CIRCLES OF SUPPORT AND ACCOUNTABILITY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE NATURE OF THE RELATIONSHIP BETWEEN VOLUNTEERS AND THE CORE MEMBER

by

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A THESIS SUBMITTED TO THE UNIVERSITY OF BIRMINGHAM FOR THE DEGREE OF DOCTOR OF FORENSIC CLINICAL PSYCHOLOGY

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June 2018

Thesis Overview

This thesis was submitted as part of the Doctorate in Forensic Clinical Psychology at

the School of Psychology, University of Birmingham. It comprises of two volumes. The first volume is the research component and includes an empirical study and a review of the literature. The second volume is the clinical component and includes five Forensic Clinical Practice Reports (FCPR).

Volume I: Research Component

Volume I of this thesis consists of a systematic literature review and an empirical paper. The literature review evaluates research on the use of third wave cognitive behaviour therapy (CBT) in forensic mental health settings. The empirical paper presents a qualitative study exploring the experiences of volunteers working with Circles of Support and Accountability (CoSA), a community based initiative that uses volunteers to support newly released individuals who have committed sexual offences to reintegrate back into society.

Volume II: Clinical Component

Volume II of this thesis consists of five Forensic Clinical Practice Reports. FCPR 1 presents a cognitive behavioural and a behavioural formulation of a 31-year-old male forensic patient with a diagnosis of bipolar affective disorder. FCPR 2 is a service evaluation assessing levels of relational security across a medium secure hospital. FCPR 3 reports a single case experimental design used to evaluate the effectiveness of CBT with a 19-year-old male with Autism Spectrum Disorder and health anxiety. FCPR 4 presents a case study of 11-year-old boy with a phobia of buttons and FCPR 5 was an oral case study of an adult male forensic patient with diagnosis of paranoid schizophrenia.

Dedication

This is dedicated to my parents, my family and my partner.

Thank you for everything.

Acknowledgements

I would like to acknowledge a number of people who have supported me throughout my training. First and foremost, I would like to thank my parents, Anita and Sean (RIP), and my sister, Danielle and brother Andrew for their support and encouragement.

I would also like to say a special thanks to my partner, Juliane for her patience and support.

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I would also like to thank our Course Director, Professor John Rose and everyone on both the clinical and forensic course teams for their hard work and guidance throughout my training.

Finally, I would like to thank Circles of Support and Accountability for giving me the opportunity to do this piece of research. I would like to give special thanks to Professor Anthony Beech, Steve Davis, and Dr Caroline Oliver for their support and guidance on my research.

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Abstract

Introduction

The rehabilitation and management of mentally ill offenders represents a significant challenge for secure facilities and is an important issue for public safety. Considering the high financial costs associated with secure care and the complex clinical presentations of forensic patients, the importance of ensuring that the most effective and evidence-based treatment practices are in place is both an issue of ethical and fiscal concern. Over the past decade, there has been a shift within psychology to a 'third wave' of Cognitive Behavioural Therapy (CBT).

The aim of this systematic review is to review the current evidence for the use of this third wave CBT in forensic mental health settings, with a view to assessing its current impact as well as discussing the potential benefits such an approach might bring

Method

A systematic search for studies involving third wave CBT in forensic mental health settings was conducted

Results

A total of nine papers were included in the review. The review focussed on Acceptance and Commitment therapy, Dialectical Behaviour Therapy, Meta Cognitive Therapy, and Compassion Focussed Therapy. Overall, the quality of the studies that met the inclusion criteria was assessed as ‘fair’.

Conclusion

The findings across the nine studies evaluated, suggest that third wave therapies may be effective in forensic settings, however the evidence base is in its infancy and therefore further research is required before this can be concluded with more confidence.

Background

The rehabilitation and management of mentally ill offenders represents a significant challenge for secure facilities and is an important issue for public safety. According to the National Health Service (NHS), in 2013, Commissioners in England purchased approximately 7719 inpatient beds in high, medium, and low secure mental health services (NHS, 2013). The average cost per annum of keeping a patient in a low secure facility has been estimated at £152,000, rising to £273,000 per patient residing in high secure (Durcan, Hoare, & Cumming, 2011). Individuals who are detained in secure care under the Mental Health Act (1983/2007) will typically have complex mental disorders linked to offending behaviour and often present with co-morbid substance misuse and/or personality disorders (NHS, 2013). Considering the high financial costs associated with secure care and the complex clinical presentations of forensic patients, the importance of ensuring that the most effective and evidence-based treatment practices are in place is both an issue of ethical and fiscal concern.

Historically, a medical model of treatment has been dominant over psychological approaches in such settings (Witharana & Adshead, 2007). However, as a result of changes within general mental health, as well as support from the increasing evidence base for the efficacy of psychological therapies (e.g. NICE Guidelines), the use of psychotherapy to treat mentally ill offenders has increased significantly. Cognitive Behavioural Therapy (CBT; Beck, 1967) has been central to this increase in psychotherapeutic interventions and, although lacking a strong evidence base specific to a forensic population, the efficacy of CBT approaches across non-secure settings has

provided a useful framework for practitioners and services on which to base their interventions.

Cognitive Behavioural Therapy in Secure Settings.

Treatment interventions and offender rehabilitation programmes in secure settings over the past 20 years have largely been based on a 'second wave' CBT model, with an emphasis on psycho-education and altering maladaptive cognitions (Howells, Tennant, Day, & Elmer, 2010). In this respect, forensic practice has been heavily influenced by both clinical psychology and the 'What Works' movement in offender rehabilitation (Hollin & Palmer, 2006). Second wave CBT philosophy currently informs many offender rehabilitation programmes, including sexual offending (Beech, Fisher, & Beckett, 1999), violent offending (Tew, Harkins, & Dixon, 2013), arson-related offending (Gannon, Lockerbie & Tyler, 2012), and general offending (McGuire, 2006). Within these programmes, one of the suggested key mechanisms of change is the restructuring of cognitive distortions, whereby offenders are taught to challenge their maladaptive thoughts and beliefs (Shonin, Van Gordon, Slade, & Griffiths, 2013). Although many of the above offender rehabilitation programmes have been evaluated and found to be effective in reducing recidivism, Wright, Day, and Howells (2009) suggest that while some interventions have an implicit requirement for self-awareness and insight at their core, many do not specifically develop these skills explicitly. Critics of ‘traditional’ CBT also point to the fact that often therapeutic change occurs before cognitions are altered (Longmore & Worrell, 2007), and that changes in dysfunctional beliefs do not always correlate well with therapeutic improvement (Burns & Spangler, 2001). This suggests that

while traditional CBT may be producing positive outcomes, less is probably understood about the mechanisms of change that are taking place.

Over the past decade, there has been a shift within clinical psychology to a 'third wave' of CBT, characterised by a move from first order change (i.e. changing cognitions) to second order change (i.e., changing the emotional context within which negative cognitions function; Witharana & Adshead, 2013), as well as a focus on indirect experiential strategies rather than direct strategies to bring about change. In an editorial, Howells et al. (2010) questions whether the forensic model of CBT is up-to-date, and suggests that the field has been slow to incorporate third wave CBT philosophies into its practices. He concludes that "there is a demonstrable need for forensic practitioners to be aware of the rapid progress and accumulating evidence for third-wave therapies" (Howells et al., 2010, p. 255)

The aim of the present paper is to review the current evidence for the use of third wave CBT in forensic mental health settings, with a view to assessing its current impact as well as discussing the potential benefits such an approach might bring.

Third Wave CBT

The origins of modern day CBT (Beck 1967) are to be found in the so called 'first wave' of behavioural psychotherapies that developed during the early 1950s on both sides of the Atlantic. Hans Eysenck in the United Kindom, alongside Ogden Lindsley in the United States, at almost the same time, inspired by a lack of faith in the efficacy of psychoanalysis, began to develop a therapeutic approach that used the principles of behaviourism (Skinner, 1938) as their foundation and rationale. The new behavioural therapy (BT) claimed to be more scientific than psychoanalysis, and according to Eysenck

was “a method of treatment for neurotic disorders which would regard them as conditioned emotional responses to be extinguished through well-known processes described in all the textbooks of learning and conditioning” (Eysenck, 1997, p. 1136).

In the 1980s, the commitment of BT to the principles of conditioning theory began to wane and gradually the influence of the 'cognitive revolution', that was taking place in psychology, began to take effect. Cognitive psychologists argued that animal models of conditioning were inadequate to explain human learning and that more complex cognitive and emotional factors must also be considered (Miller, 2003). Thus, the 'second wave' of CBT was born and the resulting paradigm shift would become the most enduring and evidence-based psychotherapies in the history of psychology (Baker, 2011). CBT, by combining the principles of Behaviour Therapy and Cognitive Therapy, aimed not only to change overt behaviours but also to modify the underlying thoughts, beliefs and assumptions that support those behaviours (Beck, 1967).

Over the last two decades, psychology has witnessed a 'third wave' of CBT emerge that has seen the existing model incorporate methods influenced by Eastern philosophical traditions (Hayes, 2004). Third wave CBT differs from its predecessor in that it no longer seeks to modify dysfunctional beliefs or assumptions, but instead encourages the individual to observe and accept them (Ost, 2008). An ever-increasing evidence base suggests that such an approach may benefit individuals who struggle with traditional CBT methods, such as thought suppression and challenging negative assumptions (Kahl, Winter, & Schweiger, 2012) as well as resulting in lower attrition rates amongst difficult client groups (Pompoli et al., 2016).

Currently, there is little consensus as to what constitutes a 'third wave' CBT (Hofmann, Sawyer, & Fang, 2010). However, commonalities between third wave therapies include a reduced focus on content-oriented cognitive interventions in favour of developing an individual's awareness of and relationship to their thoughts, as well as a targeting of broader life goals and skills instead of specific symptoms (Taylor, Hailes, & Ong, 2015).

Mindfulness-based interventions. Many of the 'third wave' psychotherapies have been influenced by Buddhist philosophy and this is particularly evident with regards to mindfulness-based interventions (MBI; Kabat-Zinn, 2003). Mindfulness has been operationally defined as being "the awareness that emerges through paying attention on purpose, in the present moment, and nonjudgmentally to the unfolding of experience moment by moment" (Kabat-Zinn, 2003, p. 145). Traditionally, MBIs have been delivered in group format with mindfulness-based stress reduction (MBSR) and mindfulness-based cognitive therapy (MBCT) being the most dominant. A number of other group interventions have also been developed to target specific populations/disorders, such as eating disorders (Wanden-Berghe, Javier, & Wanden-Berghe, 2010), mood disorders (Eisendrath et al., 2008), substance use (Marlatt, 2002), and psychosis (Chadwick, Newman-Taylor, & Abba, 2005). Mindfulness has also been incorporated into other third wave therapies and forms a significant element of ACT and DBT (Shonin et al., 2013). Some of the mechanisms of MBI that have been suggested to lead to therapeutic change include a reduction in arousal levels leading to improved relaxation (Baer, 2003), greater self-awareness resulting in an ability to recognise and therefore regulate one's current emotional state (Gillespie, Mitchell, Fisher, & Beech, 2012), and enhanced self-

acceptance (Dalai Lama, 2005). For the purpose of this review, only interventions that use MBCT and MBSR will be included.

