolve to do better. The role emphases of therapists, therefore, are likely important elements that may affect treatment quality. Further research into how role emphases are related to the quality of treatment is necessary and important.

Predictors and Covariates of Role Emphasis

In line with the hypotheses, characteristics of the therapist such as age, gender, level of education, and college major were unrelated to which aspects of their positions they emphasize. However, nearly all of the facility and therapist characteristics that were expected to vary with the role emphasis scores did not. Although there was a small difference in emphasis scores based on the security level of the therapist's facility, interpretation of this finding is difficult because it was found only between therapists working in maximum security facilities and those

working with mixed security levels. There were no differences in emphases between therapists who work within only one security level. It is possible that a relationship between security levels and emphases exists that could not be examined with these data. Specifically, although the survey asked therapists how many years of experience they have working in corrections, and the security level of their current facility, it is impossible to determine from these data in what security level they have the most experience. As it is fairly common for corrections workers to transfer between facilities (e.g., Arizona's Department of Corrections, 2013), it is certainly possible that many therapists' current facilities are different security levels than those in which they have the majority of their corrections experience. For example, a therapist who was first hired and trained within a maximum security facility may retain the practices and attitudes from that environment throughout her or his career, even after being transferred to lower-security facilities.

Gender of therapists and sex of offenders. The hypothesis that a therapist's role emphasis would be influenced by the sex of the offenders he or she supervises was partially supported. Offenders' sex was found to associate with role emphasis scores only among the female therapists, but not among male therapists. Female therapists working with female offenders are more likely to view their roles as rehabilitative and less security- and stabilization-focused than those working with male offenders primarily.

Reasons for this finding are unclear, but may be due to the lower likelihood and lower seriousness of assaultive behavior from female offenders than male offenders (Harer & Langan, 2001). Even so, this relationship was not expected to exist only among female therapists. The finding that male therapists' role emphases do not differ based on the sex of the offenders they treat may be best attributed to the additional institutional pressures for male staff members to

avoid any appearance of inappropriate relationships with female offenders (see Marquart et al., 2001). Additionally, the apparently different manner in which female therapists approach male and female offenders may also be related to the higher likelihood of male offenders to view female staff members in terms of their gender (e.g., sexual objectification; Crewe, 2006). It appears reasonable to expect female therapists working with male offenders to be more likely to "put up their guard" during therapeutic sessions. This finding suggests that consideration of the therapist's gender and the sex of the offenders may be important to take into account in the prison environment. Supervisors and administrators should consider these gender-specific challenges to inform clinician trainings, paying special attention to the awkward situations that female therapists may face when working with men whose primary female contacts are staff members. It may be common for therapeutic clients to become attracted to their therapists (or vice versa; e.g., Martin, Godfrey, Meekums, & Madill, 2011; Moleski & Kiselica, 2005), considering the emotional intimacy that is formed, but such feelings may be exacerbated when the clients are not permitted to have physical contact with others in any capacity.

Role Emphasis and Treatment Decisions

One of the primary aims of this research was to further understand how a therapist's differential emphases of rehabilitative and security elements may influence his decisions in treating offenders. Contrary to the hypothesis, analyses did not find an overall effect of role emphasis on treatment decisions when they were quantified. However, for the prison therapists who gave free responses to the vignettes in addition to the response options available, the PTOM subscale regarding the therapists' perceptions of the purpose of prison therapy was able to predict the type of free response with some accuracy. Specifically, the therapists who believed that the purpose of prison therapy was more for the benefit of offenders were also more likely to

engage in behaviors that would focus on their relationship with an offender after he had caused a facility disruption. Although the number of free responses upon which this analysis was based is limited, this finding is important in that it suggests that a therapist's role emphasis does have some bearing on treatment decisions.

Further supporting this idea is that the role emphasis measure accounted for a significant amount of variation in the measure of the therapeutic alliance. Because it is well established that the therapeutic alliance affects the therapeutic outcome (e.g., Johansson & Jansson, 2010), it is likely that the therapist's role emphasis also has some influence on the quality of treatment for offenders. The measures used in this project did not detect this influence in the quantitative response options, perhaps due to the manner in which the treatment decisions were assessed. That is, the vignette responses presented several treatment options that were not mutually exclusive and generally appeared reasonable. It may be that by presenting each of these options the respondents were more likely to endorse them, whereas if the options had not been suggested the responses may have differed enough to detect differences between therapists based on their role emphases.

A similar obstacle in this research was that these responses were hypothetical in nature—referring to realistic but fictional scenarios. This is certainly an oversimplification of the treatment process. In reality, prison therapists likely take dozens of elements into account before making treatment-related decisions, such as reviewing an offender's history, speaking with security staff members who often have more information on behavior patterns (Dvoskin & Spiers, 2004), and reading cues such as an offender's body language and tone of voice. Using the scale scores as a proxy for what the therapists believe they would be likely to do during these situations found only a small difference in how much therapists would implement elements of

the therapeutic alliance. For the scenario where the offender had only talked about wanting to end his life, the therapists' likelihood of using an element of the therapeutic alliance increased slightly with his or her self-reported level of emotional engagement with offenders. However, the emphases on the other subscales and the overall measure were not different between the two scenarios. Had the scenarios been less focused on scenarios where security appeared to be the primary concern, the differences in action may have been larger. For example, therapists who endorsed more emphasis on emotional engagement would likely do more in a group or individual therapy session that would reinforce that emotional engagement, such as expressing and demonstrating empathy, genuineness, and sincerity. Because these elements are crucial to the therapeutic process (Keijsers, Schaap, & Hoogduin, 2000) and effective correctional practices (Dowden & Andrews, 2004), these would likely also relate to better correctional and mental health outcomes.

It is reasonable to expect that therapists who work in prison settings would be more likely to emphasize the security, safety, and stabilization of the situation that presented an offender who had already behaved in a dangerous and defiant manner, regardless of their personal attitudes about the aims of prison therapy, their view of offenders, and their level of emotional engagement, and this is also what was found—therapists overall rated themselves as less likely to use elements of the therapeutic alliance when the offender had broken his television, and more likely to work toward the safety and stabilization of the offender. With these data, differences in how the therapists reported likely reacting to the situations was not predictable from how they emphasize their roles, except for the small but significant change in emotional engagement use between the scenarios. In the scenario where the offender had expressed suicidal thoughts, but had no behavioral disruption, more emphasis on emotional engagement was associated with a

very slight increase in a therapist's self-rated likelihood of doing some action that would build the therapeutic alliance. Although the difference was small, it partially supports the hypotheses.

A plausible explanation for the lack of predictability is that both of the vignettes in this research described offenders presenting serious risk. The offender in the first scenario was reportedly suicidal, and the second had refused to comply with restraining procedures after breaking a television set. Both of these situations require a high level of attention for the safety risks that they pose. It may be that the respondents viewed both situations as somewhat similar in their seriousness, which may explain the general lack of variability in responses. Safety was clearly an important and immediate issue in both scenarios. Additionally, it is not unusual for offenders to threaten suicide or use behavioral outbursts as means to get secondary gain (Mobley, 2008). Ergo, it is possible that the therapists in this sample who commonly deal with crises such as these were skeptical of either scenario because they often experience them as attempts to get attention, cause a facility disruption, be moved to a different cell, or gain some other special favor.

Future research should consider vignettes that are less crisis-oriented and more related to everyday treatment situations, such as one a therapist might face during a routine mental health assessment or an individual therapy session with an offender. A situation that is not potentially life threatening would likely get a larger degree of variation in the therapists' responses; that would then allow better assessment of the relation between role emphases and actions. Additionally, including sections that allow for therapists to explain their thought processes in making treatment decisions would provide insight as to what elements of the vignettes were most important for their decisions. Had this been included in the present project, it is likely that the first offender's suicidal threat and the second offender's destruction of property with the refusal

to comply with orders would be the primary guiding elements to the therapists' decisions. In less serious scenarios, other factors would be enlightening to help determine whereupon therapists base their treatment decisions.

Secondary Findings

Therapists' perceptions of role conflict and job satisfaction. The therapists in this sample reported perceiving role conflict in their work. Some especially noteworthy responses to the role conflict items were in the apparently competing goals of psychotherapy and corrections. For example, the majority of therapists reported feeling that some of what they are required to do with offenders should be done differently (58.6%; item 1). Similarly, most of the therapists recognize that they approach offenders "quite differently" than do the security staff (83.5%; item 5), and the same proportion did not see the prison environment as contributing to their therapeutic aims (item 11). These responses echo the literature suggesting that prison aims and/or methods are at odds with the aims and/or methods of psychotherapy (Arboleda-Florez, 1987; Crespi, 1990; Gannon & Ward, 2014; Karcher, 2003; Osofsky, 1996; Sweet, 1973; Weinberger & Sreenivasan, 1994), and appear to contradict Dignam's (2003) conceptualization of mental health and corrections goals as being far more similar than not, at least in the therapists' views. In general, it appears that therapists believe that the prison environment and some prison policies are either not compatible with psychotherapy, or are being poorly implemented in regards to treatment aims.

