Therapeutic Relationships & Boundary Maintenance: The Perspective of Forensic Patients Enrolled in the Aggressive Behaviour Control Program

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Abstract

The complexity of the therapeutic relationship is amplified when the setting is a prison and the patient is incarcerated. A challenge essential to the therapeutic process is the establishment and maintenance of a therapeutic relationship, including therapeutic boundaries (Peternelj-Taylor, 1998). Theoretical and empirical literature related to boundaries in the therapeutic relationship has focused primarily on outpatient settings where the therapeutic relationship demands only one role from the mental health professional – that of therapist. Conversely, the therapeutic relationship in the inpatient setting with a forensic patient demands that the mental health professional occupy multiple roles all within the realms of the therapeutic relationship. Although existing knowledge may provide some guidance, the complexity of therapeutic relationships with forensic patients has not been adequately addressed in either theoretical or empirical literature. Developing an understanding of the complexity of maintaining therapeutic boundaries with forensic patients is essential to guide nurses and other professionals in their therapeutic relationships with this group of patients.

To extend current knowledge about therapeutic relationships and therapeutic boundary maintenance with the incarcerated forensic patient, the focus of this study was the exploration of the perspectives of forensic patients enrolled in the Aggressive Behaviour Control (ABC) Program. The study was conducted using a naturalistic inquiry research design (Lincoln & Guba, 1985). Data was collected through indepth interviews with 12 participants enrolled in the ABC program. All participants were given an opportunity to review, confirm, clarify, correct, amend or extend the
interview transcripts and the elements identified in analyzing the data they provided. Field notes, reflective journal entries, and interview transcripts constituted the data for analysis.

Analysis of the data collected revealed a core process – the development of “therapeutic” relationships – indicating that the development of “therapeutic” relationships was a complex process. Associated with this process were five interrelated themes. Adjusting to the House, describes the participants’ transition from their parent institutions to the treatment environment. Knowing the Fundamental Structures of the House, provides the participants’ perception of the influential contextual factors in the treatment environment. Evaluating the Primay Therapist as a Guide, describes the process that the participants engaged in to determine the approach to treatment of the primary therapist. Experiences that Promote or Hinder the Relationship, described those experiences that the participants had with the primary therapist that either promoted or hindered “therapeutic” relationships. Finally, Ways of Being with the Primary Therapist: Head, Heart, Head and Heart, and Wallet depicted four different types of relationships that evolved between the participants and the primary therapists.
ACKNOWLEDGEMENTS

Many people contributed to this study in a variety of ways. To the 12 participants in the study I would like to extend my sincere appreciation. By sharing your experiences with the nurse-patient therapeutic relationship you have contributed to the knowledge and understanding of the therapeutic relationship from the perspective of forensic patients enrolled in a treatment program. I would also like to recognize the contribution of those patients, who during the conceptualization of this study, suggested that the focus be the forensic patient’s perspective. To examine a perspective not previously captured was a rewarding and enlightening experience. I wish to acknowledge the Regional Psychiatric Centre (Prairies) for the support that they have provided over the past two years, and to the staff who assisted in the selection of participants. I also wish to thank Audrey Gordon and Marlene Mirasity for their contributions to this study.

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Finally, I wish to recognize the contribution of my husband, Mike, for always having the faith that I would achieve my goals, and whose humor and patience make the most trying times easier.
DEDICATION

I would like to dedicate this work to the memory of my father (Roger Schafer), who died in September 1995. I recall sharing a story with a colleague about my father that illustrates the nature of our relationship that I would like to also share with the reader. Even in the last days of my father’s life he never abandoned his role as a father. He told me that his having cancer was a bad thing happening to the family, but that it did not need to be a negative experience, that even in death there was opportunity to learn and grow. Only after a careful assessment of my ability and my confirmation that I was generally able to find the strength to do what was necessary for others, did he ask if I would care for him during his worst times. This story illustrates the negotiation of our roles that often marked developmental milestones. My father taught me the value of having a safe place to grow and become. When I thanked him for making space for me in the family, he replied “I was only doing my job”.
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Glossary of Terms

**Boundary crossings:** Departures from usual practice that may be outside the theoretical orientation of the therapist that may or may not be harmful to the patient (Gutheil & Gabbard, 1993). Boundary crossings are distinguishable from boundary violations in that they are not exploitative (Gutheil, 1994).

**Boundary violations:** Are harmful transgressions of therapeutic boundaries (Gutheil & Gabbard, 1993).

**CCRA:** Correctional Conditional Release Act, legislation that outlines the rights of offenders and the responsibilities of correctional institutions.

**Correctional Supervisor:** Correctional officer responsible for the operation of the institution on weekends and evenings.

**COII:** Correctional officer who is assigned to a treatment unit. They are assigned a small group of patients for whom they prepare and manage all case work under the jurisdiction of the Executive Director.

**CSC:** Correctional Services of Canada

**Hound:** Prison slang name for a sex offender.

**Parent institution:** The institution where the participant was incarcerated prior to being admitted to the RPC.

**Parole:** The portion of a sentence served in the community with supervision. The offender is eligible for parole after serving one third of the sentence imposed by the court.

**Parole Officer:** Refers to the institutional parole officer who functions as a case manager in planning release and preparing cases for presentation to the National Parole Board.

**PC:** Protective custody

**PFV:** Private family visit. Participants would spend the weekend with their family in apartment like accommodations on the institutional grounds.

**SHU:** Special handling unit, also commonly referred to as super maximum security.

**Statutory release date:** The date upon which an offender has served two thirds of the sentence imposed by the courts and is released to the community with supervision.
The **man**: a prison sub-culture term, referring to the Correctional System of Canada.

**Wardrounds**: An interdisciplinary conference (that includes the participant), for the purpose of evaluating the participant’s treatment progress, and to evaluate and revise the treatment plan.

... : Indicates a pause in the participants’ responses

..... : Indicates where a portion of the participants’ response was not included in the quote.
CHAPTER ONE

Background for the Study

1.1 Introduction

With the introduction of Peplau’s (1952) interpersonal theory, nursing moved from doing “to” to doing “with” patients (Forchuk, 1993) and the therapeutic relationship became central to nursing in general, and specific to psychiatric nursing. Peplau (1952, 1989a) maintained that the role of counselor or psychotherapist, where emphasis is on the psychotherapeutic process, was the primary role of psychiatric nurses. Consequently, therapeutic relationship shall be used to refer to the relationship between a mental health professional and a patient, where the emphasis is on the psychotherapeutic process.

The therapeutic relationship exists for the sole benefit of the patient and is characterized by an inequitable power distribution, with the professional occupying a position of power. While the mental health professional may receive a monetary reward, may take pride in achieving effective therapeutic relationships, and may grow professionally and personally, the patient and the patient’s needs are central to the therapeutic relationship (Peplau, 1989a). The purpose of the therapeutic relationship is to enhance change and growth in the patient. Any personal and professional growth of the mental health professional stems from self-reflection and not from the patient meeting the therapist’s needs. Additionally, the expert knowledge held by the professional, coupled with the unilateral self-disclosure and vulnerability of the patient, creates a situation where mental health professionals possess more power than their
patients (Strasburger, Jorgenson & Sutherland, 1992). The uniqueness of the therapeutic relationship demands that therapeutic boundaries receive special consideration.

Well functioning boundaries tend to go unnoticed. However, most individuals recognize when someone has crossed the line and violated their sense of self. In this context, a boundary indicates where one ceases and another begins (Epstein, 1994). Pilette, Berck and Achber (1995) defined a boundary as a margin or a limit, while Owen (1995) defined boundaries as the “extent of personal power or autonomy, freedom and constraint” (p.101). Clearly, boundaries mark the limits that allow for safe connections between people. Without boundaries individuals would not be able to connect with others without losing themselves or engulfing another. Boundaries allow for safe interpersonal relationships, including therapeutic relationships.

The importance of therapeutic boundaries is widely recognized (Atkins & Stein, 1993; Borys & Pope, 1989; Brown, 1994; Collins, 1989; Epstein & Simon, 1990; Evans & Hearn, 1997; Folman, 1991; Gabbard, 1996; Gallop, 1998; Gottlieb, 1993; Gutheil & Gabbard, 1993; Hartmann, 1997; Herlihy & Corey, 1997; Johnston & Farber, 1996; Kagle & Geibelhausen, 1994; Lamb & Catanzaro, 1998, Pilette, Berck & Achber, 1995; Plaut, 1997; Simon, 1992; Smith & Fitzpatrick, 1995; Williams & Swartz, 1998). Establishing and maintaining therapeutic boundaries is recognized as a challenge of particular significance for nurses engaging in the psychotherapeutic process with incarcerated forensic patients (Melia, Moran & Mason, 1999; Peternelj-Taylor & Johnson, 1995; Peternelj-Taylor, 1998). Given the significance of boundary maintenance to therapeutic relationships, it is surprising that research regarding
therapeutic boundaries in the forensic inpatient setting has not been an area of focus (Peternelj-Taylor, 1998). It is less surprising that as the forensic inpatient setting is emerging as an area of focus in the research on therapeutic boundaries that boundary violations resulting from over involvements are being examined (C. Love, personal communication, April 20, 1999). The impetus being the extreme consequences that both nurses and patients suffer when over involvement occurs. Involved nurses have become the victims of violent crimes, including murder; while distressed patients have committed suicide (C. Love, personal communication, April 20, 1999). To date no study has focused on boundary maintenance from the perspective of the forensic inpatient.

Participation in treatment programs is generally voluntary; however, forensic patients often feel that they have limited options (Haynes, 1997; Norton, 1996; Peternelj-Taylor & Hufft, 1997). For those incarcerated, parole and freedom are often dependent upon the successful completion of a treatment program and favorable assessment of their risk to re-offend. Duress, rather than a desire to change, characterizes the sentiments of some forensic patients as they enter treatment and the therapeutic relationship. The duress forensic patients may experience, coupled with the necessity of receiving favorable reports and risk assessments, may make deceit and manipulation favorable options when compared to truth and honesty.

Mental health professionals working in the forensic inpatient setting have dual obligations – to the justice system, as well as to the patient. They are required to report the patient’s progress, and to assess the patient’s risk of re-offending. Consequently, forensic patients are obligated to accept treatment in a situation where the power
differentiation between the mental health professional and the patient extends beyond
the power difference typically associated with therapeutic relationships (Strasburger, et
al., 1992). Mental health professionals in the forensic inpatient setting, in essence, have
power to deny the patient freedom. Clearly, forensic patients are a unique and
vulnerable group. The reality of their experiences with therapeutic relationships and
therapeutic boundaries has not yet been captured and is not likely reflected in the
experiences of non-forensic patients.

1.2 The Purpose of the Study

The intent of this study was to contribute to contemporary understanding of the
complexity of therapeutic boundary maintenance with forensic inpatients. An
understanding of this complex phenomenon is essential to guide nurses and other
professionals in their therapeutic relationships with this group of patients. The purpose
of this study was to gather data from forensic patients enrolled in the Aggressive
Behaviour Control (ABC) treatment program regarding their experiences in therapeutic
relationships, and specifically their experiences with boundary maintenance.

A second purpose of the study was to give forensic patients enrolled in the ABC
program an opportunity to share their experience. During the early stages of
conceptualizing this study it was certain that the focus would be therapeutic
relationships and therapeutic boundary maintenance with the forensic patient enrolled in
the ABC program. Interestingly, patients suggested that the study focus on the patients’
perspective, a perspective that the researcher had not previously considered in any
detail. During informal discussion with a small group of patients enrolled in the ABC
program they shared that they felt vulnerable when it came to therapeutic boundaries.
They feared that they would be blamed for any boundary transgressions that occurred, and were confused by what they perceived to be mixed messages from the treatment team members or primary therapists. The basic nature of their fear is captured in the forensic nursing literature.

Although therapeutic boundary maintenance is the nurse’s responsibility, nurses who become over involved are often viewed as victims (Gallop, 1998), while the forensic patient involved is often viewed as the perpetrator (Petemelj-Taylor, 1998). In terms of boundary maintenance, nurses are often seen as crossing boundaries out of necessity to care for the forensic patient, while forensic patients uncertain about the limits of the therapeutic relationship are viewed as purposely violating boundaries and attempting to manipulate or exploit the nurse (Melia, et al, 1999). In the researcher’s experience, patients that are viewed as perpetrators and manipulators may be discharged from treatment programs for boundary violations. Ironically, the forensic patient may be held accountable for boundary maintenance, an area clearly within the nurse’s responsibility, or at minimum a shared responsibility between the patient and the nurse.

1.3 The Relevance for Nursing

Peplau (1952), the first modern nursing theorist (Forchuk, 1993; O'Toole & Welt, 1989), contended that the nurse-patient therapeutic relationship was the means of promoting growth in patients. The therapeutic relationship continues to be central to the work of nurses in general, and particularly forensic psychiatric nurses. Therapeutic boundaries are an essential aspect of the therapeutic relationship. They protect the patient, the nurse, and the psychotherapeutic process (Smith & Fitapatrick, 1995). Therapeutic boundary maintenance is a challenge frequently faced by forensic
psychiatric nurses engaged in therapeutic relationships with forensic inpatients. Therapeutic boundary maintenance, as an essential aspect of therapeutic relationships, invariably becomes a component of the means of promoting growth in patients (Peplau, 1952). Consequently, examination of the forensic patients' perspective of therapeutic boundaries is of relevance to forensic psychiatric nursing practice.

1.4 Research Question

The following broad question guided this study: what are the perspectives of patients who have nurses as primary therapists and who are enrolled in the ABC program, regarding therapeutic relationships and specifically, therapeutic boundary maintenance.
CHAPTER TWO

A Review of the Literature

2.1 Introduction

A literature review was conducted to explore previous research examining the perspective of the forensic inpatient regarding therapeutic relationships and therapeutic boundary maintenance. No previous studies that addressed the purpose of this study could be found. Out of necessity, the review was expanded to include relevant theoretical literature about therapeutic relationships in the forensic environment and empirical literature regarding the perspective of out-patients, on a variety of therapeutic boundary issues, including dual relationships, physical contact, therapist self-disclosure, and patient's ethical judgement and knowledge. The theoretical literature, reviewed first, reflects the complexity of therapeutic relationships and therapeutic boundary maintenance in the forensic environment. The empirical literature, considered next, includes both quantitative and qualitative studies. A discussion of methodological issues associated with these studies concludes this chapter.

2.2 The Challenge of Therapeutic Boundary Maintenance

The challenges surrounding the establishment and maintenance of therapeutic boundaries in therapeutic relationships with forensic patients is conceptualized in the theoretical literature as an interaction between the professional, the environment, and the patient.
2.2.1 The Professional

Schafer (1997) argued that the socialization of women and nurses discourages the establishment of personal, and, subsequently professional boundaries. The inequality nurses experience within the traditions of the medical model, coupled with the nursing profession’s emphasis on caring and objectivity as the essence of the nurse’s role, has lead to the internalization of the sociocultural stereotype of an ideal nurse as one that sacrifices personal needs to care for others. Nurses entering correctional institutions are confronted with a culture where forensic patients consider manipulation and exploitation as acceptable means to meet personal needs (Schafer, 1997). Subsequently, the difficulty that nurses experience in establishing and maintaining therapeutic boundaries is amplified.

As self-sacrificing, caring individuals, nurses are more likely to consider themselves victims of boundary violations rather than perpetrators (Gallop, 1993). Nurses, as victims, may view themselves as powerless and not responsible for boundary violations that occur in the nurse-patient relationship. Accordingly, if nurses do not see themselves as responsible for the problem, they likely will not perceive themselves as responsible or capable of finding a solution. Worse yet, nurses may view themselves as heroes by virtue of their willingness to cross boundaries to connect with and care for forensic patients. It could be that crossing boundaries is necessary to provide care (Melia, et al., 1999). It could also be that nurses fail to establish therapeutic boundaries in order to meet their need to be seen as caring (Pilette, et al., 1995). In any event, it is safe to say that the nursing profession has not adequately examined therapeutic
boundary maintenance (Gallop, 1998; Peternelj-Taylor, 1998). Consequently, nurses, without adequate guidance from their profession, must draw on personal resources in order to respond to the challenge of establishing and maintaining therapeutic boundaries with forensic patients.

2.2.2 The Environment

Peternelj-Taylor and Johnson (1995) asserted that the “intensity of the correctional environment contributes to the immediate risk of complicated relationships, as institutions are ‘ripe’ for potential problems regarding therapeutic relationships” (p. 8). Correctional institutions are closed systems and nurses that care for the incarcerated in these institutions may experience personal and professional isolation (Peternelj-Taylor & Johnson, 1995; Peternelj-Taylor, 1998). Nurses spend long hours interacting with patients (Peternelj-Taylor, 1998), during which time intimate conversations occur (Melia, et al., 1999).

In addition to the isolation that professionals working in correctional environments may experience, closed systems pose a special hazard. Professionals and patients, often out of necessity, have dual relationships in closed systems (Plaut, 1997). Although the term “dual relationships” is rarely used in related forensic literature (Schafer, 1997), the challenge of multiple roles is widely recognized as a challenge of particular significance in working with incarcerated forensic patients (Haynes, 1997; Peternelj-Taylor & Johnson, 1995; Peternelj-Taylor, 1998; Schafer, 1997).

Haynes (1997) identified therapist, security enforcer, case manager, and predictor of the patient’s future dangerousness as some of the roles required of mental health professionals in the forensic environment. Furthermore, a social role is often
considered an aspect of the therapeutic relationship with forensic patients (Peternelj-Taylor, 1998). Multiple roles increase the complexity of therapeutic relationships and the potential for boundary crossings and violations.

The inherent conflict associated with expectations and requirements of multiple roles of mental health professionals may increase the potential to violate the therapeutic boundary. For example, assuming a social role with a patient typically constitutes a departure from the usual practice of many mental health professionals, and, as such, may be considered a boundary crossing (Smith & Fitzpatrick, 1995). Clearly the requirements and expectations of a social role, conflict with the requirements of the authority of a security enforcer role. The role conflict experienced by nurses and other mental health professionals working with incarcerated forensic patients is frequently related to the demands of the environment; that they fulfill conflicting obligations—custody and caring (Peternelj-Taylor & Johnson, 1995; Willmott, 1997).

Professionals are not alone in navigating the multiple roles involved in working in correctional institutions. Incarcerated forensic patients are also affected by the multiple roles of their caregivers. As Poorman (1995) suggested, patients experience difficulty discerning professional and social relationships. This may be particularly true of forensic patients who typically experience difficulties in their interpersonal relationships.

2.2.3 The Patient

Melia, et al. (1999) described personality disordered forensic patients, as being intensely concerned and preoccupied with the protection of self, while they showed little concern for others. Additionally, they described these patients as having an
exaggerated moral outrage when their own personal rights were violated, even though they blatantly disregarded the rights of others. This description of the forensic patient is not unlike other descriptions (Hufft & Fawkes, 1994; Norton, 1996; Peternelj-Taylor & Johnson, 1995), where exploitation of others, and manipulation are prominent behaviours. Melia, et al. (1999) asserted that these characteristics create a number of clinical challenges in the clinical setting, such as the establishment of relationships, splitting and keeping secrets, and rejection.

The challenge of establishing relationships is related to the patient’s tendency to blame and deny responsibility for their actions. They may attempt to persuade staff to validate their point of view, and seek out staff that are less challenging. Patients may use one, or both forms of splitting – splitting by either coercion, or the more seductive form of keeping secrets (Melia, et al., 1999; Shimmin & Storey, 2000).

Splitting is a commonly used defense mechanism (Gallop, 1985; 1992; Melia, et al., 1999). Melia et al. (1999) described the coercive form of splitting as the pressure that the patient exerts on those staff attempting to be consistent. Patients will present themselves as victims of uncaring rigid staff members who will not disregard a rule, as others have, to help them. This results in splitting team members about the approach to treatment and the patient’s motivation.

Often patients using seductive secrets as a method of splitting staff, paint a picture of the staff member as a hero rather than a villain. Patients may describe how a particular staff member is “special”, or as “the only one who has ever listened”, or as “the only one” that they “ever talked to about this”. Once the relationship is established as “special” the patient may invite the staff member to keep a “secret”, which solidifies
the relationship as special and perpetuates conflict among team members (Peternelj-Taylor, 1998).

Personality disordered patients typically have histories colored by abuse, exploitation and rejection (Melia, et. al., 1999; Norton, 1996). They come to use rejection of others as a method to defend their egos. Repeated rejection by the patient may lead to “nurses losing sight of their own value base and conduct boundaries to the point where they may avoid challenging an issue or enforcing a policy” (Melia, et al., p.18). Additionally, repeated rejection by patients may magnify the seductive pull of keeping “secrets” for the nurse, and perpetuate boundary violations.

Forensic patients frequently present with histories of using aggression and interpersonal violence, and have rarely received or conveyed genuine caring in their lives. More frequently they have experienced a distorted form of caring which Norton (1996) called “perverted caring”. Perverted caring is not given freely by the conveyor of this type of caring, but rather with the expectation of receiving something in return, and is wielded as a weapon that serves to silence or manipulate others. Forensic patients bring their sense of perverted caring into their therapeutic relationships. They may be suspicious of any form of genuine caring on the part of the mental health professional, thereby making it difficult for mental health professionals to establish a therapeutic relationship. For example, forensic patients will not use aggression, violence, or threats of violence as long as the therapist is not overly challenging and provides favorable reports. Although this may provide the illusion of a comfortable working relationship for both the therapist and the patient, the relationship established is
not therapeutic; rather it replicates pathology producing situations and demonstrates the mental health professional's failure to establish therapeutic boundaries.

Absent from the theoretical literature reviewed here is the patients’ perspective. The perspective of non-forensic patients’ voluntarily seeking counseling on an outpatient basis is considered next.

2.3 The Out-Patients’ Perspective

Dual relationships (Nerison, 1992), physical contact (Geib, 1998; Ramsdell & Ramsdell, 1994), and self-disclosure (Knox, Hess, Petersen & Hill, 1997) have all been studied from the patient’s perspective. In addition, Hillerbrand and Claiborn (1988), and later Claiborn, Berberoglu, Nerison, and Somberg (1994) examined the patient’s ethical judgement.

2.3.1 Dual Relationships

Using a combination of quantitative and qualitative approaches, Nerison’s (1992) study examined the patient’s attitude toward the therapist’s behaviour and what it was like experientially to be a patient in a dual relationship. Following the completion of four questionnaires, patients who had experienced a dual relationship and agreed to participate were interviewed. Nerison found that 82% of the attitude survey items received a rating indicating that patients viewed dual relationships as never, rarely or only sometimes acceptable. Sexual activity with a current patient was rated never acceptable by 99% of the patients. Three dual professional relationships were also rated as never acceptable by the majority of the patients surveyed: (a) providing therapy to a current employee (78%), (b) providing therapy to a current student (59%), and (c) offering a client employment (55%). Dual social relationships were viewed more
favorably than either sexual or professional dual relationships, with 46% viewing becoming friends after termination as acceptable at least part of the time.

Forty-six patients in Nerison’s (1992) study were interviewed, 13% indicated that they had experienced dual sexual relationships, which were universally viewed as negative. Thirty-two percent of the patients interviewed reported friendships with former therapists, which half reported had positive outcomes while half reported that the friendships had negative outcomes. However, both groups expressed ambivalence and a diminished sense of respect for therapists that engaged in such relationships.

Ramsdell and Ramsdell (1993; 1994) examined the patient’s perspective regarding social and physical contact to discern how former clients viewed their experiences with their therapists, and the forms of social and physical contact they regarded as beneficial. Using a self-administered questionnaire, participants were asked to report the frequency and effect on therapy of 8 physical contact behaviours and 13 social contact behaviours. The social contact behaviours they used closely resembled a dual relationship, and are considered here.

The participants in Ramsdell’s and Ramsdell’s (1993) study viewed dating, going to bars, nightclubs, or dances with their therapist, as most likely to be detrimental to therapy. However, the majority of the participants viewed therapists’ visiting hospitalized patients as likely to be beneficial to therapy. Interestingly, social interaction where the patient was no longer a patient was considered detrimental, yet a visit to the hospital where the patient retained the status of a patient was viewed as beneficial.
2.3.2 Physical Contact

Ramsdell and Ramsdell (1993) also studied the patient’s perspective of physical contact with their therapist. Ninety percent of the participants viewed sexual contact as very detrimental, and 46.3% thought that “being held” would be very detrimental to therapy. Shaking hands was the only form of physical contact between a patient and therapist viewed by the majority of participants (55.4%) as likely to be beneficial.

The participants in Ramsdell’s and Ramsdell’s (1993) study were randomly selected from former patients of a single agency where a multidisciplinary team provided services. Of the 250 surveys delivered, 67 individuals responded for a response rate of 26.8%. Consequently, the small number of participants likely did not result in a sample that was representative of the population. Finally, the language in the survey, “being held”, was ambiguous. Did being held mean sexually or non-sexually?

Geib (1998) also studied physical contact between female patients and male therapists. Interviews were conducted with 10 women who had experienced nonerotic physical contact with their male therapist. Six of the women reported that being touched had been a positive experience and four reported being touched had been a negative experience. Geib found that the groups assigned different meanings to the touch and that therapeutic practices appeared to substantially affect the outcome.

Participants who viewed touch as a positive experience had therapists who: (a) provided an environment where the participant was in control; (b) were clearly responding to the participant’s needs rather than their own; (c) encouraged open discussion of the contact; and (d) were sensitive to the issue of timing to ensure that physical intimacy and emotional intimacy developed at the same pace. Participants
who experienced touch as countertherapeutic shared a strong ambivalence about the touch and were unable to discuss this ambivalence with their therapists.

Horton (1998) expanded on Geib's (1998) study to determine if the factors affecting the way participants evaluated touch would be reflected in a larger, more diverse group of participants. Horton also hypothesized that the level of therapeutic alliance as measured by the Working Alliance Inventory (WAI, Horvath & Greenberg, 1986) would be predictive of the patient's evaluation of touch in therapy. Finally, Horton hypothesized that discomfort with touch in therapy would be more likely if there was an increased potential for sexual attraction.

Horton (1998) sent surveys to 300 therapists, and to support groups, churches, and bookstores. Participants were also reached through advertisements in a weekly newspaper. The survey, developed by Horton, consisted of three questions to assess the patients' receptivity to touch. Scale items covering the occurrence of touch in therapy, and whether their feelings about themselves, their therapists, or about the quality of therapeutic work were affected positively or negatively by the touch were included. Additional scale items evaluating the factors Geib (1998) identified as being associated with the patients' evaluation of touch were also included. Short-answer and open ended questions allowed participants to elaborate on their answers. The WAI and a symptoms checklist were also included in the survey package.

Two hundred and thirty one completed survey packages were returned, of which the majority were from individuals in therapy with private practitioners (94%). Eighty-four percent of the participants were female and 16% were male. The majority of the
participants were seeing a same sex therapist (84% of the females, and 68% of the males).

All of the factors Geib (1998) identified were confirmed with the exception of whether patients felt the touch was for their benefit. Patient or therapist gender, patient sexual orientation or age, and patient-therapist age difference did not influence how the patient evaluated touch. Participants seeking therapy for sexual problems, having a history of sexual abuse and fears/phobias as reported on the symptom checklist significantly evaluated touch more positively. Of the participants who reported a history of abuse (sexual, physical, and neglect) 71% wrote that touch repaired self-esteem, trust, and a sense of their own power. Two themes in the written descriptions were: (a) that touch created a feeling of closeness and facilitated trust and openness (69%); and (b) that touch communicated acceptance and enhanced the patient's self-esteem (47%). A positive therapeutic alliance was significantly related to positive evaluation of touch in therapy. Finally, relationships where the potential for a sexual attraction existed did not affect the evaluation of touch as hypothesized.

Interestingly, only 10 participants gave descriptions of negative experiences with touch with their current therapists. Four of these 10 participants indicated that the touch was tolerated but they perceived it had not been offered to meet their needs. The remaining six indicated that their discomfort with touch was an experience that had been beneficially resolved, or an issue they were working on in therapy. Finally, 13% of the participants made reference to unwelcome, intrusive, seductive or sexualized touch with previous therapists. These participants rated these experiences as negative or very negative and described them as ‘confusing’ and ‘very destructive’.
Clearly, patients experience physical touch in a variety of ways. This is not unlike the different experiences of patients with therapist self-disclosure.

2.3.3 Therapists' Self-disclosure

Self disclosure has been studied more often from the patient’s perceptive than the professional’s perceptive (Edwards & Murdock, 1994), perhaps owing to the tendency to view self-disclosure as a therapeutic technique rather than a potential boundary violation.

Knox, et al. (1997) studied three consequences of therapist self-disclosure: (a) influence on the “real relationship”; (b) feeling of universality; and (c) modeling. Knox, et al. interviewed thirteen current long-term patients of psychologists who were able to describe an example of helpful therapist self-disclosure. During data analysis the researchers found that the data regarding general and unhelpful, or less helpful self-disclosure was too diffuse to be useful and was dropped from the study. Over half of the participant’s reported feeling that their therapists self-disclosed to normalize their experience or to reassure them. The same number of participants reported the positive effects of self-disclosure as; gaining insight or perspective to make changes, seeing the therapist as more real and the relationship as improved, and feeling normalized or reassured. Less than half of the clients identified using the therapist as a model for self-disclosure as a positive consequence of the therapist self-disclosure.

Wells (1994) interviewed eight patients (seven female and one male) post termination to examine patients’ perspectives on therapist self-disclosure. Participants were asked to share a therapist self-disclosure of their choice. Trust and confidence appeared to be factors affecting how patients experienced the therapist’s self-disclosure.
Two of the three participants that reported low trust and confidence in the therapist at the time of the therapist self-disclosure terminated therapy. The five participants who reported moderate to high trust and confidence in their therapist expressed some disappointment around the disclosure but were able to integrate the experience and maintain positive feelings toward the therapist. All eight participants reported some disappointment, disillusionment or “surprise” resulting in inhibition around exploration of feelings related to the disclosure and related treatment issues. Increased feelings of mutuality and an increased sense of connection with the therapist were reported as positive consequences for half of the respondents.

Differences in the findings of these two studies may relate to differences in the participants. Wells (1994) excluded current patients, while Knox et al. (1997) excluded patients who had terminated treatment. Additionally, Wells failed to report the measure used to enhance the trustworthiness of the study, thereby raising questions regarding the conclusions.

2.3.4 Patients’ Ethical Judgement

Studies of patients’ ethical judgement are mixed. Hillerband and Claiborn (1988) conducted two studies. The first study indicated that ethical judgement did not differ as a function of experience in therapy. However, in their second study they found that patients demonstrated superior ethical judgement on specific issues. Analysis revealed that the patients in the second study were significantly older than the patients in the first study.

Claiborn et al. (1994) studied the patient’s perspective of ethical judgement and their experience in therapy. Ninety-six participants (65 female and 31 male) completed
a modified version of the Therapeutic Practices Survey (Pope, Tabachnick & Keith-Spiegel, 1987). Fifty-two of the participants had experienced therapy as patients, while the rest had never been in therapy. Generally, findings of the study suggested that adults without formal ethical training were able to distinguish among ethically appropriate and inappropriate therapist practices within each group of items (confidentiality, dual relationship, informed consent and business practices, competence, sensitivity to difference, and interventions). Patients judged the therapist sharing of values at the beginning of treatment as more ethical than non-patients. Furthermore, they also found a significant effect for gender in the confidentiality group (MANOVAs $F(4,80)=3.06$, $p<.025$) and the competence group ($F(9,79)=2.24$, $p<.03$) with men judging violations in confidentiality, and the therapist discussing personal problems with the patient, as more ethical.

2.4 Methodological Issues

Both quantitative and qualitative methods have been used to study the complex area of therapeutic boundaries from the perspective of patients. Most quantitative studies were conducted using surveys or self-reports. This method is limited in three ways, in that, self-reports are affected by memory, cultural bias, and self-selection, or volunteer bias (Pope, 1990).

The influence of memory must be considered in any survey research. Survey participants may not be able to recall the specific information or the exact number of occurrences of any particular event. While memory influences what participants can report and with what accuracy, cultural biases influence what participants are likely to report (Pope, 1990).
Generally held beliefs of consumers, specifically that mental health professionals must safeguard the rights of those they serve, creates a bias influencing how patients view violations and what they report. Consequently, patients may not be willing to report their therapists’ boundary violations. Nerison (1992) found that although most patients who were involved in dual relationship had considered reporting their therapist for misconduct, they did not file complaints.

Additionally, self-selection must also be considered as a potential source of bias. Those who volunteer and return completed surveys may in some way differ from those who do not volunteer. Pope (1990) argued that patients who have been harmed or perceive their therapy as compromised by boundary violations, may be more likely to self select into the respondent group. Consequently, those who volunteer have not been harmed or benefited from therapy where a boundary violation has occurred are not as likely to respond. However, it could also be argued that the reverse is also true.

In addition to bias associated with memory, self-selection and culture, the survey questionnaires themselves may represent a bias or create a research issue. Ambiguous language, such as “being held” (Ramsdell & Ramsdell, 1993; 1994) may influence the participants responses. Questionnaires adapted from instruments designed to assess the beliefs and practices of professionals (Borys & Pope, 1989), such as those used in the studies of Nerison (1992) and Claiborn et al. (1994), may not be sensitive to the beliefs and experiences of patients, or cultural differences among participants. Finally, comparison between studies is more complex when a different instrument is used to elicit similar information.
Although memory, cultural bias, and self-selection may be limitations of the quantitative studies already discussed, the qualitative studies reviewed are not without limitations. Researcher bias, trustworthiness, and representativeness of study participants are potential limitations associated with the qualitative studies reviewed.

Bias is a concern with qualitative research (Erlandson, Harris, Skipper & Allen, 1993). Rather than openly acknowledging their expectations, which allows the reader to make a judgement about any researcher bias, Knox et al. (1997) indicated that the researchers attempted to bracket and set aside their expectations, without stating their position. This limits the reader's ability to make a judgement regarding any bias. However, the studies where it was most difficult to make a judgment about research bias are those where the measures taken to guard against bias are not mentioned at all (Geib, 1998; Horton, 1998; Nerison, 1992; Wells, 1994).

Additionally, there was wide variance in the reported measures adapted to enhance trustworthiness. While one study reviewed used in-depth interviews, member checks, cross case analysis and auditing of core ideas (Knox, et al., 1997), the remaining studies failed to identify measures taken to enhance trustworthiness (Geib, 1998; Nerison, 1992; Wells, 1994). Nerison's (1992) study used a combined qualitative and quantitative approach, a comprehensive approach with the potential to make significant contributions. However, the measures taken to ensure trustworthiness of the qualitative aspects of the study was not made evident.