Acceptance and Commitment Therapy. Acceptance and Commitment Therapy (ACT) uses acceptance and mindfulness techniques, as well as commitment and behaviour change strategies to increase 'psychological flexibility' (Hayes et al., 2004). Psychological flexibility is defined as "contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values" (Biglan, Hayes, & Pistorello, 2008, p. 140). Using metaphor and experiential exercises, therapists work with clients to help them accept difficult thoughts and emotions, as well as moving closer to their personal values and fully committing to behaviour change (Hayes, n.d.). ACT is perhaps the best-evidenced of the third wave therapies, and has been found to be successful in treating a wide range of psychological disorders, including anxiety (Roemer & Orsillo, 2005), depression following psychosis (White et al., 2015), psychosis (Bach & Hayes, 2002), substance abuse (Hayes et al., 2004), and personality disorder (Gratz & Gunderson, 2006).

Dialectical Behaviour Therapy. Dialectical Behaviour Therapy (DBT) was originally developed to treat women with Borderline Personality Disorder (BPD). DBT focuses on helping clients change their dysfunctional behaviours and environments, as well as promoting acceptance of their current situation, integrating both acceptance and change through a dialectical process (Linehan, 1993). The treatment model has been found to be effective in treating a wide range of disorders beyond what it was specifically designed for. DBT has been used effectively in working with patients with eating disorders (Telch, Agras, & Linehan, 2001), depression (Lynch, Morse, Mendelson, & Robins, 2003),

ADHD (Hesslinger et al., 2002), and bipolar disorder (Goldstein, Axelson, Birmaher, & Brent, 2007). Some of the key therapeutic elements of DBT include letting go of attachments that are causing distress, being mindful of the present moment, accepting your reality without judgement, and the belief in the principle that everyone possesses wisdom, which is referred to as the 'Wise Mind' in DBT (Linehan, 1993). Unique to DBT, delivery of the therapy also involves a requirement for therapists to form part of a consultation team, whereby therapists 'treat' each other using DBT techniques, with the aim of optimising their delivery of therapy to often difficult-to-treat patients (Robins & Rosenthal, 2011).

Meta-cognitive Therapy. Metacognitive therapy (MCT) is grounded in the principle that worry and rumination are universal processes that result in emotional disorder (Wells & Matthews, 1994). Negative thoughts are viewed as normal and transient experiences that only become problematic when the individual loses the ability to self-regulate and change these thoughts (Wells, 1997). Within MCT, this dysfunctional thinking pattern is referred to as the cognitive attentional syndrome (CAS), and MCT therefore seeks to address this by using attention-training techniques to develop cognitive flexibility, mindfulness, as well as using behavioural experiments to challenge assumptions (Wells, 2008). Similar to other third wave therapies, MCT avoids attempting to change the content of an individual's cognitions. MCT has been found to be successful in treating individuals with depression (Wells et al., 2009), Post-Traumatic Stress Disorder (PTSD; Wells & Sembi, 2004), obsessive compulsive disorder (Fisher & Wells, 2005), and anxiety (Wells et al., 2010).

Compassion Focussed Therapy. Compassion focussed therapy (CFT), by applying a compassion model to psychotherapy (Gilbert, 2005), seeks to develop an individual's ability to act compassionately and, in doing so, to care for their own well-being and extend a greater warmth and understanding towards themselves (Gilbert, 2009). CFT has been described as a multi-modal psychotherapy and, as well as being influenced by Buddhist psychology, it also has a strong grounding in evolutionary psychology, and how and why humans experience suffering (Gilbert, 2005). Using techniques such as compassionate mind training, meditation, self-soothing strategies and behavioural interventions, individuals are supported in building their capacity to experience self-compassion and to care for their own wellbeing. CFT was developed specifically to treat individuals with high levels of both shame and self-criticism, but there is growing evidence that CFT can have a positive impact on psychological well-being across a number of client groups (Neff & Germer, 2013). Studies have shown it to be effective in treating individuals with a personality disorder (Lucre & Cortin, 2012), psychosis (Laithwaite et al., 2009), bipolar disorder (Lowens, 2010), eating disorders (Goss & Allen, 2010), and schizophrenia (Ellerby, 2016).

Behavioural Activation. Behavioural Activation (BA) has traditionally been used in the treatment of depression (Martell et al., 2001), although more recently studies have begun to demonstrate its efficacy in other areas, including PTSD (Jakupcak et al., 2007), substance use (Daughters et al., 2008), and anxiety (Barlow, Allen, & Choate, 2004). BA seeks to target approach goals (e.g., 'living a good life') rather than eliminative goals (e.g. symptom reduction), teaching clients to be present through mindfulness and to accept rather than fight their negative emotions (Kanter et al., 2008). Activation is central to BA,

whereby engagement in pleasurable activities that bring a sense of mastery, and a client closer to their life goals, are encouraged. Within BA, clients are taught to understand and recognise avoidance behaviours, and to view them as short-term negative reinforcers (Kanter, Baruch, & Gaynor, 2006). BA therapists do not attempt to change a client's negative thoughts but instead work from the outside in (Jacobson & Gortner, 2000), in order to teach them to shift their attention away from such thoughts towards their more immediate experience in the here and now (Hopko et al., 2003).

Functional Analytic Psychotherapy. Functional Analytic Psychotherapy (FAP) has been described as a relational based psychotherapy that is grounded in behavioural principles (Wetterneck & Hart, 2012). FAP asserts that the therapeutic relationship is fundamental to the change process and uses here and now therapist-client interactions to promote and reinforce adaptive behaviour change (Tsai, Yard, & Kohlenberg, 2014). Key aspects of FAP include the therapist seeking to experience their client's problems within session, to better understand them, and for the therapist to have the client's goal behaviours within their own skill repertoire, (e.g., interpersonal relating skills). The suggested mechanism of change within FAP is the contingent responses of the therapist to client behaviours within session, which results in positive behaviour change that is then transferred to the outside world (Tsai et al., 2009). FAP has been used successfully to treat a wide range of client groups and disorders, including depression (Kohlenberg et al., 2002), personality disorder (Callaghan, Summers, & Weidman, 2003), and trauma (Kohlenberg, Tsai, & Kohlenberg, 2006).

Criticisms of Third Wave CBT. Using criteria developed by the American Psychological Association (APA) for empirically-supported therapies (Chambless et al.,

1998), Ost (2008) conducted a comprehensive meta-analysis that included 29 RCTs involving five third wave therapies and concluded that none met the required criteria such as two between-group design experiments and experiments being completed with treatment manuals. Methodologically, studies involving third wave therapies were also reported as being less stringent than CBT studies published in similar journals. The review also highlighted the low publication rate associated with third wave therapy (e.g. mean number of RCTs per year, >10 years after the publication of treatment manuals: FAP 0, ACT 1.6, and DBT .9; Ost, 2008). The review acknowledged that third wave therapies were newer and more recent than traditional CBT but pointed out that a therapy can only be viewed as "young and promising" for so long (Ost, 2008).

Despite these initial criticisms that third wave studies lack methodological rigour and did not meet the criteria for Empirically Supported Therapies (EST) (Chambless & Hollon, 1998; Ost, 2008), more recent reviews of third wave CBT have demonstrated its efficacy in treating a number of disorders across a wide range of settings (Kahl et al., 2012). A more recent meta-analysis applied the EST criterion of at least two RCTs of sufficient quality (e.g., high treatment adherence, and reliable and valid outcome measures), and size (25-30 per condition) and concluded that all but one of the third wave therapies that were included, fulfilled this requirement (Kahl et al., 2012).

Hofmann, Sawyer, and Fang (2010) have also argued that, on a technical level, there is insufficient evidence regarding mechanisms of action to even differentiate between second and third wave therapies. Using ACT and traditional CBT as an example, they suggest that while theoretical differences exist regarding how cognitions are viewed, both use very similar techniques including exposure, role play, being aware of one's

thoughts and feelings without being controlled by them, goal setting and between session work. Hofmann and Asmundson (2007) also question the validity of a so called third wave, citing personal correspondences from the founders of MCT and DBT, who refute the claim that their therapies are even part of the movement, instead seeing them more as extensions of CBT.

A number of studies have attempted to assess whether third wave therapies are more effective than second wave therapies (Kahl et al., 2012; Ost, 2008). Assessing the effectiveness of one form of therapy over another is a challenging endeavor due in part to the fact that therapeutic outcome is often said to be less influenced by what modality is employed and more by other factors such as therapeutic alliance (Miller, Hubble, & Duncan, 2007). Several studies have compared the efficacy of ACT versus traditional CBT, with a recently conducted meta-analysis looking at 16 RCT studies comparing the two treatments, concluding that ACT performed slightly better on primary outcomes, equally as good at reducing anxiety symptoms, and possibly better at reducing symptoms of depression (Ruiz, 2012). Kahl et al. (2012) suggest that third wave CBT is perhaps more strongly rooted in psychological science and our understanding of psychological mechanisms than second wave. Examples such as metacognition, thought suppression, and experiential avoidance are given as evidence for this, along with the strong relationship third wave therapies such as ACT have with learning theory.

The National Institute for Health and Care Excellence (NICE) now recommends third wave CBT interventions such as mindfulness, ACT, MCT, DBT, and BA, for a wide range of disorders, including depression, anxiety and personality disorder (NICE, 2012). Given the increasing popularity of third wave CBT approaches and the growing evidence

base, a comprehensive review of the prevalence and efficacy of third wave CBT in forensic mental health settings is warranted, in order to inform practice and support future direction, as well as to provide justification for its implementation in such settings given the financial implications involved.

Objectives

1. To review the use of third wave CBT in forensic mental health settings
2. To evaluate the quality of the evidence for the efficacy of third wave CBT in forensic mental health settings.