On a more positive note, the respondents in this sample appear to be generally satisfied with most aspects of their positions. As is also seen on some of the role conflict items, their responses to the job satisfaction questions indicate that therapists appreciate their levels of autonomy in what they do. They also appear to appreciate their coworkers for the most part and,

as was also a theme in Karcher's (2003) qualitative research, the therapists appear to enjoy the sense of meaning or accomplishment that they find in the work. Combined with the role conflict measure, it appears that, despite the sometimes conflicting roles they face, seeing the differences they may make in offenders' lives is rewarding. This pattern may be of most importance as an indicator of a therapist's burnout. If supervisors and prison administrators make efforts to emphasize the changes that mental health work can mean for offenders, it may lead to higher job satisfaction overall among prison therapists.

Implications. Based on responses to the role conflict measure, prison psychotherapists appear to experience feelings of role conflict in their work. Although this conflict was expected (Borritz et al., 2006; Karcher, 2003), and has been seen among prison employees in other capacities (Grusky, 1959; Hepburn & Albonetti, 1980; Schaufeli & Peeters, 2000) it is likely to be of particular concern to prison administrations and mental health supervisors, as there is a need to retain their mental health staff. When role conflict is present, it is almost natural for the quality of duty fulfillment to decline, as the workers wrestle with which role to serve primarily. Role conflict may further lead to staff burnout and an increased likelihood to leave the position (Acker, 2004).

What may be the more pertinent consequence of role conflict is its potentially detrimental effect on effective treatment. Indeed, these data found that higher ratings of perceived role conflict were associated with lower quality of the therapeutic relationship with offenders. Therapists who see their treatment provider role as at odds with the aims of coworkers or the institution at large may make treatment decisions that are not in the best interest of one or the other. When a decision results in a lag in treatment quality, there may be large legal implications for prisons (e.g., Balla v. Idaho State Board of Corrections, 1984; Inmates of Allegheny County

Jail v. Pierce, 1979; also see U.S. Department of Justice, 2005). On the other hand, when a decision results in decreased safety or security, inappropriate relationships or even dangerous vulnerability may place employees and the institutions at risk (Marquart et al., 2001; Sorensen et al., 2011). This project offers an exploration of these issues, and acts as a starting point for future research that may serve to decrease role conflict where possible, work toward more effective treatment of prisoners with mental health needs, and provide effective training for prison therapists on how to appropriately merge therapeutic aims with the aims of the corrections system.

Future Directions

Many of this study's findings raise more questions about additional variables that were not included, but that may be important the future research. Additionally, these findings lead to next steps in understanding what makes effective psychotherapy in prison settings.

Which role emphasis is effective, in which circumstances? As the PTOM's utility is further explored in the future, several applications are potentially beneficial. First, assessing which role emphasis is the most effective with offenders is a vital step. Second, it is important to understand under what circumstances each role orientation may be most effective. For example, this project found that female therapists who work with female offenders tend to emphasize the therapeutic relationship more than female therapists who work with male offenders. The female therapists may have found that female offenders respond better to therapy that emphasizes the therapeutic alliance. If true, it may behoove the corrections institution to place therapists (male or female) with lower PTOM scores in facilities that house female offenders. By the same token, it may be that male offenders benefit therapeutically from therapists whose role emphases are

well balanced (PTOM scores near the mean). Such a finding may be applied by assigning therapists with balanced scores to facilities housing male offenders.

There may additionally be some effect of the facility's security level or the offenders' custody level on how effective a certain role emphasis is, which may be taken into account when determining which employees would be most effective. For example, if future research determines that offenders with higher restrictions also respond better to therapist orientations that emphasize security and stabilization somewhat more than a therapeutic alliance (perhaps because it resembles a less "touchy feely" style of interaction), then agencies may assign therapists with higher PTOM scores to work with offenders who are at higher custody levels.

Details of role emphasis. Another possible direction for future research is to attempt to more deeply focus on the reasons for different role emphases as they relate to issues of job burnout and security issues. That is, there may be differences even among prison therapists whose role emphases are fairly similar. Because therapists in prisons are prone to high rates of job burnout (Borritz et al., 2006), some of those who are less concerned with the therapeutic relationship may be that way because they are experiencing more burnout, whereas others with similarly unemotional emphases towards their work may be so because they highly value security measures of the environment (i.e., apathy toward offenders versus commitment to security). Although this study did not include a measure of job burnout, the job satisfaction measure likely is related to levels of burnout. Job satisfaction was not related to role emphases in this research, but more thorough analysis may assess any differences among the therapists with low emotional engagement in treatment.

Quantifying therapists' actions. Despite the inability to predict treatment decisions with these vignettes, therapists' role emphases were related to their self-ratings of therapeutic

relationship quality (i.e., the Working Alliance Inventory). Because the therapeutic alliance is known to be the most important element of therapy (Alexander & Luborsky, 1986; Horvath & Greenberg, 1986; Horvath & Symonds, 1991; Lambert & Barley, 2001; Marmar et al., 1986; Suh et al., 1986), it is reasonable to suspect that role emphases would have some influence on what prison therapists actually do in treatment. Although improving the vignettes in future examination is an important step to understand this relationship, such methods assess only hypothetical scenarios. Another valuable and necessary step is to formulate methods of measuring what therapists actually do in real therapeutic situations. Though this would be a difficult step considering the security concerns of prisons, the protected offender population, and the confidential nature of therapeutic interactions, future research should attempt to evaluate what therapists do in prison therapy, and how that may relate to their role emphases.

Implicit attitudes toward offenders. Results suggest that therapists appear to generally think that offenders deserve help, that there is hope in rehabilitative efforts, and that these attitudes also evoke more emotional engagement. This finding is hopeful in that it appears to be in line with the core correctional practices that suggest warmth, genuineness, enthusiasm, empathy, respect, and commitment to helping offenders are arguably the most important components of effective correctional work (Dowden & Andrews, 2004). That therapists appear to view offenders in a positive light suggests that they are also largely adopting this component of core correctional practice.

However, there were some interesting exceptions to the generally positive attitudes. For example, although half of the respondents (50.6%) agreed with the statement "Prisoners are no better or worse than other people," less than one-third (29.1%) of therapists agreed with the statement, "I wouldn't mind living next door to an ex-prisoner." Even fewer said that they would

not mind if one of their children dated an ex-prisoner (13.9%). If half of the therapists truly believed that offenders are no worse or better than other people in general, then it is reasonable to expect that the same half would have also agreed with the latter two statements.

It appears that the therapists in this sample may have an ideologically positive view toward offenders, but that this view may not be representative of their actions toward offenders. These discrepancies in answers may be indicative of implicit attitudes about offenders. It is not uncommon for people to consciously deny prejudices but express them in implicit ways (e.g., Greenwald & Banaji, 1995). It is difficult to imagine a professional seeking and accepting a position such as a prison therapist without having a conscious belief that offenders are capable of change, and may simply need the right tools to become rehabilitated (e.g., Norcross & Farber, 2005). However, because the latter two statements appear to indicate that these same therapists have reservations about truly treating ex-offenders as they would anyone else, there may be some disconnect between what the therapists state they believe and how they implicitly view offenders. The therapists in this sample appear to agree that offenders deserve to be treated humanely and have opportunities for rehabilitation, but they also appear to view offenders as not fully trustworthy.

However, this seemingly negative bias toward the clients may not be uncommon among psychotherapists. Wills (1978) found that therapists in general tend to have less favorable perceptions of their clients than do lay persons or the clients themselves. These views were affected by factors such as the therapist's perceived similarity with and attraction to the client, the perceived resistance of the client to treatment, and the tendency for therapists to focus on the negative aspects of the client's behavior (Wills, 1978). It seems likely that each of these would be exacerbated when the client is also a prisoner.

Typically, prison staff members are not allowed any contact with ex-offenders for a period of time after release (some examples in Appendix A). If the therapists in this survey took these policies into account when responding to the latter two items, it may explain the apparent discrepancy in their attitudes. A comprehensive analysis of therapists' attitudes toward offenders was beyond the scope of this project, but may prove enlightening as to the potentially conflicting feelings the therapists may face. Perhaps the measure of attitudes toward prisoners should be adjusted for use with prison employees to explain that policies were not intended to apply to the scenario. For example, an item may read, "As long as the prison policies were not opposed, I wouldn't mind living next door to an ex-prisoner." Establishing the source of the discrepancy would allow further insight into therapists' attitudes toward offenders. If prison therapists have difficulty trusting offenders, for example, it would be important to learn the impact this has on the therapeutic relationship, what the source of the distrust is (policy, experience, media, etc.), and whether treatment can still be effective. Future research should examine this issue in more depth.

Role conflict. Because there was a general pattern of therapists perceiving role conflict in their work, an important step to take in the future is to explore where the locus of the role conflict lies—whether staff members view the offenders as the source of conflict, administrative policies, security staff, or other sources. If there are steps that administrators can take to clarify the role of mental health work in the overall aims of the institution, this should reduce feelings of role conflict. Otherwise, if the role conflict lies primarily with the nature of the population, a potential solution may involve more in-depth training of how therapists should appropriately work with potentially manipulative or dangerous offenders.

Therapeutic relationship quality. Working Alliance Inventory scores from this sample suggest that the majority of therapists believe they form positive, cooperative, and respectful working relationships with the offenders. For the most part, it appears that the therapeutic alliance can exist within the prison environment, at least according to the therapists. However, it is absolutely vital to consider the offenders' perceptions of the therapeutic relationship (see Bachelor, 2013).