Generally the qualitative studies provided detailed description of the participants and the situations (Geib, 1998; Knox, et al., 1997; Wells, 1994). Which provided the
reader with an opportunity to consider issues of representativeness and transferability of findings for future studies.

2.5 Summary

The review of theoretical literature on therapeutic relationships and therapeutic boundary maintenance with forensic patients identified three interacting factors: the professional, the environment, and the patient. Establishing therapeutic relationships and maintaining therapeutic boundaries is portrayed as particularly challenging with the forensic patient. Absent in the empirical literature is the forensic patients' perspective on therapeutic relationships and therapeutic boundary maintenance. However, the outpatients' perspective of dual relationships (Nerison, 1992), physical contact (Geib, 1998; Ramsdell & Ramsdell, 1994), therapist self-disclosure (Knox, et al., 1997), and ethical judgement (Hillerbrand & Claiborn, 1988; Claiborn, et al., 1994) has been the focus of previous research. The literature reviewed is only a guide; the extent to which this literature reflects the perspectives of the forensic patients enrolled in the ABC program is yet to be determined.
Chapter Three
Methodology

3.1 Introduction

The purpose of this chapter is to familiarize the reader with the theoretical framework of the study, the researcher, the research design, the process of participant selection, and the measures taken to protect the participant’s rights and the integrity of the study. After a description of data collection and analysis, the chapter concludes with a review of the processes used to establish trustworthiness of the data and analysis, and a discussion of the factors influencing the study.

3.2 Theoretical Framework

Naturalistic inquiry (Lincoln & Guba, 1985), is consistent with the purpose of this study, which was to contribute to current understanding of the complexity of therapeutic relationships and therapeutic boundary maintenance with the forensic inpatient.

Naturalistic inquiry is anchored in the naturalist paradigm which differs from the positive paradigm in a number of ways (Lincoln & Guba, 1985). Lincoln and Guba (1985) differentiate the two in the following manner: (a) While reality is a single tangible and fragmentalable in the positivist paradigm, realities are multiple, constructed and holistic in the naturalist paradigm; (b) What is known is independent of the knower in the positivist paradigm, while knower and known are interactive and inseparable in the naturalist paradigm; (c) In the positivist paradigm, time and context
free generalizations are possible, while all working hypotheses are time and context bound in the naturalist paradigm; (d) Cause and effect relationships are possible in the positivist paradigm, while mutual simultaneous shaping makes it impossible to distinguish causes from effects in the naturalist paradigm; and (e) Finally, while the positivist paradigm views inquiry as value-free, inquiry is value-bound in the naturalist paradigm.

In naturalistic inquiry the researcher attempts to reconstruct the constructed realities of the participants in order to retain the depth and complexity of the field being investigated (Erlandson, et al. 1993). In essence, naturalistic inquiry is the process of developing and verifying shared constructions of complex phenomena. This process is influenced by the interaction between the researcher and participant, making an appreciation of what the researcher brings to the study essential.

3.3 The Researcher

I have over ten years experience in the specialized area of forensic psychiatric nursing. During these ten years I have not only experienced but also witnessed the challenges of therapeutic relationships and therapeutic boundary maintenance. Prior to envisioning this study, I explored the issue of boundary maintenance through discussions with colleagues, and by reviewing relevant literature. My reflection on boundary maintenance lead to a presentation entitled “When a client develops an attraction: Successful resolution versus boundary violation” at the Custody and Caring Conference in 1995, which was subsequently published (Schafer, 1997). This exploration resulted in a shift in my view. Instead of viewing the essence of the nurse’s role as caring, I began to view the essence of the nurse’s role as being therapeutic.
Once I perceived my role as being therapeutic, theory and the therapeutic needs of the patient became the principles that guided my relationships with patients, rather than the sociocultural views of the ideal nurse, or the varied conceptualizations of caring held by patients and nurses. Distinguishing between therapeutic and non-therapeutic became less difficult for me. Subsequently, therapeutic boundary maintenance was defined by what was therapeutic for the patient, as determined by theory explaining the patient’s behaviour, rather than by a personal need to maintain an image as a caring nurse.

The above experience has led me to a number of conclusions. Namely, that therapeutic boundary maintenance appears to be: (a) central to the therapeutic relationship; (b) dynamic and complex; (c) influenced by characteristics of the patient, the nurse, and the sociocultural context of the therapeutic relationship; and (d) is particularly challenging and confusing for patients when the nurse assumes multiple roles within the therapeutic relationship.

3.4 Selection of Participants

Participants were recruited from among the patients engaged in the Aggressive Behaviour Control (ABC) treatment program at the Regional Psychiatric Centre-Prairies (RPC). The ABC treatment program provides intensive treatment to male offenders serving sentences with the Correctional Service of Canada. The target population consists of those male offenders with an extensive history of violence, anger control problems, and/or serious institutional misconduct (Wong, 1997).

The participants in the ABC treatment program are generally viewed as the most challenging patients to work with by most treatment and security staff. Their aggressive behaviour and potential for violence provokes strong feelings in many staff. Typically,
the treatment staff who choose to work in this area are viewed as unique and courageous, yet vulnerable; alternately, patients in the ABC treatment program are viewed as difficult, threatening, and exploitative. If the potential to learn is greatest from those who present to us our greatest challenges, patients in the ABC treatment program are among those with the greatest potential to contribute to current understanding of the therapeutic relationship and boundary maintenance.

Patients enrolled in the ABC treatment program vary widely with regard to age, race, education, prior treatment, length of incarceration, and willingness to participate in treatment. Consequently, maximum variation purposive participant selection was used initially to include participants who were different from one another in terms of these characteristics, and later to extend, investigate, or fill in earlier data as Lincoln and Guba (1985) describe. All participants were expected to meet the following selection criteria: (a) be willing to participate; (b) have been enrolled in the ABC treatment program for at least two months; (c) be able to speak English; and (d) have a nurse as a primary therapist.

Upon admission into the ABC program participants are assigned a primary therapist. Participants in the program may have a nurse, a social worker, or an occupational therapist assigned as primary therapist. Additionally, the unit psychologist acts as a consultant for all program participants and may provide individual therapy for some of the participants. Although all treatment team members interact with the participants, the role of primary therapist is unique. Initially primary therapists complete an assessment to identify relevant treatment targets. Following this assessment, in collaboration with the participant, and in consultation with the entire
treatment team, the primary therapist develops a treatment plan. Primary therapists are responsible for the implementation of the treatment plan and the documentation of the participant's progress.

Ideally, the study aimed for orderly emergence of participants accomplished through serial selection of participants, whereby collected data was analyzed prior to the selection of the next participant (Lincoln & Guba, 1985). Unfortunately, the orderly emergence of participants was not consistently accomplished. Five of the twelve participants were interviewed prior to the complete analysis of data collected from the preceding participant. This was done in order to include them in the study prior to their completion of treatment and subsequent discharge. Verbatim transcripts of the first interview were routinely analyzed prior to the second interview with the same participant.

The proposed method of participant selection was to educate the elected patient representative on the unit, as well as unit managers, using a letter of introduction (Appendix A), and then to have them inform all patients participating in the ABC group using the same letter of introduction. However, upon the suggestion of the patient representative, the researcher attended the ABC treatment groups to introduce the study to the group members, discuss confidentiality, and the participant criteria set. The patient representative identified two potential misunderstandings: a) that participating in the study would be reflected as a positive behaviour in their final treatment summaries; and b) that participating in the study would result in the participant being required to participate in further programming. To avoid these potential misunderstandings the participants were advised that if they chose to participate in the study they would not be
credited with participating, in their final treatment summaries, nor would they be asked to participate in additional programs as a result of this study. Patients interested in participating were asked to approach the researcher after the group, or on subsequent visits to the unit. Introducing the study in this manner appeared to be effective, as participants readily volunteered.

Upon hearing about the study and learning the criteria set, four participants readily volunteered to participate. One of the four participants to initially volunteer did not meet the criteria set, in that the primary therapist he was working with was not a nurse. Unfortunately, his failure to meet the criteria set was not identified until the first interview had been scheduled. After consultation with the thesis supervisor the decision was made to proceed and include this participant in the study.

The remaining eight participants were selected to ensure maximum variation among the participants, and later, to extend, investigate, or fill in earlier data. The Associate Program Manager was consulted to assist in the identification of participants who belonged to a minority group, were described as non-compliant or felt coerced to participate in treatment, had a female nurse as a primary therapist, who had been actively involved in Aboriginal programs prior to and during treatment, and who were Aboriginal with a short sentence (less than 5 years). The Native Elder was also consulted regarding the selection and appropriate manner in which to approach Aboriginal participants.

A second participant who did not have a nurse as a primary therapist was also included in the study in order to ensure maximum variation among the participants. An Aboriginal participant with a sentence of less than five years had been identified as a
potential participant. However, deterioration in his mental health and concerns about his ability to give informed consent necessitated his exclusion from the study. The only other Aboriginal participant with a sentence of less than five years in the program did not have a nurse as primary therapist. Treatment team members argued that the role of primary therapist was not specific to the professional discipline, and thus he should be included in the study.

3.5 Confidentiality and Ethics

The study was designed and carried out in accordance with the Canadian Nurses Association's (1994) Ethical Guidelines for Nurses in Research Involving Human Participants. Furthermore, this study was approved by the following committees: (a) Master of Nursing Thesis Committee, College of Nursing, University of Saskatchewan; (b) University of Saskatchewan Advisory Committee on Ethics in Behavioural Sciences Research; and (c) the Regional Psychiatric Centre (Prairies) Research Review Committee.

The limits of confidentiality and anonymity were reviewed during the consent process (Appendix B). Participants were given an opportunity to ask questions and concrete examples were used to illustrate the conditions under which the researcher would be obligated to break confidentiality. Participants were advised that participation in the study was voluntary and that they could withdraw from the study without consequence. Code numbers were assigned to all transcripts, taped interviews, related field notes and journal entries. The key identifying the participants is kept in the researcher’s office separate from the data collected. Prior to the conclusion of the
study, participants were asked to select a pseudonym to be used in the presentation of the study results.

Participants were given the opportunity to review verbatim transcripts of the first and second interviews. After they had the opportunity to review the verbatim transcripts their consent to use their words as data in the study in whole or in part, with corrections, or as presented was obtained (see Appendix C).

Once the study was complete the data collected was placed in a locked cupboard in the office of the thesis supervisor, Professor Peternelj-Taylor where it will remain for five years and then be destroyed.

3.5.1 Researcher – Participant Interaction: Ethical and Study Integrity Considerations

Although the RPC is a mental health facility, it is not totally insulated from the prison subculture where an “us versus them” mentality prevails (Stevens, 1993). Additionally, treatment staff make recommendations which may have a powerful impact on the patient’s future.

The researcher remained employed on a part-time basis as a nurse during the course of this study. The researcher worked exclusively in one of the two structurally and functionally separate units of ABC treatment program. The physical structure of the ABC treatment program allowed for the researcher to limit contact with the participants in the study during hours of work. To manage threats to the study’s integrity associated with an “us versus them” mentality, a number of measures were taken. All participants were made aware of the researcher’s affiliation with the RPC and the ABC program. Informed consent and transcript release were required (Appendices B & C). Participants received a copy of the signed consent form that
included the telephone numbers of the researcher’s supervisor and the University of Saskatchewan Research Services. Lastly, patients with whom the researcher had prior contact as a primary therapist or group facilitator were excluded from the study. The potential for former patients of the researcher to feel coerced could not be eliminated. The power inequality associated with therapeutic relationships eliminates the potential of ever establishing a mutual relationship (Gallop, 1998).

To make a clear distinction between the roles of researcher and nurse, the researcher verbally clarified her role as researcher whenever meeting with study participants. While in the role of nurse the researcher wore a lab coat, like all nursing staff at the RPC. While in the role of researcher professional dress was maintained with a blazer or sweater to replace the lab coat associated with the role of the nurse. Dressing professionally and avoiding seductive clothing or posturing was necessary. Seductive clothing could have implied that the researcher was interested in being validated sexually or in hearing that romantic relationships are helpful to the patient, rather than listening to their experiences. Finally, interviews were never conducted during work hours to avoid being in the institution as both researcher and nurse on the same day.

Prolonged engagement was achieved. Interacting with participants over an extended period of time enhanced trust as evident in the increased length of interviews, comfort with the research process, and willingness of participants to participate based on the experience of earlier participants. Prolonged engagement also gave the researcher the opportunity to detect any intentional efforts of the participants to deceive the researcher (Lincoln & Guba, 1985).
3.6 Data Collection

In naturalistic inquiry the researcher is the instrument of data collection (Lincoln & Guba, 1985). A semi-structured interview protocol (Appendix D) was used as a guide to initiate sharing and thereafter as required to promote the participant’s continued exploration of their experience with therapeutic relationships and therapeutic boundary maintenance with the primary therapist. Role plays, with the research supervisor, were used to refine the researcher’s interview skills prior to actual data collection. The semi-structured interview protocol was revised (Appendix E) based on the review and comments from the first four participants. Each question was reviewed in terms of how well it was understood, and the participants reaction and response to the questions. However, questions were not dropped based on a strong reaction from the participants. For example, the question “Describe your relationship with your primary nurse” provoked a strong reaction from two of the first four participants interviewed. Given that two of these participants had the same nurse as a primary therapist, their reactions to the question may have reflected a common experience. One was clearly confused about the nature of his relationship with his primary nurse and the other stated that “boundaries are crap”. Thus, the question was retained. However, the first probe for this question, “Are you able to discuss what it is that you would like to discuss in interviews with your primary nurse”, was dropped as it typically elicited a “yes” or “no” response. Based on suggestions from two of the participants, a question about attraction was added. As one of them stated “Well I really can’t add anything if you’re not asking the questions”.

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Each of the twelve participants in the study were interviewed three times. The first two interviews were audiotaped and transcribed verbatim. The taped interviews varied in length from 2.5 hours to 20 minutes, with the majority of interviews being an hour in length. Although longer interviews were preferred, the 20 minute interview was mutually negotiated to meet the participant’s needs. The time period between the first and second interview varied from one to two weeks. During the second and third interviews participants were given the opportunity to review, confirm, clarify, correct, amend or extend the interview transcript and elements identified in analyzing the data they provided.

Eight participants were interviewed a fourth time for the purpose of a member check, four in January 2000 prior to their discharge, and four in March 2000 after data collection was complete. A diagram that depicted the participants’ adjustment, and the different relationships that participants developed with their primary therapists and other staff was shared with the participants (Appendix F). In addition, a list of contextual factors and dichotomous events that either hindered or promoted the developing relationship with the primary therapist were shared with the participants (Appendix G). Their feedback was requested and reported on feedback sheets (Appendix H).

Data collection occurred over six months. The data collected consists of the verbatim transcripts of 24 interviews with 12 participants, the researcher’s field notes and reflective journal, memos written during the coding process, and the participant feedback sheets.
3.7 Researcher Field Notes and Journal

Field notes were used to document the location, time, date and duration of each interview. The researcher’s observation of the unit at the time of the interview, and the participant’s reactions to the process were also included in the field notes. In essence, the field notes were descriptive while the researcher’s journal was reflective.

Methodological issues, exploration, and decisions were recorded in one section of the researcher’s journal, while theoretical phenomena, personal reactions, and debriefing sessions were recorded in a second section of the researcher’s journal. Together the researcher’s field notes and journal provide an accurate methodological and process data trail to establish trustworthiness of the study.

3.8 Data Analysis

Constant comparative method of data analysis was used. Constant comparative data analysis is an interactive process, whereby data analysis begins when the first data is collected and thereafter contributes to the emerging study design (Erlandson, et al., 1993; Lincoln & Guba, 1985). As described by Glasser and Strauss (1967) data collected was reduced to the smallest unit reflecting an independent thought. Groups of categories or ideas emerged after which descriptive sentences were developed for each category. Finally, the process was repeated to further focus on the content of each category. At this point new categories were developed and established categories dissipated. The emergent categories were then used to focus the next round of data collection. Participant selection was used to extend categories, determine links between
categories, and the boundaries of categories. To facilitate data analysis the software QRS NUD*IST Vivo (1999) was used.

3.9 Trustworthiness

A naturalistic inquiry cannot be properly judged by the criteria of quantitative studies (Erlandson, et al., 1993). Rather, trustworthiness is the determinant of the quality of qualitative research. Trustworthiness is determined in terms of the studies credibility, transferability, dependability, and conformability (Lincoln & Guba, 1985). The provisions that were used to achieve trustworthiness in this study are outlined below.

3.9.1. Credibility

Prolonged engagement, peer debriefing, and member checks were used to establish credibility. The researcher has been associated with the ABC program since its inception in 1993 (Wong, 1997). Consequently, minimizing the distortion that Lincoln and Guba (1985) stress is associated with being a “a stranger in a strange land”. A minimum of three interviews were conducted with 12 participants. The first being an indepth interview, the second was an opportunity for participants to clarify and add to data already gathered, and the third was an opportunity for participants to clarify and add to the data and the researcher’s interpretation of the data. A fourth interview was conducted with eight of the participants in order to complete a final member check. Twelve participants, as Lincoln and Guba (1985) suggested, was adequate to achieve saturation as no new information was being revealed.

Finally, peer debriefing guarded against premature closure, challenged the researcher’s biases, questioned methodological decisions, and provided an opportunity
for the expression of frustration associated with the inquiry. Debriefing sessions occurred with the researcher supervisor.

3.9.2 Transferability

"The extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)" is the transferability of an inquiry (Lincoln & Guba, 1985, p. 290). A thick description of the researcher, the problem, the context, participant selection, the findings of the study, as well as salient elements identified, provide the database necessary for readers of this study to make a judgement about transferability.

3.9.3 Dependability

Triangulated hypothesis testing (Erlandson, et al. 1993) was used to establish dependability. Two colleagues who were familiar with the ABC treatment program and general characteristics of the participants (but not currently involved with the participants in the study) were asked to review the transcripts from the first interview with a participant in the study. After reviewing the transcript they were asked to write a description of the participant’s experience with the therapeutic relationship and therapeutic boundary maintenance. The Aboriginal cultural background of one of the participants was shared with the Aboriginal colleague reviewing his transcript. Sharing the cultural background of this participant was deemed necessary in order to minimize the potential for misinterpretation due to cultural differences and to provide a measure of the researcher’s cultural sensitivity in data analysis. The descriptions were then compared to the researcher’s analysis of the corresponding transcripts. These descriptions were consistent with the researcher’s analysis. Comparability between the
analysis and written description of the same interview transcripts suggests that the researcher’s analysis is dependable.

3.9.4 Confirmability

An audit trail was also maintained to allow for future confirmability. All data collected and a copy of the data analysis process, shall be stored in the office of Professor Peternelj-Taylor, College of Nursing, University of Saskatchewan for five years from the date the study was completed.

3.10 Factors Influencing this Study

A semi-structured interview protocol was used. The researcher in consultation with the thesis committee developed the interview questions. Consequently, the questions are subjective and may have instilled the researcher’s position into the interview process. However, participants were encouraged to direct the course of the interview once the interview was initiated, and had the opportunity to share what was important to them.

Only one researcher collected and analyzed the data. Although, the thesis supervisor reviewed data analyses, the interpretations of the data were constructed by the researcher and participants during member checks. Experience in a variety of positions (staff nurse, group coordinator, associate program director and program director) in the ABC treatment program since its inception influences this research both in terms of content and process. Some of the patterns of interaction that the participants described were immediately recognizable and had been witnessed by the researcher many times. The researcher continuously struggled with whether the direction taken in the interviews reflected the participant’s experience or the researcher’s.
In addition to prior experience, the researcher's employment in the institution during the course of the study may have affected the way that the participants approached the study and what they shared. Although some of the first participants raised the issue of trust in the initial interviews, as the study progressed and the participants as a group gained confidence in the researcher's credibility, subsequent participants were less likely to question trust, or the research process.

The participants were all enrolled in the ABC treatment program. Although they were selected from three separate treatment groups with different start dates, the last to participate in the study arrived on the unit near the time that the first participants were leaving. The interviews were conducted over six months, a relatively short period of time in terms of institutional culture and the collective memory of the participants. Thus, the participants may have had a common experience affecting their perspective and what they shared with the researcher.

Therapeutic relationships and therapeutic boundaries were not defined extensively for the participants. Therapeutic relationships were not described in any more detail than the helping relationship, while therapeutic boundaries were described as the limits or margins that mark the point where the helping relationship begins and ends. Although possibly a limitation, this allowed for an open forum for discussion enabling participants to share what they found as therapeutic or helpful, and non-therapeutic or not helpful.

Although the study aimed to include only participants with nurses as primary therapists, two participants who had a primary therapist from a professional group other than nursing were included, and one participant had a primary therapist who was trained
as a social worker as well as a nurse, and fulfilled the role of social worker on the interdisciplinary team. One participant mistakenly identified himself as meeting the inclusion criteria; the second participant was identified by unit staff as meeting the criteria. In these cases the professional was fulfilling the role of primary therapist, as nurses do, and not a role related to their specific profession. Although the therapeutic relationship is a concept central to the work of mental health professionals in general, disciplines may vary in regard to their approach to the therapeutic relationship.

The factors influencing this study require that caution is exercised in the transfer of these findings to other therapeutic relationships with forensic patients. A description of interactions between the researcher and the participants, interactions between the researcher and institutional staff, and a detailed description of each participant are presented in the next chapter. Detailed descriptions have been included to assist the reader to determine the transferability of the study's findings to other therapeutic relationships with forensic patients.
Chapter Four

The Participants and Relationships Influencing the Study

4.1 Introduction

It was argued earlier that establishing and maintaining therapeutic relationships and boundaries with patients in the ABC treatment program presented a challenge from which the potential for mental health professionals to learn was the greatest. Examining the interactions between the participants and the researcher reveals the researcher’s response to the challenge faced in establishing rapport with the participants. Making the dynamics between the researcher and participants transparent, and providing a detailed description of the context to the reader is necessary. As the reader becomes familiar with the participants, the relationships between the participants and the researcher, and the context in which the study took place, the researcher’s influence on the interpretation of the participants’ experience will become apparent. The first person is used in this chapter to illustrate the researcher’s involvement in the relationships being described.

4.2 Relationships

The relationships that developed between the participants and myself will be examined here to ensure completeness, to avoid distortion, and to retain the meaning of the data. For the same reasons, I have described my relationships with the treatment staff, and the participants’ relationships with one another. As Lincoln and Guba (1985) assert: “Human beings are always in relationships – with one another and with the
investigator as well. One cannot study people without taking these relationships into account” (p.105).

4.2.1 Participant and Researcher Relationships

Although the participants were sharing their experiences with the primary therapists and other therapists, the interview process reflects the relationships that we developed. Interactions with the participants that were not recorded (e.g. discussions before/after the tape recorder was turned on/off) were noted in a reflective journal. Together the interview transcripts and the reflective journal provide a rich database to examine the relationships that developed. Interactions that reflected the interview process and the researcher-participant relationship were coded as the study progressed, and once data collection was complete relevant journal entries were also coded. Like the relationships between the participants and the primary therapists, my relationships with the participants were unique.

Participating in the study was voluntary. While some participants volunteered to share their experiences, others shared their experiences in order to participate. Earning “brownie points” for their primary therapist, or a diversion to pass the time made participating worth it for some. In either case, participating required the participants to interact with me and reveal part of themselves. In essence they were being asked to trust me, an individual with whom they had very little experience. Trust did not come easily for all of the participants. Trusting required vulnerability; trusting relieved vulnerability. One participant stated: “Yeah you know we want to trust you, you know, you give a good spiel, you look like a nice person. Geeze do I want to take that chance?”
Balancing the contradiction or conflict between trust and vulnerability was central to the participants' relationship with me. When the balance was maintained, interactions were comfortable. When the vulnerability exceeded the level of trust, participants used a variety of techniques to reduce the vulnerability they were feeling. Reducing the perceived differences between us, seeking approval, humor, flattery, hostility, requesting copies of their transcripts, and open discussion were among the techniques the participants used.

Requesting clarification and expressing their reactions, was how most participants reacted to being asked to sign the transcript release form, or to select a pseudonym for use in presenting the study. The participants felt an ownership over their stories and the choice to share them. It was as if their credibility was undermined when they were asked to provide pseudonyms or to sign the transcript release. They knew what they had said and would not have said it if they did not want it used in the study. For one participant, volunteering for the study was one of the few good things he had done in his life, and he wished to retain the ownership and the credit for participating. He requested a copy of the transcripts so that he would be able to retain ownership in some way and asked that I represent this viewpoint in the research report.

Like the participants, I was also struggling to achieve a balance. While the participants struggled to maintain a balance, or resolve the conflict between trust and vulnerability, as a novice, I struggled to achieve a balance between content and process. I found myself time and time again wanting to focus on the process in addition to the content of what was being said. The process appeared to be more revealing. It was like he and I were doing a dance – the tango. He was moving with me but not looking at me. At other times I was moving with him and not looking in his direction. It seemed that every time we discussed the relationship (participant's relationship with the primary therapist) he was guarded. He used
a number of methods to cope with the interview, that is, to keep me engaged and yet not reveal anything that he did not want to reveal. I found myself wondering if analysis of process is within the scope of constant comparative analysis. I took comfort in the idea that Naturalistic Inquiry affords me the opportunity to consider the simultaneous shaping and interactions between the participant and the researcher (Journal entry, Nov. 6, 1999).

The content or words would become the data of the study, but would be meaningless without consideration of the context. Clearly, content and process were not mutually exclusive. Instead they were interdependent; one could not exist in a meaningful way without the other.

In addition to the process-content conflict, I also faced a conflict between being culturally sensitive and being culturally safe (Polaschek, 1998). After consulting with the Elder I decided to use tobacco to approach an Aboriginal participant. There was a sense of pride in using a culturally sensitive approach. However, was it culturally safe? Discussion with a colleague helped clarify the issue. Tobacco was considered sacred. Once the participant accepted the tobacco and agreed to participate he had made a sacred agreement. Clearly, using tobacco had the potential to limit the participant’s ability to withdraw from the study without compromising his spiritual beliefs. This was not a comfortable realization for me. Thereafter, tobacco was not used when approaching Aboriginal participants.

A final conflict that I struggled with was whether to embrace my prior experience or not. While I was tormented by the possibility that prior experience was influencing the direction of the interview, prior experience was a resource I used in developing relationships with the participants. Understanding the prison slang, recognizing the participants’ hostility as a protective stance, being able to be direct and willing to discuss issues that appeared to be taking shape in the relationship proved to
be valuable resources in developing relationships with the participants. What was an asset in developing relationships with the participants was also a potential liability in collecting data. However, this was a liability that I managed through peer debriefing, by keeping a journal, and revealing myself to the reader.

When two balancing acts meet cooperation and adjustment is necessary. It was inevitable that the participants’ vulnerability was likely to exceed their ability to trust in our relationship. Their inability to articulate their points clearly, and their uncertainty about the direction of my questions, appeared to increase the vulnerability that the participants experienced. Of their responses, I found hostility one of the most distressing. “I feel, that as a researcher, I have failed when I provoke a hostile reaction” (Journal entry, Nov. 10, 1999). My responses to the hostility varied and were dependent on the context. Clarification of the question and direction, apologizing when appropriate, and immediacy or focusing on what was occurring between us were among my typical responses. Interestingly, focusing on the process, or what was happening between us, did not appear to increase the vulnerability that participants experienced. Instead, immediacy tended to promote trust. When the participants’ reactions to the process were recognized they generally expanded on comments they had made earlier and openly discussed what they were experiencing at the time. Alternately, talking about the dynamics between us, could have reduced the tension associated with talking about their relationships with the primary therapists.

The relationships that emerged appeared to have maintained an adequate balance. Participants did not withdraw from the study and some reported finding the process therapeutic. One participant, while reviewing the interview transcripts, was able
to identify how he had repeated old patterns of behaviour during treatment and in our relationship. Others found interacting with me an opportunity to practice being open and honest, a skill they viewed as necessary to their future success, as reflected in the following quotation. “Yeah you said that there was no benefit for me for the doing this. There is. There is a benefit for this I find because part of my trouble was opening up to people and learning to talk with people, different people and not trusting”.

4.2.2 Relationships between Participants

If, as Lincoln and Guba (1985) asserted, relationships form webs, the points of intersection had the greatest potential to influence the future direction of the study, such as the relationships between participants. All the participants were patients on the same unit and had some interaction with each other. Additionally, they were likely aware of who was, and who was not participating in the study, by virtue of seeing me with other participants. Interaction between participants was inevitable. Unfortunately, the only means to directly examine the influence of interactions between participants in the study was if the participant shared their conversation with me, or if I observed their interactions. However, my relationships with the participants were influenced by the relationships between participants and the relationships that the participants had established with therapists. Consequently, only those relationships where there was some identifiable influence on the participants’ relationships with me shall be examined.

At one point shortly after data collection began I had the distinct impression that I was being viewed as a novelty – the entertainment. Patients, if they knew me or not, would stop and ask me questions. This was not an unfamiliar pattern; I had seen
patients respond to female staff and students in this manner. It gave them “a chance to practice being a gentleman” and “less time to be an inmate”. Fortunately, this pattern did not last long, as I clarified my role as a researcher. While I lost status as a novelty I was gaining credibility as a researcher. Participants tested me and I passed. I responded non-defensively to their requests for additional information about the study, acknowledged that they would not benefit by participating, was clear about the limitations on confidentiality and anonymity, and was open about my dual role as researcher and a staff nurse.

Although they are called patients, some of the ABC treatment program participants adhere to the prison subculture and code of conduct that governs the behaviour of inmates. A principle central to the inmates’ code of conduct is “Don’t crack (talk) to staff”. A participant who was teased by his peers for the extent of his interactions with the primary therapist, requested that the second interview take place on the unit to avoid raising suspicion about his interactions with me. Some participants acknowledged talking about their research interview experiences with others on the unit, however, on only one occasion did I get the sense that one participant was attempting to promote the agenda of another participant.

4.2.3 Other Relationships

My relationships with the primary therapists of the participants in the study formed another intersection in the “web of relationships”. I had worked with most of the therapists over the past ten years. Many were aware of my professional development and my interest in therapeutic boundaries. Generally, my relationships with the primary therapists over the course of this study were co-operative. Treatment team members
were always willing to assist with the location of equipment and expressed an interest in the study and the potential benefits. On occasion, a primary therapist would express discomfort with the process. However, the value or intent of the study was never questioned, with one exception. One therapist questioned me on more than one occasion regarding the topic of the study, how the study could make staff look bad, and how the data would be used. I attempted to address her concerns and I think that she found some comfort in our discussions at the time. However, I do not believe that I was able to establish the same level of trust with her as with the remaining therapists. Despite our discussions, she continued to feel vulnerable. The only occasion where I detected efforts to deceive me appeared to center around a primary therapist feeling vulnerable, a participant who felt the need to protect the vulnerable primary therapist, and another participant who promoted this agenda.

4.3 The Environment

Familiarity with the treatment environment proved to be both an advantage and a disadvantage for me. Although an awareness of the physical structure was beneficial, it was knowing the processes associated with accessing keys and governing movement within the institution what was the most beneficial. Familiarity facilitated an awareness of the significance of some observations, while the significance of other observations may have been lost in what appeared to be common place to me. The description of the environment below is written with the awareness of the institutional history, and the fresh eyes associated with my new role as a researcher entering the environment.

Patients in the ABC treatment program live on a locked unit. Movement on and off the unit is controlled using an electronic lock and cameras. The murals painted on
the walls do not conceal the concrete block construction. The glassed in nursing station at the end of the hall sits between two identical dayrooms.

A television set and institutional furniture are the focal points in each dayroom. A coffeepot surrounded by yesterday’s coffee spills sits on a table in the corner. Tables with attached chairs, where the patients eat their meals, sit opposite the televisions. Thirteen doors, each with a small window, form the periphery of the dayrooms. Twelve doors lead to the patients’ bedrooms and the thirteenth door conceals a shower room, too small and without the ventilation required to keep it mildew free.

The bedrooms are spacious, in comparison to the cells of most institutions. There is a bed and table attached to the walls. A lamp may or may not be attached to the table. The stainless steel toilet and sink unit situated in the corner of the room does not allow for complete privacy. Anyone looking through the window in the door can view a patient using the facilities. Makeshift curtains either cover the windows or are taped up so as not to obscure the visibility of staff doing the hourly checks (to see that all patients are accounted for). Many of the windows have razors hanging in them. I found the razors a symbolic representation of power and control in the environment. At an earlier point in time the participants would not have been able to keep the razors in their rooms. Instead all razors would have been kept in the nursing station. To see them hanging in the windows of the rooms reflected a changing emphasis on control and a shift towards more equitable relationships between participants and treatment team members.

Two interview rooms, each with large windows, sit across from the nursing station so that the correctional officer on the unit can monitor the activities in both the
dayrooms and the interview rooms. Less visible from the nursing station is the one large group room. The window in the group room is much smaller and is not in direct line with the nursing station. Staff rarely facilitate a group alone.

Safety of staff and other patients is always a concern. The whereabouts of patients and staff is closely monitored. Items with potential to be used as weapons (e.g. scissors, cooking utensils) are kept in the office and signed out to patients with the expectation that they will be used for their intended purpose, and returned as soon as possible. However, trusted patients may gain permission to keep art supplies in their bedrooms overnight. All staff members wear personal protection alarms. Staff can use these alarms to alert security if attacked, or if they witness another staff member needing assistance. Therapists look out for one another.

Nine nurses, a psychologist, a social worker, an occupational therapist, a parole officer, an Aboriginal program officer, six correctional officers, a program assistant, a program manager and associate program manager complete the treatment team. The nurses, social worker, and occupational therapist are generally assigned as primary therapists to two patients in the program. They typically meet with the assigned patients on a weekly basis to supplement program content and address other therapeutic issues associated with the treatment process, such as, fostering engagement and motivation. Office space is scarce. Nurses, correctional officers, and the occupational therapist work mostly out of the nursing station. Team meetings and case conference discussions may take place in the nursing station where communications from the institutional two-way radio and telephone calls are a frequent interruption in the treatment planning.
The majority of treatment groups occur from eight in the morning until about four in the afternoon. Staffing peaks during program hours and then is at a minimal level during evenings and weekends, when two nurses and one security officer maintain the continuity of care.

Interactions with the participants occurred both on the unit, and in the group rooms on another unit. The group rooms used, like the interview rooms on the unit, had large windows to allow for observation of the occupants. However, unlike the interview rooms on the unit, these program rooms were located in a long corridor leading to a dayroom and nursing station. While staff frequently walked by there was not the constant presence of an observer. The rooms had a number of small tables grouped together that were surrounded by chairs. To accommodate the interview process, one of the small tables was pulled out of the group and two chairs placed so that the participant would be sitting diagonally across the corner of the table from me. The tape recorder sat on the table in view of the participants.