Method

Inclusion as Third Wave CBT

For the purpose of this review, only interventions classed as third wave by a recently conducted Cochrane Review (Hunut et al., 2013) will be included. The two main inclusion criteria used by the Cochrane Review were: (a) that the intervention focuses on modifying the function of thoughts rather than their content, and (b) that the intervention is described by experts in the field as third wave. The therapies included were Acceptance and Commitment Therapy (ACT; Hayes et al., 2004), Compassionate Mind Training (CMT; Gilbert, 2005), Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991), Metacognitive Therapy (MCT; Wells 2008), Mindfulness Based Cognitive Therapy/Mindfulness Based Stress Reduction (MBCT/MBSR; Teasdale, Segal & Williams, 1995), Dialectical Behaviour Therapy (DBT; Linehan, 1993), and the expanded model of Behaviour Activation (BA; Martell, Addis & Jacobson, 2001). Two therapies not included in this review that are sometimes referred to as third wave are Schema Therapy and Mode Deactivation Therapy. These therapies have not been included due to a lack of consensus within the literature whether they meet the necessary criteria to be considered third wave (Swart, Bass, & Apsche, 2015). Mindfulness based interventions other than MBCT and MBSR have also not been included in this review due to the lack of standardisation in such approaches and mindfulness commonly being referred to as an element of third wave therapies, as opposed to being a standalone therapy itself.

Identification of Studies

The following databases were searched for the period between 1967 to May week 4 2017[1]: PsychINFO, EMBASE, MEDLINE and PsycARTICLES. Google Scholar and reference lists of retrieved articles and review papers were also searched for any additional studies. The search criteria used were 'Mindfulness based cognitive therapy or MBCT' OR 'Mindfulness Based Stress Reduction or MBSR' OR 'Dialectical Behaviour Therapy or DBT' OR 'Metacognitive Therapy or MCT' OR 'Compassionate Mind Training or Compassion Focussed Therapy or CFT' OR 'Behavioural Activation' OR 'Acceptance and Commitment Therapy or ACT or 'Functional Analytic Psychotherapy or FAP', in combination with (AND) 'low' OR 'high' OR 'medium' OR 'secur*' or 'special' OR 'forensic' OR 'mentally disordered offenders'. The reference lists of all studies that met the inclusion criteria were searched to identify any research not highlighted by the database searches. In addition, a number of clinical practitioners and researchers in the field of third wave CBT were contacted and requested to recommend any published studies that met the inclusion criteria. In order to reduce the potential impact of publication bias, a search of 'grey' literature databases (National Research Register; PsycEXTRA) was conducted.

Selection of Studies

Studies were selected for inclusion in the review if they were relevant to the review questions: 1. Studies that report an empirical intervention study of a third wave

[1] Search conducted on this date.

cognitive behavioural therapy; 2. The intervention took place in a forensic mental health setting; 3. Written in English language.

Papers were excluded from further analysis if they: 1. Were qualitative or case studies; 2. Involved participants who had a learning disability or were under 18 years of age; 3. Were studies conducted in a prison setting.

Within the literature on forensic mental health there is much debate and variation as to what constitutes a forensic setting. Writers such as Davies and Nagi (2017), who favour a broader definition, often refer to a forensic setting as comprising both inpatient and community forensic mental health settings as well as any correctional setting (i.e. prison and probation). Others such as McFadyen (1999) in adopting a more narrow definition state that a forensic setting is one that deals "with those mentally ill people whose presentation has been assessed as requiring a more focused level of expertise and/ or increased levels of physical security… beyond the capabilities of general psychiatric services" (McFayden, 1999, p. 1436), therefore excluding correctional settings. This review in adopting the more narrower definition of what comprises a forensic setting does in recognition of the key differences that are suggested to exist between a correctional setting and a forensic mental health setting, including the nature and severity of presenting difficulties, goals of therapy (criminogenic versus mental health needs) and the characteristics of populations detained within.

Data Extraction

Data were extracted in accordance with recommendations by Glass, McGaw, and Smith (1981). Extracted data items included study setting, sample description, diagnosis, control group (e.g., wait-list, treatment-as-usual), intervention description, and outcome measures. Finally, studies were stratified according to intervention-type: (i) ACT, (ii) DBT, (iii) FAP, (iv) CFT, (v) BA, (vi) MCT, and (vii) MBSR/MBCT.

Quality Assessment

In order to achieve consistency of the quality review process, a number of published quality frameworks were considered. After some consideration, the quality framework suggested by Downs and Black (1998) was chosen over other frameworks due to its focus on health care intervention studies and its flexibility regarding randomised and non-randomised studies. In a review of methods for reviewing non-randomised intervention studies (Deeks et al., 2003), this framework was found to be a comprehensive, easy-to-use tool with reasonably high validity and reliability.

Data Synthesis

A meta-analysis was deemed inappropriate due to heterogeneity between intervention types and target outcomes. Results are presented instead according to a narrative synthesis method (Popay et al., 2006) with studies stratified by intervention type.

Results

Search Results

The initial literature search yielded a total of 345 papers with an additional paper being suggested by an ACT practitioner. After removing duplicates, 270 papers remained. A review of abstracts resulted in 13 papers being found to meet the inclusion criteria. Following a full-text review of the remaining papers, nine studies met the criteria for inclusion in the review. One study was excluded due to the intervention taking place in a prison setting, two studies were excluded as they were feasibility studies and not intervention studies, one study was excluded because it used a case study methodology and a further two studies were excluded because they used a learning disability and adolescent participant group. A review of reference lists found an additional two papers. See Figure 1 for a PRISMA flow diagram (Moher, Liberati, Tetzlaff, & Altman, 2009) outlining the paper selection process along with principal reasons for exclusion.

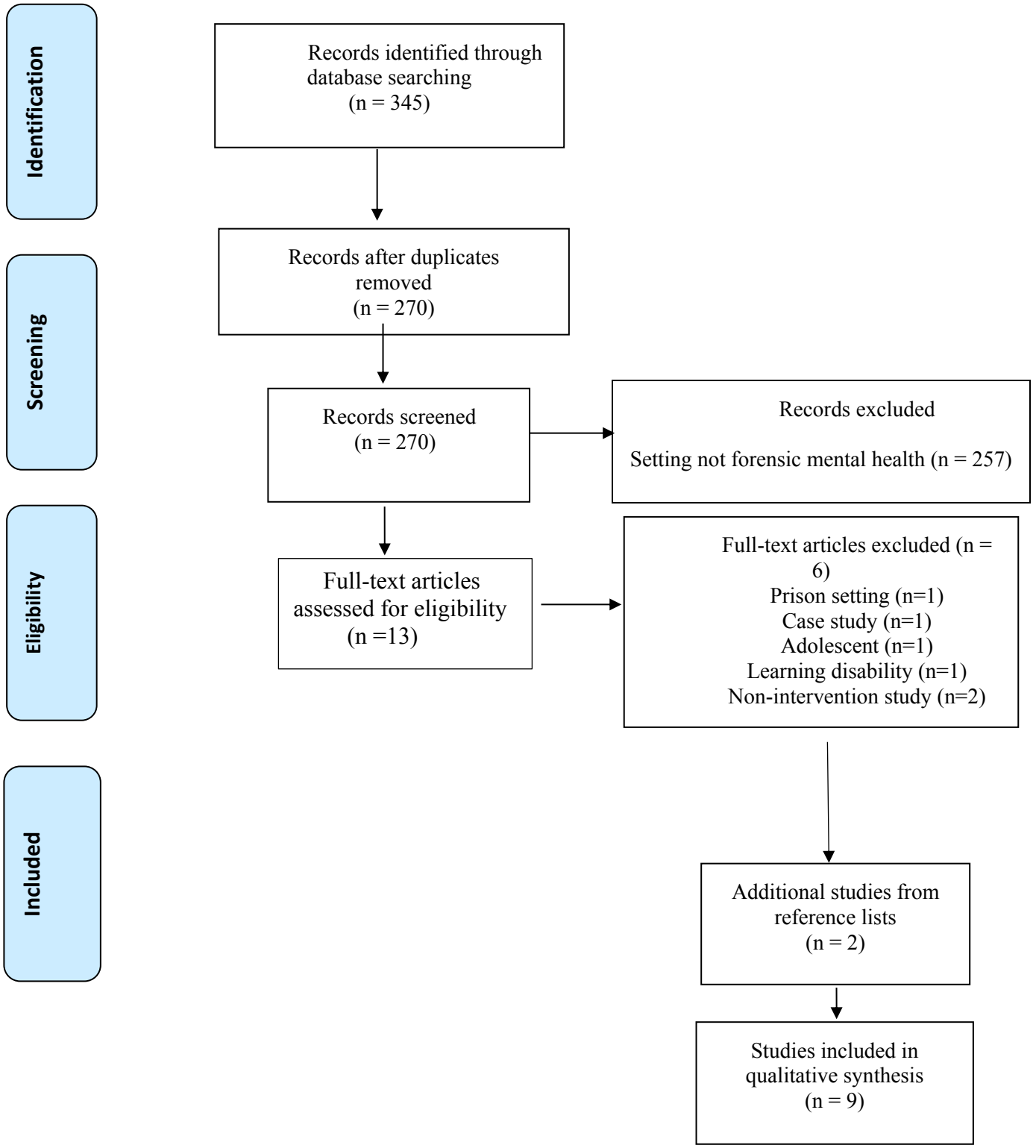


Figure 1. PRISMA Flow Diagram

Study Characteristics

Of the 9 studies that met the inclusion criteria, five were DBT intervention studies, two were MCT studies, one was an ACT study, and one a CFT study. Five studies included an active control group and one study employed a passive group. Three studies did not use any control or comparison group. Outpatient, low, medium and high secure hospitals were reflected in the selected studies also. Five studies involved patients with a diagnosis of a Personality Disorder, and in three studies participants had a diagnosis of a Psychotic Disorder. Four studies involved male participants only, three studies involved female participants only and two studies involved a mixed sample. Further characteristics of the studies that met all the inclusion criteria are presented in Table 2 on page 32.

Study Quality

Using the framework proposed by Downs and Black (1998), the quality of the studies that met the inclusion criteria was assessed. When using this quality framework, O Connor et al. (2015) recommend the grades of 'excellent' (24–28 points), 'good' (19–23 points), 'fair' (14–18 points) or 'poor' (<14 points). Overall, the quality was deemed to be 'fair' (mean quality score = 16.1). A summary of the quality ratings achieved by each study is presented in Table 1. In general, the sample sizes used were small (mean sample size = 26.1) and the majority of the studies relied heavily on self-report measures to assess treatment outcomes (73% of the measures used were self-report versus 27% being clinician rated).