Additionally, whereas the literature suggests that the therapeutic alliance is the most important element of effective therapy, this study has no way of assessing whether the alliance is also the most effective element of therapy within prisons. Due to the unique risks and challenges of the population, future research may find that the therapeutic relationship is less important to treatment outcome than, for example, environmental or social factors within prison (Ortmann, 2000).

Summary

The manner in which therapists engage their clients in therapy is the most important part of effective therapy, at least in communities. In prisons, therapists must weigh the safety needs of the facility with the offenders' therapeutic needs. Although most of the therapists in this sample endorsed equal emphasis between both demands, many therapists expressed a preference for one, seemingly at the expense of the other. The only variable that was systematically associated with this preference was the offenders' sex, and only among female therapists. Therapists preferences did not predict the actions they expected to take in mental health crises, but future research should examine how role emphasis influences actions taken in more typical (not crisis) scenarios. First, more research is necessary to understand what balance of these roles is most effective in working toward rehabilitation, and in what situations (e.g., if different role

emphases are effective at different security levels). Second, more research must work to identify elements of the therapist or job may explain the different role emphases, so that this knowledge may be applied to the education and training of prison therapists. Through these efforts, it is likely that prison therapists will become more effective at their work without sacrificing safety, that they will feel more satisfied with their positions, and that offenders will benefit from the improved practices. If offenders' mental health is improved, facility disruptions and offender mental health crises will decrease, and offenders' potential for rehabilitation may be better realized.

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Appendices

Appendix A – Descriptions of the Agencies That Participated in This Research

To provide some information about the broad approaches of the agencies toward corrections work, this section contains descriptions of each corrections department's mission statement. Regarding specific policies relevant to this project, each agency was also assessed for shared standards—most of the facilities that took part in this research were accredited by or seeking accreditation from the American Correctional Association (ACA), which is a professional organization that provides standards for nearly all aspects of correctional practice, including many mental health practices (see www.aca.org). Those that were not accredited or seeking accreditation use the ACA's standards as the framework for their own policies (for example, the State of Washington does not seek accreditation due to the associated financial costs, but largely adheres to ACA standards).

Additionally, each department's specific policies regarding staff-and-offender relationships were explored for any wording regarding the nature of interactions. Mental health policies were also examined for any indication of the scope of the therapeutic relationship that might be different from the relationships of offenders with staff in other capacities (e.g., security).

Contracted workers in all states are required to comply with corrections departments' policies, thus it is assumed that the mission statements and policies reviewed here are also adhered to by contracted mental health workers.

The Anonymous Agency

One state agency participated in this research under the condition of anonymity. The agency's mission statement includes the primary aim of reintegration through safe environments, and programs that encourage positive change. The values of the organization place "safety" as the top priority. This agency employs just more than 100 of its own mental health staff, excluding psychiatrists. The majority of facilities from this agency are accredited by the ACA.

Among this agency's published policies were no discernable guidelines regarding interactions with offenders, and its mental health policies surround offenders' rights to treatment access, the needs classification system, and assessment guidelines. In a guide for non-employees, there are some guidelines about how to avoid inappropriate relationships with offenders, which include focusing only on the work and "maintain[ing] professional boundaries at all times." Whether these same guidelines are applicable to mental health staff is not clearly discernable in the policies.

Arkansas Department of Corrections

All prisons within the Arkansas Department of Corrections are accredited by the American Correctional Association. Arkansas hires some of their own mental health workers and contracts with other mental health workers through Correct Care Solutions (correctcaresolutions.com).

The Arkansas Department of Corrections' mission statement reads in part, "to provide a safe humane environment for staff and inmates; strengthen the [*sic*] work ethic through teaching of good habits; and provide opportunities for staff and inmates to improve spiritually, mentally, and physically."

Policies relevant to the topic of this project are included in the employee handbook (Arkansas Department of Correction, 2011). Regarding staff duties, the handbook reads, in part,

> All employees are considered correctional personnel. All employees have general responsibilities that may not be related to their professional or occupational functions….Custodial responsibilities are inherent to all employees. Each employee has a fundamental duty to assist in security functions whenever necessary. Each employee must understand that the security of inmates is of primary importance, and the enforcement of inmate rules and regulations is not delegated exclusively to security personnel. (p. 32)

Regarding familiarity with offenders, the employee handbook states in part, "Employees are encouraged to maintain a professional image at all times. Employees should make every effort to avoid actions and associations that might compromise their status with the Department. ADC policy prohibits…close personal associations…with ex-inmates, parolees, or probationers…"

Similarly, in the Department's administrative regulation regarding relationships with offenders (State of Arkansas, 1980, p. 1) reads in part, "Personnel shall not…become unduly familiar in any manner with inmates, parolees, and probationers…." The term "unduly familiar" is not explicitly defined in the document.

Colorado Department of Corrections

Each prison within the Colorado Department of Corrections is accredited by the American Correctional Association. The Department employs approximately 111 mental health staff.

The Colorado Department of Corrections' vision statement is "Building a safer Colorado for today and tomorrow." Its mission statement reads, in part, "To protect the citizens of Colorado by holding offenders accountable and engaging them in opportunities to make positive behavioral changes and become law-abiding, productive citizens."

Its mental health policies primarily surround proper procedures during crises, types of treatment available, and classification systems for mental health needs. Its policy regarding the scope of

mental health services covers the role of psychotropic medications and treatment as well as restraints, among others. The purpose of its psychoeducational and skills development programs is described as follows: "These programs are designed to assist offenders in the development of social and self-management skills that will assist in the stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting…" (Colorado Department of Corrections, 2013a, p. 5). Regarding services for offenders with serious mental illness, the policy states that services available "include group and individual treatment…regarding special needs, specialized programs to promote medication compliance and self-management, specialized housing and management, and special assistance with transition to the community" (Colorado Department of Corrections, 2013a, p. 5). The only statement regarding the mental health professional's relationship to the client refers to the inappropriateness of sexual intimacy with offenders (Colorado Department of Corrections, 2013a, p. 9).

The policy regarding communication with offenders (Colorado Department of Corrections, 2015a) has no statement specific to mental health staff, but is addressed to all employees, contract workers, and volunteers. It states in part, "Inappropriate areas of communication include, but are not limited to…family relationships…substance abuse…personal history…criminal history...mental health history…" (p. 2).

Connecticut

All participants from Connecticut were contracted mental health workers through the University of Connecticut Health Center. As such, they were all required to abide by the rules and regulations of the Connecticut Department of Correction. The University Health Center employs 86 such contracted workers who work in a variety of settings within the state's Department of Correction.

The Department's training of staff follows the standards of the American Correctional Association (see State of Connecticut, 2014b). All mental health contracted workers are held to standards of the ACA and the National Commission on Correctional Health Care (see State of Connecticut, 2014c).

The Department's mission statement includes the aim to lead with "re-entry initiatives," and states that "Safety and security shall be a priority component of this responsibility as it pertains to staff…and offenders." (State of Connecticut, 2014d, p. 1)

The Department's policy regarding employee conduct contains a section related to contact between staff and offenders. It states that "Engaging in undue familiarity with inmates…includes, but shall not be limited to…personal involvement in an inmate's private or family matters outside assigned professional duties…" (see State of Connecticut, 2014a, p. 5). Whether involvement in an offender's personal and family matters is within the scope of mental

health workers' assigned professional duties is unclear in the policy regarding mental health care (State of Connecticut, 2014e).

Among the trainings that mental health professionals undergo are "recognizing potential or existing mental health emergencies" (p. 5), but there does not appear to be any statement regarding mental health's professional relationships with offenders beyond what is noted in the previously mentioned document for all staff.

Idaho

The Idaho Department of Correction employs its own mental health workers. There were 35 eligible participants for this research.

The Department's mission statement is "To promote a safer Idaho by reducing recidivism" (Idaho Department of Correction, 2013).

The Department requires that employees maintain professional relationships with offenders, and defines such a relationship as "A businesslike interaction that treats the other individual with respect, dignity and without prejudice or unlawful discrimination and in accordance with assigned job duties and the mission of the Idaho Department of Correction" (State of Idaho, 2011, p. 3). This same policy has several statements about prohibited contacts with offenders, primarily focusing on business relationships or unlawfully taking advantage of offenders. The statements of primary interest to this research topic state that employees must remain objective in their work, and show no bias.

There are no apparent additional guidelines on what constitutes the scope of the relationship of a mental health worker with an offender (see State of Idaho, 2001).

Illinois

The Illinois Department of Corrections employs its own mental health workers. There were 71 employees eligible for the survey. Virtually all Illinois correctional facilities are accredited by the American Correctional Association, and the Department is currently striving for all facilities to receive accreditation.

The Department's mission statement "is to protect the public from criminal offenders through a system of incarceration and supervision which securely segregates offenders from society…and maintains programs to enhance the success of offenders' reentry into society" (Illinois Department of Corrections, 2015).

Regarding staff's relationships with offenders, a brief policy states that "Employees shall not knowingly socialize with…any offender…except in the performance of an assignment…" (Joint Committee on Administrative Rules, 2006). It is not clear what the definition of "socialize" is in this context, or whether mental health work fits the "performance of an assignment."