Using the program rooms off the unit required that I escort the participant to the room and advise unit staff where the participant would be, and for approximately how long. It also required the coordination with other institutional movement and periods of waiting. At times, participants requested to be interviewed on the unit to avoid the procedures of moving off the unit for the interview.

Interviews on the unit took place in the interview rooms. The interview room was arranged in the same fashion as described above. Interactions outside of the interview rooms were limited to those interactions necessary to schedule interviews and, once I was known to the participants, very brief social recognition.
4.4 The Participants

The perspective of the participants in this study stands in sharp contrast to the depiction of personality disordered forensic patients as perpetrators of boundary violations that generally dominates the forensic nursing literature. This section includes a description of each participant and his experience in the therapeutic relationship with the treatment team member assigned as primary therapist. The participants were interviewed at different points in their treatment program, from 2 months 11 days into the treatment program to 5 months and 25 days. The descriptions here are based on my understanding of the content of interviews, and reflect the participants' perspective at the time of the interviews. Demographic information was obtained by reviewing participant’s files at the RPC.

4.4.1 Daniel: The Chance of a Lifetime

Daniel, nearly 30 years old, had one prior admission to the RPC during a period he described as the lowest point in his life. Although he had spent several months at the RPC during his first admission, he never developed a trusting relationship with treatment staff. Beginning a sentence of more than 10 years, he could not afford to connect with others. Instead, he never initiated conversation with staff and would only answer direct questions. He purposefully remained vague revealing very little of himself. Yet he found the treatment team’s persistent efforts to engage him and the advice he received from other patients helpful.

Of interest, Daniel had witnessed a romantic involvement that developed between another patient and a nurse. Although envious, he played an active role in concealing the romantic involvement from staff. This proved to be an influential
experience for Daniel. He came to believe that there is little or no benefit in social interactions with staff, that treatment should always be a priority over social conversation, and that favoritism was a destructive force in the treatment environment.

Since Daniel’s first admission to the RPC he had been involved in the prison subculture. Out of necessity, he engaged in activities that he was not proud of. However, he took pride in the relationships that he developed with institutional staff preceding his return to the RPC. Believing it was time to begin preparations to reintegrate into society, he worked hard at presenting himself differently to change the way he was perceived by institutional staff in his parent institution.

Although the time was now right, Daniel initially experienced the therapeutic relationship as awkward. He was uncomfortable not pursuing a mutual relationship, or assuming a role of helper, as he did with family and friends. He did all the talking and the primary therapist, listened and occasionally interjected. Uncertain about the inequality he was experiencing, he attempted to address the issue with the primary therapist. Although difficult to articulate what he was experiencing, he was able to ask her to be more direct with him. He found it frustrating when he sensed that she perceived him as fragile, like he was made of glass. Following this the primary therapist was more direct with him. However, she maintained what Daniel perceived as a professional barrier, which he occasionally tested.

Aware of when the primary therapist was about to terminate an interview, by the quick glance she gave her watch, he would purposefully initiate a new topic just to see what she would do, and to see the look on her face. Typically he would advise her that he was just joking and he knew it was time to end the session. Although not a mutual
termination to the session, he experienced it as more equitable when he played an active role.

As time progressed, what Daniel initially experienced as a professional barrier became a source of comfort. He came to know that when he was going to have a session with his primary therapist that it would be about him, that there was nothing expected of him other than to make use of the time to help himself. He came to view treatment as the chance of a lifetime. He had six months to be selfish, to examine himself and to work towards becoming the man he aspired to be.

4.4.2 Paul: Finding a Match

Paul, in his thirties, was serving a sentence of more than 10 years for violent and drug related offenses. He struggled with an addiction for which he participated in several community based inpatient treatment programs. Typically the addiction programs he participated in were of short duration and only slightly longer than the 20 days of resistance he was good for. This was a pattern that he repeated during his admission to the ABC program.

Paul believed that the program was too long. He felt he gained what he needed in the first two months, and everything after that had been unnecessary. He needed to practice the skills he had acquired and continue to develop his trade. Paul felt restricted and confined at RPC, a feeling that was compounded by Paul’s difficulty with authority. He avoided staff who he perceived as having power or holding positions of authority, because of their potential to jeopardize his future. Instead, he sought out relationships with staff he perceived as similar to himself in terms of the power they held within the treatment team, and their views of institutional policies and procedures.
Paul recalls the night he was admitted into the ABC program. A very attractive nurse showed him to his room and then later came back to see if he had a pillow. Although she was not initially assigned as the primary therapist in his treatment plan, he sought her out whenever he had a request. He thought that she was gorgeous and she was always willing to deal with his requests personally, rather than asking him to follow the institutional procedures. Paul spent more time with this nurse than he did the primary therapist, both out of preference and necessity. The primary therapist did not work regularly. Four months into the treatment program, the nurse originally assigned to the role of primary therapist left the treatment program. Consequently, it was an easy adjustment for him when the nurse he first met upon admission was assigned the role of primary therapist. He viewed her as down to earth, and similar to him in terms of relationship history, experience as a parent, and views of institutional policies and procedures as barriers.

Paul was able to cope with the attraction he felt for his new primary therapist. He was comfortable knowing that he would not be acting on these feelings. He knew that no matter where he went there would always be women he found attractive. However, he did feel a need to protect his primary therapist. He felt embarrassed when other patients on the unit would make inappropriate comments about her. He also avoided asking her personal questions. He wanted to avoid putting her in a position where her colleagues might view her as being inappropriate. Although he did not believe they would become friends, due to geography, he saw nothing wrong with a friendship and thought that boundaries were “crap”.

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Paul's identification with his primary therapist was strongly based on the similarities he perceived them as sharing and her being a "good lady"; he identified less with her in terms of her ability to help him as a nurse. Together they formed an alliance for protection and comfort against the depersonalization of the bureaucracy, against the harshness of the other patients' inappropriate comments, and in the end, to protect against any potential unfavorable interpretations that I might make.

Paul was pleased with the relationship he had established with his primary therapist. Neither of them judged the other and he thought that she liked him as a person and found some comfort through their relationship, in what was otherwise, a harassing environment for her.

4.4.3 Ernest: A Showdown

Ernest, in his mid-twenties, was serving a sentence of more than five years for a number of violent offenses. Although eligible for full parole, he had not yet addressed his correctional treatment plan and consequently had not applied for parole. Instead, he was making release plans for his statutory release date. He described himself as shy and quiet. He did not identify a need to participate in the ABC program, beyond the recognition he would gain with his case management team upon successful completion.

Shortly after he was admitted into the ABC treatment program he experienced a significant loss. Rather than cope in his usual manner he acted on the advice of the primary therapist. He sought the primary therapist out and requested an interview. Although the primary therapist accommodated his request, he left the session feeling totally invalidated, and with homework. He attempted to meet the primary therapist's expectations, even though he thought these were beyond his capabilities. However,
feelings of vulnerability kept him from disclosing his inabilities. He came to believe that the only way to find safety in this relationship was to be right. He tried and failed. His only alternative to achieve a level of safety or comfort in the relationship was to somehow overpower the primary therapist.

He sought out other treatment staff and shared his concerns about his relationship with the primary therapist. Although other staff were willing to spend time with him, and through them, he was able to meet some of his treatment needs, he did not find a solution for the relationship with his primary therapist. More and more the relationship became a struggle. Everything was a lesson where he was the student and the primary therapist was the expert. Feeling forced to do it the primary therapist’s way, served to increase his resistance, and the struggle continued. He would refuse to do his homework, or he would do it his way, ignoring the primary therapist’s suggestions.

A struggle characterized their entire relationship. Ernest was never pleased with their relationship and in the end felt defeated as the primary therapist retained the ultimate power. She would author the final treatment summary, that would or would not gain him the expected recognition by his case management team.

4.4.4 Peter: A Picnic

Peter, a young Metis man, was approaching the end of his first federal period of incarceration. He had been sentenced to less than five years for a violent offense. This was not Peter’s first period of incarceration. His criminal lifestyle, which included gang involvement, had resulted in earlier conflict with the law.

Prior to coming to the RPC Peter participated in programs in his parent institution. Harassed by his fellow gang members for participating in these programs he
never felt like he was his own man. Instead he was always doing something for the
gang or jumping though hoops for “the man” in order to progress towards a release.

Although Peter reported feeling more like his own man after being admitted into
the ABC treatment program, he was particularly concerned with how he was viewed by
both the nurse assigned as the primary therapist, and other patients in the program. He
enjoyed the time spent with his primary therapist. In fact, time spent with her was like
taking one of the picnics she described to him. However, he was not comfortable with
the jokes that the other patients made about him when he would seek her out. They
often accused him of sucking up, or attention seeking. Typically, he found the pleasure
he obtained worth the harassment. He enjoyed making her laugh and found her funny.
He always wanted to show her how he was up beat and easy going. If he felt frustrated
he would cover it up in order to maintain his image with her.

Through her he saw options he had never imagined; because of her he was
willing to try harder and adopt a new lifestyle. He was delighted when she admired his
creative abilities. He felt good when she accepted a gift he made for her, but hurt and
angry when she brought it back. He did not understand why the Correctional
Supervisor would not let her take it home. He felt insulted that she now wanted to buy
it from him.

His relationship with the primary therapist was frustrating. He did not always
understand what she was talking about yet he tried. He tried really hard to focus on
what she wanted him to talk about no matter what was happening for him. In a sense he
wanted to please her. He went the direction she indicated, she opened the doors and he
followed. He listened keenly when she shared stories from her personal life. Although
he enjoyed the stories about her life, he was envious at times and wished that he was going for picnics in the park.

4.4.5 Ty: The Value of Time

Ty, in his mid thirties, was serving his first federal sentence of more than 10 years for a number of violent offenses. From a large family, Ty was the only one to have been in conflict with the law. He often questioned “why me” and why he ended up in such severe trouble. He was eager to participate in the ABC treatment program. He needed to learn why he ended up in jail, to fix it, and to never return.

Ty was not convinced that the ABC treatment program would be the answer for him, nor was he convinced that the primary therapist assigned to his treatment program, would be able to help him find the answers he was looking for. He questioned her frequent self-disclosure and wondered what her angle was. However, there was less time to be an inmate at the RPC, and he liked that. He hated putting in time and getting nothing out. He knew he owed time but felt useless when he was not given opportunities to be productive with his time. In the ABC treatment program there was less time to be an inmate because he was getting something out of the time he was serving. Even if he did not get the answers he was looking for, he at least had the distraction of interesting conversations.

Over time Ty tested the primary therapist. He needed to know if she knew what she was talking about and if he could trust her. He would tell her a little and see what she did with it. He would ask her for advice and then check it out in a book. Some time into the treatment program he learned about crime cycles. Now he had something that he could use to understand why he ended up doing time and to never owe time again.
Suddenly he was open and less guarded in sessions with the primary therapist. He was pleased that she never gave up on him and remained professional despite his failure to immediately engage in the therapeutic relationship. When his primary therapist asked about the change, he was happy to say that he had finally found what he was looking for, he was no longer wasting his time, and that he was getting something for his time.

4.4.6 Montana: My Choice

Montana, a recidivist offender in his twenties, was serving a sentence of less than five years for property and violence related offenses. Imprisoned but not broken, Montana’s time served had been stormy, characterized by a number of physical altercations.

He was nearing the end of his sentence when he was admitted into the ABC treatment program. His adjustment to the treatment program was also stormy. He was frequently disrespectful to staff and expected to be discharged from the program. However his expectation was not realized. After a third and final change in primary therapists he settled into the treatment program.

Montana found the first primary therapist assigned to his treatment program rigid, in her head, and by the book. Their relationship was a struggle he did not miss when he was “sloughed off” onto a nurse employed short-term. Although better, this new relationship was no picnic. When the term position ended, Montana was once again “sloughed off”. However, third time lucky, his new primary therapist was a good guy. He presented the options and encouraged Montana to make a choice.
Montana recalls the day he decided to give it a try. Leaving a session with the new primary therapist, he went to his room and took the time to consider the options that the primary therapist had outlined. He concluded that the primary therapist was right; he had nothing to lose.

Montana liked that the primary therapist gave him a choice rather than forcing him or “ramming it down his throat”. He liked that they always met on a regular basis and that he knew what was expected of him. Although Montana’s adjustment to treatment improved, he continued to struggle with those he perceived as authority figures and reacted strongly to nurses who he perceived as taking on a security role. In fact, he experienced it as dehumanizing when he thought that others were asserting their power and denying him a voice.

4.4.7 Parker: A Guessing Game

Parker, a Caucasian male in his forties, was serving a sentence of more than 10 years for violence and property related offenses. He came to the RPC to get an objective report. Prior to arriving, he had made up his mind to accept the report, and address any issues that were identified, in order to facilitate a reduction in his security rating and his reintegration.

Parker immediately connected with the nurse assigned as his primary therapist. During one of their first interviews the primary therapist asked what security level he was rated at. Particular about details, Parker outlined the three components assessed in a security rating and the corresponding level of low, medium, or high that he had last received. When he stated that he was rated as high for community risk the primary therapist asked “what the heck for?”. As Parker stated he had been waiting seven years
for someone to say that. Finally, he had hit the jackpot. Parker was convinced that the primary therapist had his number, and somehow just knew how to approach him.

Parker and the primary therapist engaged in lengthy conversations that flowed from treatment issues to other topics of interest that they shared. Mostly, Parker was left to his own accord. Although Parker was comfortable with the freedom to be self-directed, he felt that he often had to guess what was expected of him. He was afraid that he might not meet the ever evasive expectations. This feeling was compounded when he and the primary therapist did not follow through with the treatment plan to meet the treatment objectives they had established. He also questioned the purpose of the feedback he and other patients received from treatment team members. How could they all be doing “awesome” work? Clearly, “awesome” was just an expression and a means to boost the esteem of others, rather than meaningful feedback. Although he believed that he would receive a good final treatment summary, he was concerned. If he failed to guess what the expectations were correctly, the consequence would be an unfavorable treatment summary that could have a negative impact on his reintegration plans.

During our interviews Parker shared a number of details about his experiences in his parent institution as well as his experience at RPC. He frequently generalized and included me in the group of CSC staff he was talking about. At times he would use “you” when he described an experience with treatment team members. This gave his experience a sense of immediacy, as if what he was describing was presently occurring between us. Often the distinction between past experiences, the present and the future was not clear. Initially, this felt uncomfortable for me, like there was something
occurring outside of my awareness. Parker preferred abstract to concrete, and analogy over less figurative descriptions. Unfortunately, portions of the experiences Parker shared were not discernable as it was not clear if he was discussing the past, present or future.

4.4.8 James: A Valuable Lesson

James, an Aboriginal male in his early forties, was serving a sentence of more than 10 years for a number of violent offenses. James was now eligible for parole and hoped that the recognition he would gain by completing the ABC treatment program would assist him to gain a conditional release. He needed to be with his family and they needed him. James described himself as committed to his beliefs and culture. He accepted that he had to complete particular programs outlined by his case management team, and could even see the value of participating in these programs. He had been incarcerated over 15 years now. Any program he participated in would assist him to prepare to rejoin his family and community. However, James found it much easier to learn from the Elders.

With the Elders he shared a history. They knew what it was like to be raised in an environment where alcohol abuse renders the adults incapable of fulfilling their responsibilities as parents and community members. They lived the impact of cultural oppression and of a lost generation. The experiences he shared with the Elders made their relationships comfortable, and when they also shared a language it was especially comfortable. There was no risk to remaining committed to himself, his beliefs and his way of life. He did not need to strike a balance to avoid betraying himself while meeting the expectations of a non-traditional treatment approach.
James stretched himself trying to reach a balance in the ABC treatment program. He always completed his homework, attended the groups and generally met all expectations of the treatment team and the nurse assigned as primary therapist. He did not expect a lot from the primary therapist. The Elders provided most of the assistance he required. He thought that he had achieved a satisfactory balance whereby he was meeting the expectations of the ABC treatment program without compromising himself or his beliefs.

He was shocked when four months into the treatment program he received a progress summary authored by the primary therapist that said otherwise. He was particularly concerned about the comments related to his group behaviour. How could the primary therapist make such statements? The primary therapist had not even been there. He was also shocked to learn that the primary therapist and other treatment team members were not willing to meet him half way and meet with him and his partner on her next visit. He thought that if they would demonstrate a willingness to accept the priorities he established for himself (family), that he would be able to accept them, and maintain the balance he thought he had achieved. When he was asked to outline the objectives or reasons why he and his partner would like a couple’s session he felt hurt and concluded that the primary therapist was not interested in him. James saw the involvement of his family as a necessary aspect of his healing, and if the primary therapist and treatment team could not see that, there was no point in trying to explain it. Although he was stretching to achieve a balance, they were not reaching out. He wondered why they were working in a treatment program.
Recognizing the power of a report to have a negative impact on his plans to rejoin his family and community, James decided he needed to do something. He did not see himself as having many options, he was powerless if the primary therapist was to include "hearsay" in reports. One day the primary therapist joined the treatment group where James was a member. James confronted the primary therapist about the report in the group setting and was insistent that the issue be dealt with there and then, and not after the group as the primary therapist suggested. He asked that the primary therapist spend more time with him and in his group. Although this occurred late in the treatment program, James felt that it helped and that their relationship improved. A lesson that he would take with him was that "you have to work together".

4.4.9 Jerome: Keep it Safe

Jerome, an Aboriginal male, was nearly 30 years old at the time of the study. Severing a sentence of more than 10 years, he had not yet served half of his sentence when he was admitted into the ABC treatment program. Although he was not sure what to expect, he was clear about what he could not expect. He knew that he could not expect the primary therapist or the treatment team to grant him a reduced security classification as a result of his participating in the ABC treatment program. It was beyond their authority. A recommendation, which he could influence, was the extent of their authority. He viewed participating in the treatment program as a pleasant challenge. However, learning about his thinking and patterns was both good and bad. He found safety in knowing himself better. However, in the time he had left to serve he was likely to encounter situations where he would need to use violence. Jerome stated, that knowing a better way, and trusting in his ability would serve to intensify the self-
hate he felt after using violence. He was concerned about how he would be able to detach himself from this awareness should he be required to use violence in the future.

Jerome interacted with the primary therapist and other treatment staff, yet he remained detached. He defined the primary therapist in terms of the role of a nurse. In fact, Jerome based his expectations of all staff in terms of their role. The primary therapist was a nurse and he was the patient. The nurse was there to help and the patient to be helped. He assumed that the primary therapist had the knowledge and skill to fulfill the role of a nurse, and once they established a shared objective and direction, he could trust in the helping process and the relationship. He did not expect anything more, and did not want to be expected of anything other than a willingness to accept help. He could not afford to look at the primary therapist or other staff beyond their roles. He had seen others lose sight of their goals by becoming overly involved with female staff. He blocked any attractions he felt and insisted on viewing all staff in terms of their roles and responsibilities.

Jerome shared how one treatment team member in particular attempted to reach out to him. He did not mind playing cards with her if that was what she wanted. However, he was confused when she shared how she knew all about him, yet did not suggest how she was prepared to work with him, or help him. He guessed that she expected him to share more and discuss the details of past experiences in order that she could then see herself as having helped him. He never clarified this assumption nor did he attempt to meet her expectations, as he perceived them. Instead, he preferred to focus on what was on the surface. They played cards regularly and kept track of the number of games each won. Their relationship would end with one of them having won
more games than the other, but Jerome would be no closer to his treatment goals. He knew the treatment team wanted him to make more substantial connections to others, but that was their goal and not his. He did not feel obligated to take on their goals as his own. He was comfortable with himself, he knew who he was, where he was from, and where he was headed.

4.4.10 Victor: A Victory

Victor, an Aboriginal man in his twenties, was serving a sentence of more than 10 years. He described himself as being spoiled as a youngster. His family was both prosperous and influential. Victor typically received or did whatever he wanted without having to accept any of the responsibility for his actions. Turning himself into the authorities following his offense was one time he found the strength in himself to do what was right.

Victor made the commitment to change his life long before he was accepted into the ABC treatment program. The Elders in his parent institution had approached him. He had been taught to respect the Elders and listen to what they had to say. They wanted to know how he was going to live the rest of his life. They told him of the consequences he would face if he did not gain the forgiveness of those he had hurt. He remembers that it just hit him and he knew he had to change his ways. Victor described how from that moment on the Elders and their teachings were his guides.

Fortunately, Victor knew most of the Elders at the RPC. The Elders knew him and his family either personally or of their influence. This made his transition into the ABC treatment program easier. He sought out the Elders whenever he could. He preferred receiving guidance from them. He was at home with them.
Victor had come to the ABC treatment program to gain the recognition he needed to begin the reintegration process. Believing that he already knew what he was about, he set out to gain the recognition of completing the program, without engaging in the treatment process. He had successfully been able to perform this imitation in the past and expected that he would be able to do so again.

The nurse assigned the primary therapist for Victor's treatment program was astute and did not know of his family. The techniques he had used in the past, to evade questions or to have the inquirer answer their own questions, were not effective with the primary therapist. She would listen, and then share her observations that he had responded by telling her how most people would respond or feel, when she was asking about him. Not knowing of his family she did not have a vested interest in assisting him, and therefore, had nothing to lose. Although this was uncomfortable for Victor he was not ready to abandon his plan to gain recognition without engaging in the process.

Then one day the primary therapist disclosed personal information in the group setting about a time in her life when she had been treated badly and felt shame. During their next individual session they discussed her disclosure. He knew that he had got through to her when he saw tears forming in her eyes. He described how he felt like walking across the room to physically comfort her. Following this experience Victor was less evasive in individual and group sessions. He could see that she knew what it was like to feel shame as he had. If he could not find safety in evasiveness, power through association, then he would be open not because he needed to learn about himself, but because there was an advantage to letting his primary get to know and help him.
4.4.11 Justice: Take a Chance

Justice, an Aboriginal man in his twenties, was serving a sentence of more than five years. He had one prior admission to the ABC program, however, he was discharged from the program for not complying with treatment expectations.

Shortly after being re-admitted he was on an escorted temporary absence. He felt respected and valued by the correctional officers that escorted him. It was this experience that made him decide to take a chance. When he returned, he was to complete a personal disclosure in the treatment group he was assigned to. He did not know the other group members and only knew of the nurse assigned as the primary therapist from his last admission, and what he had heard about her. He was open and honest and when he was done the other group members and the primary therapist knew everything there was to know about him. He had nothing left to hide. His openness promoted his relationship with the primary therapist and he was committed to being open with her thereafter.

Although he was open with the primary therapist, he was constantly monitoring to determine if she was “for him or against him”. She held a lot of power over his future and he did not want to cross her. Four months into the treatment program he presented his pattern of offending, and his violent thoughts, in a group session. When he did not receive any feedback from the primary therapist he was concerned and convinced that she had got what she wanted. He believed that she would use what he had said in the group to prevent him from gaining a conditional release. He was relieved when he later asked her and she told him he had not received much feedback because he
had done a good job and was specific about the strengths of his presentation in the group.

Soon Justice started to notice the moment when his thinking would change back to old patterns, and he found that he was able to stop and ask for more information at the time, rather than making assumptions, and then setting out to show them. This was a significant achievement for him. He knew that even if he did not like everything in his final treatment summary, all he really needed was a few goals that he could work towards. He knew he could do it.

He had not considered his spirituality a strength prior to this admission into the ABC treatment program. However, his recent involvement in Aboriginal programs and ceremonies helped him stay away from the drugs. He liked that the Elders did not write reports and that they held in confidence what he shared with them. However, at the time of the study he was not able to be as open with them as he was with the primary therapist. He was concerned that they might view him differently if they knew what some of his tattoos represented.

4.4.12 Luke: In Relation to Others

Luke, a young Metis man, was not an active participant in cultural ceremonies, although he liked to demonstrate his support for the cultural practices of others, by assisting from time to time in the preparation or enactment of the ceremonies. Luke was serving a sentence of more than five years for property and violence related offenses.

Luke was ready for treatment when he was admitted into the ABC treatment program. He was tired of his lifestyle and ready for change. He liked the treatment
environment but was a little uncomfortable at first. Things got easier for him when he started to open up with the primary therapist assigned to his treatment program. Once he was open he did not have to put up any masks and he felt like he could trust the treatment staff to help him. He wouldn’t get the help he was looking for if he wasn’t open.

Luke met weekly with the primary therapist. He was comfortable with her; she was smart and willing to help. He was able to raise any concerns he had with her, including concerns about the final treatment summary. He liked how she had agreed not to surprise him with a final treatment summary that identified areas still needing improvement. Instead they would identify treatment needs and address them while he was in treatment. He had come to the RPC voluntarily to ensure that he never came back to jail. He had plans to get a conditional release and go to school.

Luke learned a lot about himself while in the ABC treatment program. He learned about his thoughts and feelings and their relationship to his behaviour. Luke revealed that one of the most important things he learned through his relationship with the primary therapist was a way of being in relation to others, that he took with him to his relationships with family. He was proud that his family noticed how he was open with them, concerned himself with their feelings, and was interested in their point of view.
Chapter Five

Findings and Discussion

5.1 Introduction

This study examined the perspective of forensic inpatients enrolled in the ABC treatment program regarding their experiences with the therapeutic relationship, and in particular, therapeutic boundary maintenance. In sharing their experiences the participants used statements analogous to a house. Treatment was “a window of opportunity”; they were “within the walls”; they worried that they would “throw ... out the window” what they had learned in treatment; “glass doors” separated the participants and treatment staff at times; they had “rooms” with “doors and windows”, but no “curtains”; primary therapist’s self-disclosure sometimes “open[ed] that window to things”; in fact, primary therapists “opened a lot of doors”; “doors open[ed], close[d], and lock[ed]”; sometimes the “wrong doors” were opened; some nurses were like “a wall”, or “off the wall”; sometimes primary therapists were on the “other side of the wall”; and most importantly, primary therapists held and turned the “key to everything that’s going to happen” in the participants lives. Consequently, it seemed most fitting to use the analogy of a house to depict the participants’ experiences. Participants were initially strangers in the house and largely dependent upon the nurse to guide them and reveal the window of opportunity that treatment could present.

The interview data was analyzed and synthesized or “deconstructed and constructed” (Erlandson, et al., 1993) to reveal a core process – the development of
The development of “therapeutic” relationships was a complex process during which participants determined the boundaries and nature of the “therapeutic” relationship. Associated with this process were five interrelated themes. Adjusting to the House described the participants’ transition from their parent institutions to the treatment environment. Knowing the Fundamental Structures of the House represented the participants’ perception of the influential contextual factors in the treatment environment. The theme Evaluating the Primary Therapist as a Guide described the complex process that the participants engaged in to determine the primary therapists’ approach to treatment, and if the primary therapist was “for them or against them”. Experiences that Promote or Hinder the Relationship described those experiences the participant had with the primary therapist that either promoted or hindered “therapeutic” relationships. Finally, Ways of Being with the Primary Therapist: Head, Head and Heart, Heart, and Wallet depicted the four different types of relationships that developed between the participants and nurses over the course of the treatment program.

All of the five themes addressed above shared a number of elements and characteristics. However the fundamental structures; time, power, gender, regulations, and learning were embedded within all themes. Power, in particular, like the foundation of the house, was always present. The interrelatedness of the themes reflects the complexity of “therapeutic” relationships. Although points where the themes overlap and intersect will become apparent in the discussion of the findings that follows, each theme is considered separately.

1 Therapeutic has been placed in quotation marks to reflect the researcher’s uncertainty about the nature of the relationships that were emerging.
5.2 Arriving at the House

Upon arrival to the RPC participants encountered an environment and atmosphere unlike the parent institutions they left behind, yet with many of the same regulations that govern all correctional institutions. Like coming in from the cold, the adjustments that the participants were required to make were influenced by differences in the atmosphere at RPC as compared to their parent institutions, as well as personal characteristics, such as, the level of motivation or degree of coercion they experienced, cultural practices, and expectations held of treatment. Adjustment was highly individualized and marked a readiness to move beyond the entrance. For example, a change in environment for Montana brought more freedom. Compared to the institution he came from, the RPC was less restrictive. This new freedom was both confusing and scary for him. An improvement in his behaviour marked his adjustment.

It was kind of confusing at first. I came here from a maximum security facility, a year in the hole, so it’s kind of you know scary at first. I had a rocky start. But I’m getting along good now.

5.2.1 Adjusting to New Relationships with CSC Staff

Common to the participants, was the adjustment to friendly interactions with treatment team members. Interacting with staff was a violation of the “con code”, an inmate code of conduct, and was particularly difficult for some of the participants. Montana found the friendliness of staff very difficult to cope with. In fact, he asked staff to stop greeting him. However, as he explains they did not comply with his request. Instead, he began to change his approach to staff.

No actually they didn’t. They still kept on saying good morning and before I knew it I was saying good morning back. It was strange a different environment. Different mentality with guards, and with the nurses, and stuff just way different.
Adjustment to the friendly manner of interacting with therapists was marked by the recognition that the "code" did not exclusively apply at the RPC, as Peter's statement illustrates.

Well at first I didn't like it. I didn't like it I felt very, very, very, uncomfortable because, because of the fact that they were staff and I was an inmate and sitting in a room uh talking to a staff member would really make others feel uncomfortable. Or so I thought.

For other participants the friendliness of staff was cause for suspicion and adjustment came with the recognition that the friendliness was not a disguise for the intention to cause harm, but rather basic respect which they had not been afforded in their parent institutions.

Daniel: Yeah it was very uh way out of my comfort zone so as I said I haven't' had anybody do that over the [last eleven years]. Just to hear those things like that when they walk by you 'Oh hey [Daniel]' . You know it really made me wonder what the heck was going on at first. A little suspicious I think. Now wait a minute but then I've seen that it wasn't, there was no intent to harm, I wasn't being set up and it, it just actually more, more it was just getting used to the uh being treated as a human rather than a convict.

Ernest: I was a piece of dirt and you know when I got here for the first moment out of the 2 1/2 years that I've been in, I was treated like a human being. Nobody looked down at me or on me what I was in for - kind, considerate, understanding, more or less a culture shock.

Adjusting to the treatment environment required that the participants extend their interactions beyond the friendly level to include trust. A willingness to trust was necessary for successful completion of the program.

Victor: Where as you have to build that trust up, you have to, the bottom line you have no choice because if you want to successfully complete this program you have to learn to trust these people and you have to come to trust them. And believe that they're here to help you and they're not going to try and shaft you or they're not here to screw you around or anything like that and they come across like that and they, they prove that in a way to them.
Jerome: The person just trusts him because they know you know it's the help that they're looking for so you've got to trust them. And if that trust isn't there you don't belong there.

Luke: So, after a while just I'm starting to meet with her [primary therapist], I felt like you know I could trust these people to help me. That's what I wanted. You know I ain't going to get help if I just block it out. Right.

Peter: Like sometimes I sit here and I don't even know what the hell she's talking about. Because she uses big words and stuff right, but I you know the trust is there, and I'm comfortable, and slowing asking: can you explain that, because I'm not exactly uh Mr. College here or anything like that.

A willingness to trust was preceded by the recognition of different levels of trust and accompanied by a belief that the treatment team was there to help.

Trust has special significance within the "con code". From this perspective trust is more than knowing that the treatment team has their best interests in mind. At this level, trust is about being with, or for the participant, and against the system. This level of trust was typically reserved for those relationships where shared experiences formed the bonds of the relationship, and the commitment to another was greater than the commitment to oneself.

Jerome: You know you go through, the like I said, the residential schools, the boarding schools, some of the foster homes, and the JV centers, the provincial correctional centers, the federal prison and and all the time that you go through that to have them you know you've got six, seven guys that are always there with you, that are always around doing the time with you. Uh it you've got that bond, that's a relationship that you know whether it goes good or bad it doesn't matter, you're always there together and you're going through it and that's again going back to the level of trust that you have in those people. You know and trust those people not to do you wrong whether it's right or wrong. Whether it's right or wrong. If they're, if they're going to say something about you or do something to you, there has to be a reason you know.

Victor describes how a story he heard from an Elder years earlier helped him to appreciate the different levels of trust, and to know that it was not deceitful to offer a different level of trust in different relationships.
Because that was told to me like about five years ago you know and I never knew what they [Elders] meant by that, but now I can see it, you know. A person, a man will, not so much a man, but just a person wears a lot of...many faces in a day, and um ... It it’s just so true, you know. Like say you’re talking with your husband and you deal with him in a certain way and you talk to him and you talk to your children and you deal with them and you talk with them in a certain way....It’s not a bad thing though. It’s it’s what we do to allow ourselves to function and keep a balance in our life. I guess, on a day to day basis, and so with that, with that bit of knowledge starting to make sense to me I’ve come to learn that I can trust you, I can talk with you about things. Not not everything. But I can trust you enough and I can trust [my primary therapist] with a lot of things, maybe a little more but it’s not bad. There’s nothing wrong with that you know. It’s just the way we find that balance in our life on a day to day basis and so again it comes down to the trust.

The different levels of trust were not as clear to Peter. On occasion the conceptualization of trust as a commitment to others above oneself appeared to influence the way Peter viewed the relationships he had with his primary therapist. Contrary to an earlier statement “that the trust phase was built” with the primary therapist Peter stated:

Uh things like that only go into a certain...certain boundary, and stuff you know. And, uh, as far as the trust is there, uh it wouldn’t be really much too much of a, of a, of a relationship even friendship.

In essence, participants faced a dilemma – to trust or not to trust. However, not trusting was not an option. More realistically, the option was to trust or deceive. While all participants adjusted to interacting with the treatment team in a friendly manner, and finding a level of trust with at least one team member that would allow them to move on, only those participants who preferred a culturally specific approach to their healing were required to adjust to an alternative approach to treatment.

5.2.2 Achieving a Balance between Cultural Beliefs and the ABC Program

Aboriginal participants who preferred a traditional approach to their healing were required to adjust to a new approach to treatment. They struggled between meeting
the expectations of the ABC treatment program and remaining true to their beliefs.

Finding a balance or a way to use resources of the ABC treatment program while maintaining their Aboriginal programs and cultural beliefs marked their adjustment. James attempted to find a balance whereby he could comply with the expectations of the ABC treatment program, yet not betray his beliefs and himself. His culture was second nature to him, while he had to learn the ABC treatment program. James described how his beliefs were his priority and his essence, and how he had to know what was expected of him in the ABC program in order to achieve that balance.