Table 1: Summary Results of the Downs and Black Checklist Evaluations

Checklist	Evershed, et al., (2003)	Naughton et al., (2012)	Low et al., (2001)	Laithwaite, et al., (2009)	White et al., (2011)	Fox et al., (2016)	Long et al., (2011)	Van de Bosch, et al., (2009)	Kuokkanen et al., (2014)
Reporting	10/11	9/11	8/11	9/11	9/11	7/11	9/11	9/11	9/11
External Validity	1/3	1/3	0/3	1/3	1/3	2/3	1/3	1/3	3/3
Internal Validity – bias	5/7	5/7	3/7	3/7	7/7	3/7	3/7	2/7	6/7
Confounding and selection bias	2/6	3/6	1/6	1/6	5/6	1/6	1/6	0/6	4/6
Power	0	0	0	0	0	0	0	0	0

Key	
Good-Excellent	
Fair	
Poor	

Use of Third Wave CBT in Forensic Mental Health Settings

Dialectical Behaviour Therapy. Over half of the studies that met the inclusion criteria involved DBT interventions. Evershed et al. (2003) undertook a non-contemporaneous, quasi-experimental design study that investigated the effectiveness of DBT with a group of male forensic patients diagnosed with borderline personality disorder (BPD) in a high secure hospital. Patients received 18 months DBT (n = 9) or treatment as usual (TAU; n = 9). TAU comprised group and individual psychological interventions. The dependent variables were violent behaviours, overt and covert hostility (Buss-Durkee

Hostility Inventory, Dutch Version – BDHI-D), anger (State-Trait Anger Expression Inventory – STAXI: Spielberger, 1996; Novaco Anger Scale – NAS: Novaco, 1980). The DBT group experienced significant improvements in reducing the seriousness of violence-related incidents and in self-report measures of hostility and anger compared to the TAU group. While the results of the study suggest that DBT may be at least as effective as standard treatment for male patients with personality disorder in forensic settings, there are a number of limitations that impact on the generalizability of the findings. As acknowledged by the authors, the two groups were not contemporaneous or equivalent and the TAU group was not offered a comparable level of therapeutic contact, making it difficult to conclude that it was the specific components of the DBT and not simply the additional contact hours that contributed to the positive results. Furthermore, the fidelity of the intervention was not assessed and adherence to the DBT programme was not reported. Additionally, although the small sample size is comparable to that of many DBT studies in the literature (Dimidjan et al., 2016) it still represents a limiting factor when considering the external validity of the study. This study achieved a quality rating of 'fair'.

A pilot study investigated the treatment of deliberate self-harm (DSH) using DBT in 10 female patients at a high secure hospital (Low et al., 2001). The study used a single group, pretest-posttest design to investigate whether DSH rates would be reduced during- and post-treatment compared with pre-treatment. A large amount of outcome data was collected, including clinical observations, and the following measures; Irritability, Depression and Anxiety Scale (IDAS; Snaith & Zigmond, 1994); Dissociative Experiences Scale (DES: Bernstein & Putnam, 1986); Reasons for Living Inventory (RFL; Linehan, Goodstein, Nielson, & Chiles, 1983); Beck Hopelessness Scale (Beck,

Weissman, Lester, & Trexler, 1974), Beck Scale for Suicide Ideation (BSI: Beck, Kovacs, & Weissman, 1979), Beck Depression Inventory (BDI; Beck & Steer, 1987) and Impulsiveness Scale (Eysenck & Eysenck, 1991). The findings suggest that DBT was associated with reductions in DSH and positive changes on a number of psychological variables, including reductions in dissociation and increased survival and coping beliefs. However, the study's quality was assessed as 'poor' with an overreliance on self-report outcome measures and a failing to comment on the potential for socially desirable responding compromising the validity of the findings. The absence of a control group also means that the study does not demonstrate that these changes were as a result of the DBT intervention. Additionally, the sample size was extremely small which limits the generalizability of the findings to similar groups of patients.

Fox, Krawczyk, Staniford, and Dickens (2015) undertook a naturalistic within-group study that examined the effectiveness of a 12-month DBT programme for women with Borderline Personality Disorder in a low secure unit. The study, conducted as part of a service evaluation, used clinical observations and measures of risk behaviours (Overt Aggression Scale; OAS; Yudofsky, Silver, Jackson, Endicott and Williams, 1986), global functioning (Global Assessment of Functioning; GAF; American Psychiatric Association, 2000), mood and symptom experience (Brief Psychiatric Rating Scale; BPRS; Ventura, Green, Shaner and Liberman, 1993), well-being (Camberwell Assessment of Need - Forensic Version; CANFOR-S; Thomas, Harty, Parrott, McCrone, Slade and Thornicroft, 2003), functioning (Health of the Nation Outcome Scales for Users of Secure and Forensic Services; HoNOS secure; Sugarman and Walker, 2007), and BPD symptom severity

(Zanarini Rating Scale for Borderline Personality Disorder ;ZAN-BPD; Zanarini, 2003) to assess the effectiveness of the DBT programme. The study reported statistically significant positive change on all measures as well as observed aggression also reducing over the period of treatment. Similar to the previous study, the results, while encouraging, do not provide strong evidence that the improvements observed were as a result of the DBT intervention, due to a lack of a control group. The study also did not include a follow-up period, therefore making it difficult to assess the longer-term effectiveness of the intervention. The study achieved a quality rating of 'fair'.

Long, Fulton, Dolley, and Hollin (2011) conducted a similar within-group pretest-posttest design study that examined the effectiveness of an adapted DBT group for 44 women in a medium secure setting. Participants completed a number of measures during the 3 months before the group and at 3 months post-intervention. These included the Barratt Impulsiveness Scale (BIS 11; Patton, Stanford and Barratt, 1995), an in-house designed Dealing with Feelings Questionnaire (DWFQ), Brief Psychiatric Rating Scale (BPRS-E; Lukoff, Nuechterlin & Ventura, 1986), Generalized Self-Efficacy Scale (GSES; Jerusalem & Schwarzer, 1992), Overt Aggression Scale (Yudofsky, Silver, Jackson, Endicott & Williams, 1986), and Coping Responses Inventory (CRI; Moos, 1990). Treatment completers (n = 29) were compared to non-completers (n = 15) and they showed significant positive improvements in risk behaviours as well as improvements in impulsivity, self-efficacy, anxiety, suicidality, hostility, and coping ability. Despite the sizeable sample, the study achieved a quality rating of 'poor'. The lack of a control group limits the validity of the findings and, similar to other studies, the validity of the results

are also weakened by the reliance on self-report measures to assess outcomes. The authors used the non-completers as a comparison group but this group differed significantly from the completers on a number of variables such as age, relationship status, diagnosis of a personality disorder and criminal record. This makes it difficult to be confident that any differences between groups on the outcome measures were as a result of completing the DBT programme and not to other variables. While the results are positive in terms of the therapeutic potential of DBT for women in secure settings, again the generalizability of the findings are limited by the study design.

Van den Bosch, Hysaj, and Jacobs (2012) conducted a feasibility study assessing the implementation of DBT in a Dutch forensic outpatient clinic. The study was comprised of a mixed-gender group of forensic patients that were compared on demographic and clinical data to an all-female group of non-forensic patients. Both groups had a primary diagnosis of BPD. While the study suggests that it is possible to implement a DBT programme in a forensic outpatient setting it does not provide information on the effectiveness of such an intervention as no outcome data was collected and this is the primary reason for the quality of the study being rated as 'poor'. The study demonstrated that clinically and etiologically both groups were similar, but that there were a number of challenges for therapists, including struggles interpreting homicidal behaviours as 'coping behaviours' and that the forensic patients were not voluntary participants but court mandated to be on the programme.

Meta-cognitive Therapy. Two MCT studies met the inclusion criteria: The first study, by Naughton et al. (2012) achieved a quality rating of 'fair'. Participants were male

forensic inpatients and they took part in a two-sessions per week, MCT group for 8 weeks. Treatment effect was evaluated using a number of outcome measures and the results were compared with a waiting list control group. The outcome measures used included the Positive and Negative Symptom Scale (PANSS; Kay, Fiszbein, & Opler, 1987), the Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 2000), the MacArthur Competence Assessment Tool – Treatment (MacCAT-T; Grisso, Appelelbaum, & Hill-Fotouchi, 1997). Patients who attended the MCT group showed improvements on the GAF and the MacCAT-T but not on the PANSS. An important aspect of the study was the finding that MCT may be useful in improving capacity and decision-making in patients with active psychosis. While the findings are positive in terms of the applicability of MCT in an inpatient forensic setting, the small sample size and lack of randomisation means that strong conclusions cannot be drawn as to the effectiveness of this treatment to the wider forensic inpatient population.

A Finnish study that met the inclusion criteria and achieved a quality rating of 'good' used a single-rater blind RCT design to examine the effectiveness of an eight-session MCT group intervention in a high secure hospital. Using the PANSS (Kay, Fiszbein, & Opler, 1987), the Psychotic Symptoms Rating Scales (PSYRATS; Haddock et al., 1999) and a measure of Jumping to Conclusions bias (JTC; Moritz et al., 2010), the results demonstrated significant positive outcomes for the MCT group versus a TAU group three and six months post intervention. In particular, the MCT group showed improvements on the PANSS' Suspiciousness Scale, with the peak improvement observed at 3 months post intervention. There was no significant improvement with regard to the measures associated with JTC and, unexpectedly, there was an apparent increase in

number of symptoms as measured by the PANSS. The authors suggest that this result does not represent a deterioration but is more likely to be due to improvements in patients' insight and them becoming more familiar with the researchers and more willing to share experiences of their illness. While a definite strength of the study is its design, the overall generalisability of the findings are impacted upon by the small sample size. As acknowledged by the authors, the sample was heterogeneous and ranged from patients who were very ill to those with few symptoms and thus limiting the validity of the results.

Acceptance and Commitment Therapy. The single ACT study that met the inclusion criteria was a 12-month Prospective Randomised Open Blind Evaluation (PROBE) clinical trial, exploring the feasibility of using ACT to facilitate emotional recovery following psychosis (White et al., 2011). PROBE designs include random assignment of participants with the outcome and end-point evaluation being subject to a blinding protocol. The design overcomes many of the practical (e.g. less financial cost and monitoring of participants) and ethical barriers (e.g. less associated risk) that make the use of RCTs difficult in clinical practice (Hanson, Hedner, & Dahlöf, 1992).

The study comprised a mixed-gender participant group who met the criteria for a psychotic disorder, with the experimental group receiving ten individual ACT sessions. Outcome measures included the PANSS, the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), the Acceptance and Action Questionnaire – II (AAQ-II; Bond et al., 2011), the Kentucky Inventory of Mindfulness Skills (KIMS; Baer, Smith, & Allen, 2004), and the Working Alliance Inventory (Short Form Revised; WAI-SR; Hatcher & Gillaspy, 2006). The ACT group showed clinically significant improvements

on the HADS, an increase in mindfulness skills and a reduction in negative symptoms and crisis contacts. The study used a robust design and achieved a rating of 'good' resulting in it being the highest rated study included in this review. A key strength of the study was the random assignment of participants and the blinding of those measuring the main outcome variables. The small sample size does somewhat limit the overall external validity but the results do provide evidence that ACT may be effective in treating emotional dysfunction following psychosis in forensic settings.