The policy regarding mental health care does not specify any scope of the relationship of mental health workers with offenders, instead primarily focusing on the offenders' access to services (Joint Committee on Administrative Rules, 2005).

Maine

The therapists in Maine who participated in this research were contracted through Correct Care Solutions. They are required to adhere to all rules and policies of the Maine Department of Corrections. Each facility at which the respondents work is accredited by the American Correctional Association.

The Department's mission statement is "to reduce the likelihood that…offenders will re-offend, by providing practices, programs and services which are evidence-based and which hold the offenders accountable" (State of Maine, 2013a).

The Department's mental health policy focuses primarily on mental health screenings, crisis intervention, the use of restraints and seclusion for mental health reasons, and hospitalization (State of Maine, 2013b). There is a separate policy specifically regarding counseling and treatment, which appears to be focused on issues related to the topic of this project. For example, the policy ensures that offenders may access services to "aid in adjustment while incarcerated and to increase their probability of functioning within normal limits of socially acceptable behavior" (State of Maine, 2013c, p. 6). The options available include group and individual counseling. There is no apparent published policy directed at the relationship between a therapist and an offender.

Nebraska

The Nebraska Department of Correctional Services employs its own mental health workers. One hundred of their mental health workers were eligible to participate in this project. All Nebraska facilities are accredited by the American Correctional Association.

The Department's mission statement is "to serve and protect the public by providing control, humane care and program opportunities for those individuals placed in its custody and supervision, thereby facilitating their return to society as responsible persons" (Nebraska Department of Correctional Services, 2015).

Regarding staff relationships with offenders, the Department's policy states that "Employees will keep their conversations with inmates…on a professional level at all times and will refrain from discussing their personal lives, activities and/or the personal lives or activities of others." (Nebraska Correctional Services, 2014a, p. 2). The same policy also states that "An employee is expected to maintain professionalism…serving as a positive role model, being credible, and exemplifying the Department's Mission…" (p. 4). The policy appears to reflect the "firm but fair" role of correctional workers described in the body of this report.

The mental health policy from the Nebraska Department of Correctional Services has a general policy that is to serve as a guide for all facilities within its organization. The policy states that "Each institution shall maintain a social services program that provides…individual and family counseling…. All inmates are made aware of available social service programs…" (Nebraska Correctional Services, 2013, p. 2). The general sense of the mental health policy is that these counseling programs exist to work toward the functioning and rehabilitation of offenders. Another policy describes the procedures regarding screenings and classifications of offenders with mental illness (Nebraska Correctional Services, 2014b).

The same policy states that "There shall be at least one social services staff… for each 100 inmates" (p. 2). The staff must hold at least a "bachelor's degree in the social or behavioral sciences, or a related field" (p. 2). There does not appear to be a published document that would further indicate a therapist-offender relationship as being different from that of any other staff member with an offender.

Pennsylvania

The Pennsylvania Department of Corrections employs its own mental health staff. Of these, 148 staff members were eligible to participate in this research. All Pennsylvania prison facilities were accredited by the American Correctional Association at the time this research was conducted.

The Department's mission statement reads, in part, that it "commits to enhancing public safety….Our mission is to reduce criminal behavior by providing individualized treatment and education to offenders, resulting in successful community reintegration through accountability and positive change" (Pennsylvania Department of Corrections, 2015).

The Department's policy regarding staff-offender relationships reads, "All employees are expected to maintain professional relationships with offenders…. No employee shall engage in any activity nor fraternize with an offender….Fraternization includes…engaging in…personal/private relationships…sharing personal information…. (Commonwealth of Pennsylvania, 2014, p. 1-1). The policy later expressly prohibits engaging in personal contact, or establishing a personal relationship, "providing treatment services, outside the scope of assigned job duties," and "engaging in any activity which might compromise the ability of the employee to perform job duties in an efficient, unbiased and professional manner" with offenders (pp. 2-1 through 2-2).

Regarding mental health services, the Department's policy states that counseling services are provided to all inmates it supervises. It defines these counseling services as including "case management, inmate assessment and placement, reentry planning and specialized programming for offense related issues" (Commonwealth of Pennsylvania, 2001, p. 1). The policy does not appear to explicitly outline the scope of the counselor's relationship with the offender (at least

not as any different from the preceding policies), but a few statements explain that, in the case of a family member's death, "The counselor will offer supportive counseling to the inmate; assess the severity of the inmate's grief and how the inmate is coping." (p. 2-5). The policy later describes the "Correctional Plan" as a process of matching the offender's needs with resources available, focusing on, among others, "Family/Relationship/Self" with the goal to have each inmate "understand the effects and consequences…criminal behavior has had on [others]…demonstrate an appropriate respect for authority, peers, and self by having a better understanding of what it means to be a member of the community…" (p. 4-1). The policy's wording appears to generally support work toward improving offenders' insight. The Department maintains a counselor manual, but this does not appear to be published for public access.

South Carolina

The South Carolina Department of Corrections employs its own mental health workers. Approximately 160 employees are defined as mental health workers, although only 57 were eligible to participate in this research. Therapists from this state reportedly work in facilities that are not currently accredited by the American Correctional Association, but the Department is currently working toward accreditation.

The Department's mission statement includes as its first two priorities, "Safety—we will protect the public, our employees, and our inmates. Service—we will provide rehabilitation and self-improvement opportunities for inmates." (South Carolina Department of Corrections, 2015a).

The policies of the Department do not appear to be published for the public, but some information about mental health programming was available through the Department's website. For example, the behavioral health and substance abuse services division offers opportunities "that are educational and therapeutic for those offenders who may require such services." (South Carolina Department of Corrections, 2015b). The statement also explains that their behavioral health services include a "broad range of relevant services, with varying levels of intensity….based on sound research, effective clinical practices, and will provide these services in a most cost-effective manner." The same webpage describes a pre-release program where offenders attend groups on topics such as self-esteem, dealing with conflict, and assertiveness.

No specific statements could be located regarding the Department's guidelines for staff-offender relationships.

Washington State

The Washington Department of Corrections employs its own mental health staff. Approximately 126 employees were eligible to participate in this research. None of the Washington State facilities is currently accredited by the American Correctional Association, but the Department uses the Association's standards in forming its own policies (e.g., State of Washington, 2013).

The Department's mission statement is simply "To improve public safety" (State of Washington, 2015a). Its statement of values includes "A safe, healthy work environment…" and "striv[ing] to treat all people—offenders, staff and public—with dignity and understanding." The value statement also includes "we acknowledge that people—offenders and staff—have the need and ability to grow and change and we support their endeavors."

The same webpage includes the agency's objectives,

> The Department was created to confine people who violate criminal laws and remove many of their personal freedoms as a legal penalty. Another objective established in law is to operate in a manner that provides maximum safety for the public, staff and offenders. DOC also aims to positively impact offenders by stressing personal responsibility and accountability, and by reducing recidivism.

The general sense from these statements is that the Washington Department of Corrections values safety and security primarily, and that rehabilitative efforts are a secondary aim. As its objectives state, the first goal is to carry out offenders' punishment, the second is to protect the public, and the third is to rehabilitate.

The published policies of the Department explain that employees are expected to "model appropriate, ethical, responsible, and respectful behavior to the public, peers, employees, and offenders…facilitate personal contact and interaction between employees and offenders" (State of Washington, 2013a, p. 4). The policy regarding relationships with offenders mirrors others in that it emphasizes professionalism, and prohibits favoritism. It states, "Association with offenders under Department jurisdiction, beyond that which is required in the performance of official Department duties, is prohibited in the interest of professional, unbiased service." (State of Washington, 2014, p. 2).

The policy that is available contains a section regarding the scope of offender mental health care (State of Washington, 2015b). The policy primarily covers offender rights and access issues, but also states that offenders have access to group and individual therapy. However, the document specifies several limitations to the amount and duration of care. For example, disorders such as adjustment disorders, dysthymic disorder, and many others are explicitly not considered severe enough to warrant treatment (see also State of Washington, 2013b).

Appendix B - Demographic and Professional Information Questions

Please complete the following questions about you. Be as accurate as possible.

1. What is your gender? □ Female □ Male □ Other

2. What is your age? _____ years.

3. Which of the following best describe(s) your race or ethnicity?

□ African American or Black
□ American Indian or Alaska Native
□ Asian or Asian American
□ Caucasian, White, or European American
□ Latino or Hispanic
□ Native Hawaiian or Other Pacific Islander
□ Other race(s) _____

4. What is the highest level of education you have completed?

□ Graduated High School or Completed GED
□ Some college or currently attending college
□ Associate's Degree or 2 year degree
□ Bachelor's Degree or 4 year degree
□ Master's Degree (i.e., M.A., M.S., M.S.W., etc.)
□ Doctoral Degree (i.e., Ph.D., Psy.D., M.D., J.D., etc.)

5. If you completed more than high school, which best describes the major area of study for your highest degree?

□ Counseling □ Social Work
□ Medicine □ Other _____
□ Psychology

6. Before beginning your work in corrections, how many <u>months</u> of training did you receive in how to do therapy in a correctional environment? _____ months.