I keep them [ABC program and Aboriginal programs] in a balance. I keep them together hey. Cause I just, like I explained, I can’t put anything ahead of what I am, you know, ahead of my, my, my belief, my, my race, I can’t put anything ahead of that. I am what I am and I can’t change it no matter how hard un anyone tries, primaries, doctors, yourself, or even myself, I can’t. This is me.

Well ... he’s got a job hey, you go you start working at a job you have to get to know your, your boss, and you know, know his expectations. Knowing your, your expectations so you know what type of performance you’re, you’re to produce or give out. So knowing all these, knowing my expectations I have to make a balance within that and uh that balance won’t come just like that with just a handshake, it takes time to build, build this relationship. For me it takes time. I suppose. I think.

Victor was able to reach a point where he embraced the advantages that his culture gave him over other participants in the ABC treatment program and was able to draw on the ABC program as a resource. Although he preferred, and was more comfortable sharing with the Elder, he was also able to select portions of the ABC treatment program that were relevant for him, and embrace them as well.

I have managed to shed some tears [with] the staff. It’s, I don’t feel uncomfortable doing it and I think that is due to my culture you know .... I guess in that respect I got a bit of a jump on a lot of guys here.

This will show me different ways of dealing, living a life again, in a positive manner and learning this and finding a balance with the program here and my
culture and through it might be the trick. But I think I can do that and in doing that I will achieve that place that I want to be, but again it’s learning how to utilize the resources that are around you I guess.

5.2.3 Evaluating Expectations and Experiences

Some participants came with clear expectations about what they hoped to achieve, and the process that treatment would take. The expectations that these participants held influenced their adjustment to the treatment environment. Ty was expecting answers. He wanted to find out why he had ended up in jail. When he could see that he was going to get some answers he felt better about treatment and was more open with the primary therapist.

Ty: You know like. I in my crime it took four years for me to go down hill. It wasn’t just what I thought hey what happened today and tomorrow’s a different day. So every program I’ve taken already that’s what I was looking for how come this happened. You know and the institution they don’t really care if it happened or not, they just schedule, just do it and be done. There’s more than just understanding what behaviour is. We’re all different.

Montana expected to be discharged from the program. This expectation influenced his willingness to try.

I just expected the bus to roll up anytime. Take me back to Edmonton and I wouldn’t have blamed them if it did because I didn’t try. I wasn’t trying. I didn’t care. You know what I mean. Cause I figured why try. You know it’s just another … and then I realized that why not.

Jerome credited his relatively easy, uneventful adjustment to the fact that he held no expectations about his treatment. He used an interesting analogy that may have reflected his own past experiences to explain.

A lot of times people come in here thinking that they have expectations of everybody and if they don’t get that expectation they start crying. Shit their diapers you know. I didn’t do that, I, you know, I don’t do that. I don’t come in here anywhere and expect people to do things in my own head what I want them to do and then they don’t do it. You know. I don’t do that. I know that uh the people that work here are here for a reason. That’s all they’re here for is to do
their job, to help people and, and of course somewhere along the way there’s a friendship there’s something that happens you know. A bonding you know whatever. You know that happens. I don’t know if that’ll happen between the, the two people. Other than that I don’t think, think too much of outside that.

5.2.4 Level of Motivation or Degree of Coercion

The participants’ level of motivation, degree of coercion, or readiness for treatment influenced their adjustment to the treatment environment. Participants identified motivation or desire to change as the greatest influence on their approach to treatment and the “therapeutic” relationship. There was a sense that if a participant was motivated, his desire to change would be the impetus needed to overcome any barriers to treatment.

Daniel: If a guy is motivated to change uh he will seek that out. It’s always there. If not [you can] take it back, but this [is] the way I see this right here is I’ve got a six month window. It’s a window of opportunity that most people in the world won’t really have. It’s my chance to sit back and relax and fix yourself. That’s really what it comes down to I mean how many other people can do that. You’ve got a staff of how many. It’s phenomenal how many people work here and they’re all willing to help.

Associated with motivation was recognition of the need for help, or a readiness for treatment that involved a willingness to trust the treatment team, coupled with the participant’s confidence in his own sincerity, and ability to retain a sense of self control. For Jerome, the belief that he would not allow himself to be powerless, and be led by a primary therapist without knowing the destination was a important aspect of being ready for treatment. He described how years earlier, the time in his sentence was right for him to come to the RPC, he did not trust himself—he was not ready.

Well you’ve got to have you know your personal trust you’ve got to know yourself, you, you’ve got to understand your feelings. You’ve got to understand who you are to really trust anybody. Some people don’t trust, some people do in certain situations. And these are one of the situations that have uh I’ve come to trust myself because I need this, I need, I need the help from here to uh move on.
To get from here to wherever else I’m going to. This program plays, it plays a major role in my, in my, uh, in my sentence. I’ve, I’ve, I’ve had to, you know, I was ready to come here years ago, but uh I, I, I didn’t trust myself. I didn’t fully trust myself I guess. Fully trust myself to come here to. You know. I know what I’m finding out today, finding out in this program that I’m taking. So it’s a level of trust between you and yourself and the people that are here to get what you want out of the program. Some guys just come here and bullshit their way through you know get nowhere. Fall on their asses and then you see them a few years later sitting in the same position they were before when they were here. That’s not trusting themselves. ... There’s a difference between jumping through the hoops and trusting yourself. See legitimate act on your part I guess to do what you feel is right. I think that, that the, if you’re, if you’re doing it to satisfy somebody else you’re not getting nothing out of it, and you’re not getting nothing for yourself, or anything out of it. You’re just doing it to please somebody else.

Participants who felt coerced to participate in treatment, or sought treatment to earn the recognition necessary to gain a conditional release, experienced an adjustment marked by movement, from feeling coerced towards feeling motivated. Paul indicated that he only came to the RPC to gain a conditional release. Embedded in this disclosure was the suggestion that the coercion he once felt was less intense.

When I first got here the only reason that I came here was for parole you know. The participants did not experience coercion and motivation as mutually exclusive concepts. The consequence of being incarcerated was often the source of motivation to change, as Luke’s account of his motivation illustrates.

Sure before the program, before I came here I made my mind up that I didn’t want to come back to jail, and uh I made all the commitments to myself that this is going to be the last time I come back, and I said you know I can’t stand the heartache and pain of sitting behind bars and you know, hating, loneliness, and prison world. You know what I mean. I, I’m sick of that life hey.

For Justice experiencing growth and a growing sense of self-efficacy were the forces that pulled motivation and coercion together.

Yeah I feel like I’m in control of what I want. I’m in control of my own feelings and thoughts and I have the skills to change those thoughts if they’re negative by
using thought stopping techniques or you know using anger logs and things like that if I'm frustrated and angry so. And so it's all beneficial for me this whole program you know. I used to hate my parole officer back in my parent institution for sending me here you know. Now I but honestly I'm going to go back and shake his hand when I get back.

Being given the option and freedom to chose, helped Montana to take a chance, and bridge the gap between coercion and motivation.

He gave me a lot of advice and he said well either you take it right. Take it and take the chance and take the advice. What do I have to lose? You know what I mean. Or say fuck the advice, excuse my language, but and uh stay the way you are. So I thought about it and I decided he's right. So I tried a few of his way, did a couple cycles, stuff like that on authority, on my drug abuse, stuff like that hey. And I got gained new insight on where I went wrong. Cause it's all a cycle and if you break...

Adjustment for each participant was greater than simply becoming familiar with their new surroundings. Adjustment meant believing that therapists were there to help, learning to trust, evaluating expectations, finding motivation, and for some participants, finding a balance between traditional healing and the ABC program. With the recognition that they were adjusting to the new environment came the awareness that they would experience a readjustment when they returned to their parent institutions.

Daniel: That, just the attitude the, the ambiance of the place. A very caring, nurturing, and learning atmosphere. Uh, I found it to be very uncomfortable and after having lived for the better part of 11 years in, in an environment that's very uncaring, completely irrational, and violent to come to a place where um it has a human side it's expressed. At first it, it was awkward. It took, it took a bit of time for me to adjust and I know once I leave here it's going to take some time to readjust to the prison environment.

The adjustments that the participants were experiencing did not occur in isolation. Instead, they were influenced by, and reflected in, the emerging relationships between participants, and treatment team members. The house was more than the physical structure. In the structure of the house were components that were not of
mortar and brick, but rather of notion, and principle. These were the structures of the house that formed the circumstances of the participants’ adjustment and the emerging relationships.

5.3 Knowing the Fundamental Structures of the House

No matter how esthetically pleasing, or how well disguised, the RPC remained a prison for the participants. The beautiful courtyard provided the opportunity to pleasantly pass the time, but they were still serving time. Although referred to as patients, implying they needed help, they were locked up each night like inmates. Interacting with female therapists gave them a chance to practice being gentlemen. However, they were not well informed as to what was acceptable, and they risked being misunderstood. Time, power and gender emerged in the experiences the participants shared as the most influential contextual factors. Learning, the “con code” and systemic factors, such as, policies and regulations, were also significant contextual factors.

5.3.1 Time

Time was multidimensional and had special significance for the participants.

Time was a valuable commodity; the participants owed time, had time, and used time, as a way to assert themselves.

Ty: The penitentiary makes you aware that you owe us time and that’s the way it is. We have that time. There’s lots of time to sit and think. It drags your time out that mentality, for me it does.

James: That’s why when I write out my crime cycle or my um relapse prevention plan I was taking my time. I want to take things in slowly you know and as, as I take them in I want to think on these, meditate with these and then when I come to bring them bring my, my stuff off and put it on paper I want to do that slow as well hey. I don’t want to be pressured, I don’t want to be pushed.
Jerome: Uh you know I, I tell them, you know, I tell them straight out. You know, it's not my thing and I'll continue on doing what I do and what you say, you know, it's been taken, your opinion's been understood. And I respect it, but you've got to respect mine as well, and uh I'm comfortable with what I do, how I do my time.

Time was also a measure of relationships; participants valued those who made time for them.

Paul: We all know request forms don't work, and if they do, they take forever. So when somebody takes the initiative to get involved and see if they can rectify this problem, you know, even if it means, well I'm going home at 10 to 3 you know it's quarter to now, so she'll take the extra 5, 10 minutes to stick around to try and find out. I mean if you get the answer well there's nothing, you know, just the fact that, you know, that they'll call or that they put some effort into finding out rather than just saying put in a request form. People like that, I like that, and it shows then I'm not just [identification number].

Time was an activity. Participants were doing time, and looked for ways to pass the time. To owe time was to be an inmate and less time to be productive; to use time constructively was being productive, and to spend less time as an inmate.

Ty: It's less time to be an inmate here. ... I don't like doing jail time either but I've done the crime, I accept it, and I'm doing it you know. As long as I'm getting something out of it also. You know like here I'm getting something out of it.


Time was a fundamental structure of the treatment environment. How the participants used or “did time” was a measure of who they were as individuals. Time was a measure of both the individual and relationships for the participants.

5.3.2 Power

Participants described power as an element of the context of treatment. The power inequality in their relationships with treatment team members was always evident. However, it was most apparent when the primary therapists completed reports
on the participants' progress. These reports were shared with decision makers who ultimately held the power over participants' potential freedom.

For James, a negative final treatment summary would mean that it would take longer to return to his family. Twenty years was too long to be incarcerated.

I have to have them if I'm going to have grandchildren, I have two grandchildren as a matter of fact, that uh, that need me out there, and I need them. I need my son. I need my common law spouse. I need to be with them, my parents, my grandparents. And then, uh, If I to be observed, or seen as a, like that, in that, that way (negative), then uh, you know, it's going to take me longer to be able to live with my family out there in society hey.

Ernest identified the power of the reports that the primary therapists would write as one reason that he was uncomfortable with the primary therapist. There was a sense that Ernest felt he needed to be more careful interacting with the primary therapist working with him. In essence, the primary therapist held the key to his future and he was vulnerable.

The one reason is, is, [uh, it's] because I'm here and the reports that are wrote about me. It's like they hold the key to everything that's going to happen to in my life. I guess I'm more cautious about the way I do things where my primary [is concerned], as opposed to others.

For Parker the reports that the primary therapist would ultimately complete had the power to give him feelings.

I mean you've actually ... how do you put it. It's sort of like I don't have empathy, guilt, or remorse until such a time as a report says I do and until that report says that I do I'm still ... this murderer.

Justice talked about how he tried to please the primary therapist as a method to equalize the power difference and guard against her using power to reduce his chances of progressing towards a gradual release to the community.

I don’t want to get on her bad side and uh cause then that gives her all the power to do whatever she wants with me you know. But uh she she thinks I'm a pretty
good person you know she thinks I have a very good sense of humor. You
know I joke around a lot and things like that. You know she tells me I’m very
intelligent you know and I’m a smart man if I put my skills to use and she
realizes that I’ve lived a rough couple years you know when I was in that
negative cycle that I had no skills or couldn’t recognize any of these thinking
errors or behaviours and today I can. So she can see that it is having an impact
on me. So it’s all good for me I think.

Although vulnerable, the participants did not view themselves as totally powerless. As
reflected in Justice’s statement above, the participants viewed themselves as being able
to influence the content of reports by demonstrating their progress, and by pleasing the
primary therapist.

Coercion was one form of power that the participants experienced. Some
participants felt forced or coerced into complying with treatment expectations.
Montana’s description of what it was like for him to disclose his personal history in a
group of peers and treatment staff shortly after his admission, reflects ambivalent
feelings about the process. Although he felt coerced to disclose, he thought that perhaps
some good things resulted. He seemed more confused than certain about the outcomes
of completing a self-disclosure in the group setting.

It was it was hard. I didn’t want to do it. But if you don’t do it, then you don’t
do the program, so it’s forced on you. You have to do it. Like I you have to do
autobiography right.... And you write that’s your life story from way back as
you can remember up until now. Every significant thing that happened in your
life; parents divorced, and why, child abuse, whatever. Right. And uh then
you’ve got to go into the group and tell your, tell your life story to the group
where you’re born, all that there stuff, right, what your crime is, how you, how
you grew up, poor, rich, whatever. You know what I mean. How you were
treated in your family, shit like that, and you’ve got to have trust to do that. I
think I felt really uncomfortable doing that cause I didn’t have the trust in my
group then but I did it anyway because I was forced to. Cause if you don’t do it
then you’re not in the group. If you’re not in the group, you go back and do
time. So maybe it’s a good thing in a way but you know I don’t know. Maybe
it forces that trust on you.

Power permeated the emerging relationships. Being at the RPC was not like
“doing time” in their parent institutions, and the participants needed to receive positive progress reports to progress in their reintegration plans. Power was a force promoting compliance with treatment, and one of the forces driving a desire to please that primary therapist. The participants were vulnerable but not powerless.

5.3.3 Gender

Participants, all male, entered a context of treatment where the majority of treatment staff were female. Although there were female staff in their parent institutions, the RPC was a different environment where the contact between participants and female staff occurred more frequently. Participants viewed it as natural to want to spend time with them, however being with an attentive female was a seductive pull for some, with very detrimental consequences for both the participant and the therapist.

Daniel: I think one of the greatest things, problems, that [there] is today, is when guys who come in here, and if they’ve done an extensive amount of time, is that there’s some very pretty ladies who work here. And so it’s natural to to want to talk to them and get to know them a little better and maybe? But the reality is is that wouldn’t be at all helpful and it’d be detrimental on both parts.

Parker: But how often have the ... had the opportunity to speak to technically normal relatively well adjusted intelligent women you know are friendly they smile and they laugh at our jokes, and they always [make] time to sit down and talk to us ... it’s pretty neat.

Having had past positive experiences with females, some participants preferred to work with female staff.

Justice: So it was just me and my mother so I was always used to having a woman in my life. That kind of thing. I don’t know I just feel more comfortable for me.

Parker recognized that the potential for complicated relationships with female treatment
team members existed for him. He enjoyed the contact with female staff, however, he had not been advised what was considered appropriate or inappropriate behaviour with the female staff. Unaware of guidelines to follow in his interactions with female staff, Parker was happy to be working with a male primary therapist.

They smell nice and you just get caught up in the moment you’re not really looking for sex or anything you just want to ... it’s easier to talk sometimes it’s easier to talk to a woman or it gives you a chance to practice being a gentleman or what have you, you know.

It’s easier with a guy cause there’s no sexual overtones or anything sexual. You know, but, but with, with, with a female primary or a nurse or whatever ... you don’t know where the line is, no one tells us guys where it is.

Participants were aware that romantic relationships between patients and staff at the RPC had developed in the past.

Ty: A few, that patient and a therapist got together and stuff like that.

Daniel: If there weren’t no emotional boundaries or just boundaries period within this kind of a setting then you’d end up with a lot more situations where there’s patient and nurse involvement and that’s happened enough with the boundaries as they are.

Parker: I know a lot of inmates who come back from conversations ‘she wants me’, you know. Now maybe it’s a bit of a joke but I hear too many guys say that [you] know the history is so. I don’t know what they are talking about but it’s a very dangerous thing.

Participants were uncertain where the boundary or line was drawn between male participants and female treatment team members, and how transgressions would be addressed. Uncertainty gave rise to a vulnerability, or fear for the participants, that boundary violations may not be managed appropriately, and a hope that nurses would respond to any transgressions professionally.

Parker: I like, I don’t know again you haven’t given any indication otherwise yet. You must have some training in that area as to what you are permitted to say and aren’t permitted to say to begin with. But I don’t know what that
training is, so I don’t know if you’ve crossed those boundaries and no one’s ever told me what my boundaries are. So I don’t know if, if that helps in the context or is that even something that should be touched upon here. You, you’re talking like in terms of relationships between primaries and staff. Would it help if those boundaries were laid down, or is that even a can of worms that you even want to open up anyway. Just let them find that out to the point that, if I’m approaching, or, or interacting with you inappropriately, that the onus is upon you to assert yourself and, and tell me, and to prevent it first, and recognize that basically as um. I mean what do you [do] in a situation like? That if, if someone crosses the line, say an inmate crosses the line and makes a remark or whatever or he starts taking liberties with his language or stuff, then the onus is on either the nurse or whatever to say well no, and set down the boundaries at that point.

Participants feared that they likely would be blamed for crossing the boundaries, even in situations where the behaviour of the therapist was misleading for the participant, as Parker explains:

But if we do cross those boundaries it becomes a security issue. Where it gets written down in a report, as opposed to recognizing that perhaps the rapport you establish with this person, rightly or wrongly, it’s been interpreted in such a way as to represent, to be what he believes friendship, or what have you, and so it’s gone beyond. So he’s crossed the boundary and it’s it’s, by all means set him straight and recognize your own probability in that. Because once you put on the report, pardon the expression.

It is within relationships where the boundaries are not clear where the participants felt the most powerless. Jerome explained how he felt there was nothing that a participant could do to manage the suspicion of an involvement, regardless of who was responsible—participant or therapist—the participant would suffer the consequences. Despite how powerless Jerome saw participants in this situation, he still portrayed the female treatment team member as a victim of circumstances, unable to help where they worked and the career they chose, as reflected in a series of Jerome’s statements.

There’s no way you can cope with something like that. Having so much female around the and you’re stuck in a position where you can’t do nothing.
Maybe you’re, it might be some other, you know, even that like [when the] further advances, uh staff that on the patient, and then the next thing you know there’s guys.

He’s gone or he’s being charged with this and that whatever. The thing is, is that it’s, you know a thing you can’t help, you can’t help it if you work here you know this is a career that you choose.

5.3.4. Living with Regulations

Policies, regulations and rules governed the conduct of participants during their stay at the RPC. Although many participants did not agree with the regulations, they accepted these as an aspect of “doing time.” However, there were regulations that were a source of distress for at least some of the participants. Participants were distressed about those regulations that minimized their control over personal space and their movement within the institution. They were also distressed by the RPC’s failure to follow the regulations that gave Elders the same privileges as the Chaplains. The disparity between policy, dictating equality between Elders and Chaplains, and the institutional practices was frustrating, and for some, preceded the loss of respect “for other people in power”.

Montana: That’s the only issue they have is security. Can’t see in your window. Well security can move that curtain and look in my room. You know what I mean. It’s that simple. No zero tolerance, well. Fuck you. Excuse my language, but that’s the way I feel about it. I don’t feel it’s right. That’s my room, that’s my private, that’s my home, that’s why I have it the way I keep it clean, I keep it as nice and tidy and stuff as I can. It’s only a small little house a small little cell but that’s my home. That’s where I go when I want to be by myself or whatever, when I’m stressed out, or when I’m just, you know, want to relax. Do you have curtains on your house? Sure you do. Why because you don’t like people walking by and looking in your house. Neither do I.

Justice: yeah the restricted movement. A lot really made me frustrated cause I found myself being bored and trying to find something to do and there was really nothing for me to do.
James: These are the things that uh I think about and it’s where I see uh as uh, Elders not being treated fairly.

Victor: They were given the same recognition as a priest within an institution now, and yet, still today, there’s this trouble trying to get that honored and followed through.

5.3.5 The Value of Learning

Participants stressed learning. Learning was an activity that characterized the Treatment environment. Participants viewed the RPC as existing for the purpose of delivering programs, as Jerome explained:

Like that’s, and uh in the institutions you know like for years this place was here for one particular reason, and that’s to provide a program, programs, many programs, whatever they’ve got here, I don’t uh.

Participants learned about themselves, their thinking, their feelings, their behaviour, and the relationships between them.

Victor: So you’ve got to really, everything in your life is [it] revolves around emotions and feelings constantly on a daily basis and while I knew that I never knew the words or how you more like the labels, the descriptions to the emotions. You know if I was feeling anxious and uh euphoric, these are all these new little words I’m, I’m learning I’m, I’m now able to put the feelings that I know, but I didn’t I couldn’t tell you how I felt cause you said if you asked me how you feel oh I don’t feel all that well. Well why not? I don’t know just I just don’t feel good. That was the extent of my knowledge.

Justice: But yeah and like that I can identify my thinking my distorted thinking things like that now and so it’s helped a lot you know. It’s actually made me think about things that I could never recognize before like my behaviours and the past, things like that.

Participants also learned a way of being in relation to others through “therapeutic” relationships with a treatment team member. Participants learned how being open and honest could assist them. They expressed a desire to be open and honest in relationships with others.
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Justice: I’ve learned that uh I have to start opening up to people. Uh this must continue when I’m released or when I get back to my parent institution. I have to be open and honest with people around me about my feelings and thoughts instead of acting on them in aggressive behaviours and things like that. So it’s made me, by doing, it’s my primary talking one on one, it’s helped me with I guess uh being able to open up when I’m released and things like that.

Luke: Being open and honest to the person you’re talking to really helps like before I never was open. You know what I mean. I would close myself up. So that’s, that’s probably one of the most important things I’ve learned. To be open with someone, want to talk to them and listen.

Although participants were enthusiastic about what they were learning, they recognized that the application of their new skills might be limited by the environment to which they were returning. Montana asked what I thought happened to everything he learned while at the RPC once he returned to his parent institution. The following is his reaction to my suggestion that he might carry it in his pocket.

Out the window, not my pocket. My pocket has got a hole in it. You can’t practice something in that environment.

The contextual factors of treatment, like the structures of the house, created the space or atmosphere where participants and treatment team members interacted. Time, power, gender, regulations, and learning, as significant contextual factors, were the structures that formed the boundaries around treatment. Participants questioned how treatment team members would function in relation to the contextual factors they had articulated. Would time be used productively? Would power be abused? Would transgressions with female staff be addressed professionally? Would regulations be enforced without considerations for the participant’s perception, or would their views be considered? What would they learn?
5.4 Evaluating the Primary Therapist as a Guide

The participants approached treatment and the “therapeutic” relationship with their primary therapist with caution. Participants were concerned about the potential for power to be abused to promote agendas opposing the participants’ interests. It seemed that trust was associated with vulnerability, and motivation with coercion. Participants were aware of contextual factors, but unaware of how these contextual factors would manifest in their relationships with primary therapists. In order to make judgements about how they would proceed, the participants evaluated the primary therapists working with them, and to a lesser extent other treatment team members. Participants appeared to engage in evaluations of the primary therapist for two purposes: 1) to determine the willingness and ability of staff to help them; and/or 2) to identify and minimize potential threats to their fulfillment of their personal agendas, or “damage control”.

In terms of the house analogy, the participants attempted to determine what floor plan or resources the primary therapist held. Knowing the floor plan the primary therapist held would allow the participants to anticipate the course that the relationship would take.

During the early stages of the relationships participants actively created and implemented tests to evaluate the primary therapists, in order to supplement their own personal observations, and the reports of other participants in the ABC treatment program. Although participants engaged in active evaluation during the early stages of the relationship, their evaluation of the primary therapists was ongoing. Participants, aware of the potential consequences of a negative progress report, were constantly
monitoring to determine if the primary therapist was “with them or against them”.

“With them” generally meant being willing and able to help, and included the
recognition that the purpose of the relationship was to reduce the likelihood of the
participant re-offending. However, like trust, the participants perceived therapists as
being ultimately “with them” when therapists were seen as joining with the participant
in a fight against the system, such as the concealment of potentially high risk situations.
For example, four months into the treatment program, when the primary therapist
agreed not to use potentially damaging information against him in his final treatment
summary, Justice was finally convinced that his primary therapist was “with him” and
not “against him”. Although it is unlikely that the primary therapist meant it just as
Justice interpreted it, “with me” appeared to have meaning on two different levels.

I think my primary’s working totally for me, not against me like I used to think.

“Being against” the participant typically meant that the primary therapist was
working to see that the participant remained incarcerated. For example, giving them
positive feedback on their progress, and then in their final treatment summary, reporting
a number of areas that participants had not addressed sufficiently. Consequently, the
participant would not be able to progress towards a gradual release until he addressed
the areas identified as high risk in the final treatment summary.

5.4.1 Testing for Integrity

Although the participants used a variety of tests to evaluate the primary
therapists, these tests shared a common purpose – to evaluate the primary therapist’s
ability and willingness to help. Through testing the primary therapists, the participants
were able to determine the extent to which they could trust the primary therapist. When
primary therapists passed the test, the relationship was enhanced by the participants’ views of the primary therapist as willing and able to help.

Daniel described how his test of treatment staff included a comparison of two different staff types based on his determination of their attitude and approach.

Intellectual and caring I would go to them. You know, if I’m struggling with an issue, I would talk to them because they would uh be able to give me insight in terms of how to, how to deal with things. For example, one of my problem areas is high in expectations for myself and others. And because I’m struggling with that, I went and spoke to [a] few different people, and actually chose one that was caring and one that was intellectual and caring, and I compared them. And afterwards I seen two very different people, not, not really speaking with each other in regards to it. You know I’m a very different person in their approach, and in their what would you call it...advice. So between the caring, and the intellectual and the caring, uh that’s where I go, that’s where I prefer to go.

Unlike Daniel, Victor’s method of evaluating staff was uncomplicated. Victor simply took his time, gave staff a little bit of information and then watched to see what they did with it. Did they make assumptions and read into the information he revealed, or did they ask for clarification and use the information to help him?

Well now that I’m getting the trust, but before the first few months I was kind of cautious of. You know I wanted them to mind read, I guess is what I, you know. Now that I think about it that’s what I was kind of doing hey. Shooting the information out there and see where it would go.

Ty’s approach included comparing the guidance he received from treatment team members, with the content in the ABC Workbook. Give give them all their little test and they were giving me the answers I felt I was looking for. You know, if I took it right away and you know maybe they would caution why I didn’t volunteer any more but I took that, and, you know, worked with it for a couple days and checked the workbook.

Montana had three different primary therapists assigned to his treatment
program. He described how the third primary therapist remained committed to his treatment even when Montana made it difficult to do so. In turn, Montana was more receptive to suggestions from the third primary therapist.

“I tested him and he passed. Well he stuck by me, right.”

5.4.2 Monitoring for Consistency

Participants monitored the consistency between the verbal and non-verbal communication of the staff, to determine their genuiness. This was often associated with a “gut feeling” or “quiet knowing”. At a macro level participants monitored staff to see if they were consistent with what they taught them, or if they followed through with the commitments they made. Identifying an inconsistency was reason for caution for the participants. Daniel described both levels of consistency, as well as the caution exercised when an inconsistency was identified.

Yeah and watching, watching the nurses and seeing the body language uh and consistency and I found that there, there was no, um in my gut I knew that it was, they were being genuine. Anyway and that kind of meant a lot, cause no matter [what] you say, no matter what you do my gut tells you, tells me that say, wait something’s wrong but then I wouldn’t, I wouldn’t um get involved.

I look for inconsistencies and when I see inconsistencies um when I see those inconsistencies that that makes me question other aspects of them. I wonder well if she’s inconsistent? A very simple example, it’s very terrible to smoke and the person’s telling me all the negative attributes of smoking and then goes outside and, and smokes. I know them, you know them very well, but why preach about them if you do the very same thing.

What was a “gut feeling” or “quiet knowing” for Daniel, was a vibe for Victor, as he described.

Sometimes it’s a vibe I guess really you know. Um. It’s it’s human nature you know. ... If you don’t rub me the right way for some reason you know. The person didn’t say a word to you didn’t give you a dirty look or nothing but just for some reason that person just doesn’t rub me the right way you know.
5.4.3 Gathering Reports from Others

Reports from other participants about the primary therapists were a further source of information for participants. Justice received reports on the primary therapists that were assigned to his treatment program for both his first and second admission.

I've heard from other patients that this primary was a good primary to have. Uh she's pretty lenient and things like that. Uh basically a lot of guys that have had her for primary have gotten good reports and things like that. But uh.

Uh. Well my last primary was a male and you know he really didn't? I've heard a lot of stories about him.

5.4.4 Finding Similarities

Finally, participants who found it easier to relate to primary therapists who they perceived as being similar to themselves, looked for similarities. Paul described how he felt comfortable with his primary therapist, because she was the same age as him, and used his “language”.

Well because she's my age, you know what I mean, and uh you know, she doesn't talk a lot of textbook stuff. You know. She talks, you know my language, you know, and uh she's laid back, you know.

However, for Paul, the treatment team member's position and associated power were the key determinants of the relationships he developed with staff. He avoided those staff he perceived as having the power to make decisions regarding his future in the ABC program. Avoidance was based on Paul’s evaluation of these treatment team members as being capable of interfering with his ability to complete the program and gain the recognition he needed for a parole. Paul never assessed these treatment team members in terms of their willingness or ability to help, but only in terms of their power to interfere with his future.
Well similar some of them yes, but uh it all boils down to the relationships that I have with the staff is basically based on what I perceive the position to be. .... I won’t argue with them, I won’t tell them this is wrong, this is wrong, this is wrong, because they hold the position I believe to, uh, you know, to throw me the hell out of here. So, I wouldn’t, uh the less that I see them and the less they see me the better off I am in my own mind.

For James, sharing cultural beliefs and practices with the Elders made working with the Elders easier, in comparison to treatment team members, where he had to constantly monitor his presentation.

It’s a, it’s a lot of work hey. It’s a lot of work, it’s a lot on my mind like I’m, I’m looking at helping myself first and then I’m looking at uh my presentation to from day to day, with primaries and staff. How I’m going to deal with myself, my problems, then I’m looking at the same thing with the brotherhood another area, and the brotherhood being, uh of, a, being of natives, and native Elders, myself being native. It’s not hard for me working with them.

Although most of the participants engaged in processes to evaluate the competency of treatment team members, there was one participant who expected that therapists would have basic competencies. Jerome, viewed all staff in terms of the roles and associated responsibilities. Also clear to Jerome was his role as a patient, and an offender serving a very long sentence, a part of which included trusting the institution and therapists to guide him.

Well obviously they are if they’re working here they’re capable of doing their job.

When participants were able to determine that treatment team members were willing to help them, the therapeutic relationship was promoted. Participants gradually identified with therapists based on their willingness to help, and embraced the resources they had access to. Victor describes how he was able to accept the help of therapists once he saw them as willing and able to help him.
Seeing help, like just seeing that your staff here are willing to help in spite of what I’ve done, and they know why I’m here, and what I’m in for, and all that that. They’re still willing to help, and see me as a person. [It] makes me feel good when seeing them still willing to help them get through the struggles I guess if, if, if, it allows me to accept their help, and it allows me to realize the resources that are here for me you know.

Participants engaged in an evaluation of treatment team members to determine their willingness and ability to help, and to a lesser degree, to identify and minimize potential damage. However, their evaluations alone did not determine the relationships that developed. Participants experienced a variety of interactions with treatment team members that either promoted or hindered the development of “therapeutic” relationships.

5.5 Experiences that Promote or Hinder the Relationship

Participants’ experiences with treatment team members that promoted the relationship were interpreted as being on route, and the direction taken by the team member was consistent with the participants expectations of the “therapeutic” relationship. Conversely, experiences that hindered the relationship were inconsistent with the participants’ expectations of the “therapeutic” relationship, and interpreted as being off route. The participants’ perceptions of hindering factors were not static, instead their perceptions were related to the consequences they experienced. What was initially accepted as neutral and a desired condition of the relationship, based on the participants perception of the primary therapist desires, may later be viewed as hindering the relationship when the participant experienced negative consequences, such as an unfavorable report. As Parker described, participants came to accept the terms of the relationship as established by the therapist, not as a means of promoting
their therapeutic interests, but rather, as a means of minimizing the potential damage to their future plans regarding reintegration.

I mean, I, I had a case manager once that um...if I know I've got heart disease but the case manager gets it into their head that I've got liver disease, and I'm trying to explain no this is, what's wrong and they're saying no, no I'm educated one I can tell that he's got liver disease. And then you find out the only way to get out of prison is to basically say, I've got liver disease, let them go on their kick, let them push at you, through the system, get you cured of liver disease, and you get out that much faster, cause you didn't fight the system.

5.5.1 Being or Not Being There

Although "being there" for a treatment team member included being physically present, it extended beyond a mere physical presence to include being attentive, being aware of the participants' current treatment issues, and being able to maintain a focus on the participant. Participants who felt that their primary therapists "were there" were more willing to be open and honest with the primary therapists, which in turn, enhanced the "therapeutic" relationship. Justice described the value of having access to his primary therapist, and knowing that the time they spent together would be used to help him.

I honestly, [it] takes a lot, but, you know, my primary, has never sloughed me off for an interview. If I wanted to meet, we'd set up a time, and it was always, it always took place for interviews. You know that made me feel that I wasn't being neglected, that she honestly did want to help me. So by doing that and knowing I was having these interviews, it was for one purpose only to discuss what's bothering me. Uh my feelings, and thoughts, and you know, it's uh it was hard at first you know explaining a lot of my past to [the primary therapist] but she now knows where I'm coming from and what I'm doing to better myself. And just by being open and honest and it's really helped me and you know it's helped [the primary therapist] understand me and work with me, instead of against me.