Compassion Focussed Therapy. Using a within-subjects design, Laithwaite et al. (2009) evaluated a compassion-focussed Recovery After Psychosis Programme. They assessed the effectiveness of the programme using the PANSS (Kay, Fiszbein, & Opler, 1987), the Social Comparison Scale (SCS; Allan & Gilbert, 1995), the External Shame (the Other as Shamer Scale – OAS; Goss, Gilbert, & Allen, 1994), the Self Compassion Scale (SeCS; Neff, 2003), the Beck Depression Inventory II (BDI II; Beck, Steer, & Brown, 1996), the Rosenberg Self-Esteem measure (RSE; Rosenberg, 1965) and the Self-Image Profile for Adults (SIP-AD; Butler & Gasso, 2004). The study involved a male-only high secure inpatient participant group, all of whom met the diagnostic criteria for a psychotic disorder. CFT was delivered twice weekly for 10 weeks and outcome data was collected mid-group, post-group and 6 weeks after the group ended. Significant positive improvements were reported on measures of social comparison, depression, self-esteem and on the General Psychopathology Scale of the PANSS. Once again, while the results do provide positive evidence that contributes to our knowledge about the effectiveness of CFT in an inpatient forensic setting, due to methodological weakness, the generalisability of the findings is limited and the overall quality was assessed as 'poor'. The lack of a

control group also makes it difficult to say with any confidence that the observed improvements are as a result of the CFT, and the small sample size limits the external validity more generally.

Other third wave therapies. No studies that involved the use of Functional Analytic Psychotherapy, Behavioural Activation, Mindfulness Based Stress Reduction or Mindfulness Based Cognitive Therapy met the inclusion criteria. A summary of the studies that met the inclusion criteria is presented in Table 2.

Table 2. Summary of Study Characteristics

	Study	Therapy	Setting	Diagnosis *Primary & secondary	Sample characteristics	Type of Intervention & Duration	Study / control Groups	Attrition Rate & Blinding	Follow up Period	Outcome Measure	Outcome	Quality Rating
1	Evershed, Tennant, Boomer, et al. (2003)	DBT	Inpatientz (HS)	BPD	N = 20 All male Mean age = 34.8 Index offence = sex & violence Mean admissions = 2.43	Group & individual intervention 18-month DBT group and 12 months for TAU group	TAU group (9) compared to DBT group (9)	1 drop out from DBT group Not clear for TAU group No blinding	Pre, 7-12 months into Post	Behavioural observations BDHI-D STAXI NAS	DBT group engaged in less serious violent behaviour than TAU group DBT group improved on BDHI-D, STAXI and NAS. TAU group showed a pattern of deterioration	Fair
2	Naughton et al., (2012)	MCT	Inpatient	Psychotic Disorder	N=19 All male Mean age = 36.7	Group 2 X week for 8 weeks	Treatment group (11) compared to waiting list (8)			PANSS GAF MacCAT-T DUNDRUM1 HCR-20	MCT group showed improvements in MacCAT-T and GAF	Fair
3	Low et al., (2001)	DBT	Inpatient (HS)	BPD	N = 10 All female Mean age = 28.7 Mean hospital stay = 4.5 years	Group & individual weekly sessions for 12 months	No control group	3 drop outs	3 month and 6 months' post intervention	Clinical Obs IDAS DES RFL Beck Hopelessness Scale BSI BDI Impulsiveness Scale	Significant reductions in DSH, dissociative experiences, increases in survival and coping beliefs, and improvements in depression, suicide ideation and impulsiveness	Poor
4	Laithwaite, et al., (2009)	CFT	Inpatient (HS)	Schizophrenia Schizo-affective disorder Bi-polar affective disorder	N = 19 All male Mean age = 36.9 Mean hospital stay = 8 years	Group 10 weeks 2 sessions per week	No control group		6 weeks follow up	SCS OAS SeCS BDI II RSE SIP-AD PANSS	Significant improvements on SCS, BDI, OAS, RSE, and PANSS (General Psychology Scale)	Poor

Abbreviations

DBT: Dialectical Behaviour Therapy
BPD: Borderline Personality Disorder
TAU: Treatment as usual
BDHI-D: Buss-Durkee Hostility Inventory
STAXI: State-Trait Anger Expression Invento
NAS: Novaco Anger Scale
MCT: Meta-Cognitive Therapy
PANSS: Positive and Negative Symptom Scale
GAF: Global Assessment of Functioning Scale
MacCAT-T: MacArthur Competence Assessment Tool
HCR-20: Historical Clinical Risk-20
CFT: Compassion Focussed Therapy
HS: High Security
SCS: Social Comparison Scale
RSE: Rosenberg Self-Esteem measure
OAS: Overt Aggression Scale;
SeCS: Self Compassion Scale
BDI: Beck Depression Inventory
SIP-AD: Self-Image Profile for Adults

Table 2. Summary of Study Characteristics

	Study	Therapy	Setting	Diagnosis *Primary & secondary	Sample characteristics	Type of Intervention & Duration	Study / control Groups	Attrition Rate & Blinding	Follow up Period	Outcome Measure	Outcome	Quality Rating
5	White et al., (2011)	ACT	Inpatient (MS)	Psychotic Disorder	N=27 Male = 21, Female = 6 Mean age = 34	Individual 10 sessions	ACT & TAU group (14) compared to TAU group (13)	No drop outs from ACT group. 3 drop outs from TAU group	3 months' post baseline	PANSS HADS KIMS AAQ-II WAI-SR	Significant improvements on HADS (depression), reduction in negative symptoms and an improvement in mindfulness skills	Good
6	Fox et al., (2016)	DBT	Inpatient (LS)	BPD	N = 18 All female Mean age = 29 MHA Sec 3 (89%), Sec 37 (6%) & Sec 47/49 (6%)	Group & individual 12 months	No control group	No drop outs reported	No follow up	Clinical Obs OAS GAF BPRS CANFOR-S HoNOS-secure ZAN-BPD	Statistically significant improvement on all measures over the 12 months' treatment	Fair
7	Long, et al., (2011)	DBT	Inpatient (MS)	PD Bi-polar disorder Depressive disorder	N = 44 All female Mean age = 31.7 Index offences: Violence (38.7%). Arson (27.3%), and GBH (22.6%)	Group & individual sessions 17 weeks	No control group Completers compared to non-completers	15 women failed to complete the group	3 months' post intervention	BIS DWFQ CRI BPRS-E GSES OAS	Treatment completers showed significant improvements on coping response measures of positive reappraisal, problem solving and on measures of anxiety and suicidality. Self-harming and aggressive acts also reduced.	Fair

Abbreviations

ACT: Acceptance and Commitment Therapy
MS: Medium Secure
HADS: Hospital Anxiety and Depression Scale
KIMS: Kentucky Inventory of Mindfulness Skills
AAQ-II: Acceptance and Action Questionnaire
WAI-SR: Working Alliance Inventory
LS: Low Secure
MHA: Mental Health Act
BPRS: Brief Psychiatric Rating Scale
CANFOR-S: Camberwell Assessment of Need - Forensic Version
PD: Personality Disorder
BIS: Barratt Impulsiveness Scale
DWFQ: Dealing with Feelings Questionnaire
CRI: Coping Responses Inventory
BPRS-E: Brief Psychiatric Rating Scale
GSES: Generalized Self-Efficacy Scale
HoNOS-secure: Health of the Nation Outcome Scales for Users of Secure and Forensic Services
ZAN-BPD: Zanarini Rating Scale for Borderline Personality Disorder

Table 2. Summary of Study Characteristics

	Study	Therapy	Setting	Diagnosis *Primary & secondary	Sample characteristics	Type of Intervention & Duration	Study / control Groups	Attrition Rate & Blinding	Follow up Period	Outcome Measure	Outcome	Quality Rating
8	Van den Bosch, Hysaj & Jacobs (2009)	DBT	Forensic Outpatient	BPD* ASPD (48%) PTSD (31%)	N = 29 Male = 10 Female = 19 Mean age = 34.2 Mean crimes committed = .92 Mean admissions not reported	Group & individual intervention 12 months	Non- forensic comparison group (N = 58, all female)	22 drop outs 7 from forensic group No blinding	None	Working alliance as measured by drop-out rates	No differences between forensic and non-forensic were found for dropout rates	Poor
9	Kuokkanen, Lappalainen, Repo-Tiihonen, & Tiihonen, (2014)	MCT	Inpatient (HS)	Schizophrenia	N = 20 All male Mean age = 43.55	Group 8 sessions	MCT group (N = 10, 4 forensic, 6 non-forensic) compared with TAU group (N = 10, 6 forensic, 4 non-forensic)	2 drop outs from MCT group No information re blinding	3 & 6 months follow up	PANSS CGI PSYRATS	MCT group showed significant improvements on the PANSS Suspiciousness Scale and the PSYRATS	Good

Abbreviations
ASPD: Anti-social Personality Disorder
PTSD: Post Traumatic Stress Disorder
CGI: Clinical Global Impressions
PSYRATS: Psychotic Symptoms Rating Scale

Discussion

A systematic literature review of the use of third wave CBT in forensic mental health settings was conducted with the aim of assessing the quality of the evidence base supporting its use. The findings across the nine studies evaluated suggest that third wave therapies can be effective in forensic settings, although in many cases, the quality of the studies that met the inclusion criteria was merely assessed as 'fair'. Only two of the studies employed a random assignment methodology and in most cases the sample size was small (Mean sample size = 26.1), making it difficult to conclude with confidence that observed outcomes were as a result of the intervention, as well as generalising findings to the wider forensic population. Third wave therapies such as ACT often describe an 'incubation effect' as being an important mechanism of change, whereby therapeutic gains are observed after treatment ceases. It is suggested that this is due to the focus of the intervention not being to suppress but to develop skills, such as psychological flexibility and to encourage acceptance (Hollon, Stuart, & Strunk, 2006). This finding is not unique to third wave CBT but has also been observed across a wide range of CBT studies for the treatment of schizophrenia (Zimmermann et al., 2005). Taking this into account, it is surprising to see that not all of the studies used a follow up period greater than 6 months in their outcome analysis, something which may have adversely impacted on the reported results. Most of the measures used to assess the effectiveness of the intervention of interest were self-report measures of psychological variables. Given the evidence that suggests that overly positive self-reporting and impression management may be more prevalent in offender populations (Andrews & Meyer, 2003; Gudjonsson, 1990), it is suggested that reliance on self-

report outcome data in forensic mental health settings may result in overestimating the potential effectiveness of interventions.