7. Does your current position require a license to practice? □Yes □No □Not sure

8. How many years have you worked in corrections? _____ years.

9. How many years have you done mental health work <u>outside</u> of corrections? _____ years.

10. On an average work day, how many hours do you spend face to face with offenders? _____ hours.

11. On an average work day, how many hours do you spend doing some form of mental health treatment (i.e., group or individual therapy, etc.)? _____ hours.

12. Which best describes the security level of the offenders with whom you do most of your work?

□ Low or minimum security
□ Medium security
□ High or maximum security
□ Mixed security levels—I do not work within one level more than another.

13. Please indicate the custody level of the typical offender on your caseload.

_____% Maximum (highest restrictions)
_____% Close (high restrictions)
_____% Medium (moderate restrictions)
_____% Minimum (lowest restrictions)
□Not sure
□There is not a typical custody level among my caseload.

14. Do you work primarily with female or male offenders? □Female □Male □Both equally

15. Please estimate how much of your time you spend doing each of the following (note that they must add up to 100%):

_____Research
_____Training (being trained or training other staff members)
_____Psychological assessment of offenders
_____Crisis intervention
_____Group therapy
_____Individual therapy
_____Administration (e.g., paperwork, meetings, etc.)

16. Please indicate any specializations that apply to your caseload:

□ I work primarily with offenders with substance abuse issues.
□ I work primarily with offenders with intellectual disabilities.
□ I work primarily with sex offenders.
□ I work primarily with offenders with psychotic disorders.
□ I work primarily with offenders with mood disorders.
□ I work primarily with offenders with personality disorders.
□ I work primarily with another kind of group. It is _____.
□ My caseload is not specialized—I work with many different issues.

17. Which best describes your professional orientation towards psychotherapy?

□ Behavioral
□ Client-centered (Rogerian)
□ Cognitive-Behavioral
□ Dialectical behavior therapy
□ Existential
□ Gestalt
□ Group therapy
□ Motivational interviewing
□ Psychoanalytic (Freudian)
□ Eclectic (use elements of many orientations—no preferred orientation)
□ Undecided
□ Other _____

18. Which of the following best describes your position?

□ I am employed by a department of corrections
□ I am contracted to work for a department of corrections through another institution (e.g., a hospital, university, private company, etc.)
□ Neither of these describes my position.

19. Please enter the correct name of the primary facility where you work, and the state in which it is located (this information is used only to test for independence of observations).

_____ _____

Facility name State

Appendix C – Sample Text of Recruitment Email

Subject: Prison Therapist Orientation Research Invitation

Dear Sir or Madam,

I am a psychology student working on my doctoral dissertation at the University of Texas at El Paso (IRB #621442-1). My project concerns how therapists in the prisons think about their role, the prison environment, and the offenders with whom they work. This research will help us identify the best ways of improving training and practices for prison therapists.

To complete the project, I need the cooperation of as many correctional therapists as possible in taking this 30 minute **confidential** survey, simply asking your opinions on several topics. You are eligible to participate in this survey if you currently **work in a prison where you provide mental health treatment to the inmates** (excluding psychiatrists and psychiatric nurses). Your supervisor will not know whether you participated, and will never have access to your responses. Participation is entirely voluntary. Choosing not to participate will not be penalized or keep you from gaining any of the benefits of the research. To compensate you for your time, I offer a code worth **$10 toward any purchase on Amazon.com**. Simply enter a valid email address at the end of the survey. I will never use your email for any purpose other than delivering your code.

To complete this survey online, please enter this URL into a web browser:

http://XXXXXXXX

Although The Department of Corrections has reviewed and approved this research, it is not conducting this research project. The Department may receive a copy of the overall results at the end of the study but will not be able to identify you personally from the copy they receive. They will never see your personal responses, or even know whether or not you participated.

Thank you for your participation, and please feel free to contact me with any questions or concerns!

Sincerely,

Elijah Ricks, M.A.

Appendix D – Prison Therapist Orientation Measure

Instructions: There are many ways that a therapist in prison can view his or her job. On the following pages you will see two statements a prison therapist might make about a particular aspect of the job. Notice that the two statements stress different values in a prison therapist's role. You can agree with one of the statements completely, while disagreeing with the other completely, or you can agree partially with each. If you agree partially with both statements, you can select a point between the two that shows you agree with some characteristics of one and some of the other.

With this in mind, please rate yourself on the spectrum. If you completely agree with statement A on the left, but completely disagree with statement B on the right, circle "-3". If you completely agree with statement B on the right, but completely disagree with statement A on the left, circle "+3". If you agree with both statements, but agree with one side more than the other, place the check closer to the side with which you agree more. And, if you agree with both statements equally, circle "0". For example,

Example Item

Statement A Everyone knows right from wrong.						Statement B Right and wrong are relative value statements, and differ depending on the person or situation.
-3 Agree only with A.	-2 Agree mostly with A, but also a little with B.	-1 Agree with both, but more with A than B.	0 Agree with A and B equally.	+1 Agree with both, but more with B than A.	+2 Agree mostly with B, but also a little with A.	+3 Agree only with B.

Please follow this guide as you read through these next statements. Mark what you believe personally—not what you think someone else would want you to answer.

1a. Therapy in prison should primarily benefit the offenders.	1b. Therapy in prison should primarily benefit the facility.
2a. The prison therapist works to empower offenders.	2b. The prison therapist works to keep offenders calm and stable.
3a. An offender's rehabilitation should be a prison's top priority.	3b. Safety and stability should be a prison's top priority.

4a. I try to interact with offenders in a caring, personable way.	4b. I put up my guard during interactions with offenders.
5a. Prison dehumanizes offenders, making antisocial attitudes worse.	5b. Prison provides structure and protection necessary for behavior change.
6a. Effective therapy requires some inherent trust in offenders.	6b. A prison therapist should not trust offenders.
7a. I work hard to have good relationships with offenders.	7b. I work hard to keep a healthy emotional distance from offenders.
8a. I often feel empathy for offenders.	8b. I avoid emotional connection with offenders.
9a. I sometimes think about how offenders are doing when I'm not at work.	9b. It is easy for me to leave my work at work.
10a. The primary purpose of prison mental health treatment is to help offenders adopt new thought patterns so that they can be prepared for civilian life.	10b. The primary purpose of prison mental health treatment is to keep offenders stable—reduce symptoms, prevent suicide, and ensure medication compliance.
11a. True therapy requires that I care about the offenders with whom I work.	11b. Caring about offenders crosses professional boundaries.
12a. Knowing the details of offenders' crimes probably biases the therapist against them.	12b. Knowing the details of offenders' crimes helps the therapist remember what they are capable of.
13a. Most offenders committed their crimes for circumstantial reasons (e.g., intoxicated, desperate, scared, etc.).	13b. Most offenders committed their crimes because of their values, beliefs, and worldviews.
14a. Most offenders are normal people who made poor choices.	14b. Most offenders have pathological personalities.
15a. Offenders frequently try to hide mental health symptoms to avoid stigma and vulnerability.	15b. Offenders frequently exaggerate or malinger mental health symptoms to take advantage of the system.

Resulting Proportions of Endorsements on PTOM Items

Statement A	A > B	A = B	A < B	Statement B
Therapy in prison should primarily benefit the offenders.	186 (78.5%)	38 (16.0%)	13 (5.5%)	Therapy in prison should primarily benefit the facility.
The prison therapist works to empower offenders.	110 (46.4%)	79 (33.3%)	48 (20.3%)	The prison therapist works to keep offenders calm and stable.
An offender's rehabilitation should be a prison's top priority.	68 (28.7%)	85 (35.9%)	84 (35.4%)	Safety and stability should be a prison's top priority.
I try to interact with offenders in a caring, personable way.	186 (78.5%)	30 (12.7%)	21 (8.9%)	I put up my guard during interactions with offenders.
Prison dehumanizes offenders, making antisocial attitudes worse.	96 (40.5%)	49 (20.7%)	92 (38.8%)	Prison provides structure and protection necessary for behavior change.
Effective therapy requires some inherent trust in offenders.	168 (70.9%)	32 (13.5%)	37 (15.6%)	A prison therapist should not trust offenders.
I work hard to have good relationships with offenders.	134 (56.5%)	61 (25.7%)	42 (17.7%)	I work hard to keep a healthy emotional distance from offenders.
I often feel empathy for offenders.	162 (68.4%)	43 (18.1%)	32 (13.5%)	I avoid emotional connection with offenders.
I sometimes think about how offenders are doing when I'm not at work.	63 (26.6%)	21 (8.9%)	153 (64.5%)	It is easy for me to leave my work at work.
Mental health treatment in prison consists mostly of helping offenders adopt new thought patterns so that they can be prepared for civilian life.	115 (48.5%)	78 (32.9%)	44 (18.6%)	Mental health treatment in prison consists mostly of keeping offenders stable—reducing symptoms, preventing suicide, and ensuring medication compliance.
True therapy requires that I care about the offenders with whom I work.	158 (66.7%)	50 (21.1%)	29 (12.2%)	Caring about offenders crosses professional boundaries.
Knowing the details of offenders' crimes probably biases the therapist against them.	52 (21.9%)	81 (34.2%)	104 (43.9%)	Knowing the details of offenders' crimes helps the therapist remember what they are capable of.
Most offenders committed their crimes for circumstantial reasons (e.g., intoxicated, desperate, scared, etc.).	57 (24.1%)	92 (38.8%)	88 (37.1%)	Most offenders committed their crimes because of their values, beliefs, and worldviews.
Most offenders are normal people who made poor choices.	104 (43.9%)	58 (24.5%)	75 (31.6%)	Most offenders have pathological personalities.
Offenders frequently try to hide mental health symptoms.	49 (20.7%)	114 (48.1%)	80 (33.7%)	Offenders frequently exaggerate or malinger mental health symptoms.