I guess it would be ... the fact that uh she's seen my crime cycle when I presented it and was there when I presented it and my autobiography and was there for my disclosure in group. She knew who I was after that. She knew what I was all about and the life that I've lived and ... I guess that was for me.
looked at it, it was a way for me to express to people how I my past was, and my feelings back then, and thoughts back then. So she understood, I guess she uh, once she heard that you know that I couldn’t, I couldn’t deny what I said, I couldn’t uh try to turn it around, it was all there, she was there, she heard it all and I guess it just made it more comfortable.

For Ernest, not having access to the primary therapist to discuss written feedback, hindered the relationship. He was unable to see how he was benefiting from this relationship.

It was frustrating because I didn’t see myself gaining anything from it um … like I welcome the feedback that she gives me but I want more. I don’t know. I or I’d like more um explanations upon why she does a lot of the things that she does, the way she does them. Like when she writes in my journal I’d like to know why she writes in my journal and writes the comments that she does without just writing them and then leaving, leaving me hanging wondering well what did she mean by this or why did she write that. It’d be a lot easier if I could just sit down after she’d written it out and say well why did you write this and then she’d give me her explanation on why she wrote it and what she meant by it. I see more benefit from that than you know leaving myself hanging.

James recognized the absence of the primary therapist in his treatment, however he initially did not experience it as a violation of the their relationship. Instead, James, comfortable working with the Elders, accepted the minimal level of involvement with his primary therapist, until he received a progress summary that was potentially damaging to his future plans for reintegration into the community.

You know although I, I knew, I identified what was missing, which was my primary. I didn’t really act on it or say much. I just, uh I just went along with with, went with the flow of, uh you know. They said well um … our primaries can’t be in every group but the primaries have certain groups that they work with and it just so happened my primary is always in the other group expect for when I presented. Like I presented my uh autobiography my crime cycle those types of things. That’s the only time he was in my group. Then when I got a copy of the uh progress summary of ward rounds whatever and when I read that I didn’t really, I didn’t really get off on it.

After receiving the report there was a shift in James’s view of the level of involvement between himself and the primary therapist. What was initially experienced
as neither promoting or hindering the relationship, and an accepted condition of the relationship, was now experienced as a violation of the “therapeutic” relationship—an under-involvement of the primary therapist.

So I came here with uh with problems, yes. I’m here with problems and I came here for treatment. But if I’m going to be getting uh receiving some type of treatment through uh a primary that’s on the other side of the wall that doesn’t see me operate in a group that doesn’t hear me speak and doesn’t see the facial expressions or the body signs or whatever, then he goes and puts something else totally different on paper that’s not fair, that’s not right.

While “being there” promoted the participants relationship with primary therapists, “not being there” for James was not immediately experienced as a violation of the relationship. Instead, what was experienced as a violation shifted when the potential power associated with a negative progress summary was actualized.

5.5.2 No Voice or Being Heard

Like being there and not being there, having no voice hindered the “therapeutic” relationship, while being heard promoted the “therapeutic” relationship. However, unlike not being there, the participants experienced having no voice as a personal violation, and subsequently, a violation of the “therapeutic” relationship.

Being heard was being treated with respect, and like a human. Montana described how being listened to, was a basic human right which he retained, regardless of his offending history or incarceration, and how he experienced not being heard.

It feels good. You’ve got something accomplished. You know what I mean. Cause being in our group, I know, I know, I turned myself in right. There, yeah, I did it right. I got sentenced, and uh I know I done wrong, but I’m still a person. I’m still a human being right. And even though I don’t have many rights one of the rights I should have is to be treated like a human being. And that includes being listened to.
But even if you can’t compromise, discuss why not. You know what I mean. Don’t say no, zero tolerance, direct order. We’re people. You know what I mean. I’m not a goddamn dog that’s chained up outside in the backyard that you say no, no, no [to] when he’s digging a hole in your flower garden. You know what I mean. I’m a person, I’m a human being. Talk to me, tell me why. All right. That’s all I ask. That’s all anybody any of us ask...It’s very frustrating right when you’re not heard. It’s just you know, they’re nobody.

For Parker being able to see how his input was incorporated into the treatment plan was evidence that he was being heard.

It feels good to have input into it and what’s better is that you can actually see it reflected on paper. You can say, you know, okay I, I meant to say that. I didn’t participate in whatever’s been written there. You can paraphrase, you can recognize the gist. So in that sense it’s, it’s good.

Furthermore, being able to review a draft version of a report gave him a sense that he was an active partner in his treatment.

Draft form and, and have it clarified and get a better understanding. You know right, wrong, or indifferent, at least you’ll know where it came from and why it’s being written in that fashion and whether you agree or disagree in the end at least you’ve had the satisfaction of at least being treated like I have an interest here.

Being heard promoted a sense of partnership for the participants, while having “no voice” was experienced as inequality.

5.5.3 Feeling Objectified

Participants experienced objectification when they were not treated like individuals. Feeling objectified generally hindered the “therapeutic” relationship and was experienced as a personal violation by the participants. Being treated as an individual promoted relationships, as participants felt valued. Victor described how being treated like an individual was what made the difference.

They didn’t treat me like I was a number. They treated me like a person and so just that alone for myself is enough you know.
Paul described how when he was not treated like a person, that a significant part of him was not recognized.

Well that I'm here and I am a patient and I'm here for treatment. There's no if, ands, or buts about that. But I'm also an adult and uh you know. I'm also an educated adult, you know, and, yes I got all doped up one night and went and shot somebody, but I also lived 30 years of my life, or not quite 30 years 28 years of my life you know, where I kept a full-time job. Uh I had a wife, I raised a child. I was a good citizen, I paid my taxes, I was just like the average Joe Blow. I made a terrible mistake and I'm paying for it and I'm paying for it severely and I pay for it every day. So you know, I've got some anger problems and whatever and I have to deal with them, and that's why I'm here, to deal with, but at the same time I don't want people to, to forget that I am a normal person. You know and the fact is that I got caught doing something wrong. But I'm still normal.

Ernest felt that the primary therapist viewed him as exclusively what he said or wrote, and that she frequently demonstrated how he was “wrong”. In essence, Ernest felt robbed of the freedom to say what he wanted to say.

It's almost like I'm leading two lives. Like with one or one nurse I can relax, be comfortable, and feel free to say what I want to say without being you know attacked or torn apart because of what I said. But with my primary I'm more cautious and more um careful with the things that I say knowing that if I say something wrong she'll take it and tear it apart and show me all the wrong things out of it and when I'd said it wasn't, it wasn't necessarily meant to be wrong.

5.5.4 Receiving or not Receiving Feedback

Participants described two types of feedback that they often received from treatment team members – specific and nonspecific. While specific feedback enhanced the “therapeutic” relationship, nonspecific positive feedback was reason for concern. Participants questioned treatment team members’ motives, and wondered if the feedback was valuable, that is, would it help them learn what they needed to know to stay out of jail. The participants worried that, although delivered with good intentions, the feedback they sometimes received was meaningless.
Justice, in a series of statements, illustrated the tendency to question the intentions behind a lack of feedback. He described how he received little feedback after presenting his crime cycle to his treatment group. Upon revealing the violent thoughts he experienced leading up to his crime, he was left wondering if this information was what the primary therapist had been looking for, and if it might be used against him.

At first after I presented it she, she [primary therapist] was in the group when I presented it, and it was a pretty long crime cycle. But I got the impression after I was done presenting it, I didn’t get any feedback from any of the staff, and she [primary therapist] was sitting right in there, and I was expecting a whole bunch of feedback from everybody. And it was like okay good job, uh she said after that, ‘I, I would like your crime cycle so I can photocopy it and put it on your file’ and stuff like that. And just by the way they got up and they all left the room right away right after I was done made me, you know. I found that really strange like it was like they got that information now!

And that really had me discouraged for a while you know I’ve journalled about that you know. I was pretty discouraged about the fact that I didn’t get any feedback from my primary or the group members or the other primary nurse that was in on that you know so. That’s how I felt about that just the way their posture was when they left you know. And I was I was pretty confused when they did that you know.

Like Justice, Paul questioned the motives of therapists who offered non-specific positive feedback; unlike Justice, Paul was not confused. Paul viewed the non-specific feedback as condescending and felt anger when it was offered, particularly when it was offered by a treatment team member that he did not highly value.

Like he’s, you know, he’s, he goes out of his way to say things. You know, like you’re doing really good. And I’m thinking to myself like why are you telling me that I’m doing really good. You know what I mean. I’m not, you don’t have to bate me like a two year old, you know what I mean. I’ve got to find an example to to uh. Even the simplest things that I wrote down [on the board]. Oh that is so good that you recognize it, well I didn’t recognize it because I came to RPC. I knew it at my, my whole life you know, and by you know I, I always picture oh that’s very good, I, I think I’m a three year old sitting in a chair across [from] you know a nursery school teacher, and they’re telling me [that] you know you’re doing wonderful you know. I, I don’t need that.
In a series of statements Parker described how the overuse of a term or expression renders the term meaningless. Although Parker was certain that the treatment team members had good intentions, he was concerned that he may not be receiving the feedback he needed to reach his goal – a successful reintegration into the community.

Here you’ve actually got an excess of it. You know, [they] use the word awesome an awful lot. I mean it’s kind of a suspect word in my books but everybody seems to be awesome so what’s that supposed to mean.

It’s awesome to clean up your room almost. So for the first time you hear it, it might be significant, but then you realize it’s just an expression. Although I gather it’s used [to] boaster someone’s self-confidence.

And not necessarily and they’ll give you you know say it’s awesome but uh it may not be what’s going to keep you out of jail.

Jerome had received feedback that he had changed. He could not see it and began to question his own attentiveness.

All of them actually said that uh they noticed a change and I said well I didn’t know that, I didn’t I didn’t see nothing. I don’t recognize it myself you know I don’t pay attention to that part. I don’t pay attention to a lot of the things that I do.

Specific feedback demonstrated to the participants that the primary therapist had an interest in helping them. Additionally, receiving specific feedback gave the participants some reassurance that they would be given an opportunity to address any concerns raised during the course of treatment, rather than learning about them for the first time, when they received their final treatment summary.

Justice: And you know I she was straight up with me and I respected that. She was honest with me like she could have told me yeah your risks are low just to get my expectations up there and things like that. But she was straight out. She told me my risks were high. So that made me feel a lot more comfortable right then and there that she wasn’t holding anything back from me, she told me the
truth when I asked for information in regards to me, things like that. So it helped a lot.

5.5.5 Modifying their Approach

In a similar manner, participants also questioned why treatment team members might modify their approach to them. Participants had a sense when the primary therapists or other treatment team members were not being direct or were being incongruent. Participants speculated that the lack of directness was based on what the treatment team members anticipated their probable response to be. There was a sense that perhaps the treatment team members involved did not believe in the participants capabilities.

Daniel described how he found that treatment team members were not being direct with him and how he had to ask that they be more direct. He did not see himself as fragile as they seemed to believe.

Well I, I just found that when a staff will call me on something I’m doing that could be improved on or yeah just very blunt with me I find. I’ve actually asked for it and I found that, that approach of saying you’re doing this is, is much more effective than than the pretty soft and gentle approach when I don’t want to hurt your feelings. Well I’m not glass, I won’t break. You know I will recover from this. Say what you’ve got to say. I’ve found that much more effective personally.

Paul shared how he wondered why a treatment team member was unable to say no to him. Paul was unable to recall when this therapist ever said “No” to him. Consequently, he wondered what the team member’s reaction was based on, and questioned if this team member thought he had difficulty understanding. Paul concluded that the team member had a problem with the answer “No”.

Uh I thought to myself, this is coming from the guy that told me that I can’t handle the answer no. So I said to him how do you figure I can’t handle the answer no. You never give me one you know.
Uh I sometimes feel why is this person beating around the bush with me. Like is he scared. I mean is he scared of my reaction. Uh what does he think that I, he or she, think that I don’t have the uh skills to comprehend what he’s trying to get across.

But again you know that was his perception you know I think you have a real hard time with the answer no. Well how would somebody be able to say that to me if it's never given me the answer no? Where would that even come from?

Conversely, Victor describes how the here and now focus and direct approach of the primary therapist he was working with helped him identify and challenge an old pattern of interacting.

So and I wasn’t doing any of that but growing up with a political family [with that] background you learn to dance with words you know. And she started to realize that that’s what I was doing, and she realized that the question like she’d ask like right now you asked me a question. Initially I gave you a straight forward answer some are positive some are negative. And so I was able to dance around things when she’d ask me something, I’d dance around it. I would avoid answering it direct answer to the question. You know, like she’d say well how does this, how does it make you feel when this and that happens, well how does it make anybody feel I’d say you know. Like think about it, how would you feel? So I’d throw it back on her you know and so I wouldn’t really answer the question with what I’d certainly talk a lot. But initially she’d, she’d be comfortable with thinking oh wow and then you know she’d think about it for about a minute or two. Well how do you really feel about that you know. I, I thought [that] we just went through that. No we talked about other people, I’m asking about you and you know so she’d kind of started catching me. Uh I felt like laughing. And not just at her but at myself too cause shit you know it it’s so, so much part of my character now after serving years of living like that, talking like that and..... Bottom line, it was a good thing because I needed it. Because in the past people were scared of me and scared of my parents, who they were so they wouldn’t do anything to piss them off.

Participants experienced an opportunity to learn about their patterns of interaction, when treatment team members directed the participants attention to what was transpiring in the interview. When participants had a sense of the treatment team members’ apprehension, it hindered the relationship.
5.5.6 A Clear or Shared Direction

Having shared objectives promoted the “therapeutic” relationship. Participants that were clear about the direction of treatment and their relationship with the treatment team member were able to trust. Participants uncertain of the direction of treatment, and their relationships with the treatment team member, were suspicious and questioned the treatment team member’s intentions. Unaware, of the direction of treatment and the direction of the relationship, participants assumed what was expected of them and feared that they had not anticipated the expectations correctly.

Victor’s description of his initial encounters with the therapist assigned to his treatment program indicated ambivalent feelings. While he was glad that she was persistent, he felt vulnerable when he would share with her information that he was not ready to reveal. There was no agreement on what was to be achieved and how.

Well I feel okay so I’d have, she’d, she’d pull it out of me you know and she knew she was fighting me with it but she wouldn’t stop, she didn’t give up on me so. I kind of had that little, little rift that kept, that first kept that distance because I kind of resented this in a way in that, because she was doing this to me. And I felt exposed and vulnerable.

Jerome used an interesting analogy to describe what it was like to not be informed about the direction of treatment and the expected outcomes.

Uh you know, so you get a primary, that say for instance would be uh would be like a the tortoise and the hare, and the guy’s sitting on the fucking turtle’s back with a 10’ pole and a carrot sticking onto it. You know, come on and get the fucking, you know. The guy can’t see what he’s, what he’s, he’s uh striving for yet the primary does and the primary’s only giving him so much, and so much at a time to understand where he’s going. Give him a whole picture of what he’s trying to get here. Uh. Throwing out bits and pieces at a time is not going to satisfy many people. A lot of guys want the whole thing at one time to understand it so they can dig around and find what they’re looking for you know. Like for myself, uh I, I, I would get so much information on something and then I would stop.
In fact all interactions where the purpose was not clear were of concern to Jerome. He expected therapists to clarify the purpose, and when they did not, he wondered what they wanted. He speculated that it may be more about them and their desire to see themselves as helping rather than his treatment needs.

Like I had one primary tell me that everything, that she read everything that’s on file of me right. So now there’s a conversation going on between me and this nurse and therapist or whatever and they’re called, and it sits in your mind, okay this sits in your mind. This person knows everything about you in the institution, your crime that, this, and that. And then you ask this person if they want to talk about something. They talk on anything. Oh what have you got to say, you got anything to say you know stuff like that. The one, she uh they don’t want to talk to you, yet they know everything about you. It’s like playing a game. Some guys don’t want to play games, some guys want the information that they’re looking for, understand it.

About my past you just want to talk about everything else. It’s like sitting there with a big smile on your face you know waiting for information to be fed to you. You know when you get that information you’re going to rip it up, you’re just going to tie into it, try and find something in there that would click with the programming to say okay I helped this guy.

Conversely, when a common ground or a shared objective was established Jerome was able to trust.

Have to have trust in yourself and the people that work here to … have a common ground. You have the same objectives and they’re here to help you and you’re here to help yourself and that’s where that trust level comes in.

For Justice, having a shared objective clarified the purpose and priorities of the collaborative effort embarked upon with the primary therapist.

See that I can see that she’s not here to make me look bad or give me a bad report. She’s helping me identify my high risk areas. You know that’s all that matters to me right now
5.5. 7 Cultural Insensitivity or Cultural Sensitivity

Cultural insensitivity in the approach of the treatment program (or institutional practices) was experienced as a personal violation that hindered the treatment process. Conversely, demonstrating an interest in the cultural ceremonies that the participants participated in was perceived as respectful.

For James there was a sense that if the treatment team demonstrated that they recognized that his culture was a priority for him, that he would be more accepting of them and their approach. For James his family needed to be a part of his treatment. James described how he was his culture. He shared an example of how he reacted when he perceived that he was being asked to alter his priorities and to accept the priorities established by someone else.

I can’t change that hey. And I do run into problems sometimes belief like cause of my beliefs. One would be uh like racism I don’t like racism, I’ve been through enough of that, I’ve been put down since I was since I can remember going to school. I went to school in .... all uh white communities, like there were nuns, you know working with nuns as teachers and I didn’t you know I’ve been put down a lot hey. I’ve been called savage and good for nothing drunken Indian, you name it hey. I’ve been in conflict in the pen, I’ve been stabbed, because I was native, you know. And when these things happen it’s just like being branded hey. So when an instance comes up, like uh for instance, I had a run-in with uh [a treatment team member]. I asked if I could take the morning off and go and cook for a ceremony and she says no, no, no. She says the ABC program comes first here. I says no like hell it does! My life comes first. I’m native and I immediately thought you know she’s being racist hey I told her no my life comes first, I’m native, I ain’t putting it on the back burner you know and that was it. She stormed away. I went I stormed away my way too and later a few days later we, she offered me some tobacco and we talked about it and she said you know I shouldn’t have said it that way I should have uh ... uh I said it in a different form. See those types of things trigger me my uh anger or whatever hey. That triggers me. Cause years ago I said you know enough is enough I’m not putting up with anymore of this racism bullshit hey. And that’s the way it has been for me. And I’ve been living that life, that mentality within the prisons for over 20 years now and uh it’s not something I’m going to change like overnight hey.
Unlike James, participating in cultural ceremonies was a new experience for Justice, and he experienced it as respectful when the primary therapist demonstrated interest in the ceremonies he was participating in.

5.5.8 Defining Roles

Nurse, guard, or a friend: Patient, inmate, or a friend. Participants experienced nurses fulfilling three roles: 1) primary therapist; 2) enforcer of rules and regulations; and 3) a social role. The role of primary therapist was consistent with the participants’ expectations that the primary therapists were their source of support and guidance during treatment. However, some participants, regardless of their awareness of treatment team members’ obligations to enforce institutional rules, viewed nurses who enforced rules and issued offense reports as violating the role of the nurse, a violation that was experienced as a betrayal.

Parker: A lot of this thing comes back in fact that, although more inmates in the institution have probably read the you know CCRA, a lot of inmates know what staff jobs are supposed to be on paper. And a lot of them know that CCRA inside and out, better than the staff member, cause that’s not surprising, and on the other hand there are a lot that don’t. Like this they see the nurse and some guys wear a security uniform, someone working in the library there’s my parole officer. They make the distinction. You’re a parole officer, you’re not a security guard, you’re a parole, you’re not a security guard, you’re a librarian, you’re not a security guard, yet in truth each and every one of them as individuals has to accept to work for CSC have the right to frisk us if called upon to do so if they think it’s necessary. However it’s also my understanding that it’s best that it be left to security unless otherwise you know can you avoid it and uh then my why are you acting like a guard, you’re not a guard. You’re supposed to be my primary. You’re a nurse, you’re a clerk, why are you charging me. You know why you know send a security guy in to the aggressive time because it undermines the efforts that you make. It just undermines it there’s, there’s neither right nor wrong it’s just a perception it’s just going to be hard to overcome.

Montana: Oh yeah like they they they treat us like they come here and they push that patient thing hey. Oh you’re a patient, you’re not an inmate, you’re a patient, patient, patient. Bullshit right. That’s what I say to them. Bullshit. I’m
still an inmate. Okay. I'm property a CSC until I'm released and that's the way they see it too. Right. But they're saying this patient shit, patient, patient, patient. They don't treat you like a patient. They still treat you like an inmate. Some of them worse than others you know and this three in a room thing. Right. You go and visit a friend, phone them right on, you're charged. They take $20. out of your pay. You're paid $50. every 2 weeks and if you're a smoker that $20. is a big chunk. You know what I mean. If you want to be a guard put on a blue suit. You know what I mean. Don't wear the white jacket and pretend to be my friend right. That really pisses me off.

Engaging in social activities, such as playing a game of cards was valued by some of the participants as a means to pass the time or increase their comfort in the relationship with treatment team members.

Ty: You know a card game for an hour let's say and, and you just start voicing this and that and talk about the news or at least a, a conversation maybe and it just goes from there. You feel happier when you leave and when you come from you enjoy it. I do anyway.

Ernest: Games sometimes like I a lot of times I usually like a card game or a game of backgammon or chess or whatnot. Is an ice breaker. As for me I'm I'm not usually uh a talkative person. I uh I'm quite shy, I don't um I don't uh converse or communicate with a lot of people so I find that always being helpful and it sometimes puts the nurses at ease too.

While others viewed social interactions with staff as a nonproductive use of their time.

Daniel: I can certainly spend better use of my time than talking to a person for an hour about nothing. I guess I'm somewhat selfish in that respect. I'm looking for a benefit out of the conversation. To learn something, to gain some knowledge or insight into a certain area, or to, if it's, if it's with family that's family, close friends, it's a little different thing. Not just talking for talking sake. It seems a waste of time for me and quite often I'll just you know I'm always pleasant and polite and but short.

Some participants viewed social interactions with staff as an acceptable way to interact with staff at the RPC for others, but not themselves.

Montana: Doesn't take long for you to develop the hate for the system and those who are in it. That are on the opposite side of you. It's like a war. That's the way I felt about it you know. If you were a guard, I'm a con, that's as far as it goes. Step in my way and I'll take you down. If I step in yours you going to take me down right. ...I mean personally it, it you know. I see a guy playing
cards I don’t think nothing of it. Cause look where we’re at but if I seen that same guy sitting and say in Edmonton Institution sitting in the room and playing cards with a COII, Joe Blow then that guy’s getting off the range checking into PC.

The “us versus them” attitude associated with the “con code” appeared to be one reason why some participants did not engage in social activities with treatment team members.

Finally, Daniel described how he saw that social interactions were a priority for some treatment team members. He considered this inappropriate, as he felt that the priority should be treatment and not “shooting the breeze”.

Another thing some nurses have they have favorite patients. I guess. Which is understandable, but I see sometimes that a guy really needs an interview and isn’t give one because a favorite patient is being accommodated. And what I mean is that if a guy [has] troubling ask him for the interview in the first place and he goes and says that I need an interview and they say no to him. He won’t ask again. That may be rigid thinking, yeah but, it’s reality for a long time. So I think is very important that each, each person be looked at a little...I, I don’t know really how to go about doing that, I don’t know. If, it’s a little, there’s a choice between shooting the breeze or talking to somebody [that’s] come up to talk to you. Then in my mind there is no real choice.

Participants had a number of experiences that either hindered or promoted the development of “therapeutic” relationships. Ultimately, the relationships that developed between participants, primary therapists and other treatment team members had the potential to assist the participants to maximize the window of opportunity that treatment presented.

5.6 Ways of Being with the Primary Therapist:

Head, Head and Heart, Heart, Wallet

The participants’ evaluations of, and experiences with treatment team members, ultimately lead to the categorization of treatment team members into one of four categories. These categorizations are based on the participants’ conclusions about the
resources of the treatment team members, and their approaches to treatment. In essence, The Ways of Being with the Primary Therapist represents an abstraction of the participants’ experiences with, and observations of, the primary therapists’ and other treatment team members’ behaviours. The formulation of these categories stemmed from Daniel’s description of the different styles of treatment team members.

I mean every, every staff member. I, I see there’s a variety of different styles and different type of people working here and every environment you’re going to have some who are there just for the pay cheque and there are some who are very intellectually and they don’t care so much uh they’re more just very uh I do not know, they remain in their heads and the other ones who are intellectual and care and then there’s the ones who care and hold on. So there’s a wide variety.

Although Daniel only described the intellectual treatment team member in terms analogous to a location on the body, for consistency, the body analogy has been used for all categories he described. As in Daniel’s description, the category for the intellectual treatment team members is entitled “The Heads”. The group of treatment team members that Daniel described as “the ones who care and hold on” are “The Hearts”. Those described as “intellectual and care” are referred to as “The Head and Hearts”, and finally, those described as “there just for the pay cheque” are referred to as “The Wallets”.

All participants described differences between staff. Some participants discussed the different “personalities” of staff, while others described some treatment team members as being “more by the book” or “more personal” than others. Participants presented treatment team members consistent with the categories Daniel described. Additionally, consultation with the participants regarding the researcher’s understanding of their experiences revealed general agreement in regard to the categories used here.
The participants experienced different “therapeutic” relationships with the four categories of treatment team members. The treatment team members’ resources determined how they guided the participants to the window of opportunity, and largely determined the emerging relationships. These relationships emerged as distinct in terms of the focus of the relationship, where the participants found safety or comfort in the relationship, and boundary maintenance. If treatment is a window of opportunity, then the “therapeutic” relationship, is the window covering determining the light that will reflect through the window, and ultimately what the participant will see. “Therapeutic” relationships, like window coverings, may be sheer and allow the light to shine in, or they may block light out, as when the focus of the relationship is not the therapeutic interests of the participant.

The four relationship types were discernable from the participants’ descriptions of the relationships that developed with the primary therapists, with one exception. Jerome described interactions with treatment team members that shared characteristics of the relationship categories that emerged here. However, his description of the relationship between the primary therapist and himself was limited to a description of the roles of nurse and patient. Jerome viewed himself as not being able to allow himself to connect to others, related to the length of time he was serving. It would appear that Jerome maintained this position during the course of his treatment program.

5.6.1 The Heads

Participants perceived treatment team members as in their heads when they did everything by the book, made everything a lesson, or were always “on”. Although participants were able to appreciate the knowledge of this group of treatment team
members, their sense was that the resources of this group of therapists was limited by an inability, as opposed to an unwillingness, to connect with them.

Paul: You know rather than the somebody to sit down and say okay open the textbook to page uh 23 and uh read out those first 2 lines and that’s the way things are, and that’s the way you should do some[things]. Well, it’s it’s again it all boils down to it’s so impersonal.

Ernest: she would turn it into, more of a, a lesson she’d get out the marker and she’d actually write out reasons on why I didn’t, as opposed to being heart to heart and turn it into a uh, I get an essay.

Parker: they’ve got the odd staff member here, but I mean, that might need a vacation, but, I mean, overall I’d say you know I haven’t had too many negative experiences and for some staff you have to turn them off, they’re on all the time.

Daniel: The intellectuals um again more good for discussion and and sparring but not really. I wouldn’t go for them to them for help.

Parker: But you get back on the street and you’ve still got problems you came in with because you couldn’t establish that link. And um, I guess, in terms of the over analytical, the ones that in that kind of situation neither one seems to be hearing themselves. One’s, one is looking at everything you say but they’re not hearing. They’re not hearing with their heart. You know, they’re just hearing with their head, with preconceived notions or whatever [they] get out of the textbook.

During a consultation with Victor regarding the researcher’s interpretation of the participants experiences, Victor described this group of treatment team members as unable to withstand the uncertainty and personal vulnerability of connecting with a patient (Journal entry, March 12, 2000). He thought that they kept themselves safe by staying in their heads. Other participants also identified a discrepancy between the knowledge and ability of this group of therapists.

Daniel: I’ve met a lot of people who are who are very intelligent people but there’s little balance. They know intellectually how to do things and they’re, they’re dead on when it comes to talking about it, but the walking of it is, is less applicable. You can look at it and go okay this person can talk the talk. He or she knows it very well but after watching I see.
Parker: They got textbook learning, they haven’t learned how to listen to the point where they are living life....like experienced life, experience us where I, I know we’re only clients, but we’re people too.

Parker: You know that’s, that’s weird and, and that goes back to what I was saying earlier in regards to um maybe overanalyzing like in, in our first interview. There it’s not the proper sense it’s sort of like ... lending interpretation to what’s been saying to you based upon your own approach to life or whatever you know.

Several participants described how they would avoid treatment team members they perceived as in their heads believing that the greatest potential to damage their future release plans would result from interactions with this group of treatment team members. Parker’s description captured the participants’ sentiments.

So you tend to avoid those kind of people even though they’re very nice people. I’m thinking of one in particular, very nice person, but in my mind dangerous. However, not all participants avoided treatment team members they perceived to be in their heads. Participants seeking a challenge sought out this group of therapists to debate, or fine tune a skill. However, a constant challenge may lead to weariness for those participants with primary therapists they perceived as being in their heads.

5.6.1.1 The Focus of the Relationship. The focus of the relationship between a participant and primary therapist perceived as in their head was on what the primary therapist could teach the participant. Ernest described how he approached the primary therapist to discuss the loss of a significant relationship. He was hoping for an opportunity to express his feelings and gain support. However, he perceived that it was difficult for the primary therapist to provide support or have a “heart to heart”, and that everything had to be a lesson “to her, for her”.

It’s difficult for her to do that because everything has to be a lesson to her, for her. In a situation like that she has to write it all out on the board and point out
how things I said that made me wrong for thinking it all out about it a lot of the things I was thinking.

The primary therapist was seen as setting the agenda for individual sessions without consideration of the participant’s priorities. There was a sense that the primary therapist was not interested in the participant’s priorities, nor was she willing to negotiate. This was experienced as rejection. When encouraged to expand on his statement that “she (primary therapist) never really seen much of a relationship there”, Ernest explained how he would enter an interview with the intention of being receptive to the primary therapist’s suggestions. However, not being consulted on the direction of the session or given the opportunity to make a transition into the session, was experienced as a rejection, and confirmation of the primary therapist’s inability to connect with him, and his undesirability.

It’s a feeling that I got. Like when that I’m in there you know my sights set, and going in there feeling pretty good, positive, outgoing, and whatnot, to the things that she had to say. That would kind of, um like the way that I went in there and felt and seen everything as being positive, and, you know, hopeful. She already had her set agenda on what she wanted to do so there wasn’t really time for that uh ...relax, let’s talk for a moment or whatnot. The relationship was strictly business, that was it. Once that was done and I went about my own thing, she did her own thing.

5.6.1.2 Finding Comfort and Safety. In relationships where participants considered primary therapists to be in their heads, comfort or safety for the participants stemmed from being right, and from meeting the expectations of the primary therapists’; or at least acknowledging the primary therapists’ expertise. Participants’ perceived that primary therapists expected that they would accept and apply their solutions (based on the primary therapists’ knowledge), rather than the strengths, abilities, experience, and limitations of the participants.
Ernest: Whereas my primary nurse she's a ... I guess more headstrong with the way she does her things. Like she has her own set routines and ways of doing things which makes it difficult because the way I do things she does really different, and what she expects is that I incorporate what she does into my ways of thinking and that's not usually how I work.

As a result, a level of comfort in the relationship was never achieved, due to the fact that the participant was not able to meet the primary therapist's expectations. Ernest shared how he attempted to meet the primary therapist's expectations at first but found it difficult and uncomfortable.

My primary has her own way of doing things, and one of the expectations that she, I think, held on me was that I would be willing enough to follow through or adjust to her way of doing things. And I did at first, but I found it difficult to adjust to something that it wasn't comfortable.

Vulnerability replaced comfort in their relationship, and instead of equality there was disparity. Ernest felt demeaned and like a child, instead of the man he was.

It was frustrating. Sometimes annoying. A little bit of a little bit demeaning I guess. I, I don’t know, I felt like a little kid when she would take my journal and write half a page of what all the wrong things that I did and give it back and disappear. It made it difficult.

A lot of times when I go and talk to her it turns out into a, a dissection of the things that I talked about. So a lot of the times I, I'm cautious when things are stated, cause I’m afraid that she’ll end up taking apart everything that we've said and then correcting me on it all.

Ernest shared how he came to believe that the primary therapist intentionally attempted to find fault in what he was doing.

Like if I’ve presented her with a situation I’m having trouble with, she’ll find a reason to um just to see where I’m wrong.

What surfaced was a need to protect an already vulnerable self. Defensiveness and resistance replaced his initial willingness to try to work with the primary therapist.

For Ernest, the defensiveness took the form of attempting to avoid contact with the
primary therapist, and when avoidance was not possible, he prepared for combat. Ernest considered it lucky that the primary therapist was not in many of the treatment groups. He was afraid that she would force her ways on him.

Well [be]cause of the relationship that we have I think she would take off on me to un enforce her values and ways of doing things more on me. I think she’d be a lot harder on me. Just because you know the relationship that we have now is kind of push and pull thing.

Yeah it turns into a business meeting where there’s no uh I guess sense of comfort. Like, like when my primary sets an interview with me I’ve already mentally prepared myself that I’m not going into a comfort zone nor a comforting I guess uh or comfortable setting for an interview.

5.6.1.3 Establishing Boundaries. Personal boundaries rather than therapeutic boundaries were emphasized in this type of relationship. While the primary therapist determined personal boundaries through the status of expert (to protect a vulnerable self), the participants attempted to establish personal boundaries by increasing their resistance in order to avoid feeling vulnerable. Ernest described how he found ways to resist the primary therapist’s methods, to avoid revealing his inability, and increase the vulnerability he felt in the relationship.

I was meeting them but not not exactly the way that she wanted me to. So I was still getting the expectations and objectives done. They just weren’t the way she wanted them.

When Ernest did not follow his primary therapist’s recommended method there was frustration, for both the primary therapist and himself. During these periods Ernest had a sense of the primary therapist’s vulnerability, and perhaps a sense of connection with her.

When I do that (use an approach not recommended by the primary therapist) um it makes things difficult, she gets frustrated, I get frustrated and that’s where you know I guess her … emotion along runs soft or considerate or understanding.
Receiving written feedback maintained the distance in the relationship, hindered the progress of the relationship, and was experienced as abandonment by the participants, particularly when they could not access the primary therapist to clarify the feedback. Ernest welcomed the feedback he received from his primary therapist; however, he wanted to understand the rationale behind the feedback. The potential benefits of the feedback were lost when Ernest did not understand it, and was not able to discuss it with his primary therapist. He wanted more of an explanation, he wanted her to notice he did not understand the feedback, and that he desired more of a relationship.