The findings of the present review share a number of similarities with the results of systematic literature reviews of third wave CBT in non-forensic settings. In a recently conducted systematic literature review of third wave therapy meta-analyses, the authors reported that DBT had the strongest evidence base, followed by ACT (MCT and CFT were not included in the review; Dimidjian et al., 2016). Demonstrating the significantly larger evidence base that exists for non-forensic settings, the study reviewed eight ACT, five DBT, six MBCT and seven BA meta-analyses, with the study concluding that there exists 'a strong and growing evidence base supporting the efficacy of individual therapies commonly identified as third wave' pp. 898.

Whilst the evidence base for the use of third wave CBT in general mental health settings is promising, caution should be taken in assuming that this efficacy can be directly transferred to forensic settings. Forensic patients differ significantly not only on the legal status of their detention and the need for treatment to address criminogenic as well as mental health needs (Blackburn, 2004), but also on prevalence of comorbidity and severity of difficulties.

Furthermore, the complex nature of forensic settings presents a number of barriers to the evaluation of outcome studies. Firstly, there are challenges in relation to conducting RCTs with a detained population of patients who often have treatment-mandated court orders and can sometimes lack capacity to consent or are unwilling to consent for treatment or to participate in clinical trials (Owen et al., 2008). Secondly, in a secure inpatient setting, without using a matched control group it can often be

difficult to determine what elements of observed change are due to the intervention and which are as a result of the environment and other activities such as occupational therapy (Lee & Harris, 2010). Thirdly, many of the outcome measures commonly used to assess the effectiveness of interventions often have not been validated with a forensic population and this is especially true of measures used to specifically assess clinical outcomes relevant to third wave therapies, such as the Self Compassion Scale (CFT; Neff, 2003) and the Acceptance and Action Questionnaire – II (ACT; Bond et al., 2011). Fourthly, researchers are faced with uncertainty in deciding what outcomes should be focussed on – reducing risk or improving well-being and finally, forensic patients commonly have comorbid psychological disorders which are severe and treatment resistant (Shonin et al., 2013).

Implications for Clinical Practice and Service Providers

Psychologists working in forensic settings will often have obligations to treat both criminogenic and mental health needs in the patients that they work with. Supported by an ever-increasing evidence base, there is a recent shift in general mental health away from a traditional CBT towards a third wave. Although not without its critics (e.g. Ost, 2008), third wave CBT has been found to be effective across a wide range of disorders. Within the 'What Works' offender rehabilitation literature, however, traditional CBT still dominates (Hollin & Palmer, 2006). It has been suggested that third wave therapies, by targeting the emotional brain rather than the cognitive brain and by having a compassionate and non-judgemental stance (Witharana & Adshead, 2013), may be inherently suited to treating forensic patients. Howells et al. (2010) also suggests that mindfulness, a key component of third wave therapies, may be effective in addressing three key areas of criminogenic need: poor anger control, poor affect

regulation and impulsivity. It must, however, be acknowledged that the evidence base for the use of third wave CBT in forensic settings is not strong and practitioners should therefore proceed with caution, using the positive findings from existing general mental health studies to inform their practice and to begin to develop an evidence base for the use of this approach in a forensic setting.

Recommendations for Future Research

There remains a need for further methodologically robust outcome studies on the effectiveness of third wave CBT in forensic mental health settings. While the achievement of being listed as an Empirically Supported Therapy (Chambless & Hollon, 1998) may seem unattainable given the obstacles to conducting clinical trials in forensic settings, both practitioners and researchers must still strive to develop and improve the current status of the evidence base.

Based on the findings of this review the following recommendations for future research are made.

1. Future studies should include a matched control group (with random assignment where possible). There are significant ethical limitations of such an approach and therefore in place of withholding treatment from participants, the use of an active treatment that has been found to be effective should be considered for a comparison group.

2. Studies should, where possible, include outcome measures that have been validated in a forensic setting and a minimum of 12 months follow-up period should be used.

3. Procedures should be put in place to control for other concomitant treatments that patients may be receiving as part of their hospital stay. While it is

acknowledged that this is also ethically and practically a difficult standard to achieve, it is suggested that as a minimum, efforts should be made to limit the number of adjunct treatments study participants could potentially be receiving.

4. Third party and clinician-rated outcome measures should be used to compliment self-report measures.

Limitations of the Review

The threat of publications bias is an important limitation to be acknowledged by the present review. By focusing solely on published papers, unpublished studies, ones that possibly do not show an expected result, may have been excluded, resulting in an over estimation of the potential positive effects of using third wave CBT in a forensic mental health setting. Additionally, this review was conducted by a single researcher and despite the use of a recognised data extraction process (Glass, McGaw, & Smith, 1981) and a published quality criteria checklist (Downs & Black, 1998), the presence of further bias in the selection of studies to be included in the review cannot be ruled out.

Conclusion

Third wave CBT has previously been accused of "getting ahead of the data" (Corrigan, 2001, p. 189), with its adherence to the empirically-guided principles that have been a characteristic of the cognitive behavioural tradition, being brought into question. More recent reviews have, however, described the current evidence base for third wave as "substantial and compelling" (Dimidjan et al., 2016, p. 901). This review has presented a number of positive research findings that support the use of this approach in a forensic mental health setting. The evidence base, while promising, remains only fair and therefore further methodologically robust research is warranted in order to support and develop our understanding of how third wave CBT can be used effectively in such settings.

References

Allan, S. & Gilbert, P. (1995). A social comparison scale: psychometric properties and relationships to psychopathology. *Personality and Individual Differences*, 1, 293–299.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th edn Text Rev.) (DSM-IV-TR). Washington, DC: American Psychiatric Association.

Bach, P., & Hayes, S. C. (2002). The use of acceptance and commitment therapy to prevent the rehospitalization of psychotic patients. A randomized controlled trial. *Journal of Consulting and Clinical Psychology*, 70, 1129–1139.

Baer, R. A. (2003). Mindfulness training as a clinical intervention: A conceptual and empirical review. *Clinical Psychology: Science and Practice*,10, 125-143.

Baer, R.A., Smith, G.T., & Allen, K.B. (2004). Assessment of mindfulness by self-report: The Kentucky Inventory of Mindfulness Skills. *Assessment,* 11, 191–206.

Baker, D. B. (2011). *The oxford handbook of the history of psychology: global perspectives*. New York: Oxford University Press.

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behaviour Therapy*, 35:205–230.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology*, 47, 343–352.

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology*, 42, 861–865.

Beck, A.T. (1967). *The diagnosis and management of depression*. Philadelphia, PA: University of Pennsylvania Press.

Beck, A.T., Steer, R.A. & Brown, G.K. (1996). *Manual for the Beck Depression Inventory –II.* San Antonio TX, The Psychological Corporation.

Beech, A.R., Fisher, D., & Beckett, R.C. (1999). *An evaluation of the prison sex offender treatment programme*. UK Home Office Occasional Report.

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease*, 174, 727–735.

Biglan, A., Hayes, S. C., & Pistorello, J. (2008). Acceptance and Commitment: Implications for prevention science. *Prevention Science*, 9, 139-152.

Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary psychometric properties of the acceptance and action questionnaire-II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, 42, 676–688.

Burns, D. D. & Spangler, D. L. (2001). Do changes in dysfunctional attitudes mediate changes in depression and anxiety in cognitive-behavioral therapy? *Behaviour Therapy*, 32, 337-369.

Butler, R.J. & Gasson, S.L. (2004). *The self-image profile for adults (SIP-Adult).* San Antonio, TX: Harcourt Assessment.

Callaghan, G., Summers, C., & Weidman, M. (2003). The treatment of histrionic and narcissistic personality disorder behaviors: A single-subject demonstration of clinical effectiveness using Functional Analytic Psychotherapy. *Journal of Contemporary Psychotherapy*, 33, 321–339.

Chadwick, P., Newman-Taylor, K. & Abba, N. (2005). Mindfulness groups for people with psychosis. *Behavioural & Cognitive Psychotherapy*, 33, 351–359.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66,7–18.

Chambless, D. L., Baker, M. J., Baucom, D. H., Beutler, L. E., Calhoun, K. S., Crits-Christoph, P., & Woody, S. (1998). Update on empirically validated therapies. II. *The Clinical Psychologist*, 51(1), 3–16.

Coelho, H. F., Canter, P.H., & Ernst, E. (2007). Mindfulness-based cognitive therapy: evaluating current evidence and informing future research. *Journal of Consulting and Clinical Psychology*, 6, 1000-1006.

Corrigan, P. W. (2001). Getting ahead of the data: A threat to some behavior therapies. *The Behavior Therapist,* 24(9), 189-193.

Dalai Lama. (2005). *Practicing wisdom*. Boston: Wisdom Publications.

Daughters, S., Braun, A., Sargeant, M., Reynolds, E., Hopko, D., Blanco, C., & Lejuez, C. W. (2008). Effectiveness of a brief behavioral treatment for inner-city illicit drug users with elevated depressive symptoms: The life enhancement treatment for substance use (LETS Act!). *Journal of Clinical Psychiatry*, 69, 122-129.

Davies, J. & Nagi, C. (2017). Introduction. In Davies, J. & Nagi, C. Editors (Ed). *Individual psychotherapies in forensic mental health Settings: research and practice*. (pp.1-8). Routledge. London and New York.

Dimidjian, S., Arch, J.J., Schneider, R.L., Desormeau, P., Felder, J.N., & Segal, Z.V. (2016). Considering meta-analysis, meaning, and metaphor: A systematic review and critical examination of "Third Wave" cognitive and behavioral therapies. *Behavior Therapy*. 47: 886-905.

Deeks, J. J., Dinnes, J., D'amico, R., Sowden, A. J., Sakarovitch, C., Song, F., & Altman, D. G. (2003). Evaluating non-randomised intervention studies. *Health Technology Assessment* (Winchester, England), 7(27), iii–x.

Dobson, K. S., Hollon, S. D., Dimidjian, S., Schmaling, K. B., Kohlenberg, R. J., Gallop, R. J., Rizvi, S. L., Gollan, J. K., Dunner, D. L., & Jacobson, N. S. (2008). Randomized trial of behavioral activation, cognitive therapy, and antidepressant medication in the prevention of relapse and recurrence in major depression. *Journal of Consulting and Clinical Psychology*, 76(3), 468-477.

Downs, S.H., & Black, N. (1998). The feasibility of creating a checklist for the assessment of the methodological quality both of randomised and non-randomised studies of health care interventions. *J Epidemiol Community Health*. 52(6):377-84.

Durcan, G., Hoare, T., & Cumming, I. (2011). *Unlocking pathways to secure mental health care.* Centre for Mental Health.

Eisendrath, S. J., Delucchi, K., Bitner, R., Fenimore, P., Smit, M., & McLane, M. (2008). Mindfulness-Based Cognitive Therapy for treatment-resistant depression: a pilot study. *Psychotherapy and Psychosomatics*, 77, 319–320.