Appendix E – Attitudes Toward Prisoners Scale

Instructions: The statements listed below describe different attitudes toward prisoners in the United States. There are no right or wrong answers, only opinions. You are asked to express *your* feelings about each statement by indicating whether you (1) Disagree Strongly, (2) Disagree, are (3) Undecided, (4) Agree, or (5) Agree Strongly. Indicate your opinion by writing the number that best describes your personal attitude in the left-hand margin. Please answer *every* item.

Rating Scale

1	2	3	4	5
Disagree Strongly	Disagree	Undecided	Agree	Agree Strongly

1. Prisoners are different from most people.
2. Only a few prisoners are really dangerous.
3. Prisoners never change.*
4. Most prisoners are victims of circumstance and deserve to be helped.
5. Prisoners have feelings like the rest of us.
6. It is not wise to trust a prisoner too far.*
7. I like a lot of prisoners I know.
8. Bad prison conditions just make a prisoner more bitter.
9. Give a prisoner an inch and (s)he'll take a mile.
10. Most prisoners are stupid.*
11. Prisoners need affection and praise just like anybody else.*
12. You should not expect too much from a prisoner.
13. Trying to rehabilitate prisoners is a waste of time and money.
14. You never know when a prisoner is telling the truth.
15. Prisoners are no better or worse than other people.
16. You have to be constantly on your guard with prisoners.*
17. In general, prisoners think and act alike.*
18. If you give a prisoner your respect, he'll give you the same.*
19. Prisoners think only about themselves.*
20. There are some prisoners I would trust with my life.
21. Prisoners will listen to reason.
22. Most prisoners are too lazy to earn an honest living.*
23. I wouldn't mind living next door to an ex-prisoner.
24. Prisoners are just plain mean at heart.*
25. Prisoners are always trying to get something out of somebody.
26. The values of most prisoners are about the same as the rest of us.
27. I would never want one of my children dating an ex-prisoner.
28. Most prisoners have the capacity for love.*
29. Prisoners are just plain immoral.*
30. Prisoners should be under strict, harsh discipline.*
31. In general, prisoners are basically bad people.*

32. Most prisoners can be rehabilitated.
33. Some prisoners are pretty nice people.*
34. I like getting to know some prisoners.
35. Prisoners respect only brute force.*
36. If a person does well in prison, he should be let out on parole.*

*These items were removed from the scale after the pilot study, due to low variance.

Response Frequencies to Attitudes Toward Prisoners Items

Statement	Disagree	Agree
Prisoners are different from most people.	137	67
Only a few prisoners are really dangerous.	92	132
Most prisoners are victims of circumstance and deserve to be helped.	56	106
Prisoners have feelings like the rest of us.	8	223
I like a lot of prisoners I know.	68	95
Bad prison conditions just make a prisoner more bitter.	20	204
Give a prisoner an inch and (s)he'll take a mile.	60	113
You should not expect too much from a prisoner.	134	34
Trying to rehabilitate prisoners is a waste of time and money.	226	2
You never know when a prisoner is telling the truth.	114	73
Prisoners are no better or worse than other people.	55	120
There are some prisoners I would trust with my life.	117	66
Prisoners will listen to reason.	22	159
I wouldn't mind living next door to an ex-prisoner.	82	69
Prisoners are always trying to get something out of somebody.	110	58
The values of most prisoners are about the same as the rest of us.	118	66
I would never want one of my children dating an ex-prisoner.	28	140
Most prisoners can be rehabilitated.	33	138
I like getting to know some prisoners.	51	140

Note. This table summarizes responses from 237 participants. "Disagree" includes the number who responded "Disagree Strongly" and "Agree" includes the number who responded "Agree Strongly". The remaining participants selected "Undecided".

Appendix F – Measure of Role Conflict

The next few questions are about how you feel about your job. Please carefully read each statement below, and then indicate how often each condition applies to how you feel at work.

Response Scale

Strongly disagree	Disagree	Somewhat disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6

1. I am required to do things with offenders that should be done differently.
2. I am able to act the same with offenders regardless of what other staff members are with me.
3. My professional ethical guidelines are incompatible with prison policies.
4. I have to bend prison rules or policies in order to do my job with offenders properly.
5. Mental health staff and security staff approach offenders quite differently.
6. My responsibilities to the prison are compatible with my responsibilities to the offenders.
7. I do things that are likely to be accepted by either the offenders or administration, but not both.
8. I perform work that is in line with my professional values.
9. If these offenders were my clients in the community, I would do some things differently.
10. I feel that the offenders' therapeutic needs are at odds with the facility's security needs.
11. The prison environment contributes to good psychotherapy.
12. From a therapeutic point of view, I disagree with custody-related choices for offenders.
13. When offenders are not honest with me, it is because I am a staff member.
14. I believe that prisons are more concerned with punishment than rehabilitation.
15. When offenders request something of me, I think about their hidden motives.
16. The therapeutic methods I use are decided by prison policies.

Response Summaries to Role Conflict Items

Statement	Disagree	Agree
I am required to do things with offenders that should be done differently.	98	139
I am able to act the same with offenders regardless of what other staff members are with me.	35	202
My professional ethical guidelines are incompatible with prison policies.	157	80
I have to bend prison rules or policies in order to do my job with offenders properly.	193	44
Mental health staff and security staff approach offenders quite differently.	39	198
My responsibilities to the prison are compatible with my responsibilities to the offenders.	51	186
I do things that are likely to be accepted by either the offenders or administration, but not both.	186	51
I perform work that is in line with my professional values.	9	228
If these offenders were my clients in the community, I would do some things differently.	63	174
I feel that the offenders' therapeutic needs are at odds with the facility's security needs.	97	140
The prison environment contributes to good psychotherapy.	198	39
From a therapeutic point of view, I disagree with custody-related choices for offenders.	130	107
When offenders are not honest with me, it is because I am a staff member.	141	96
I believe that prisons are more concerned with punishment than rehabilitation.	92	145
When offenders request something of me, I think about their hidden motives.	32	205
The therapeutic methods I use are decided by prison policies.	140	97

Note. This scale has no midpoint, thus all responses from 237 participants are included. Any amount of disagreement was combined into the table's "Disagree" column, and any degree of agreement is included in the "Agree" column.

Appendix G – Minnesota Satisfaction Questionnaire Revised Short Form

Please mark your level of satisfaction with your current job in the areas indicated. Use the following scale for your response:

Very Dissatisfied	Somewhat Dissatisfied	Neither Satisfied Nor Dissatisfied	Somewhat Satisfied	Very Satisfied
1	2	3	4	5

1. The chance to do different things from time to time.	1	2	3	4	5
2. The chance to be "somebody" in the community.	1	2	3	4	5
3. The way my boss handles his/her workers.	1	2	3	4	5
4. The competence of my supervisor in making decisions.	1	2	3	4	5
5. Being able to do things that don't go against my conscience.	1	2	3	4	5
6. The way my job provides for steady employment.	1	2	3	4	5
7. The chance to do things for other people.	1	2	3	4	5
8. The chance to do something that makes use of my abilities.	1	2	3	4	5
9. The way company policies are put into practice.	1	2	3	4	5
10. My pay and the amount of work I do.	1	2	3	4	5
11. The chances for advancement on this job.	1	2	3	4	5
12. The freedom to use my own judgment.	1	2	3	4	5
13. The chance to try my own methods of doing the job.	1	2	3	4	5
14. The working conditions.	1	2	3	4	5
15. The way my co-workers get along with each other.	1	2	3	4	5
16. The praise I get for doing a good job.	1	2	3	4	5
17. The feeling of accomplishment I get from the job.	1	2	3	4	5

Summarized Responses to Job Satisfaction Measure

Aspect of Job	Dissatisfied	Satisfied
The chance to do different things from time to time.	63	146
The chance to be "somebody" in the community.	40	77
The way my boss handles his/her workers.	94	124
The competence of my supervisor in making decisions.	79	136
Being able to do things that don't go against my conscience.	32	174
The way my job provides for steady employment.	14	211
The chance to do things for other people.	14	187
The chance to do something that makes use of my abilities.	24	193
The way company policies are put into practice.	123	57
My pay and the amount of work I do.	110	99
The chance for advancement on this job.	125	57
The freedom to use my own judgment.	59	152
The chance to try my own methods of doing the job.	53	142
The working conditions.	86	110
The way my co-workers get along with each other.	79	131
The praise I get for doing a good job.	82	117
The feeling of accomplishment I get from the job.	40	164

Note. Responses of "Very dissatisfied" and "Somewhat dissatisfied" were combined into the "Dissatisfied" column. Responses of "Very satisfied" and "Somewhat satisfied" were combined into the "Satisfied" column. Responses of "Neither satisfied nor dissatisfied" are not included in this table.