A lot of the times I never had a chance to uh consult, consult with her in regards to a lot of things that she’d wrote or said. And uh, when she’d write you know a little paragraphs on things that I’d done wrong, or she’d write a page on how I could have done, or said something differently, um without giving me an explanation on why she wrote it. She’d disappear, and then a week later she’d come back and say well, you know, the problem would be gone by then. I wouldn’t really have time to converse or consult with her on why she said that last, last time. It was always a new a new problem that came up you know. So a lot of the things that she wrote and then I didn’t understand kind of went unnoticed or unheard.

It was frustrating because I didn’t see myself gaining anything from it um ... like I welcome the feedback that she gives me, but I want more. I don’t know, I, or, I’d like more um explanations.

In turn, Ernest’s journal provided him with the means to express his concerns. The journal provided a means to communicate indirectly what could not be communicated directly.

It I wrote in my journal and said that today was good in my uh primary had a an interview. Things unfortunately didn’t go very well. We were knocking heads and uh then I would write down how I felt about that. Um when I shared that with her later on through the week, she would take it and think what did I do wrong, why did you write this, you know.
Their relationship was characterized by a struggle, where avoiding vulnerability took precedence over the establishment of a collaborative therapeutic relationship. The struggle represented the only safe means of connection.

Just more of a combative relationship. I don’t really I’ve never felt comfortable sitting down and having a one of those heart to heart conversations that I have with other nurses.

Participants who were unable to meet the expectations of primary therapists sought out relationships with other treatment team members. In these relationships they found comfort. Ernest felt "heard" rather than "pulled apart" in his relationships with other nurses.

Um and instead of taking what I wrote and dissecting it all... what they’d do is they’d hear me more or less hear me out hear why I wrote it. What was the feeling at the time.

In addition to comfort, there was some indication that the relationships with other nurses also provided an avenue to indirectly express dissatisfaction with the relationship with the primary therapist. Ernest described how the primary therapist expected him to be as open with her as he was with other nurses.

When she does initiate an interview with me she expects the same, I guess, same uh, I guess, the amount of input that I share with other nurses or that is hard to explain.

A struggle characterized relationships with treatment team members perceived as “the heads”. The struggle prevented the relationship from progressing to a “therapeutic” relationship.

5.6.2 The Hearts

Participants perceived treatment team members as being in their hearts if they were caring, concerned with feelings, willing to support, and less likely to challenge
them. Relationships with this group of treatment team members were warm and supportive in comparison to the relationships that participants developed with treatment team members they perceived as in their heads. They were perceived as concerned with emotion and perhaps “too caring”. Daniel explains how he felt he was not getting the direction he needed from this group of therapists. He felt he needed more in order to benefit from treatment.

I don’t want the, the problem with the caring sometimes is that it’s too caring and I like to be nailed. If I’m doing something wrong my behaviour is not up to par or if it’s off in a direction that’s going to hurt me in the long run I want to be, them to nail me….with the caring it’s more feelings based and a lot of support.

Participants had a sense that the treatment team members they perceived as being in their hearts were fragile or required protection. Daniel described how it was clear that they cared, but perhaps they had too much invested as they tended to grow weary from time-to-time and like a computer not functioning properly they had to go “reboot”.

They wear their heart on their sleeves, and I can see that, but the down side for them is that, I see that they get a little tired, they start to burn out a little bit, and they have to reboot, start again.

Participants presented therapists in their hearts in two ways: 1) as real and needing to help; or 2) as real, misunderstood, and needing an ally. Victor shared how after the primary therapist had self-disclosed in the group setting, he knew she had experienced some of the same feelings as him. He decided to be more open in their next individual session. When she noticed, he told her it was because she had disclosed in the group. When she nearly cried he knew that he had “got through to her” by letting her help.
And so she mentioned that in the group setting, but that changed the whole atmosphere for the one to one, that I know that too, if she asks why are you opening up to me, cause of what you said, you know, been there. Now I know you. I know you’ve been there. I know you’ve felt the way I feel and you understand how I feel, and I know that for myself now I, when I sit in the room she understands. She was uh ... she almost she was getting pretty emotional though too because she was happy. That day I got through to her.

Paul described how he felt embarrassed when other participants in the ABC treatment program, who he referred to as “pigs”, made rude remarks to the primary therapist he worked with. He was concerned that if other participants misunderstood the way she walked and talked, for something other than being nice, then she could end up becoming over involved or perceived as being over involved.

I mean they well they’re, they’re very inappropriate comments. Christ I feel embarrassed.

Yeah she’s got to be careful that uh she talks and the way that she acts because uh you know if somebody takes the way that she walks or talks or acts or whatever the wrong way, then she could be in shit saying that you know people say that you know what I mean.

With a note of skepticism, Parker described how if a treatment team member is being genuine, and ABC program participants misunderstand their kindness, then there is little that a therapist can do.

I, I again, I think like when I used to think about how the guys talk about her, and um ... oh I don’t think there is anything how, how can you help how a guy responses, his thoughts, attention. How I mean if you’re actually genuinely just being person a nice person.

5.6.2.1 Focus of the Relationship. The focus of the relationship where the participants presented the primary therapist as being in their hearts is on the comfort or the good feelings of the primary therapist. Initially, to the researcher, the focus of these relationships appeared to be on the good feelings of the therapist, including feelings of being liked. It was during a consultation regarding the researcher’s interpretations that
Jerome suggested it would be more accurate to describe the focus of these relationships as being the comfort of the primary therapist (Journal Entry, March 12, 2000). He explained that, although this group of treatment team members may care if others liked them, he believed that they were indifferent as to how he felt about them. Jerome viewed treatment team members in terms of their roles, he expected them to establish objectives, and when they did not, he suspected that they were trying to play a game with him, perhaps to meet their own needs. Typically, he remained neutral, watched and waited, but did not play along. Jerome’s neutrality may have influenced his interactions with this group of treatment team members. However, comfort and the good feelings of the nurse are not unrelated. Both terms shall be used here.

During an unrecorded interview with Paul, he acknowledged that he experienced a need to protect the primary therapist from the judgement of others (Journal entry, Nov. 24, 1999). Peter often referred to the primary therapist he worked with as a “good lady” and shared how humor was a common occurrence in their relationship, “So I’m always making her laugh and she always making me laugh”. In fact, Peter felt valued for his sense of humor and consequently came to believe that he needed to be cheery in the presence of his primary therapist.

Well if I’m grumpy you know I’m usually the bright spirited guy you know grumpy and and uh sitting there. I’m more on my toes when she’s there.

5.6.2.2 Finding Comfort and Safety. Participants with primary therapists presented as being in their hearts found comfort in safe guarding the good feelings or comfort of the therapist. For some, finding a means to provide for the comfort of the primary therapist, be it, allowing them to help and direct, or assuming a protective position, was rewarding. A close relationship where they were supported felt good,
and, if not a "therapeutic" relationship, was therapeutic for some. Others found allies in primary therapists and acknowledged that they protected them against the judgment of other therapists and participants in the program.

Victor described how allowing the primary therapist to help him made all the difference with her.

Sometimes that helps me say, okay yeah you’re right. So how, how would, how do we fix this kind of thing. How do we change that way of thinking, so being able to uh accept that help, I guess, makes all the difference with her.

Peter followed the emotional route his primary therapist established despite how difficult it was for him at times. Because he liked her humor and thought that she was a good person he would try a little harder, as reflected in the following passages.

Uh, uh, like opening doors meaning, um like she’s, uh she’s, uh, brought up conversations and pointed me in the directions where a lot of emotions, a lot of struggles, uh low self esteem, and things like that, that she’s recognized. Like she’s pointed in that direction. Only, I answer and open those doors she really directs me into that direction.

Sometimes it drags, sometimes it doesn’t because I’m dealing with so many emotions I feel drained sometimes you know. I feel drained and, and I feel so frustrated, and, uh, sometimes even irritated because I’m trying to focus on one thing, and I’m trying to look at one thing from a different perspective and here I am drained and frustrated. Trying to sit there and concentrate on what she’s also saying you know.

Although Paul thought boundaries that governed his relationships with treatment team members were stupid, he no longer asked the primary therapist or other treatment team members personal questions, nor would he ever again give a staff member a birthday card (as he once did, only after first receiving one from a staff member). Prior experience had taught him a valuable lesson. Although the card recipient appreciated his kindness, other staff thought it was inappropriate which created discomfort for the card recipient and himself. Comfort was maintained by adhering to
the guidelines that were generally acceptable, and not what the primary therapist found acceptable.

So I think those boundaries are really stupid you know and I don’t know who makes this stuff up but you know I think that having boundaries like that is what makes it so not personal. You know it makes people uh pull apart.

I wouldn’t ask because I’m scared to ask cause I don’t want to cross that boundary and I don’t want to put them in a position where they feel uncomfortable either. So I just don’t.

A sense of closeness was confirmed and the comfort and good feelings of the therapist maintained by valuing the primary therapist over others. Paul shared his thoughts related to an experience where he compared a treatment team member who would not break procedure for his benefit, with the primary therapist who often did.

And I think to myself no, no that’s not all you can do, that’s all you’re willing to do. You know what I mean. That’s the difference between [the name of a treatment team member] and [the primary therapist]. If [his primary therapist] says well yeah I’ll do it but you’re going to have to give me an hour you know what I mean. But she goes she goes out of her way to help somebody out and not just me either.

However, not all participants were willing to just let the primary therapist help. Ty needed to know he was going to get the answers he need to stay out of jail. He initially thought the primary therapist’s self-disclosure was “some kind of angularity”. Once he recognized that he was going to receive the answers he needed from the program content (ABC workbook and groups) he was less guarded and developed what he described as a “friendship” with the primary therapist.

5.6.2.3 Establishing Boundaries. A connection had been established: an alliance formed. However, it was not the therapeutic interests of the participant that guided the connection. There was a sense of closeness that was highly valued by the participants.
Participants did not view the primary therapist as threatening or placing limits on the sense of closeness that they established. However, they viewed institutional policies, other therapists, and on occasion, other participants in the ABC treatment program as setting or attempting to set limits on the desired closeness. Victor shared how he wanted to comfort the primary therapist during one of their interviews when he noticed that she was overcome with emotion.

She was kind of getting teary eyed and you know I wanted to get up and just go and say hey like it's cool you know. But again the limits. We’re only allowed to go so far and they’re only allowed to go so far so.

Victor would have also preferred to demonstrate his appreciation for his primary therapist with touch. However, as before, this would contravene CSC policy governing the relationships between staff and patients. Instead Victor decided just to tell her how he would like to hug her.

Like I told her, I said, like right now in the past when I was appreciative of somebody helping me do something I’d give them a hug or a handshake, or, you know, just let them know how much I appreciated them for being there, and supporting me and stuff. And I couldn’t do something like that to the staff here because of CSC policy and uh the staff and the interactions.

For Paul the past, present, and future reactions of other staff dictated his conduct in the relationship with the primary therapist. He was committed to avoiding the discomfort that he and the primary therapist experienced when others thought that their interactions were inappropriate, like when she disclosed personal information to him.

I’d never do it again and for the plain and simple reason that I wouldn’t want to put anybody on the spot.

In sharing why it was uncomfortable for him to discuss the relationship between himself and the primary therapist, Peter described how other ABC program participants
made rude comments about his interactions with the primary therapist. Although he did not like their comments he continued to see her on a regular basis.

Yeah they’re making a like I’m a crumb or something or slapping on the shoulder pads or knee pads or stuff like that.

Having others set the limits on their relationships with their primary therapists was a negative experience for the participants. There was an acute sense of the inequality in their relationships, and for some anger. Paul described that he had always been respectful, and therefore should be treated differently. He felt devalued when he was reminded of the boundaries which he thought were senseless. So when others established a limit on the relationship between himself and the primary therapist, he saw this as a personal insult.

Well I think they’re (boundaries) are crap. You know. I’ve, uh, I’ve always been polite with, with staff, other than I had one incident at the max with a male staff member. He got in my face, he threatened me, I got in his and threatened him. You, you know what I mean, but as a general rule I’m very polite with staff. I’m never, uh you know, I don’t make inappropriate comments you know. I’m not uh a sexist, I’m not a pervert, I’m not any of those things, and uh you know, therefore the boundaries for me should be different than from somebody that’s you know constantly uh battling with the staff, is a pervert, or you know, things like that.

Victor described a sense of frustration related to not being able to respond naturally and to hold the primary therapist.

When you want to comfort somebody or you want to show appreciation sincere appreciation to somebody that you respect, you know for, for who they are and what they’ve done to help you. You know it’s, it’s human nature to comfort and hug. You know, to hold a person, you know. It’s not an [sexual thing], it’s not so much as, hey let’s go let’s go have sex, or hey can you do this for me, do this, maybe bring this into the institution, well you know, it’s not like that. But that’s their concern, I can see that. So I have to respect that but ... to, to, to, to give a guy so much you know what I’m saying. It’s like dangling a carrot in front of him ... so you’re going to meet here, go and get it.
In a series of statements Peter described how he felt angry and disrespected when the primary therapist attempted to return a gift, one of his paintings, that she had earlier accepted. It was as if she was rejecting him. He was angry with her and the security officer who would not let her take it home that night.

I was mad, I was disappointed. She wanted to give me back. I felt disrespected. She wanted to buy it off me instead. I told her no the way, I, you know, and uh she said that she couldn’t have it. I was just going to take it back and rip it up instead of giving it to the staff like the entire staff. I was just going to rip it up and yet she wanted to pay for it. I didn’t want any part of that. So I said might as well, uh come on, give it to all the staff.

Well for one it wasn’t her it wasn’t their birthday. You know what I mean. Like come on you know. It wasn’t like, like what is it all of a sudden their, their entire birthday here like. I don’t know, I just, I just felt really mad.

And I as far as any other anger goes. It was to whoever the keeper was because he wasn’t allowing her to take that uh, uh picture painting home so, you know, so that’s, that’s as far as it went.

For Peter confusion regarding the nature of the relationship was the end result.

You know I we don’t know some place I don’t know she’s behaviours behaviours that she sees and uh frustrations that I feel instantly cause I’m confused.

5.6.2.4 Valuing Self-Disclosure. Participants in relationships with primary therapists represented as being in their hearts valued the primary therapist’s self-disclosure. The distance between the participants and primary therapists seemed less after a therapist disclosure, and, in some cases, depending on the content of the disclosure, the distance between the participants and the community was reduced. Primary therapist self-disclosure was not merely for the benefit of the participants, but also for the primary therapists. Paul described how he felt more comfortable knowing that the primary therapist could identify with the parenting and marital issues he struggled with. He thought that it was “nice for her” as well.
But it’s nice for when she’s sitting down and we’re talking about something she says oh I know what you mean I have [a number] kids of my own. You know I was married at a very young age. So I know she’s married, I know she has kids. You know I know enough about her you know. It just makes it more, more comfortable you know.

Paul also liked hearing about the kind of activities that staff engaged in on their days off. Knowing about the kind of things people were doing helped him feel in touch with the rest of the world.

And I’ve been in prison for a long time and I might end up being in prison for a lot longer you know, and, uh, I like to hear what goes on out in the real world and you know. I’d like to hear about the Gordon Lightfoot concert, and, uh, you know. Beer is now, uh you know, $3. Things like that, I’d like to hear that type of stuff. I’d like to know that people still go out and do those things.

For Victor the primary therapist’s self-disclosure about feeling shame related to an ongoing issue in her life, revealed to him her vulnerability. This marked a transition in their relationship. Thereafter, he was more open, and willing to let her help.

You know that she was always not on the outside looking in.... It helped me open up. Just because of the fact that she shared, the she shared feelings and emotion about, hey I’ve gone through this, and kind of still going through.

Peter found the primary therapist’s self-disclosures about the activities she engaged in pleasant and yet irritating. Her disclosures allowed him to leave prison for the moment and invited him to relate to her on a more personal level. However, her disclosures also served as a reminder of what he did not have, and the privileges he had lost. Peter described what it was like to learn about the picnic the primary therapist enjoyed with her family.

Um. Just um the imaginative like, uh when she’s, when she’s, uh I don’t know when she goes to, goes to a park or you know goes on a picnic and you know she’s having fun with her family, her husband, kids you know. I can picture myself outside sometimes doing. Wishing that I had kids, kids of my own, wife of my own.
And as if the therapist self-disclosure had been an invitation, Peter had picnics of his own with the primary therapist. He described a card game with the primary therapist as "uh like going on a picnic".

Participants valued the relationships that they established with primary therapists that they presented as being in their hearts. There was a connection and closeness that they appreciated. They were comfortable in these relationships, and anything that threatened their sense of closeness with the primary therapist was experienced as a limitation or a personal violation. However, having a primary therapist categorized as a heart was also associated with participants allowing the primary therapist to fulfill their need to help, as well as feeling the need to protect the primary therapist.

5.6.3 Head and Heart

Participants viewed staff who they believed were both concerned about them, as well as knowledgeable, as being in their head and heart. Therapists presented as being in their head and heart provided both support and challenge. They cared, but were not committed to the ways of the heart. They were knowledgeable yet they did not follow the ways of the head. Their way was more than a combination of the ways of the heart and the head. The routes they revealed were wide enough for two to walk side by side, and although they both knew where they were going, the primary therapist kept them on route. Participants with primary therapists represented as being in their head and heart, learned more than the content of the program; they learned a way of being in relation to others, that they wanted to take with them to other relationships. Daniel described how as the participants’ commitment to treatment and change increased, they were more
likely to seek out this group of treatment team members, even if they were not assigned as their primary therapists.

Uh okay depending on where a person is in their rehabilitation process, but more in their growth. They, they will approach a person who they feel was important for where they’re at, at the moment. If you know you can go and talk to somebody and they say that’s okay you’re doing all right, right now then you feel good about it, but if they know that if they go to this nurse or that nurse and they get dinged for it, and they say wait a minute straighten out mister then they don’t, may not necessarily want that. So it’s initially, as soon as they get in, I see that some guys will, will go to certain nurses because they feel that yeah they can shoot the breeze, and they can not get too deep into anything, and they can just discuss what they’re doing, how they are finding their adjustment and if you’re keeping it on a very a very safe level. But for those who, who surpass that and they get past that and they’re starting to get serious then they’ll go to someone who will challenge them. So initially you’ll have guys going to the ones who are collecting the pay cheques, I guess, that’s a judgment call on my part, but that’s how I see it. But over time you see this transition where people start moving into different, different areas in their own lives they’re going to talk to different nurses.

Participants had a sense that this group of treatment team members were knowledgeable and capable, which was a source of comfort, if not immediately, then with time. Daniel found the primary therapist working with him to be both caring and knowledgeable. He stated “that she cares and that she’s willing to help”. Luke felt comfortable with the primary therapist because she was smart, and he was confident that she cared as she always listened to him.

And she’s been she’s really smart so she’s helps me a lot. You know what I mean, like I feel, I feel really comfortable with her on a level where, I can talk to her about whatever I need to talk to her about.

Well it tells me that she’s, she’s sincere about what she’s doing, and she’s caring and you know she’s a very good communicator.

Smart was more than being knowledgeable, unlike primary therapists presented as being in their heads, being smart included the ability to apply the knowledge in a
meaningful way. Montana also found the primary therapist working with him to be smart, and because he was smart Montana was willing to accept his advice.

I found he’s a smart man. He knew what he was talking about so I took his advice. Gave my cycles and found out where I was going wrong and stuff like that.

5.6.3.1 Focus of the Relationship. When the participants viewed the primary therapist as being in their head and heart, the area of focus, or the desired destination, was the participants’ therapeutic interests. Daniel describes how when he had an interview with the primary therapist he knew that it would be about him and that he would benefit.

I’m very comfortable with her. I know that when we have an interview I’ll gain something and she’s, she’s very effective.

Justice did not engage in leisure activities with his primary therapist, although he would have had she expected it. He did not see how he would benefit from playing a game of cards with the primary therapist.

She knows what my routine is now here, while I’m here at RPC, un, I basically keep my part of the contract, and that’s a journal daily, and you know keep up with what ever goals that I have set for the weeks ahead of me and I think she’s pretty happy with that you know. ... You know as long as I can meet and discuss these issues that, uh maybe high risk, as she feels, you know, and discuss and work with her on these and things. Like that would be more beneficial to me than play a card game or I think talking about these issues would help me a lot more than you know leisure activities and things like that.

Like Daniel, Montana and Justice, Luke had regular interviews with his primary therapist where he knew he would receive help and did not seek out social interactions with her.

It’s been a good experience. I’ve met with her once a week for the past how many months now. And uh she’s helped me a lot as to, you know, pointing out different areas of my behaviours and stuff that I have troubles with.
Luke did not see much value in social interactions with staff for himself, however, he did think that there may be some value for ABC program participants who needed help in learning how to talk to different people.

It’s all right it’s good I guess you could say cause you’re, you’re trying to, uh, it helps you know people with their confidence I guess. You know what I mean, uh their good at something a total stranger kind of thing, and as opposed to most of these guys jail don’t, uh. When you’re in a penitentiary or in a jail that they don’t feel comfortable with people they don’t know. Only with their own kind or their own friends. So when they’re doing this with other people you know it’s, it’s you know helping them being able to talk to different people.

All participants who presented their primary therapist as being in their head and heart preferred to interact with all treatment team members in a purposeful manner.

When describing his interactions with other treatment team members outside of the groups or interviews, Daniel stated “I keep it very professional, and very comfortable with that now...”.

5.6.3.2 Finding Comfort and Safety. Initially, being in a relationship where the focus was exclusively on their treatment needs was experienced as uncomfortable for some of the participants. However, all participants found comfort within this relationship, and subsequently, maintained a treatment orientation in all their interactions with treatment team members. There was a sense of freedom from the obligations associated with many relationships. Daniel described how, although not pursuing a mutual relationship was awkward at first, he grew comfortable with the freedom of having to meet only one expectation – to focus on himself.

No I initially it was more needing, uh of equals, and just wanting to talk to them sometimes, and it wasn’t that I was looking to start something or start a relationship, or, or anything like that. What I mean, is more, that conversation or intelligent conversation within the walls is it’s kind of hard to come by. And when you want to go and, and have a conversation with a person it’s very enjoyable. And I found it frustrating because, oh yeah, there’s a line, that I’m
uh more than it was one sided. I was doing a lot of the talking with, with some interjection from the staff and that’s, that’s what I found frustrating. It wasn’t, it wasn’t a two-way conversation for the most part. And that, that was difficult at first but as soon as I, I got comfortable with reality, the boundaries, and professional uh behaviour on their part I was comfortable and, and much more relaxing, [be]cause I know when I go in there I’m saying, saying my peace and getting some feedback and in regards to it. And there is no further expectation. So it’s very helpful.

Montana’s description of why the third primary therapist assigned to him was smarter and more helpful that the previous two also reflected a sense of freedom from interpersonal obligations, such as those associated with keeping the focus of the relationship, where the primary therapists are represented as being either in their heads or in their hearts.

Uh huh. Yeah he, he knows where I’m coming from. He understands and all he can do is give me his advice, show me different tools, and if I take them great, if I don’t well he doesn’t push them down my throat.

There was a sense that the relationship was a partnership where they were working together to achieve mutual objectives. Jerome described a shared direction was an aspect of the partnership.

Shared direction. It’s all for the betterment of yourself. If we feel better, they feel better. So, it’s a team effort I guess you could say.

Thus, there was safety in being open and honest. There was no threat associated with raising an issue or concern about the treatment process with the primary therapist. Participants had a sense that they would be heard, and met with a willingness to negotiate. Luke described how he approached the primary therapist to ensure that she would raise any issues prior to the final treatment summary, so that they would have an opportunity to address them.

Yeah I just approached her about it and told her what was bothering me about it you know what was ... what was you know on my mind that’s the way I thought
about it cause like somebody else, that happened to them where they got a bad report at the end of this saying that, you know, this and that and that, and, you know, the way I look at it. This guy was in, in that program but they’re way ahead of us you know. But I’ve seen the way this person was and it seemed like it, you know a good person, polite, respectful and I’m saying well, how, how can this guy get a bad report. Well I see him always talking, you know, treatment staff and that’s what I told her about. I go, you know, this happened this person and I’m afraid that it might happen to me, and, you know, I don’t want to at the end have a report saying oh yeah he did good but he still needs help in these areas, this, and, that, and that right. So I said this, you, if you were to think like that I would want you to tell me the areas you still think I need to work on. That way at the end of it, you know, it’s not written up so then we can work on it now instead of you know what I mean?

Participants learned that being open and honest about personal issues was a contribution that they could make to the treatment process. Justice described being open and honest as fulfilling his portion of the contract of trust he held with the primary therapist.

Yeah. I think we’ve signed a pretty solid contract of trust me and my primary and uh I’m going to stick to my end of the contract you know that’s complete the program, be open and honest with myself, and that’s the way I’m going to go.

Luke described how he found being open and honest helped the relationship.

It helps the conversation. It helps the problem or uh whatever you’re talking about, the person you’re talking [to]. Helps them more better and easier and you know it well if there was a problem you were talking about and you’re being open and honest to the person better communication skills I guess you could say. Better communication.

In fact, Justice viewed his willingness to take a risk, and be open as influencing the direction of the relationships that developed between himself and the primary therapist.

But like I said I never talked to her since coming back and she was assigned my primary nurse and my feelings at the time were okay. I guess I’m going to have to open up, you know, share some of the stuff that’s bothering me and I did and as time went on and uh she ... basically assisted me in opening up and giving
me some feedback in some areas it just it was like a chain reaction. I could
starts opening up a lot more and not holding things back you know.

5.6.3.3 Establishing Boundaries. In relationships where the primary therapists
were described as being in their head and heart, the therapeutic interests of the
participants were the foundation for the relationship boundaries. Participants came to
view boundaries as necessary in order to create space, free from interpersonal
obligation, and to provide a safe environment for the therapeutic process. In fact, they
were not interested in therapists’ self-disclosure about their personal lives. Instead, they
were interested in therapist’s self-disclosures that would help them gain insight.

Daniel: Yeah and as far as I’m concerned it is about to cross a lot of boundaries
out there. Relating a staff member, a staff member relating a personal
experience that would benefit me in understanding something that’s happened in
my own self that’s one thing. And it’s actually very helpful but to for me to
understand or, or to know about a staff member’s life and problems and that.
That actually, what would happen is, for me is, if I knew the staff had problems
or were dealing with problems of their own, I would have difficulty going to talk
with them about my problems. And it’s not saying that the staff don’t have
problems and we’re all human, we all do. But I look up to staff and see them as
as more adept, more knowledgeable in matters I’m trying to address thoughts
emotions. All of these things that I’m looking at here you’re trained to deal with
that stuff. And when I go to them I expect to be helped. If I was to know that a
nurse was struggling with her own personal problems I would not go to that
person first of all. Got enough on your plate at the moment [already]. If I’m
hearing about them that means they’re, they’re having problems. It’s a little
difficult to explain. I, I like maybe I’ll just put it this way. I will go to
somebody I think is doing better than myself for assistance. If I know that the
person is struggling a lot harder than I am to deal with issues why would I go to
that person for help. Obviously that person is not uh capable yet to deal with
those emotions as he or she is, how would they give me help. Doesn’t make a
lot of sense.

Participants had a sense that the primary therapist retained ownership of, and
responsibility for, therapeutic boundaries. Daniel described the primary therapist
as maintaining the boundaries.
On the other hand, I’ve also found that she’s very cautious and that she keeps a professional barrier very firmly in place, and that’s not a bad thing.

Perhaps, the greatest testament to the value and necessity of therapeutic boundaries, was the participants’ efforts to transfer this learning to other relationships. Luke attempted to describe how he learned a great deal through individual sessions with the primary therapist.

I’ve learned a lot anyway by participating in one on one’s with her and stuff like that. So yeah I’ve, uh, I don’t know even. You know even talking to her like, like, uh, the way she is, uh, as a good person, you know what I mean, uh. I admire that and I respect that. You know that’s how I, I like to be a good person like that. I’ve learned like stuff like that you know or.

What Luke learned through individual sessions with his primary therapist he applied in other relationships. He described how he was now in his relationship with his partner.

Well it’s been oh it’s been good because I uh I’m more respectful and uh I look to things from her side too not just my side. Like before I used to be just selfish. I never cared about what other people felt or, or you know I never cared for other people kind of in that way. Now I’m more, more caring and you know what I mean. I, I’m more respectful, and you know, I respect her and a lot of different ways.

Daniel, once uncomfortable with the exclusive focus placed on him in the relationship with the primary therapist, described how he now expected to benefit from all interactions with treatment team members. He was no longer seeking interesting conversation.

But if I go to speak to a staff member I’m I’m looking for help in a certain area or if there’s feelings or saying what’s on my mind and looking for a little guidance.
Participants who had relationships with primary therapists presented as being in their head and hearts learned through the relationship. This was a factor distinguishing these relationships as "therapeutic" relationships.

5.6.4 The Wallets

Participants viewed therapists as being in their wallets, or only there for the pay cheque, if they got the sense that therapists were not interested in their treatment program. Participants identified both advantages and disadvantages of working with primary therapists that were in their wallets. For participants looking to shoot the breeze they were a wonderful resource. And for participants considering themselves as changed, seeking assistance elsewhere, or engaging in some damage control, these treatment team members were perceived as not being as demanding as other treatment team members. Daniel shared his view of this group of treatment staff as fun to talk to.

For those who are here for the pay cheque they're fun to talk with and to shoot the breeze with but as a rule I wouldn't go to them.

Parker described how he had more freedom at RPC with his primary therapists. He did not believe he required any further treatment and was pleased when the case manager (as he referred to the primary therapist), appeared to agree with him.

I got enough on the ball once ... the types of contacts that we have don't necessarily all [need] to be treatment. Just be touching base and shooting the shit and basically I can be left at my own devices and be trusted not to shoot myself in the foot. Unless my behaviour indicates otherwise you know I'm probably fine, you don't need to see me all the bloody time and so I just [don't you don't] necessarily have to see me all the time, looking over my shoulder. I get that here.

I mean he, he got my number as far as I could tell right off the bat.... He was intelligent and uh knows what he's talking about and just seems to have a feel for how to best approach me. Now whether or not that was done on purpose or not maybe it's just that we clicked you know.
Justice described a good report as one of the advantages of having primary therapists represented as being in their wallets. His description also captures the lack of commitment characteristic of this group of treatment team members, which was considered a disadvantage for some of the participants.

Well my last primary was a male and you know he really didn’t I’ve heard a lot of stories about him that he didn’t he was just there to give you a good report and get you out basically, he didn’t like doing all the paperwork that was involved and assessments and progress reports and things like that. Last time I was here I hardly met with him. For the two months I was here I had two interviews with him.

James described how he and his partner were both affected when the primary therapist declined an offer to join them during their family visit at the institution. James questioned if the primary therapist was interested in helping him or was only there to collect a pay cheque.

And she’s wondering why you know this is not happening at PFV’s and the invitation is there we both voiced our our requests why but we’d like to see that. We want to be able to be feel uh open and free to deal with whatever issues and and identify my problems and my problem areas together you know. So if there is a if they would come out and you know spend even an hour or something so that yeah they are here to help. Cause that would might, might make things easier for me to accept things, to accept the primaries. Other than other than that uh what are they good for a pay cheque or are they here to to help us right.

5.6.4.1 The Focus of the Relationship. The focus in relationships where the participants presented the primary therapists as being in their wallets was on passing the time. Participants did not feel pressured to produce in treatment. Even when treatment objectives were established, as required in the treatment program, interventions that were mutually agreed to, were not followed through with.

Parker: There doesn’t appear to be very much pressure on me to produce much of anything really other than to continue being the way I have, continue trying and to continue making the effort that I have been and ...I mean I’ve enjoyed
myself here I mean it’s a, a, a, great boost to my confidence and I’m getting some good feedback.

5.6.4.2 Finding Comfort and Safety. Participants found safety in distance and determining the expectations of treatment correctly. Correctly determining and meeting the expectations of treatment was rewarded with favorable reports. However, if the participant was unable to correctly determine the expectations then the consequence might be an unfavorable report. Yet, to attempt to clarify the expectations would mean taking a risk, thereby shifting the focus of the relationship away from passing time, toward, treatment issues and the potential identification of risk factors that had not been addressed during the treatment process.

Parker described the frustration that he experienced when the expectations were not clarified and the emerging relationship was not a partnership.

Yeah, well it again, it’s because, okay, um here’s the assessment now you may well want after initial and you add your own, you know, get your, like to try and get a handle on who you’re dealing with, then that’s cool. But if we all agree that basically these are, like it goes back to the treatment program again like okay well how, what, what areas do you want to address while you’re here in the ABC program. Well there’s also the aspect of what areas do you think that I should be also looking at as part of the feedback there. So yes I may develop a treatment program but through your input we can both agreed as to what to direction I can be focussed on, but as least I’m getting my needs met and you’re getting whatever you need as well. But it’s based upon an assessment that’s already made on the outset.

Parker shared his understanding of what he thought the implied expectations governing interactions between primary therapists and participants were. In his statement is the sense that safety or comfort was achieved through distance.

If a person’s minding his own business and doing his time and uh making an effort that seems to be rewarded much rewarded with a half decent report and good rapport established. I, I got a good rapport with my case manager (primary therapist).
James thought he was doing what was expected of him. He believed that he had achieved a balance between the program expectations, Aboriginal programs, and being true to himself. As James stated, “It’s not easy but I am. I am achieving it. I am living it”. He was surprised when he received a negative progress report, and described how he confronted the primary therapists in the group setting.

Well when I done when I identified it like uh after seeing that report and identified it I felt very uh I felt hurt yeah, I felt very I I didn’t feel discouraged, I immediately wanted to, to say something and I waited for the opportunity and the opportunity came in group and I immediately brought it up and I expressed how I felt and how I saw things and uh … uh

5.6.4.3 Establishing Boundaries. The relationship boundaries, the foundation of the relationship between participants and primary therapists perceived as being in their wallets, were not clear. Interactions between this group of treatment staff and participants, varied in length of time from a few minutes, to hours of conversation. The topics of the interviews fluctuated between shared topics of interest, such as movies, to treatment issues. There was no clear distinction between casual conversation and interviews for therapeutic purposes. Participants had the sense that interviews were taking place in the dayroom or hallway, as well as in the interview rooms. Parker described how his interactions with the primary therapist varied in length from a few minutes to three hours and covered a wide variety of topics.

They all been good I mean you sit down and start to talk about just talk base for 5 or 10 minutes and end up talking for an hour and a half, three hours sometimes. And it’s just very natural just unfolds just about everything under the sun really.