Ellerby, M. (2016). Schizophrenia, Maslow's hierarchy, and compassion-focussed therapy. *Schitzophrenia Bulletin*, 42, 3, 531-534.

Evershed, S., Tennant, A., Boomer, D., Rees, A., Barkham, M., & Watson, A. (2003). Practice-based outcomes of dialectical behaviour therapy (DBT) targeting anger and violence, with male forensic patients: A pragmatic and non-contemporaneous comparison. *Criminal Behaviour and Mental Health*, 13(3), 198–213.

Eysenck, H. J. (1997). *Rebel with a cause*. London: Transaction Publishers.

Eysenck, H. J., & Eysenck, S. B. G. (1991). *Manual of the eysenck personality scales.* London: Hodder & Stoughton.

Fisher, P. L., & Wells, A. (2005). Experimental modification of beliefs in obsessive-compulsive disorder: a test of the metacognitive model. *Behaviour Research and Therapy,*43, 821–829.

Fox, E., Krawczyk, K., Staniford, J., & Dickens, G. L. (2015). A service evaluation of a 1-year dialecticalbehaviour therapy programme for women with borderline personality disorder in a low secure unit. *Behavioural and Cognitive Psychotherapy, 43(06), 676–691*.

Gannon, T.A., Lockerbie, L., & Tyler, N. (2012). A long time coming? The fire-setting intervention program for mentally disordered offenders. *Forensic Update*, 106, 1-10.

Gilbert, P. (2005). *Compassion: conceptualisations, research and use in psychotherapy*. Hove: Routledge.

Gilbert, P. (2009). *The compassionate mind: A new approach to the challenges of life*. London, UK: Constable & Robinson.

Gillespie, S. M., Mitchell, I. J., Fisher, D., & Beech, A. R. (2012). Treating disturbed emotional regulation in sexual offenders: The potential applications of mindful self-regulation and controlled breathing techniques. *Aggression and Violent Behavior*, 17, 333-343.

Glass, G.V., McGaw, B., & Smith, M.L. (1981). Meta-analysis in social research. Beverly Hills, CA: SAGE.

Goldstein, T. R., Axelson, D. A., Birmaher, B., & Brent, D. A. (2007). Dialectical behavior therapy for adolescents with bipolar disorder: A one-year open trial. *J Am Acad Child Adolesc Psychiatry,* 46, 820–830.

Goss, K., & Allan, S. (2010). Compassion focussed therapy for eating disorders. *International Journal of Cognitive Therapy*, 3, 2, 141-159.

Goss, K., Gilbert, P. and Allan, S. (1994). An exploration of shame measures I. the "other as shamer scale". *Personality and Individual Differences*, 17, 713–717.

Gratz, K. L., & Gunderson, J. G. (2006). Preliminary data on an acceptance-based emotion regulation group intervention for deliberate self-harm among women with borderline personality disorder. *Behavior Therapy*, 37, 25–35.

Grisso, T., Appelbaum, P. S., & Hill-Fotouhi, C. (1997). The MacCAT-T: A clinical tool to assess patient's capacities to make treatment decisions. *Psychiatric Services*, 48, 1415–1419.

Haddock, G., McCarron, J., Tarrier, N., & Faragher, E.B. (1999). Scales to measure dimensions of hallucinations and delusions: the Psychotic Symptom Rating Scales (PSYRATS). *Psychological Medicine*, 29, 879-889.

Hansson, L., Hedner, T., & Dahlöf, B. (1992). Prospective Randomized Open Blinded End-point (PROBE) Study. A novel design for intervention trials. *Blood Pressure*, 1, 113–119.

Hatcher, R.L., & Gillaspy, J.A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy Research*, 16, 12–25.

Hayes, S. (n.d.) *Acceptance & commitment therapy* (ACT). Retrieved from https://contextualscience.org/act

Hayes, S. C., Masuda, A., Bassett. R., Luoma, J., & Guerrero, L. F. (2004). DBT, FAP and ACT: how empirically oriented are the new behaviour therapy technologies? *Behavior Therapy*, 35, 135–54.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Bissett, R., Piasecki, M., et al. (2004). A preliminary trial of twelve-step facilitation and acceptance and commitment therapy with polysubstance-abusing methadone-maintained opiate addicts. *Behavior Therapy*, 35, 667–688.

Hesslinger, B., Tebartz van Elst. L., Nyberg, E., Dykierek, P., Richter H., Berner M., Ebert D. (2002). Psychotherapy of attention deficit hyper-activity disorder in adults: A pilot study using a structured skills training program. *European Archives of Psychiatry and Clinical Neuroscience*., 252,177-184.

Hofmann, S. G., & Asmundson, G. J. G. (2008). Acceptance and mind-fulness-based therapy: New wave or old hat? *Clinical Psychology Review*, 28(1), 1-16.

Hofmann, S. G., Sawyer, A. T., & Fang, A. (2010). The empirical status of the "new wave" of CBT. *Psychiatric Clinics of North America*, 33 (3), 701-710.

Hollin, C.R., & Palmer, E.J. (Eds). (2006). *Offending behaviour programmes: Development, application, and controversies*. Chichester: John Wiley & Sons.

Hollon, S. D., Stewart, M. O., & Strunk, D. (2006). Enduring effects for cognitive behavior therapy in the treatment of depression and anxiety. *Annual Review of Psychology*, 57, 285–315.

Hopko, D. R., Lejuez, C. W., Ruggiero, K. J., & Eifert, G. H. (2003). Contemporary behavioural activation treatments for depression: procedures, principles and progress. *Clinical Psychology Review*, 23, 5, 699-717.

Howells, K. (2010). The "third wave" of cognitive-behavioural therapy and forensic practice. *Criminal Behaviour and Mental Health*, 20(4), 251–256.

Howells, K., Tennant, A., Day, A., & Elmer, R. (2010). Mindfulness in forensic mental health: Does it have a role? *Mindfulness*, 1, 4-9.

Hunot, V., Moore, T. H. M., Caldwell, D. M., Furukawa, T. A., Davies, P., Jones, H., …Churchill, R. (2013). 'Third wave' cognitive and behavioural therapies versus other psychological therapies for depression. *Cochrane Database of Systematic Reviews*, 10.

Ilardi, S. S. & Craighead, W. E. (1994). The role of non-specific factors in cognitive-behavior therapy for depression. *Clinical Psychology: Science and Practice*, 1, 138-156.

Jacobson, N. S., & Gortner, E. T. (2000). Can depression be de-medicalized in the 21st century. Scientific revolutions, counter revolutions and the magnetic field of normal science. *Behavior Research and Therapy*, 38, 103-117.

Jakupcak. M., Conybeare, D., Phelps, L., Hunt, S., Holmes, H. A., Felker, B., … McFall, M. E. (2007). Anger, hostility and aggression among Iraq and Afghanistan War veterans reporting PTSD and subthreshold PTSD. *J Traum Stress*. 20, 945–954.

Jerusalem, M. and Schwarzer, R. (1992). Self-efficacy as a resource factor in stress appraisal process. In R. Schwarzer (Ed.), *Self-efficacy: thought control of action*. Washington, DC: Hemisphere.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: past, present, and future. *Clinical Psychology: Science & Practice*, 10,2, 144-156.

Kahl, K. G., Winter, L., & Schweiger, U. (2012). The third wave of cognitive behavioral therapies. *Current Opinion in Psychiatry*, 25 (6), 522-528.

Kanter J. W., Hurtado G. D., Rusch L. C., Busch A. M., Santiago-Rivera A. (2008). Behavioral activation for Latinos with depression. *Clinical Case Studies*, 7, 491-506.

Kanter, J. W., Baruch, D. E., & Gaynor, S. T. (2006). Acceptance and Commitment Therapy and Behavioral Activation for the treatment of depression: Description and comparison. *The Behavior Analyst*, 29(2), 161–185.

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia Bulletin*, 13 ,261-276.

Kohlenberg, B. S., Tsai, M., & Kohlenberg, R. J. (2006). Healing interpersonal trauma with the intimacy of the therapeutic relationship. In Follette, V. & Ruzek, J. (eds.) *Cognitive Behavioral Therapies for Trauma*. Second Edition. New York: Guilford.

Kohlenberg, R., Kanter, J., Bolling, M., Parker, C., &. Tsai, M. (2002). Enhancing cognitive therapy for depression with functional analytic psychotherapy: Treatment guidelines and empirical findings. *Cognitive and Behavioral Practice*, 9, 213–229.

Kohlenberg, R.J. & Tsai, M. (1991). *Functional Analytic Psychotherapy: A guide for creating intense and curative therapeutic relationships.* New York: Plenum.

Kuokkanen, R., Lappalainen, R., Repo-Tiihonen, E., & Tiihonen, J. (2014). Metacognitive group training for forensic and dangerous non-forensic patients with schizophrenia: A randomised controlled feasibility trial: MCT for schizophrenia in forensic setting. *Criminal Behaviour and Mental Health*, 24(5), 345–357.

Laithwaite, H., Gumley, A.,O'Hanlon, M., Collins, P.,Doyle, P., Abraham, L., & Porter, S. (2009). Recovery after psychosis (RAP): A compassion focussed programme for individuals residing in high security settings. *Behavioural and Cognitive Psychotherapy*, 37, 511–526.

Lee, S., & Harris, M. (2010). The development of an effective occupational therapy assessment and treatment pathway for women with a diagnosis of borderline personality disorder: Implementing the Model of Human Occupation. *British Journal of Occupational Therapy*, 73(11), 559–63.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Linehan, M. M., Goodstein, J. L., Neilsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. *Journal of Consulting and Clinical Psychology*, 51, 276–286.

Long, C. G., Fulton, B., Dolley, O., & Hollin, C. R. (2011). Dealing with Feelings: The Effectiveness of Cognitive Behavioural Group Treatment for Women in Secure Settings. *Behavioural and Cognitive Psychotherapy*, 39(02), 243–247.

Longmore, R. J. & Worrell, M. (2007). Do we need to challenge thoughts in cognitive behavior therapy? *Clinical Psychology Review*, 27, 173–187.

Low, G., Jones, D., Duggan, C., Power, M., & MacLeod, A. (2001). The treatment of deliberate self-harm in borderline personality disorder using dialectical behaviour therapy: A pilot study in a high security hospital. *Behavioural and Cognitive Psychotherapy*, 29(01), 85–92.

Lowens, I. (2010). Compassion focussed therapy for bipolar disorder. *International Journal of Cognitive Therapy*, 3, 2, 172-186.

Lucre, K., & Corten, N. (2012). An exploration of group compassion-focussed therapy for personality disorder. *Psychology and Psychotherapy: Theory, Research and Practice*, 86, 353-465.