Appendix H – Adapted Working Alliance Inventory—Short

Instructions: Below is a list of statements about experiences therapists might have with offenders on their caseloads. Please complete the form as if it is referring to a typical offender. Please take your time, and consider each question carefully.

Response Scale

1	2	3	4	5
Seldom	Sometimes	Fairly Often	Very Often	Always

1. The offender and I agree about the steps to be taken to improve his/her situation.

2. I am genuinely concerned for the offender's welfare.

3. We are working towards mutually agreed upon goals.

4. The offender and I feel confident about the usefulness of our current activity in therapy.

5. I appreciate the offender as a person.

6. The offender and I have established a good understanding of the kind of changes that would be good for him/her.

7. The offender and I respect each other.

8. The offender and I have a common perception of his/her goals.

9. I respect the offender, even when he/she does things that I do not approve of.

10. The offender and I agree on what is important for him/her to work on.

Response Distribution for Working Alliance Inventory Items

Item	Seldom	Sometimes	Fairly Often	Very Often	Always
The offender and I agree about the steps to be taken to improve his/her situation.	5	60	98	70	4
I am genuinely concerned for the offender's welfare.	2	19	44	106	66
We are working towards mutually agreed upon goals.	2	34	76	106	19
The offender and I feel confident about the usefulness of our current activity in therapy.	7	54	91	81	4
I appreciate the offender as a person.	5	25	54	99	54
The offender and I have established a good understanding of the kind of changes that would be good for him/her.	7	28	79	109	14
The offender and I respect each other.	4	22	74	118	19
The offender and I have a common perception of his/her goals.	6	35	89	101	6
I respect the offender, even when he/she does things that I do not approve of.	6	36	49	89	57
The offender and I agree on what is important for him/her to work on.	7	44	79	97	10

Appendix I – Vignettes

Scenario 1:

Offender L. is a prisoner in the facility where you work. He has served 9 years of a 16-year sentence. He has no history of self-harm. You receive a call from the corrections officers who supervise him, telling you that Offender L. says he does not want to live anymore. When you go to speak with him at his cell, Offender L. says that he just discovered his daughter dropped out of high school.

Please rate how likely you are to do each of the following:

Rating Scale

1	2	3	4	5
Very unlikely	Not likely	Unsure	Somewhat likely	Very likely

a. Refer him to a psychiatrist (symptom reduction).

b. Process his feelings with him (alliance).

c. Arrange to meet with him in a setting where he can speak without others listening (alliance).

d. Practice coping skills with Offender L., such as relaxation techniques, challenging cognitive distortions, or writing down his feelings (symptom reduction).

e. Place Offender L. on the least restrictive suicide watch necessary (symptom reduction).

f. Disclose about a time when you felt like giving up (alliance).

g. Ask him for more details about his daughter's situation (alliance).

h. Assess him for suicidality (symptom reduction).

Are there any other things you would do that are not listed? _____

Scenario 2:

After meeting with the parole board earlier in the day, Offender C. destroys a television set in his cell. He then refuses to cooperate with restraining procedures. A group of correctional officers used force to enter his cell and restrain him. You are now speaking with Offender C. while he is in an observation cell. Please mark how likely you would be to do each of the following:

a. Encourage him to tell you what happened with the parole board (alliance).

b. Refer him to a psychiatrist (symptom reduction).

c. Talk about anger management techniques (symptom reduction).

d. Explore his emotions about being forcibly restrained (alliance).

e. Discuss how his choices disrupted the facility (security).

f. Express sincere disappointment in his actions (alliance).

g. Assess him for suicidality (symptom reduction).

h. Praise him for other areas in which he has made progress (alliance).

i. Take steps to limit his access to other expensive equipment for a time (security).

Are there any other things you would do that were not listed? _____

Appendix J—Noteworthy Comments From Participants

Many participants left comments in the free response section of the survey materials that are relevant to the topic. The emerging themes from these comments are organized here, and some of the comments are presented with discussion. It must be stressed that these responses are not necessarily representative of the participants as a whole, nor do they necessarily pertain to any one agency or facility. Sentiments that were not shared by several respondents are excluded from this section.

Role conflict. Many respondents' comments appeared to acknowledge the duality of their roles, as expected from much of the past literature. For example, one therapist wrote, "For mental health it is always a balancing act between the system and treatment." Another respondent gave a lengthy description of the duality, clearly noting the conflict between treatment and security needs (emphasis in original):

> It's a sad, sad truth that offenders are seen just as numbers and that rehabilitation is only a political term used to talk the talk. It's a sad reality that staff's personal issues take precedent when dealing with offenders versus truly having the offenders [*sic*] issues in mind to attempt to rehabilitate…. I have been in corrections for [more than 10] years and can honestly tell you that most staff [members] (to include those in the "helping professions") are in this field IN ERROR. The correctional setting allows for and seems to attract staff [members] who have "unfinished personal business" of their own, and working in the correctional setting provides many with abundant opportunities to vent/dump their personal issues on others who have no recourse on responding to such treatment.

This respondent first describes his or her views of the conflicting aims of incarceration and treatment, suggesting that prisons are focused on incapacitation or isolation, with little to no real intent to rehabilitate. The respondent then focuses on his or her views of why the aims conflict—due to staff approaches toward the offenders. Indeed, it seems clear from this statement that this respondent believes the attitudes of staff have a large effect on offenders. Expressing a similar view, another therapist explained that the roles of staff do not necessarily dictate the manner in which they interact with offenders; "I have seen some security staff be very thoughtful and therapeutic and have seen mental health staff be very demeaning and unhelpful." These two statements not only give credence to the findings in this study regarding the different approaches that prison therapists use, but also connote the importance of approach toward offenders, regardless of the staff's role. This is in line with the core correctional practices discussed earlier (Dowden & Andrews, 2004). Positive and prosocial interaction between staff and offenders is at the foundation of effective corrections.

Another wrote more specifically about the role conflict in interactions with offenders: "My first thought is ['H]ow can I guide them into a better life[?']. My second thought involves whether or not the offender is manipulating me…." This is an excellent description of the opposing pressures on the correctional therapist. On the one hand is the nature of psychotherapy to assist others in improving their lives, but this aim faces obstacles due to the nature of the population the therapist serves. Another shared similar sentiments with, "There is nothing black and white when working in a prison setting. You have to both trust and question…." Such a sentiment reflects previously reported feelings from prison mental health staff (e.g., Huffman, 2005).

Others made comments about opposing aims of security and treatment staff. "Therapeutic culture is not accepted, and often prosecuted [persecuted] by ex-military staff." This respondent apparently finds a great deal of the difficulty in the work to originate in the opposing methods or aims of the adversarial approach toward incarceration and the treatment-oriented approach. The therapist specifies that he or she views the most conflict coming from "ex-military" staff members, who presumably approach their work with a security and safety emphasis. However, the different approaches may be present with other security personnel, as prisons are organized in a paramilitary fashion (Mobley, 2008), which chains of command and ranks that are similar to those within the armed forces. Of course, as a previous commenter noted, the role of the staff member does not dictate whether he or she will interact with offenders in an authoritarian or prosocial manner, but the present comment may be reflective of trends from staff roles in his or her experience.

Others shared comments on the impact of the challenging work, perhaps as a testament to the effect it can have on job satisfaction. One stated, "This is an incredibly challenging job… The caseloads and issues can be daunting…" As an example of how these challenges may negatively affect a staff member, another therapist candidly shared the consequences of the difficult position: "I've been working in corrections for [fewer than 10] years now and feel extremely burnt out to the point where I question my career decision." This comment captures the findings from past research on burnout and job turnover within the correctional psychotherapist field (Borritz, 2006), and underscores one of the broader goals of this research—to assist in increasing job satisfaction by decreasing feelings of role conflict that prison therapists have. The level of burnout is certainly not representative of the entire sample, but it is also

unlikely that this commenter's feelings were unique. The importance of retention of prison therapists is in the Discussion section.

A balanced approach. Many respondents left comments that appear to address the importance and possibility of establishing a balance of security with treatment. For example, one person wrote, "Safety and security [are] always a priority; however, mental health and rehab treatment ultimately enhances [*sic*] that." This comment appears to advocate for the unified approach toward correctional mental health also endorsed by Dignam (2003). The therapist appears to advocate for the view that mental health treatment serves the facility's safety and security needs, and thus the two are not intrinsically at odds.

Others made statements that reflect differing aims of corrections and treatment, but with optimism about integrating them. One wrote, "There are sometimes [*sic*] where there is conflict in personal therapy style and approach, and the policy and procedures of the work of doing prison counseling but as a counselor it is important to adapt and be flexible." This comment appears to encourage therapists to be accepting of the facility needs for safety and security even though they may be a hindrance to treatment at times. This notion of unification in the overall mission of corrections was perhaps best expressed in another therapist's comment, stating

> I think the…State DOC has responded to an increase in seriously mentally ill individuals in a thoughtful and proactive manner. Prisons were not designed to serve servere [severe] and persistently mentally ill people…. Where I work there is collective agreement [b]etween mental health providers, corrections officers, and other corrections staff that we need to work together to be a part of the solution to this very sad and serious situation. While there is clearly much work in front of us at least we are moving fo[r]ward together.