That’s why they tend to go on that long, it’s a combination of interview and casual talk.

Time spent together did not automatically lead to a partnership. As illustrated
by Parker's earlier statement, the absence of a partnership was felt.

Participants, with a strong initiative, could alter the direction of their relationships with primary therapists presented as being in their wallets. However, they were likely to wait until the disadvantages of working with this group of treatment team members exceeded any advantages. James initially accepted the relationship as offered by the primary therapist, albeit less than he expected, until he experienced consequences that could potentially hinder his future plans to rejoin his family. Confronting the primary therapist and clarifying his expectations accelerated their relationship. James stated:

You know he has spent some, some time with me now helping me with my prevent uh prevention my relapse prevention plan. He's helping me with that. So I think uh that is needed. Like if I have a primary or anyone has a primary I feel that that primary should be you know if he's going to be right in the boat, .... What he says has a impact on your like, well I think he should be working directly with you and not in another group and you know taking the advice of other primaries when you know he doesn't experience this personally.

Passing the time together characterized some, but not all of the relationships where primary therapist were presented as being in their wallets. For some, there was little contact. These participants did not learn through their relationships like the participants with primary therapists in their head and heart.

5.7 Summary

The personal contributions of the participants, and primary therapist characteristics contributing to the "therapeutic" relationships that developed, have been reflected in the experiences of the participants described here. Treatment was the window of opportunity for the participants, the treatment environment was the house where the window rested. The fundamental structures formed the treatment context.
Elements of the fundamental structures were present in the overall process of developing “therapeutic” relationships, such as, the participants’ evaluations of their primary therapists (who served as their guides). Primary therapists’ approaches to treatment were represented as a reflection of the resources they contributed to the “therapeutic” relationship. Four different relationships were described, each relating to the participants’ categorization of the primary therapist. The “therapeutic” relationship, was like the window covering that determined the amount of light allowed in and where the light would reflect. In essence, the “therapeutic” relationship influenced what the participants learned through their experiences in treatment.
Chapter Six
Integration of Findings

6.1 Introduction

In this chapter the findings of the study are compared to existing literature. Both similarities and departures from prior research are identified, and reasons for disparities and the absence of support for the findings are suggested. This chapter is divided into five sections corresponding to the themes identified in this study. Developing “Therapeutic” Relationships, describes the relationships of the findings and Peplau’s (1952) conceptualization of therapeutic relationships, and the empirical nursing literature on developing “therapeutic” relationships. Arriving at the House, describes the relationship of the findings and empirical literature on developing trust, and the theoretical literature on the role that coercion plays in treatment with forensic patients. In discussing Knowing the Fundamental Structures of the House, previous literature on the influences of the sociocultural context on the therapeutic relationship is presented. Evaluating the Primary Therapist as a Guide, discusses the similarities found in an earlier study by Morse (1991). Experiences that Promote or Hinder the Relationship, describes the relationship between the findings and prior research on patients’ perspectives of factors promoting or hindering the “therapeutic” relationship, and boundary violations. Ways of Being with the Primary Therapist: Head, Heart, Head and Heart, and Wallet, discusses the similarities and disparities of the findings and prior research.
This study was unique in that the participants were forensic patients enrolled in an in-patient treatment program. No other studies have examined the forensic patients’ perspective of therapeutic relationships and therapeutic boundary maintenance. Additionally, much of the literature reviewed was quantitative in nature, and examined the perspective of patients who had, or were receiving treatment on an out-patient basis. These differences made comparisons difficult.

6.2 Developing “Therapeutic” Relationships

A variety of terms are used to describe the nurse-patient relationship in the nursing literature, such as, the nurse-client relationship (Forchuk, & Brown, 1989), the therapeutic relationship (Forchuk, 1995; Gallop, 1997; Heifner, 1993), and the trusting relationship (Repper, Ford, & Cooke, 1994). “Therapeutic” relationship shall be used here to refer to the relationships that developed between participants and the primary therapists. Consistent with the principles of cognitive behavioural therapy (Freeman & Reinecke, 1995), it was the expressed expectation of the treatment setting that the establishment of a “therapeutic” relationship was the means to deliver effective treatment. The following statement captures the importance of the relationship reflected in the views of participants in this study, “Relationships that went along, or that were necessary in order to get help”. However, as the findings indicate the therapeutic interests of the participants did not consistently form the foundation of the relationships that developed, and, as such, were incongruent with Peplau’s (1952) conceptualization of the therapeutic relationship in nursing. Consequently, therapeutic appears within quotation marks here to reflect the intended, as opposed to the actual nature of the relationships.
Peplau’s (1952) interpersonal nursing theory provided a theoretical model of the therapeutic relationship and the foundation for later interpersonal theories of nursing (Forchuk & Brown, 1989). The centrality of Peplau’s theory in psychiatric nursing warrants consideration of the findings in terms of her conceptualization of the therapeutic relationship.

6.2.1 Peplau’s Conceptualization of the Therapeutic Relationship

Peplau (1952) conceptualized the therapeutic relationship as four interrelated phases. During the orientation phase a problem is felt but may remain largely undefined. Patients learn about the regulations that govern the provision of care and the resources available to them. The caregivers’ recognition of the orientation process the patient is experiencing, and their responses to the patient, constituted the orientation for the patient. The establishment of a partnership is emphasized as the patient is encouraged to participate in the identification of the problem. The second phase in the therapeutic relationship is identification. It is during this phase that the patient’s problem is clearly defined and the patient begins to selectively respond to those caregivers they perceive as able to help them with their problem. Exploitation is the third phase of the therapeutic relationship. During this phase the patient exploits the services available for self-interests and needs. The final phase, resolution, is a freeing process whereby the patient gradually decreases identification with the caregivers and the helping process, and experiences a strengthening of the ability to stand alone, complete with an aspiration to pursue new goals formulated earlier in the relationship.

The themes described in this study share some similarities with the phases of the therapeutic relationship as described by Peplau (1952). Arriving at the House, and
Evaluating the Primary Therapist as a Guide, correspond with the orientation phase and identification phase of the therapeutic relationship (Peplau, 1952). The importance of the responses of mental health professional and identification of resources available was reflected in the participants' experiences of adjusting to the treatment environment. The following statement of one of the participants in this study illustrates this similarity, “seeing that they’re willing to help ....it allows me to realize the resources that are here for me”. However, it appeared that these themes were experienced more intensely than in the writings of Peplau (1952, 1989a, 1989b, 1989c). The intensity of these phases in the current study was likely related to Knowing the Fundamental Structures of the House, such as time, power, gender, regulations, and the unique circumstances surrounding admission to the RPC. The participants in this study were admitted to a forensic psychiatric hospital (a term likely to provoke frightening images of the “criminally insane”, and forced treatment), from prisons, one of the most extreme and psychologically stressful environments in society (Phillips, & Caplan, 1994).

Ways of Being with the Primary Therapist, corresponded to Peplau’s (1952) exploitation phase. The statement of one participant, “I know it’s selfish”, clearly reflected the essence of the exploitation phase. As Peplau described, patients used the relationship based on self-interests.

Participants were interviewed at different points in the treatment program and appeared to identify with the primary therapists differently. Although those participants that were interviewed near the end of their treatment program shared their future plans, they were not questioned about the termination of the relationship.
Research findings on Peplau’s (1952) conceptualization of the therapeutic relationship (Forchuk 1995; Forchuk et. al., 2000) have provided support for the four phases of the therapeutic relationship. However, Forchuk and associates (2000) have suggested that the identification phase and the exploitation phase are subgroups of the working phase, rather than two separate phases. Considering the significance that the participants in this study placed on the evaluation of the primary therapist, the findings of this study are more congruent with Peplau’s original theory of the therapeutic relationship. The disparity between previous research (Forchuk, 1995; Forchuk, et. al., 2000) and the current findings may be related to the changing context of psychiatric care. Pharmacological developments, increased recognition of the rights of psychiatric patients, and a growing emphasis on community care over hospitalization have contributed to a context of care whereby psychiatric patients are less stigmatized, retain more personal power, and are more likely to receive services based on their needs, as opposed to social control. Conversely, forensic patients often feel coerced to participate in treatment programs (Group for the Advancement of Psychiatry [GAP], 1994; Serin & Kennedy, 1997) and often receive services in institutions where social control, if not a primary function, is certainly a secondary function. The context of treatment appears to influence the process of developing relationships.

Comparison between prior research on the development of therapeutic relationships and the findings is complex, owing to the uniqueness of the participants, and the context in which they received treatment. However, consideration of prior research in light of the findings reveals directions for future research in the development of therapeutic relationships in nursing, and exposes further limitations of the current
findings. Namely, that the current study only considered the perspective of the forensic patient. While the perspective of the forensic patient has not previously been the focus of research on the therapeutic relationship, the perspective of the primary therapist, and what actually occurred between primary therapists and patients, was not considered in this study.

6.3 Arriving at the House

The participants experienced an adjustment period when they arrived at the RPC. Initially they found that the “atmosphere [of] the whole place awkward”, and many experienced a “culture shock”. Although coping with imprisonment and rehabilitation has been the subject of prior research (Zamble, & Porporino, 1990), the adjustment of forensic patients to an inpatient treatment program has not. The sub-themes depicting the participants’ adjustment are considered in terms of relevant literature.

6.3.1 Adjusting to New Relationships with CSC Staff

Although adjustment was highly individualized, all participants found themselves adjusting to friendly interactions with the staff at the RPC. Unique to the participants was a sense that they had no choice but to trust if they were going to complete the treatment program. Trusting was “the bottom line”. Participants had “no choice”. They had to “learn to trust these people, and you have to come to trust them”. Trust was facilitated by the recognition that the treatment team members were there to help and that trusting was not absolute, but rather progressive, and a matter of degree. As one participant stated, “They’re here to help you and you’re here to help yourself and that’s where that trust level comes in”.

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The patient’s trust in the therapist, in the Rogerian sense, is promoted by the therapist’s belief in the patient’s potential, as displayed by the therapist’s genuineness, empathy, congruence, and unconditional positive regard (Rogers, 1951). Although trust for the participants was promoted when they were able to see that treatment team members were willing to help them (a finding consistent with the conceptualization of trust as being inspired by qualities within the therapist), trust was also a phenomenon occurring within the participants. Participants had to resolve the discrepancy between conceptualizations of trust as being absolute, and the trust they perceived as forced upon them, in order to achieve a level of comfort with the “therapeutic” relationship. The disorders that forensic patients experience may affect their ability to trust (Preston, 2000), and the conditions under which they receive treatment, may account for these differences. However, the rather limited research on trust in the therapeutic relationship, indicates that trust is more complex than Rogerian theory suggests.

Peschken and Johnson (1997) did not find the expected correlations between patient and therapists’ ratings of facilitative attitudes and trust. This suggests that these relationship variables are experienced differently by patients and therapists, indicating the need for further research to capture the patients perspective of the therapeutic relationship, and the need to re-evaluate the construct validity of the facilitative attitudes measures (Peschken & Johnson, 1997).

6.3.2 Achieving a Balance between Cultural Beliefs and the ABC Program

The Aboriginal participants were a heterogeneous group, with two out of the five clearly preferring a traditional approach to personal healing. The fact that participants who preferred a traditional approach found themselves struggling to “make
a balance" between the ABC program expectations, cultural programs, and being true to themselves, supports the claim that models of counselling are derived from values and belief systems consistent with the mainstream point of view, and are not responsive to cultural diversity (Ibrahim, 1999; McFadden, 1999). Findings that not all Aboriginal participants preferred a traditional approach, lends support to the assertion that matching treatment program, therapist, and patient on cultural values and beliefs is more important than matching on ethnic similarity (Ibrahim, 1999). This is contrary to Bonta’s (2000) assertion that there is no need for assessment measures of personal and demographic characteristics that may operate as responsivity factors (gender and ethnicity). Consequently, assessment and consideration of an individual’s cultural experiences, values, and beliefs, may enhance treatment.

6.3.3 Evaluating Expectations and Experiences

The expectations of treatment influenced the adjustment for some of the participants. One participant in particular was not prepared to be open with the primary therapist until he was able to see that he was going to get the answers that he was looking for. He expected the primary therapist to “give (him) an answer”, and once he learned why he ended up in jail he “took a bigger risk”. This is consistent with prior research indicating that the patient’s expectations of personal commitment were positively related to subsequent measures of therapeutic alliance, and patients’ expectations of counselor expertise were inversely related to therapeutic alliance (Tokar, Hardin, Adams, & Brandel, 1996).
6.3.4 Level of Motivation or Degree of Coercion

The notion of coercion regarding participation in treatment is frequently experienced by forensic patients, and represents a dichotomy regarding their treatment. Treatment that is the result of coercion is of no therapeutic value: or, coercion and secondary gains increase the therapeutic value and outcome of treatment GAP (1994). Although this study did not consider the outcome of treatment, participants reported feeling coerced to participate in treatment, and as GAP (1994) asserted, coercion lead to motivation for many of the participants. Being given a choice to “take it or leave it” (participate); being assisted to consider the options or being asked “what do you have to lose?”; and gaining a sense of self-efficacy and having “control over (my)feelings and thoughts” promoted the participants movement from feeling coerced to feeling motivated. Consistent with the principles of motivational interviewing (Miller & Rollnick, 1991), the conceptualizations of motivation as a dynamic relationship factor, rather than solely a characteristic of the patient (Kennedy, 2000), suggests that engagement of treatment-resistant clients is promoted by giving them a choice, and by supporting efforts towards self-efficacy (Preston, & Murphy, 1997). Current emphasis on enhancing motivation as a means to enhance treatment outcome is warranted. In the words of one of the participants in this study, “If you’re willing and you’re sincere about change you’ll take in everything”.

6.4 Knowing the Fundamental Structures of the House

The “therapeutic” relationship does not develop in isolation. The context of treatment influences the “therapeutic” relationships that develop, and what will be experienced as a boundary violation (Brown, 1994; Smith & Fitzpatrick, 1995). More
specifically, in terms of correctional treatment programs, characteristics of the institutional setting are an important aspect of treatment programs (Losel, 1996). However, “little systematic research has been conducted on the impact of organizational characteristics such as facility climate, prison regime or relationship with other services” (Losel, 1996, p.35).

This study was conducted in a treatment centre for federally incarcerated offenders. In this setting, the prison environment, which one participant described as “very uncaring, completely irrational and violent”, existed concurrently with the treatment environment, which the same participant described as “very caring, nurturing, and a learning atmosphere”. While the challenges of providing treatment in a prison environment have been explored in the literature from the perspective of the mental health professional, the perspective of the treatment recipient has not been previously examined. Consequently, the findings here are compared to relevant theoretical and empirical literature regarding therapeutic relationships, in both the inpatient and outpatient settings, and are not specific to the forensic setting.

6.4.1 Time

Time spent together, and the length of interviews, have been identified as factors promoting the therapeutic relationship in both quantitative (Forchuk 1992; 1995), and qualitative studies on the therapeutic relationship in nursing (Forchuk, et. al.1998; Forchuk, et al. 2000). Morse (1991) found that the time, or the duration of the relationship, was one factor determining the type of relationship that developed. The relationships of greater duration were more intense, and moved from therapeutic, to connected, and over-involved. Consistent with Morse’s research, participants in the
study presented here valued those staff who would make time to spend with them, and found that developing trust in their relationships with primary therapists happened when they “gave it time”. Conversely, when the primary therapist “disappeared” and the participants “wouldn’t have time to converse or consult with [the primary therapist]” it was experienced as a violation of the “therapeutic” relationship. When participants saw treatment team members spending time with patients that was unrelated to treatment needs, these behaviours were viewed as favoritism, and a violation of the expectations of treatment when the “favorite patient” was accommodated, while others requiring help were not. In the words of one participant in this study, “In my mind there is no real choice....as far as I’m concerned this is a therapeutic environment...if somebody wants to talk that should be given precedence”. Time was a fundamental structure of the context that influenced what was experienced as a boundary violation of the therapeutic relationship, and the treatment environment.

Participants shared how they were “doing time” and some valued social activities as a way of passing the time, but believed “disuss[ing] and work[ing] with [the primary therapist] on things like that would be more beneficial ....than playing a game of cards”. These are findings consistent with a study of an inpatient substance abuse program. Bacchus et al. (1999) found that participants valued recreational groups as a useful means of occupying time during the day, but of little benefit in a therapeutic sense. This is not a surprising similarity, as secondary gains or pressure from others may be factors motivating both individuals experiencing substance abuse and forensic patients.
The power inequality in the “therapeutic” relationship has been widely recognized, and efforts to achieve more equitable relationships, the focus of many theoretical approaches to the “therapeutic” relationship and treatment. In this study the participants viewed the primary therapists as having “a lot of power for [their] future”. Primary therapists were viewed as having power over the participants’ freedom which made the participants particularly vulnerable. However, as discussed earlier, the nursing literature rarely describes the forensic patient as vulnerable. Instead, forensic patients are often described as manipulative while forensic nurses are described as vulnerable and needing to guard against being exploited (Melia, et al., 1999). In contrast the limited nursing literature that addresses power in therapeutic relationships describes how power is abused when nurses feel vulnerable. Gallop (1998) described how nurses abuse power in their relationships to meet personal needs and to violate therapeutic boundaries. Hardin et al. (1985) found that beginning nurse-therapists engaged in power struggles with their patients, or used exploitive power, when they perceived their expert power to be threatened.

Glenister (1997) stated, that the emphasis on caring in nursing “may soothe consciences and present a favourable image to others, yet at the same time deny the centrality of coercion and control in mental health nursing practice” (p.43). The good intentions of nurses, are unquestioned, particularly when the patient is an offender. In this study the participants’ experiences resonated the centrality of power and coercion in their relationships with their primary therapists. The statement of one participant reflects the sentiments of other participants as well, “I don’t want to get on her bad
side....cause then that gives her all the power to do whatever she wants with me”. The inequality of power that the participants experienced in their relationships with primary therapists had the potential to be abused, leading to boundary violations.

6.4.3 Gender

Gender issues are among the vast array of sociocultural factors inherent in treatment that affects the “therapeutic” relationship (Cochran & Rabinowitz, 1996; Farber & Geller, 1994; Gallop, 1997). As a participant described “one of the greatest things, problems that there is today, is when guys who have done an extensive period of time, is that there’s some very pretty ladies who work here. And so it’s natural to want to talk to them and get to know them a little better and maybe?” The ways in which gender issues affect the therapeutic relationship have been an area of study and concern in the last two decades (Farber & Geller, 1994).

Although the consideration of gender issues has been stressed in the forensic psychiatric nursing literature (Schafer, 1997), gender issues as a factor affecting the “therapeutic” relationships between female nurses and male forensic patients has not been an area of study. Instead, the tendency for female nurses to be viewed as victims and exploited when a boundary violation occurs is depicted in the nursing literature (Gallop, 1998; Peternelj-Taylor, 1998). Consistent with this view, the eight participants in this study who worked with a female primary therapist believed that they would likely be blamed for any boundary violations that occurred while in treatment. One participant suggested that the researcher needed to emphasize more how participants are not advised about the limits of the relationship yet are held responsible and suffer negative consequences when boundaries are crossed. Some participants considered an
attraction to the primary therapist or another treatment team member inappropriate and appeared to equate experiencing an inappropriate attraction with being a sex offender. A response from one of the participants to my question regarding attraction reflects the sentiments of other participants as well, “I’m not no hound, so I know what my role is.”

The current emphasis on gender issues in therapy appears warranted in terms of the findings here. As one participant in this study stated “It’s easier with a guy cause there’s no sexual overtones or anything sexual”. The potential for violations of the therapeutic relationship related to attraction, and the potential destructiveness that could occur when an attraction is not addressed appropriately, was well recognized by the participants in this study.

6.4.4 Living with Regulations

Incarcerated forensic patients, perhaps more than any other group of patients, are subject to a host of regulations governing their conduct. However, a limited comparison can be made between incarcerated forensic patients and inpatients enrolled in substance abuse programs, where regulations governing the patients visiting and movement privileges are often instituted as a security measure to guard against the risk of substances being brought into the treatment setting (Bacchus et al., 1999). Participants in this study experienced the regulations regarding personal space, movement, and making requests as a source of frustration. Comments such as, “It’s driving me nuts right nuts” and “No that’s extremely frustrating” reflect the sentiments of the participants. Likewise, Bacchus et al. (1999) found that regulations were a source of frustration for inpatients seeking treatment for substance abuse.
Particularly distressing for some of the Aboriginal participants was the disparity between policy related to Aboriginal programs and the institutional practices. A disparity that, Preston (2000) stressed, had a negative impact on some participants willingness to accept their primary therapist and the treatment approach, as one participant stated, "sometimes its even how, has me losing respect for for people in power".

6.4.5 The Value of Learning

The participants in this study experienced the atmosphere at the RPC as an atmosphere that promoted learning, where they were free to apply the skills they learned in treatment, unlike their parent institutions. Coming to the RPC was “a learning experience” for the participants, while, as one participant stated, taking programs in the parent institution “felt like I was getting nowhere....because of the atmosphere I can only get so far”. Similarly, the literature on correctional programming emphasizes the development of a therapeutic atmosphere (Preston, 2000), or an environment that is emotionally and socially responsive (Losel, 1996).

Comparison of the fundamental structures identified is this study with the contextual factors of treatment has been tentative at best. Although the influence of the context of treatment is recognized, it is rarely studied (Losel, 1996). In the prison environment, the context of treatment may take on greater significance. It is not the office space of the therapist where the forensic patient receives help, but rather a forensic treatment centre, where the prison subculture and treatment environment meet and often conflict. Participants in this study had to find a way to operate within the new treatment environment. Resources that participants had access to included the primary
therapists, who together with them, coordinated their treatment programs. However, aware of the power imbalance that existed between themselves and their primary therapists, participants, like those in Morse's (1991) study, engaged in an evaluation of the primary therapists.

6.5 Evaluating the Primary Therapist as a Guide

Morse (1991) examined both the patient’s and the nurse’s perspective of the “therapeutic” relationship in eight different clinical settings, including psychiatry. Patients, aware of different types of nurses, including “angels”, “bossy”, and “careless”, assessed nurses to first determine if the nurse was a good person, and second to see if the nurse was a good nurse. To determine whether the nurse was a good person, participants sought personal self-disclosure to place the nurse in a social context, and tested for dependability. To determine if the nurse was a good nurse, participants in Morse’s study watched to see if they knew what they were doing, asked other patients for references on the nurse, and conducted tests to determine trustworthiness. Similar to the findings presented in this study, participants in Morse’s study tested the nurse’s trustworthiness by giving the nurse personal information about themselves and then waited to see if the nurse kept the information confidential.

The similarity between the process of assessing or evaluating the nurses in Morse’s (1991) study, and the findings here, was surprising, given that only a portion of the participants in Morse’s study were patients in psychiatry. Both groups of participants conducted tests, and considered reports from other patients. However, the tests that some of the participants in this study conducted were more elaborate than
those used by participants in Morse’s study. Differences in the context and power imbalance of the “therapeutic” relationships may account for this variation.

6.6 Experiences that Promote or Hinder the Relationship

The development of a positive therapeutic alliance between forensic patients and therapists is considered to be contingent upon the patients’ ability to establish positive interpersonal relationships, and therapist qualities such as, “being open, enthusiastic, flexible, attentive and understanding, and demonstrating acceptance, respect and caring for offenders” (Preston & Murphy, 1997, pp. 39). Additionally, therapist characteristics of clarity, honest, empathy and fairness are associated with effective counselling in corrections (Gendreau & Goggin, 1997). Although participants in this study were not asked to identify therapist characteristics that promoted the “therapeutic” relationship, embedded in the experiences they shared is their perception of the therapists’ characteristics. The experiences of the participants in this study that promoted “therapeutic” relationships parallels the facilitative therapist characteristics identified in the literature. The explicitness of what the participants experienced as either promoting or hindering the developing relationships is a significant finding.

Wright and Davis (1994) examined the expectations of more than 24 patients seeking therapy at an outpatient mood disorder clinic that used a cognitive behavioural approach. The expectations identified by the patients in Wright’s and Davis’s work are similar to the factors determined to promote the relationships in this study. Namely, to be treated like an individual, that time is taken to understand the patient, that scheduled appointments generally occur, that the therapist not hold back ideas, that the therapist encourages patients to make choices based on accurate information and the therapist’s
suggestions, that therapists follow up on suggestions, and that they are good role models, were the expectations similar to the experiences that promoted the relationships for participants in this study. Additionally, the findings of this current study are consistent with the assertion that attention to these “non-specific” relationship factors promotes a therapeutic alliance (Wright & Davis, 1994). Logically, when these “non-specific” relationship factors are not addressed, the development of a therapeutic alliance is inhibited. As this study revealed, experiences that either promoted or hindered the development of “therapeutic” relationships were like opposing ends of a continuum.

6.6.1 Being There and Being Heard

The importance of listening to patients and being empathic is well recognized. Listening skills are one of the first communication skills taught in nursing. The emphasis on listening in nursing education is consistent with the findings of this study that being there and being heard are factors that promoted the “therapeutic” relationships. While “to not be heard [was] dehumanizing”, listening was “the big point” for the participants in this study. The participants in this study knew they were heard when their input was reflected in their treatment plans, and progress reports. This finding resonated the importance of involving patients in their treatment planning to promote engagement in treatment and the “therapeutic” relationship (Preston, 2000).

6.6.2 Feeling Objectified

Feeling objectified hindered the development of “therapeutic” relationships, while being treated as an individual promoted “therapeutic” relationships for the participants. In fact, as one participant described, being treated like an individual was
“alone for myself enough”. When participants were treated like individuals they knew they “weren’t just a number in the system”. This finding is reflected in the importance that is placed on therapists maintaining a non-judgmental attitude (Kennedy, 2000), as well as the consideration of individual differences in treatment planning (Gendreau & Goggin, 1997; Howells, Watt, Hall & Baldwin, 1997; Kennedy, 2000; Losel, 1996). Furthermore, this finding is consistent with conceptualization of boundary violations that includes objectification of the patient as a characteristic of a therapeutic boundary violation (Brown, 1994).

6.6.3 Receiving or Not Receiving Feedback

The findings of this study indicate that receiving specific feedback on their progress promoted the development of “therapeutic” relationships for the participants, while non-specific positive feedback was reason for concern. Not receiving feedback was “discouraging”. Receiving feedback that something was awesome was questioned, “everybody seems to be awesome so what’s that suppose to mean” and viewed as “something you say to a child”. While receiving specific feedback was associated with therapist characteristics of being “direct”, “open” and “honest”, and reflected the therapist’s commitment to the participants. As one participant stated “She’s there for me, she gives me a lot of feedback”. This finding is consistent with characteristics related to effective correctional programming, specifically, clarity and honesty in the therapist, (Gendreau & Goggin, 1997), and the importance of feedback in reducing treatment-related resistance (Preston, 2000).
6.6.4 Modifying Their Approach

When primary therapists were not direct with participants, or when they modified their approach, participants experienced or perceived that the therapist lacked faith in their ability. Participants in this study concluded that treatment team members worried that they might "fall to pieces", or feared them and their reactions, as reflected in the following statement, "I think they might be scared of my reaction". Conversely, when the primary therapists were direct, and focused on current dynamics, participants experienced this as an opportunity to challenge ineffective patterns of interacting. This finding supports the importance of openness, as a therapist characteristic associated with effective counselling (Preston, 2000; Preston & Murphy, 1997); and the use of skilled confrontation consistent with motivational interviewing techniques (Miller & Rollnick, 1991).

6.6.5 A Clear and Shared Direction

Having shared objectives promoted the "therapeutic" relationships in this study, and resonates with the importance of mutually established treatment goals (Freeman & Reinecke, 1995, Preston, 2000). This further supports the evaluation of agreement on goals of treatment and tasks to reach those goals (Horvath, & Greenberg 1986). As one participant described knowing the goals and expectations was good because there were "no surprises", or as another participant described "that's where that trust level comes in".

6.6.6 Cultural Insensitivity or Cultural Sensitivity

Although some Aboriginal participants preferred a traditional approach to their healing, it was not their expectation that primary therapists share their cultural
background. However, it was their expectation that the primary therapist would be understanding of cultural differences and demonstrate a willingness to consider cultural differences in planning their treatment. When this expectation was not met the participants experienced difficulty accepting the primary therapist and the treatment approach, as one participant stated “it doesn’t help towards treatment”. This finding confirms the consideration of cultural background as a patient characteristic that correctional treatment programs need to be responsive to (Howells, et al., 1997; Kennedy, 2000; Preston, 2000), and the consideration of cultural background in treatment planning with the patient (Preston, 2000).

6.6.7 Defining Roles

Although the patients’ perspective of dual relationships has been the object of previous studies (Nerison, 1992), the fulfillment of multiple roles within the scope of a single relationship has rarely been the subject of investigation. In this study, participants identified three roles that nurses fulfilled – security enforcer, a social role, and primary therapist. The role of security enforcer hindered the development of “therapeutic” relationships for at least some of the participants. In the words of one of the participants in this study it “undermine[s] your ability to treat a patient….cause that’s strike one, two, and three”. The social role of the nurse was considered helpful in terms of promoting comfort within the relationship for some of the participants, while others preferred keeping all interactions with the primary therapist and other treatment team members within the expectations associated with the roles of patient and therapist. The ownership that many of the participants felt to keep interactions within the expectations associated with their role is reflected in the following statement, “I keep it
very professional and [I’m] very comfortable with that now”. The latter is consistent
with prior research findings that indicated that the only social contact that patients
identified as likely to be beneficial to therapy, was when therapists visited hospitalized
patients, where the status of patient was retained (Ramsdell & Ramsdell 1993; 1994).
The need for further research on the impact of multiple roles on the therapeutic
relationship is essential.

6.7 Ways of Being With the Primary Therapist: Head, Heart, Head and Heart, Wallet

Participants in this study grouped treatment team members into one of four
categories. Treatment team members were presented as being in their head, heart, head
and heart, or wallet. Participants found a different way of being with each group of
treatment team members. Likewise, the corresponding “therapeutic” relationships that
developed between the participants and the primary therapists were different with each
group of treatment team members. The focus of the relationship, where the participants
found comfort and safety in the relationship, and the relationship boundaries were
unique for each of the four different relationship types that emerged. No other research
was found in the literature that examined the development of different types of
“therapeutic” relationships as defined from the perspective of the forensic patients.
However, as noted previously Forchuk et al.(1998; 2000), and Morse (1991) have
examined the development of “therapeutic” relationships from the perceptive of both
the patient and the nurse, while Heifner (1993) examined psychiatric nurses’
perspectives on establishing connectedness with their patients.

Forchuk et al. (1998; 2000) examined ten nurse-patient dyads to reveal two
different types of relationships: therapeutic and non-therapeutic. The phase of the
therapeutic relationships studied followed Peplau's conceptualization of the therapeutic relationship, and resembled the relationships that developed between participants and the primary therapists presented as being in their heads and hearts. The non-therapeutic relationships did not follow Peplau's conceptualization of the therapeutic relationship. In these relationships the orientation phase was followed by a period of grappling and struggling that lead to mutual withdrawal. In this study, an extended period of struggling, or a "push-pull" characterized one of the "therapeutic" relationships where the primary therapist was described as being in his head. The participant's experience in this case was consistent with the classification of a relationship characterized by a struggle as non-therapeutic (Forchuk, et al., 2000).

In an exploratory, descriptive, qualitative study Heifner (1993), interviewed eight nurses who had worked in psychiatric nursing (mean of 6.75 years SD = 4.2). Using grounded theory, Heifner suggested that development of a connectedness in the therapeutic relationship developed progressively. The process of establishing connectedness was initiated when the patient expressed vulnerability, after which nurses responded by identifying commonalities they shared with the patient and encouraging further disclosure. Nurses experienced feelings of reciprocity and being valued by patients. "The patient's ability to respond resulted in a mutual investment, with mutual trust and risk-taking" (Heifner, 1993, p. 14).

Relationships that were established with primary therapists perceived as in their hearts appeared to be promoted by the participants' responses to the vulnerability they perceived in the primary therapists. This is reflected in the following description of a participant's response to a self-disclosure of the primary therapist, "she was kind of
getting teary eyed and you know I wanted to get up and just go and say hey like it’s cool”. Forensic patients are not likely to express vulnerability directly or early in the relationship. Instead they are likely to use aggression or hostility to avoid feelings of vulnerability. This type of behaviour was demonstrated during periods of vulnerability during the research interviews. The findings here are the opposite to the psychiatric nurses’ points of view captured in Heinfer’s study, giving rise to further questions. For example, do forensic nurses learn to connect to others based on vulnerability of one individual in the relationship? If so what does this imply about power in the nurse-patient relationship? When the patient does not demonstrate vulnerability, or does not appear to value the nurse, do forensic nurses use vulnerability to promote their patients’ connections with them? Nurses who demonstrate vulnerability may promote a connectedness, whereby the patient will do things to please the nurse or keep the nurse from feeling vulnerable and helpless. The connection is not based on the therapeutic interests of the patient and therefore does not constitute a “therapeutic” relationship (Peplau, 1952).

Morse (1991) determined that there were four different types of mutual relationships that developed between patients and nurses as the result of covert negotiation: clinical, therapeutic, connected, and over-involved. Additionally, she found a unilateral relationship that was characterized by the lack of mutually agreed upon level of involvement. Morse found that the duration of the relationship, the need of the patient, and the commitment of the nurse, were factors determining the mutual relationships that developed. The finding of different relationship types in the present study is consistent with Morse’s findings. Additionally, the influence of the primary
therapist on the type of relationships that developed was not unlike the commitment of the nurse in Morse’s study.

Morse (1991) also found that patients were aware of three different types of nurses: those described as “angels”, “bossy”, and “careless”. Unfortunately, the characteristics of nurses that led the patients to form these conclusions are not described in the study. Based on the language, and the surmised connotations, some similarities may be drawn with the current study. Angel is often used to describe individuals who are caring and committed to helping others, an image not unlike the “hearts” described here. Bossy is typically used to describe individuals who, believing that they know what is best, direct others, an image similar to the description of the “heads”. Careless is generally used to refer to individuals who are not committed to their professional practice, an image similar to the “wallets”. This tenuous comparison reveals a disparity between Morse’s research and the findings in the present study. The group “head and hearts” was not reflected in prior research on the nurse-patient “therapeutic” relationship.

While the intention was to include only those participants who had a nurse as a primary therapist in this study, three participants had primary therapists representing two other professional groups. Interestingly, both of the primary therapists representing these professional groups were presented as being in their “head and hearts”, accounting for the majority of the relationships in this category, raising the obvious question, why?