The comment first acknowledges the challenge of integrating mental health treatment with prison aims, but frames it in a way that appears to unify their mutual goals. The notion of unification of prison aims has been expressed previously by researchers, who argue that the goals of treatment and custody are more similar than perhaps realized (Dvoskin & Spiers, 2004). Working toward broadening this view among psychotherapists who work in corrections appears to be an important aim.

In a statement that is strikingly similar to the conceptualization of the balanced approach, one respondent stated,

> I make it a rule to establish firm boundaries with regard to personal information in my work outside [t]he facility as well as inside the facility. I do not believe this hinders me from establishing trust and building positive relationships with the men I work with daily. My role isn't to judge them. That was done by the judge and jury. When they are re[c]eptive to treatment, we/I am available to provide that assistance.

This approach acknowledges the risk inherent with the population, but makes it clear that elements of the therapeutic alliance are important and attainable even in the prison environment. The therapist can take a nonjudgmental approach that is positive, but not placing the therapist in a compromising position. Again, this view appears to represent the "firm but fair" model of correctional rehabilitation discussed above (Dowden & Andrews, 2004).

Facility obstacles. Many respondents used the free response section on the survey to express their frustrations with their positions, apparently elaborating their responses from the job satisfaction section. Those that are relevant to the overarching theme of this research are presented here, as it was clear that these issues were important to the respondents.

A few therapists noted restrictions to their job performance that originate with the facility and its operations. One wrote, "Then there are time constraints. We have to work around count-time, occasional lock-downs, and security exercises. I have [j]ust over 100 clients. This is a ridiculous amount of clients. Group therapy is supposed to help with high caseloads. I can't say that it helps."

The theme of having inadequate resources was repeated by others. Another therapist wrote, "We are expected to complete all the requirements of the mental health job even though we have been short-staffed for over two years." Another explained that the

> Biggest issue is not enough [staff] to help therapists for the influx of mentally ill offenders. Our main goal in the day is putting out crisis [*sic*]. Hard to do tx [treatment] and deal with crises, paperwork, m[ee]t[in]gs, etc.... I would say we are in dire need of more professionals.

This sentiment was shared by other commenters as well. The shortage of mental health staff is a problem noted in much of the extant literature (Boothby & Clements, 2000; Magaletta & Boothby, 2003; Mobley, 2008; Roberts & Biswas, 2008), and appears to be a concern for many of the professionals in the field (also see Karcher, 2003).

This theme of lacking resources was also noted in regards to its effect on prisoners. One respondent wrote, "Offenders essentially get the minimum amount of mental health care possible due to lack of funding." If this statement is true, then it has large legal and ethical implications for prisons. As noted previously, a lack of resources was part of the reason that thousands of offenders were released early from the California state prisons in the last few years—many of their basic medical and mental health needs could not be met (Brown v. Plata, 2011; Salins & Simpson, 2013).

In addition to the many comments regarding the lack of enough staff members to meet the mental health needs of offenders, there were many comments about elements of the prison environment that reportedly work against the aims of therapy. One respondent wrote, "Many who want to change are in an environment that makes positive change difficult…" As others have stated, prison structures (McConville, 2000; Wright, 1993), prison policies (Ward & Salmon, 2009), and prison culture (Mobley, 2008) often appear to be obstacles to improving mental health of prisoners.

In a similar vein were some complaints regarding the facility practices and policies that some therapists viewed as being obstacles to their work. Two therapists voiced concern over their perceived discord between their work and the goals of the administration. The first stated

> The experience of practicing therapy in the correctional setting is individually guided, yet policies are produced by those that do not practice therapy in the correctional setting, which places stressors on the inmates making the job more difficult for st[a]ff. Attitudes are the refle[c]tion of leadership!

This respondent appears to desire more representation of mental health's interests in policies, and suggests that the lack thereof leads to problems for the offenders and staff. Another respondent echoed this desire for mental health treatment interests to have more prominence in the aims of the administration:

> The department of corrections is a large bureaucracy that is over-staffed on the administrative side and understaffed on the frontline…. Health services in general is considered to be fair game when budgeting matters occur, and there appears [t]o be active pressure to reduce services coming from the administration these days.

Not only does this commenter find that mental health staff are overburdened, but states that there is an overly-bureaucratic element of prisons that perhaps undervalues mental health work in this person's view. This again underscores the theme from many commenters about inherent obstacles to the work that therapists do. However, it must be emphasized that these comments were not universally shared among respondents, as others expressed how the aims of prison and therapy may coincide and can work together.

Endorsement of security emphasis. Some respondents made additional comments in defense of the security-minded emphasis, as it was conceptualized in this research. For example, one wrote "I practice and advocate a philosophy of no emotional investment in the success or failure of an offender. I provide them the tools and support, but if they fail or succeed it is all on them." This statement appears to endorse an emotionally disengaged approach toward therapy, appearing void of elements of the therapeutic alliance. Although avoiding investment in an offender's success or failure does not necessarily imply an emotional disengagement during therapy, the tone of this comment appears to be in line with the author's conceptualization of therapists with relatively less emphasis on the alliance than the safety and security of the facility (see hypotheses). In a somewhat similar statement, another therapist wrote

> I view therapy in prison as being a bit like being a teacher in a shop class. I generally hand out tools. These are tools that I have used and have experience with that can help the offender improve their life. I am always clear that the use of these tool[s] are [*sic*] suggested and they can choose to use them or not, it is their choice.

Although this respondent did not explicitly state the level of emotional engagement he or she uses in treatment, the analogy of handing out tools for offenders to choose to use appears to be in line with the conceptualization of a therapist who uses a treatment manual to discuss coping

skills, anger management skills and the like, but has relatively less concern for forming a warm, emotional bond with the offenders.

Another therapist described a similarly detached approach by writing,

> I don't feel attached to inmates; I feel genuine concern for their wellbeing; I am interested in their stories, but I don't necessarily take a p[e]rsonal interest in building [a] relationship with the inmates. I draw a distinct line. Both to protect their vulnerability and mine.

Interestingly, this therapist describes protecting the offender's vulnerability as a reason to avoid building a personal relationship. Although the therapist did not elaborate, it seems plausible that he or she refers to the difficulty inherent in a client forming a relationship with a therapist when ultimately the relationship may end prematurely (i.e., without the therapeutic process of termination). This was similarly cited as a problem in Karcher's (2003) interviews with prison psychologists; an offender or staff member may be transferred to another facility with little or no notice, perhaps serving as another obstacle to their desire to form a therapeutic relationship. Another possibility is that this therapist is concerned that an offender may face ridicule or hazing from other offenders if he or she is seen building a relationship with the therapist. Indeed, because offenders tend to perceive mental health staff as untrustworthy (Howerton et al., 2007), if they appear to form trusting relationships with therapists, they may be perceived by other offenders as traitors, perhaps liable to disclose rule violations or illegal activity of the other offenders (Mobley, 2008). This seemingly altruistic purpose of emotional detachment is another possible explanation for the security-minded approach toward therapy that was not examined in this project, but should be considered in the future. The precise meaning of

the comment was not clear, but it could be interpreted as remaining emotionally distant for the protection of the offender.

Positive work. In contrast to many of the apparently discouraging comments about the current state and potential for good therapy within prisons, there was one comment that was also found among Karcher's (2003) sample regarding the potential rewards of prison therapy. "One positive aspect of my work is to actually see changes offenders have made. I see more positive growth than severe psychopathy within this structured environment." This sentiment appears to be shared by many of the therapists in the sample, considering the way in which they responded to an item on the job satisfaction measure—24% of participants were "very satisfied," and 44% were "somewhat satisfied" with the feeling of accomplishment they get from their work. As virtually all of the respondents believe rehabilitating offenders is a worthwhile effort (Appendix E), this view is likely to be shared among many prison therapists. Although the environment and population present many challenges to therapeutic work, it seems that many of the therapists remain dedicated to the cause of psychotherapy and the role it can have in an offender's rehabilitation.

Curriculum Vita

Elijah Ricks graduated from Brigham Young University in Provo, Utah in 2006, with his bachelor's degree in psychology. Thereafter, he worked as a vocational case manager at a residential school for men with learning disabilities and autism spectrum disorders. He departed from that position in 2008 to attend the University of Colorado, Colorado Springs, seeking a Master of Arts degree in clinical psychology. Before completing the degree in 2010, he began a clinical internship at San Carlos Correctional Facility, working primarily with offenders who had developmental disabilities. He simultaneously assisted with research in several other state correctional institutions, facilitating substance abuse recovery and prevention protocol. Upon graduation, he was hired as a therapist for the Colorado Department of Corrections, serving as the primary mental health contact for a group of offenders at the Colorado State Penitentiary. He left that position in 2011 to seek his doctoral degree at The University of Texas at El Paso.

At UTEP he worked with the El Paso County Juvenile Probation Department to assist with its research, published his own research on how community corrections officers' work attitudes may influence their decisions (Ricks & Eno Louden, 2014), and has other manuscripts currently under review. He has also presented projects at national conferences, including meetings of the American Psychology-Law Society, and the High Value Detainee Interrogation Group.

Permanent Address: 2011 Essex Lane
Colorado Springs, Colorado 80909
Or
elijah.ricks@gmail.com

This dissertation was typed by Elijah Ricks.