“Several decades of studies have consistently identified the fact that nurses tend not to interact with their clients in a therapeutic fashion” (Porter, 1993, p. 1559), that “therapeutic” relationships are a rarity, and that relationships that exist are improper
(Glenister, 1997). Instead, “psychiatric nurses tend to concentrate on activities which promote occupational comfort and institutional efficiency” (Porter, 1993, p.1560). The stress associated with interpersonal relationships, a lack of interpersonal resources (Cook, 1991; Llewlyn, 1984), and the failure of nursing education to adequately prepare nurses (Llewlyn, 1984; Glenister, 1997) are among the explanations that account for the finding that psychiatric nurses fail to develop “therapeutic” relationships with their patients. Glenister (1997) argued that a “simplistic and naïve consensus concerning care(ing)” in nursing that takes the therapeutic nature of nursing for granted, allows nurses to deny the role of coercion and control in mental health nursing, and leaves them vulnerable to be used as agents of social control by institutions. Similarly, Porter (1993) asserted that the occupational situations of psychiatric nurses may account for the reason why psychiatric nurses tend to favor actions leading to institutional order over therapeutic interactions with their patients. The findings of the present study provide support for some of these explanations.

The stress associated with interpersonal interactions and inadequate interpersonal resources, was reflected in the study participants’ conclusions that the primary therapists presented as being in their “heads” were unable to connect with the participants because they were unable to cope with the uncertainty of interacting on an interpersonal level with them. Although the participants did not comment on the educational preparation of the primary therapists, educational difference did exist. At the time of the study, nurses as primary therapists were the only professional group that were not required to be prepared at the baccalaureate level to register with their respective professional associations. Furthermore, the occupational situation for the
nurses in the study was different than all other primary therapists. Unlike other professional groups, nursing hours included shift work, supervision of patients engaged in evening activities, and a responsibility, albeit shared with institutional security, to complete a multitude of procedures to ensure the safety and control of the institution. In essence, the nurses represented in this study fulfilled dual responsibilities – those related to therapy and security. The nurses in this study were managing the most complex relationships with the participants while being the least academically prepared. This raises significant implications for both nursing education, forensic nursing practice, and organizational practices regarding the role expectations of forensic psychiatric nurses.

The findings in the present study indicate that what the participants experienced, as a boundary violation is a function of the “therapeutic” relationship that has been established. This finding is consistent with Brown’s (1994) conceptualization of boundary maintenance as a dynamic process that does not lie in the identification of concrete rules governing the therapist behaviour, but rather in the understanding of what the patient experiences as a boundary violation, the influence of culture, setting, and the pattern of interacting among those involved. If what is experienced as a violation of the “therapeutic” relationship is a function of the relationship that has been established one should question the validity of surveys, that assess patient attitudes, without also examining the nature of the relationship. Although many of the participants experienced a connection with the primary therapist, this connection was not always associated with a “therapeutic” relationship as conceptualized in the theoretical
literature. With this in mind, one has to question if reports of closeness or attachment indicate a therapeutic alliance (Horvath, & Greenberg 1986).

6.8 Summary

The literature reviewed in preparation of this study provided little in terms of understanding the findings of the present study. Although this literature examined the patients' perspective of boundary maintenance and boundary violations, the nature of the patient-therapist relationships were not examined. The relationship between boundary maintenance, what the participants experienced as boundary violations, and the "therapeutic" relationships that developed, found in this study necessitated the consideration of relevant literature on the development of therapeutic relationships.

The participants' experiences of adjusting to the treatment environment, and Knowing the Fundamental Structures of the House, or the context of treatment, reiterates the influence of the context of treatment on the patient-therapist relationship stressed in the literature. More specific to the correctional environment, these findings support the consideration of the influence of treatment atmosphere on the effectiveness of correctional programming (Losel, 1996) and patient resistance (Preston, 2000). The themes Evaluating the Primary Therapist as a Guide, and Experiences that Promote or Hinder the Relationship support the attention given to establishing collaborative relationships with forensic patients, and to therapist characteristics associated with effective counselling in correctional programs. The theme Ways of Being with the Primary Therapist, is a significant finding that suggests that boundary maintenance and what is experienced as a boundary violation is a function of the "therapeutic" relationship that has been established. This may have implications for subsequent
research on boundary maintenance and boundary violations in the “therapeutic” relationship with forensic patients.

The purpose of this study was to examine the perspective of participants enrolled in the ABC treatment program regarding therapeutic relationships and particularly therapeutic boundary maintenance. The findings of this study validate the importance and relevance of the therapeutic relationship for nursing, the importance of the therapeutic relationship in correctional programming, and the establishment and maintenance of therapeutic boundaries as essential components in the development of therapeutic relationships. Participants working with primary therapists described as being in their head and heart knew that when they had an interview that they would “gain something”. Like one participant stated “when I go in there I’m saying, saying my peace and getting some feedback and in regards to it. And there is no further expectation. So it’s very helpful”.

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Chapter Seven

Reflections

7.1 Introduction

The researcher and the findings of this study are inseparable, and the interactions between the researcher and the participants shaped the reality constructed. Lincoln and Guba (1985) assert that the knower and known are inseparable, and together the investigator and respondent create the data of the research. The first person is used in this chapter to reflect this interdependence. It was difficult for some of the participants to articulate their responses and I found myself being interpretive in order to understand their experiences. Readers are encouraged to draw their own interpretations, to challenge the findings, and to question the implications for nursing practice, education, and research suggested here.

This study, on “therapeutic” relationships and therapeutic boundary maintenance examined the perspective of forensic patients’ enrolled in the ABC program. The complexity of “therapeutic” relationships and the interdependence between boundaries and the “therapeutic” relationships, emerged from the participants’ stories. Therapeutic boundary maintenance and the therapeutic process were interrelated. Relationship boundaries were dynamic and determined the nature of the relationship. Developing relationships was a complex process influenced by the context of treatment, the primary therapist, and the participants.
Drawing on what emerged from this study, therapeutic boundaries might be conceptualized as walls that house the therapeutic process. Therapeutic boundary maintenance is the process of learning where the walls are and ensuring that the walls retain their integrity. The fundamental structures of the house, along with the resources of the primary therapists, and characteristics of the participants (such as, motivation, and past experience), form the walls. Therapeutic boundary maintenance is a dynamic process that requires therapists to be aware of the influence of the context of treatment, their impact on the relationship, and what the participants experience as a violation. Such awareness is not easily achieved. It is likely impossible for the therapist to always know where the walls are. Therapists may occasionally discover the walls only after they have made contact with them. Boundary maintenance requires that the therapist recognizes when they have made contact with a wall, repairs any damage to the walls, and acquires sensitivity to their location in each therapeutic relationship.

In addition to the conceptualization of boundary maintenance presented above, the research revealed a number of questions: What are the factors influencing relationship boundaries, and subsequently the relationships that develop? What can forensic nurses do to foster therapeutic relationships with their patients? What can nursing education and research contribute? Finally, what suggestions might the forensic patient offer to forensic nurses and researchers? Reflections on each of these questions are presented here.

7.2 Relationship Boundaries and the Emerging Relationships

As the study progressed, a discrepancy between the conceptualization of therapeutic boundaries, as the distinction between what is therapeutic and non-
therapeutic, and the relationship boundaries (discernable from some of the participants descriptions of their relationships with primary therapists) grew. Although all relationships were defined by the boundaries that characterized them, the term therapeutic boundaries was not descriptive of all relationships. Consequently, it seemed less fitting to use the term therapeutic boundaries to describe the relationship boundaries between all the participants and primary therapists. It was not the professional role of the primary therapist, nor the role of patient, that created therapeutic boundaries. Instead, it was an exclusive focus on the therapeutic interests of the patient that created therapeutic boundaries and "therapeutic" relationships. Although the role of the nurse dictates that the relationships that nurses develop should be based on the needs of the patient, failure to establish therapeutic boundaries is not typically viewed as a boundary violation. Roles define the expectations of individuals, while boundaries determine the nature of the relationship.

Following guidelines regarding the length and frequency of interviews, dress, the giving and receiving of gifts, and self-disclosure is not sufficient to the establishment and maintenance of therapeutic boundaries. While following guidelines may contribute to managing the risk of boundary violations, in terms of over involvement, adhering to guidelines does not guarantee that a therapeutic relationship will develop. Therapeutic interests of the patient can be distorted, even while adhering to general guidelines, and meeting the role expectations of a nurse. Establishing and maintaining therapeutic boundaries requires that the therapeutic interests of the forensic patient remain central to the relationship.
7.3 Factors Influencing Relationship Boundaries and Subsequently the Relationships that Developed

The study offered insight into the complexity of therapeutic boundary maintenance. Where the therapeutic interests of the participants formed the foundation of relationship boundaries, therapeutic boundaries were established, and the relationships that emerged were characteristic of therapeutic relationships. Where the therapeutic interests of the patient were distorted to match the primary therapist’s comfort, ability, and knowledge, the therapist's interests formed the foundation of the relationship boundaries, and the subsequent relationships that developed were not “therapeutic” relationships. Although participants found some benefit in these relationships, the ability and knowledge of the primary therapist limited the potential of these relationships. Interestingly, highly motivated participants demanded less of their primary therapists, and were able to take risks in the absence of an established “therapeutic” relationship.

In addition to the resources of the primary therapist, and the motivation of the participant, power imbalances had a significant influence on the relationships that developed. Power imbalances rendered the participants vulnerable. This appeared to be the impetus behind the tendency of participants to seek comfort and safety in the relationship, by accepting the conditions of the relationship, that they perceived the primary therapist covertly established. Clearly, the resources of the primary therapist, the participant’s motivation, and power imbalances strongly influenced relationship boundaries, and subsequently the relationships that developed.
7.4 Promoting Therapeutic Relationships

The establishment and maintenance of therapeutic boundaries was associated with the development of "therapeutic" relationships. Forensic nurses, by establishing and maintaining therapeutic boundaries in relationships with patients, can promote the development of "therapeutic" relationships. This task requires that forensic nurses increase both their knowledge and competence. Increasing the knowledge about the therapeutic relationship, and the therapeutic process is relatively easy compared to achieving competence. Clinical competence requires personal resources, as well as professional knowledge. Personal resources include a self-awareness that is greater than knowing personal values and biases, and includes an awareness of personal needs and expectations held of patients, in addition to what is felt, and what is occurring within the nurse during interactions with patients. Self-awareness enhances the individual's ability to self-nurture (Peplau, 1952) and withstand the anxiety or stress associated with "therapeutic" relationships. While ability can be demonstrated outside of the context of the relationship, clinical competence can only be evaluated and achieved within the context of the relationship. Consequently, clinical supervision emphasizing professional development, where forensic nurses feel free to examine their reactions to patients, and explore the duality of their roles, is essential to the development of clinical competence. In essence, forensic psychiatric nurses must practice from both their heads and their hearts.

Working in forensic settings may require that nurses periodically assume a role of security enforcer, or implement policies and carry out procedures, for the purpose of maintaining control and safety of the institution. Given that assuming a role of security
enforcer clearly hindered the development of “therapeutic” relationships, with at least some of the participants, it is essential that forensic nurses examine their roles and the impact of assuming dual roles on the “therapeutic” relationship. Clearly, the therapeutic relationship should be a priority for forensic nurses.

Social control is often an unapprised aspect of the role of forensic nurses. Consequently, the challenges that nurses face in establishing “therapeutic” relationships with forensic patients is often attributed solely to a lack of desire, skills, or knowledge on the part of the nurse, or to the patient’s pathology (Melia, et. al., 1999). More realistically, the challenge that forensic nurses face in establishing “therapeutic” relationships and maintaining therapeutic boundaries with forensic patients is more complex. As Glenister (1997) asserted, mental health nurses must examine the role of coercion and control in their work. However, as Glenister also points out, the primacy of caring in nursing, the assumption of the therapeutic nature of nursing, and nursing vocabulary, promotes denial of the role of social control in mental health nursing, and restricts the examination of the roles of control and coercion.

Like me, many forensic nurses have experienced the anguish of facing the discrepancy between their practice and the view of nursing as caring. Perhaps my preference to define my role in terms of being therapeutic rather than caring, is as Glenister charges, a euphemism for coercion. Clearly, the “therapeutic” relationship cannot be considered in isolation of the sociocultural context. The challenge that forensic nurses face in establishing therapeutic relationships and maintaining therapeutic boundaries, must be considered in relation to the roles that institutions require forensic nurses to fulfill. What are the institutional expectations of nurses – to
establish therapeutic relationships or to be control agents? If nurses, by virtue of their hours of work, are required more so than other professional disciplines to fulfill roles contributing to institutional control, is it realistic to expect that nurses will be able to establish therapeutic relationships with their patients? Lastly, how can institutions assist nurses to manage the duality of their role?

Nurses are often asked fulfill roles to meet institutional requirements. Nurses may be deployed or floated to a unit where there is a staffing shortage. Deployed nurses are virtually inaccessible to their assigned patients. Scheduled appointments may be cancelled or postponed, and nurses may not be present for interdisciplinary team conferences, or the treatment milestones that mark the patient’s progress in the treatment program. “Not being there” hinders the development of therapeutic relationships. Clearly, employers need to make every effort to ensure that nurses, as primary therapists, are accessible to their assigned patients. If deployment of nurses is unavoidable, at a minimum, provisions must be made for nurses to be able to maintain scheduled appointments with those patients for whom they are primary therapists. Additionally, nurses aware of the current status of their therapeutic relationships with their patients need to advise employers of the potential consequences of being inaccessible to their patients.

In addition to scheduling nursing staff in order to ensure that they are accessible to the patients for whom they are primary therapists, employers can also promote the development of therapeutic relationships through the development of interdisciplinary teams where professional boundaries are respected. Whenever possible, nurses and other mental health professionals should not be asked to fulfill security functions. The
consequences of dual roles (therapeutic and custodial) on therapeutic relationships is greater than the benefits associated with having all treatment team members fulfill functions that are primarily security functions.

Managers also need to be aware of the impact of institutional dynamics on nurses. What may appear to be a lack of interest in therapeutic or clinical involvement with patients, and a preference for activities associated with the operation of the institution, may be, as Fisher (1995) discovered, the result of an ethical problem that nurses face. Nurses work in close proximity to security officers. During evenings and weekends they work side-by-side without the benefit of being able to consult with other interdisciplinary team members. They depend on one another for personal safety in the event of an incident. It is this dependence on one another for safety that Fisher discovered was the reason why nurses, who wanted to promote the therapeutic interests of the patient, made decisions that were not in the patient’s best interest. Instead, nurses made decisions that met their need to get along with colleagues, and more importantly, have the assurance of their safety in case of an emergency. Clearly, nurses need to know that they have the support of their managers to advocate for the therapeutic interests of the patients, and their roles as primary therapists. Additionally, the development of interdisciplinary teams where professional boundaries are clearly defined would promote supportive collegial relationships between disciplines, where the expert knowledge of each discipline is respected, where nurses would be free to advocate for the therapeutic interests of their patients without the fear of losing the support of their colleagues.
7.5 Nursing Education

As forensic psychiatric nursing grows and gains recognition as a specialty, forensic psychiatric nursing courses are also emerging. In terms of the findings of this research, the study of therapeutic relationships is deemed an essential course topic, and clinical supervision, a necessary course component. Clinical competence is specific to the clinical situation and does not develop in a vacuum. Forensic nursing students need clinical experience in the forensic milieu, complete with clinical supervision, to assist them to achieve an entry level of competence.

Nursing programs are often based on process orientated curriculums, where students learn and experience caring as being the essence of nursing (University of Saskatchewan & Saskatchewan Institute of Applied Science and Technology, 1997). Caring is often promoted as a universal concept, a concept distinguishing nursing from other health care professionals, and applicable to all clinical settings. Pillete et. al. (1995) argued that this emphasis on caring in nursing has resulted in a need for nurses to be seen as caring, thereby interfering with their ability to establish therapeutic boundaries. In the forensic setting, the need to maintain a caring practice may lead to restricted practice styles that stunts the psychotherapeutic process. If caring is to be used as a concept to guide nursing practice, then caring needs to be defined in terms of the clinical area of practice, where the essential knowledge and skills are identified, which becomes the foundation of a caring practice.

Nursing education needs to ensure that nursing students are well prepared for forensic clinical experiences. Often, setting limits and boundary guidelines are emphasized in isolation of the therapeutic process. "Focusing exclusively on
boundaries and ethical conduct leave the clinician vulnerable, unprepared, and often confused about techniques to handle these issues” (Bridges, 1995, p.338). This research indicates that therapeutic relationships, anxiety, self-awareness, patterns of interacting, gender issues, and power are among the essential concepts to guide forensic nurses in the establishment and maintenance of “therapeutic” relationships and therapeutic boundaries. Nursing students require an understanding of these concepts, including the ability to apply them in their clinical practice.

Involvement in continuing education is also a necessity for practicing forensic nurses, not only to develop and maintain their skills, but also to develop continuing educational programs to meet the needs of nurses entering the specialty of forensic psychiatric nursing.

Currently, a certification program within the Canadian Nurses Association is nonexistent in forensic psychiatric nursing. However, as forensic psychiatric nursing acquires recognition as a specialty the need to develop a certification program grows. In terms of the findings of this research, nurses need to be more than knowledgeable. They must be able to develop therapeutic relationships with forensic patients. Thus, it is essential that a period of clinical supervision be a mandatory component of certification. If certification is based exclusively on a knowledge based examination and continued education, then forensic psychiatric nursing risks potentiating the gap between knowledge and ability.

7.6 Nursing Research

This research has demonstrated the complexity of therapeutic relationships with forensic patients, the relationship between the therapist’s resources and the relationships
that develop, and the importance of the context of treatment. Additionally, the findings of this research have provided support for Peplau's (1952) conceptualization of the therapeutic relationship. However, there are many questions that merit further investigation: 1) does the gender of the nurse influence the participants’ perception of the nurse?; 2) what is the influence of negative processes, such as hostility, on the relationships that develop?; 3) what is the experience of expert forensic nurses in the development of therapeutic relationships and boundary maintenance?; 4) is there a relationship between the therapeutic self view forensic nurses hold and the relationships that they develop?; 5) how does forensic nursing literature on the therapeutic relationship depict forensic patients and nurses (is the view of nurses as victims and forensic patients as responsible for boundary violations perpetuated)?; 6) what is the relationship between personal boundaries or maturity and the establishment and maintenance of therapeutic boundaries?; 7) is there a relationship between personal boundaries of the nurse, and patient outcomes?; 8) what is the relationship between personal boundaries of the patient, the nurse, the relationship that develops, and patient outcomes? 9) how does self assessment of boundary maintenance influence the nurses actions?; 10) what is the forensic nurses’ experiences of social control as an aspect of their work?; and 11) what is the forensic nurses’ perspective of contextual factors in their practice that enhances or hinders their development of therapeutic relationships with their patients?

7.7 Suggestions from the Participants

A secondary purpose of this study was to give the participants an opportunity to share their experiences. The following hypothetical letter, composed by the researcher,
represents the collective and candid responses of the participants' experiences that were shared over the course of the research.

Dear Forensic Nurse and Researcher,

Adjusting to the treatment environment and the therapeutic relationship is a challenge for us. Initially the friendliness of all staff at RPC is confusing and reason for suspicion. For many of us such frequent friendly contact with staff, particularly attractive attentive females, is new, and although not unwelcome is awkward. With time we come to see that we are not being set up and that no one means us harm. We come to believe in your good intentions. We are, however, afraid to be vulnerable with you, while recognizing that trusting you is the only way to complete the program. The intention of the following suggestions is not to make you feel bad or to insult your professional integrity. Instead it is our hope to enlighten you regarding our perspective. Let our words be a gift to you, given in recognition of all you do to help us, and with an awareness of your commitment to continually improving the treatment you provide.

Recognize the power you hold. You hold the key to our futures. We may not act or look like we are vulnerable but we are. Our desire to return to our communities and families colors our worlds. We are likely to do what it takes to get a good report, one that will take us one step closer to home. We trust in you to lead us in the right direction. When the direction is not clear we may assume that being respectful and not causing you trouble is what it takes to get a good report, but we are not sure. Don't sit on our back, and hold out a carrot in front of us, and not tell us where we are headed. It is demeaning. Let us know what we are aiming for, where we are going. Be sure to let us know when we are not on track, and give us meaningful feedback. It is nice to hear we are doing awesome, but when everything is awesome to you, we worry that we are not receiving the feedback we need to reach our goals and stay out of jail.

We recognize that we may not always seem grateful for the feedback we receive. However, we ask that you take a risk and be direct with us. It is frustrating when we can see that you are not being direct. It tells us that you have little confidence in our ability to consider what you have to say, that you may be afraid of us, that you think we are fragile, or that perhaps you are overly concerned about being nice. Know that we are not made of glass, that we will not break.

Recognize that although we have irrational thoughts, we are not totally irrational. If we cross the line, believing that the relationship we have with you goes beyond our roles (as patient and nurse), recognize your influence on the relationship that has emerged. Let us know that we have crossed the line, and, by all means, set us straight. No one tells us where our boundaries are, or where the line is drawn. Not knowing we assume the responsibility is yours. Yet it seems we are held responsible to maintain a line we cannot see. Betrayal and confusion are the least of the consequences that we face when a line is crossed. We know of others before us who have been shipped out and lost the opportunity to complete their treatment. We also know of
romantic relationships between nurses and patients that have developed. Generally, we know the risk is not worth the consequences, but the opportunity to be other than an inmate, and to be a gentleman, can be a seductive pull for some of us.

Even the prospect of intelligent conversation is appealing. Relationships where we can be equals with you and talk about something other than drugs, and crime is what we may want. And though some us may protest when you insist on keeping the focus on our treatment, know that by being consistent you show us the window of opportunity that treatment can be. We come to welcome a relationship where nothing is expected of us other than to use the time together to help ourselves. It sounds selfish, but it feels wonderful. Here we learn more than how to challenge our distorted thoughts, you show us a way of being with others that we want to take with us to our relationships with others.

Remember that touch is foreign to some of us. If your shoulder brushes my chest as you lean towards me making a funny comment, it is nice but awkward. Who is watching, how will it be interpreted, and who can initiate touch, are all questions that touching raises for some of us. Yes, our perceptions may be distorted. Knowing this about us, is it not advisable to limit touching to shaking our hands? Or at least be prepared to discuss touch with us, and if we have misinterpreted it, assist us to understand.

Some of us like to know a little about you. It helps to reduce the inequality we feel in our relationship. Even sharing a past personal experience may help us, but sharing your current problems with us may provoke a desire in us to be your hero, or diminishes our perception of you as able to help. Be careful, some of you play with fire, and are crossing the line when you disclose too much. There are a few among us who are playing the game, and may be looking to exploit you.

Listening and being there for the significant periods in our treatment tells us you are interested in us and not just your pay cheque. Know that if you are not there we may not challenge you to work with us. We have not all come out of a desire to change. Feeling coerced and fearing a negative report we may just go with the flow, stay out of your way, not cause you too much trouble, and hope for the best.

Listening to us makes us feel like we have a voice, when you include our perspective in your reports we know we have been heard and that our interests in the treatment process recognized. To have no voice is to be nobody. Listen to us; let us know that we are more than a number to you.

Be sensitive to cultural difference. Accept that for some of us a traditional approach to healing is more comfortable. We benefit from your program, but struggle to find a balance between the ABC Program, Aboriginal Programs, and ourselves. Show us that you are prepared to meet us half way. It helps us to accept you.
Remember you are a nurse and not a guard. It undermines your creditability with some of us when you issue an offense report. Let the officer on the unit do their job, you do yours.

Know that we watch you to see if you are consistent with what you say. Your credibility with us is reduced when you tell us that smoking is bad for you and yet you smoke yourself.

To the researcher, what is wrong with using our names? Why must we sign transcript releases for each taped interview? All we have is our word. We know what we say and would not tell you things that we do not want you to use in your study. Having us sign transcript releases undermines the agreement that we have entered into with you. We wonder if you see us as incompetent. For some of us participating in your study was one of the few things that we have done in our lives that was not about us. When you don't use our names you take ownership away from us.

Respectfully submitted for your consideration.

The participants.

7.8 Epilogue

The purpose of this study was to capture the perspective of forensic patients' enrolled in the ABC treatment program regarding therapeutic relationships, and particularly therapeutic boundary maintenance. The reader is reminded that this study reflects my interpretation of the participants' experiences and their validation of that interpretation. The constructed reality presented here fails to represent other realities equally as valid and true. Readers must bring their own understanding and interpretation to the participants' experiences.

Reflecting on the process of this study, I am struck by what I learned from the participants. I have gained a greater appreciation for the vulnerability of the participants. From their perspective I am reminded of the value of caring and the importance of knowledge.
I was delighted when I saw illustrations of how therapeutic boundaries protect the psychotherapeutic process, but equally disappointed when these descriptions stemmed from participants who had not met the inclusion criteria of having a nurse as a primary therapist. As the study progressed I grew uncomfortable referring to therapeutic boundaries as the relationship boundaries in the nurse-patient relationship, and the nurse-patient relationship as a “therapeutic” relationship. My conviction to continue my own professional development grew, and I became even more convinced of the need to promote the professional development of my colleagues. The question I face now is: How do I proceed?

I encountered my greatest struggle in reporting my findings. Although I had been coding and analyzing the data as the study progressed, the findings remained uncertain. Putting the findings down on paper finalized them and concluded the study, and I was certain that there was still more to learn. Also, I wanted to be certain that I had interpreted the findings accurately, and that I was not misrepresenting the experiences of the participants. I wanted to be sure to represent the uniqueness of each participant’s experience. It seemed that differences within the categories of relationships were beginning to emerge. Although, beyond the requirements of this study as a thesis project, further data collection may have revealed the factors distinguishing relationships within categories.

I am grateful to the participants who shared their experiences with me. While some participated for the opportunity to practice “being open and honest” with someone new, others participated hoping to earn “brownie points” for the primary therapist. Finally, there are likely those who participated to pass the time as diversion from their
regular routines. Despite their reason for participating I learned from each and every word and through each and every interaction.
References


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Appendix A

Letter of Introduction

Penny Schafer is a nurse who has worked at the RPC since 1985. She is presently conducting a study in order to complete a Masters degree in nursing. Penny is studying boundary maintenance in the therapeutic relationship (or helping relationship) from the patient's point of view. Boundaries are often thought of as limits or margins. Boundary maintenance in the helping relationship is about the limits or margins that mark the point where the helping relationship begins and ends.

This study will give you a chance to express your thoughts and feelings about boundary maintenance in the helping relationship. Participation in this study is voluntary. There are no disadvantages for those who choose not to participate. If you chose to participate you will be providing information that might help nurses build helping relationships with future patients.

If you are interested in participating in this study or would like more information you can contact Penny by submitting a request for an interview with her and forwarding it to Assiniboine unit. Please indicate on the request if you do not wish to be interviewed on the unit. If you are not comfortable being interviewed on the unit Penny with arrange to see you in another area.

Thank you,

Penny Schafer
Appendix B

Consent Form

Study Title: Therapeutic Boundary Maintenance: The Perspective of Forensic Patients Enrolled in the Aggressive Behaviour Control Program. This study was formerly entitle: The Forensic Patient’s Perspective on Boundary Maintenance in the Nurse-Patient Therapeutic Relationship: A Naturalistic Inquiry

Researcher: Penny E. Schafer BSN RN
University of Saskatchewan
College of Nursing
966-6255

Supervisor: Cindy Peternelj-Taylor RN, BScN, MSc, Professor
University of Saskatchewan
College of Nursing
966-6238

Penny is studying boundary maintenance in the therapeutic relationship or helping relationship from the patient’s point of view. Boundaries are often thought of as limits or margins. Boundary maintenance in the helping relationship is about the limits or margins that mark the point where the helping relationship begins and ends.

This study will give you a chance to express your thoughts and feelings about boundary maintenance in the helping relationship. Sharing your thoughts and feelings about helping relationships may bring up past feelings. The researcher will arrange for follow-up with a member of your treatment team should your require support. If you chose to participate, you will be providing information that might help nurses build helping relationships with future patients.

You will be asked to have three interviews with Penny. The first two interviews will be tape-recorded. The third interview will be for reviewing a draft copy of the report. The first interview may be from one to two hours long. The second and third interviews will be about an hour long. A written copy of the first interview, and Penny’s thoughts about the key points in the first interview, will be made available to you during the second interview.

Your medical file at the Regional Psychiatric Centre (RPC) will be reviewed to find the dates that you were at the RPC, your date of birth and any psychiatric diagnosis.

Your participation in this study is voluntary. You can stop participating at any time. If you stop participating any information you have given will be returned to you. There are no consequences to you should you wish to stop participating in the study.
Your name will not be associated with the responses you give. Your responses will be coded with an identification number known only to Penny. Penny shall keep a list of the identification numbers and names locked in her office at the University of Saskatchewan. All other study information that you share will be collected by Penny and stored under lock and key in Cindy Peternelj-Taylor’s office at the University of Saskatchewan for five years after the study is completed.

Although Penny will not be sharing your name with RPC treatment or security staff, they may conclude that you are participating in this study based on their observations of your interviews with Penny.

Your responses will be used only for purposes of this study with the following exceptions:
- If the researcher is ordered by a Court of Law to release the information
- Or failure to share the information would jeopardize the safety of the participant, others, or the institution.

The results of the study will be reported to the University of Saskatchewan, and may be written up for publication in professional journals or presentation at professional conferences. Statements that you made during your interviews may be used in the reporting of the results. However, your name will not be used.

If you have any questions regarding this study you may contact Penny Schafer at the Regional Psychiatric Centre Prairies on the Assinboine unit, Cindy Peternelj-Taylor at (306) 966-6238, or the University of Saskatchewan, Research Services at (306) 966-4057.

I would like a report summarizing the findings of this study.

I have read this consent form and voluntarily consent to participate in this study. A copy of the consent form has been given to me for my personal records.

__________________________________________  
Participant’s Signature                      Date

I have explained this study to the above participant and have sought his understanding for informed consent.

__________________________________________  
Researcher’s Signature                      Date
Appendix C
Transcript Release Form

Researcher: Penny E. Schafer BSN RN
University of Saskatchewan
College of Nursing
966-6255
Supervisor: Cindy Peternelj-Taylor RN, BScN, MSc, Professor
University of Saskatchewan
College of Nursing
966-6238

I was given a chance to review a complete written copy of my personal interview in this study, and acknowledge that the written copy accurately reflects what I said in my personal interview with Penny Schafer. I hereby authorize the release of this written copy to Penny Schafer to be used in the manner described in the consent form.

_____ The following data, identified by page and line number of the written copy of the interview, cannot be used in this study.

Participant’s Signature
Date

Researcher’s Signature
Date
Appendix D

Interview questions

1) Tell me about your experience with treatment at RPC?
   - Describe what that is like.

2) Tell me about your experience with your primary nurse.
   - What is it like to be in an interview with your primary nurse?
   - What is it like to be in a group that your primary nurse is leading?
   - What are some of the experiences that you have had with your primary nurse?
   - What is that like for you?
   - How do you find these experiences?
   - Tell me about interactions with your primary nurse outside of groups or interviews?

3) Describe your relationship with your primary nurse.
   - Are you able to discuss what it is that you would like to discuss in interviews with your primary nurse?
   - What topics do you bring up in interviews?
   - What is this like for you?

4) What have you learned about your relationship with your primary nurse?
   - How did you learn this?

5) Do you have concerns about your relationship with your primary nurse?
   - What are your concerns?
   - What do you do when you have a concern regarding your relationship with your primary nurse?
Appendix E

Revised Interview Questions

1) Tell me about your experience with treatment at RPC?
   - Describe what that is like.

2) Tell me about your experience with your primary nurse.
   - What is it like to be in an interview with your primary nurse?
   - What is it like to be in a group that your primary nurse is leading?
   - What are some of the experiences that you have had with your primary nurse?
   - What is that like for you?
   - How do you find these experiences?
   - Tell me about seeing your primary nurse outside of groups or interviews?

3) Describe your relationship with your primary nurse.
   - What topics do you bring up in interviews?
   - What is this like for you?

4) What have you learned about your relationship with your primary nurse?
   - How did you learn this?

5) What are your concerns about your relationship with your primary nurse?
   - What do you do when you have a concern regarding your relationship with your primary nurse?

6) What is it like for you to be assigned a primary nurse of the same or opposite sex?
   Tell me about attraction.
Appendix F
Diagram Shared with the Participants During Member Checks

The Treatment Environment/Atmosphere

Participant Entering Treatment Environment

- Learning and knowing the Treatment Environment
- Adjusting to the Treatment Environment
- Assessing the Primary Therapist

→ Head

Head and Heart

→ Heart

→ Wallet

- Expert Knowledge of Nurse
- Safety in Being Right
- No Relationship Struggle
- Seeks Out Others

- Good Feelings of the Nurse
- Safety in Liking Nurse (protecting)
- 3rd Party Sets Limits on Relationship
- Discomfort & Confusion Responsible

- Treatment Needs of the Participant
- Safety in the Relationship
- Therapist Establishes Limits
- Comfort Partnership Negotiation

- Passing Time
- Safety in Distance
- Expectations and Limits Unclear
- Accept Relationship as Presented
Feedback Sheet

This report captured the information that I shared with Penny Schafer regarding my experience with boundary maintenance in the therapeutic relationship as I experienced it during the time I was at RPC.

This report does not capture the information that I shared with Penny Schafer regarding my experience with boundary maintenance in the therapeutic relationship as I experienced it during the time I was at RPC.

The following was not captured:

You can reach Penny Schafer at 975-5400 if you wish to discuss this report in greater detail.
Appendix I

Conceptual Map

Arriving at the House
- Adjusting to New Relationships with CSC Staff
- Achieving a Balance between Cultural Beliefs and the ABC Program
- Evaluating Expectations and Experience
- Level of Motivation or Degree of Coercion

Knowing the Fundamental Structures of the House
- Time
- Power
- Gender
- Living with Regulations
- The Value of Learning

Developing Relationships

Evaluating the Primary Therapist as a Guide
- Testing for Integrity
- Monitoring Consistency
- Gathering Reports from Others
- Finding Similarities

Experiences that Promote or Hinder the Relationship
- Being or Not Being There
- No Voice or Being Heard
- Feeling Objectified
- Receiving or Not Receiving Feedback
- Modifying their Approach
- A Clear and Shared Objective
- Cultural Insensitivity or Cultural Sensitivity
- Defining Roles

Ways of Being with the Primary Therapist
- The Head
- The Heart
- The Head and Heart
- The Wallet

Focus of the Relationship
- Finding Comfort and Safety
- Establishing Boundaries
- Valuing Self-Disclosure (Hearts)