Lukoff, D., Nuechterlin, K. and Ventura, J. (1986). Manual for the expanded brief psychiatric rating scale. **Schizophrenia Bulletin**, 13, 261–276.

Lynch, T. R., Morse, J., Mendelson, T., & Robins, C. (2003). Dialectical behavior therapy for de-pressed older adults: A randomized pilot study. *American Journal of Geriatric Psychiatry*, 11, 33–45.

Marlatt, G. A. (2002). Buddhist psychology and the treatment of addictive behavior. *Cognitive and Behavioral Practice*, 9(1), 44-4.

Martell, C. R., Addis, M. E., & Jacobson, N. S. (2001). *Depression in context: strategies for guided action*. New York: Norton.

McFayden, J.A. (1999). Safe, sound and supportive: forensic mental health services. *British Journal of Nursing*, 8(21), 1436-1440.

McGuire, J. (2006). General offending behaviour programmes: Concepts, theory and practice. In C. R. Hollin & E. J. Palmer (Eds.), *Offending behaviour programmes: development, application and controversies* (pp.69-112). Chichester: Wiley.

Miller, G. A. (2003). The cognitive revolution: a historical perspective. *Trends in Cognitive. Science.* 7, 141 – 144.

Miller, S. D., Hubble, M. A., & Duncan, B. L. (2007). *Supershrinks. Psychotherapy Networker*, 31, 26–35, 56.

Moos, I. H. (1990). *Coping Responses Inventory Manual*. Palo Alto: CA: Stanford University and Veterans Administration Medical Centres.

Moritz, S., Veckenstedt, R., Hottenrott, B., Woodward, T. S., Randjbar, S., & Lincoln, T. M. (2010). Different sides of the same coin? Intercorrelations of cognitive biases in schizophrenia. *Cognitive Neuropsychiatry*, 15(4), 406–421.

Naughton, M., Nulty, A., Abidin, Z., Davoren, M., O'Dwyer, S., & Kennedy, H. G. (2012). Effects of group metacognitive training (MCT) on mental capacity and functioning in patients with psychosis in a secure forensic *psychiatric hospital: a prospective-cohort waiting list controlled study. BMC* Research Notes, 5(1), 302.

Neff, K. D. (2003). The development and validation of a scale to measure self-compassion. *Self and Identity*, 2, 223–250.

Neff, K. D., & Germer, C. K. (2013). A pilot study and randomized controlled trial of the mindful self‐compassion program. *Journal of Clinical Psychology*, 69, 28-44.

NHS England. (2013). NHS Standard Contract 2014/15- Particulars, Schedule 2- The Services, Service Specifications.

National Institute for Health and Clinical Excellence. (2012).

Novaco RW (1980) *The Novaco Anger Scale*. Irvine, CA: Department of Psychology, University of California.

O'Connor, S. R., Tully, M. A., Ryan, B., Bradley, J. M., Baxter, G. D., & McDonough, S. M. (2015). Failure of a numerical quality assessment scale to identify potential risk of bias in a systematic review: a comparison study. *BMC Research Notes*, 8, 224.

Ost, L. G. (2008). Efficacy of the third wave of behavioral therapies: a systematic review and meta-analysis. *Behavior Research and Therapy*, 46, 296–321.

Owen, G.S., Richardson, G., David, A.S., Szmukler, G., Hayward, P., & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *Brit Med J.* 337 (7660): 40-42.

Patton, J. H., Stanford, N. S. and Barratt, E. S. (1995). Factor structure of the Barratt Impulsiveness Scale. *Journal of Clinical Psychology*, 51, 768–784.

Pompoli A., Furukawa, T.A., Imai, H., Tajika, A., Efthimiou, O., & Salanti, G. (2016). Psychological therapies for panic disorder with or without agoraphobia in adults: a network meta-analysis. *Cochrane Database Syst Rev*, 4.

Popay. J. (2006). *Moving beyond effectiveness in evidence synthesis*. London: National Institute for Health and Clinical Excellence.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D.G. (2009). The PRISMA Group. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *PLoS Med*, 6(7).

Robins, C. J., & Rosenthal, M. Z. (2011). Dialectical behaviour therapy. In J. D. Herbert & E. M. Forman (Eds.), *Acceptance and mindfulness in cognitive behavior therapy: Understanding and applying the new therapies* (pp. 164–192). Hoboken, NJ: Wiley.

Roemer, L. & Orsillo, S. M. (2005). An acceptance based behavior therapy for generalized anxiety disorder. In S. M. Orsillo, & L. Roemer (Eds.), *Acceptance and mindfulness-based approaches to anxiety: Conceptualization and treatment* (pp. 213–240). New York: Springer.

Rosenberg, M. (1965). *Society and adolescent self-image*. Princeton, NJ: Princeton University Press.

Roth, A. & Fonagy, P. (2006) *What works for whom? A critical review of psychotherapy research.* Guilford Press.

Ruiz, F. J. (2012). Acceptance and commitment therapy versus traditional cognitive behavioral therapy: a systematic review and meta-analysis of current empirical evidence. *International Journal of Psychology & Psychological Therapy*, 12, 333-357.

Shonin, E., Van Gordon W., Slade, K., & Griffiths, M.D. (2013). Mindfulness and other Buddhist-derived interventions in correctional settings: A systematic review. *Aggression and Violent Behavior*, 18, 365-372.

Skinner, B.F. (1938). *Behavior of organisms*. New York: Appleton-Century-Crofts.

Snaith, R. P., & Zigmond, A. S. (1994). *Manual for the Irritability-Depression-Anxiety Scale*. Windsor, UK: NFER Nelson.

Spielberger CD (1996) *State-Trait Anger Expression Inventory: Staxi Professional Manual*. Professional Assessment Resources.

Sugarman, P. and Walker, L. (2007). *Health of the Nation Outcome Scales for Users of Secure and Forensic Services (HoNOS-Secure)*. Royal College of Psychiatrists website http://www.rcpsych.ac. uk/training/honos/secure.aspx.

Swart, J., Bass, C. K., & Apsche, J. A. (2015). Third-Wave Therapies for Children and Adolescents: Origins and Development. In J. Swart, C. K. Bass, & J. A. Apsche, *Treating Adolescents with Family-Based Mindfulness* (pp. 31–52). Cham: Springer International Publishing.

Taylor, H. L., Hailes, H. P., & Ong, J. (2015). Third-wave therapies for insomnia. Current *Sleep Medicine Reports*, 1(3), 166–176.

Teasdale, J. D., Segal, Z., & Williams, J. M. G. (1995). How does cognitive therapy prevent depressive relapse and why should attentional control (mindfulness) training help. *Behaviour Research and Therapy*, 33, 25–39.

Telch, C. F., Agras, W. S., & Linehan, M. M., (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology*, 69, 6, 1061-1065.

Tew J., Harkins L., & Dixon L. (2013). What works in reducing violent reoffending in psychopathic offenders. In Craig L. A, Dixon L., Gannon T. A. (Eds.), *What works in offender rehabilitation: An evidenced based approach to assessment and treatment* (pp. 129-141). Chichester, UK: Wiley-Blackwell.

Thomas, S., Harty, M-A., Parrott, J., McCrone, P., Slade, G., & Thornicroft, G. (2003). *CANFOR: Camberwell Assessment of Need - Forensic Version*. London: Gaskell.

Tsai, M., Kohlenberg, R., Kanter, J., Kohlenberg, B., Follette, W., & Callaghan, G. (Eds.), (2009). *A Guide to Functional Analytic Psychotherapy: Awareness, courage, love and behaviorism in the therapeutic relationship*. New York: Springer.

Tsai, M., Yard, S., & Kohlenberg, R. J. (2014). Functional analytic psychotherapy: A behavioral relational approach to treatment. *Psychotherapy*, 51(3), 364-371.

van den Bosch, L. M. C., Hysaj, M., & Jacobs, P. (2012). DBT in an outpatient forensic setting. *International Journal of Law and Psychiatry*, 35(4), 311–316.

Ventura, M. A.,Green, M. F.,Shaner, A., & Liberman, R. P.(1993).Training and quality assurance with the brief psychiatric rating scale: "the drift buster*"*. *International Journal of Methods in Psychiatric Research*, 3, 221–244.

Wanden-Berghe, R. G., Javier, S. V., & Wanden-Berghe, C. (2010). The application of mindfulness to eating disorders treatment: a systematic review. *Eating Disorders*, 19, 34-48.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: A practice manual and conceptual guide.* Chichester, UK: Wiley.

Wells, A. (2008). *Metacognitive therapy for depression and anxiety*. New York, NY: Guilford Press.

Wells, A., & Matthews, G. (1994). *Attention and emotion: A clinical perspective*. Hove, UK: Erlbaum.

Wells, A., & Sembi, S. (2004). Metacognitive therapy for PTSD: a core treatment manual. *Cognitive and Behavioral Practice*, 11, 365–377.

Wells, A., Fisher, P., Myers, S., Wheatley, J., Patel, R., & Brewin, C. R. (2009). Metacognitive therapy in recurrent and persistent depression: a multiple-baseline study of a new treatment. *Cognitive Therapy and Research*, 33, 291–300.

Wells, A., Welford, M., King, P., Papageorgiou, C., Wisely, J., & Mendel, E. (2010). A pilot randomized trial of metacognitive therapy vs applied relaxation in the treatment of

adults with generalized anxiety disorder. *Behaviour Research and Therapy*, 48,429–434.

Wetterneck, C., & Hart, J. (2012). Intimacy is a transdiagnostic problem for cognitive behavior therapy: Functional analytical psychotherapy is a solution. *International Journal of Behavioral Consultation and Therapy*, 7, 167–176.

White, R., Gumley, A., McTaggart, J., Rattrie, L., McConville, D., Cleare, S., & Mitchell, G. (2011). A feasibility study of Acceptance and Commitment Therapy for emotional dysfunction following psychosis. *Behaviour Research and Therapy*, 49(12), 901–907.

White, R.G., Gumley, A. I., McTaggart, J., Rattrie, L., McConville, D., Cleare, S., … Mitchell, G. (2015). Acceptance and commitment therapy for depression following psychosis: An examination of clinically significant change. *Journal of Contextual Behavioural Change*, 4, 3, 203-209.

Witharana, D., & Adshead, G. (2013). Mindfulness-based interventions in secure settings: challenges and opportunities. *Advances in Psychiatric Treatment*, 19(3), 191–200.

Wright, S., Day, A., & Howells, K. (2009). Mindfulness and the treatment of anger problems. *Aggression and Violent Behavior*, 14, 396–401.

Yudofsky, S. C., Silver, J. M., Jackson, W., Endicott, J., & Williams, D. (1986). The Overt Aggression Scale for the objective rating of verbal and physical aggression. *American Journal of Psychiatry,* 143, 35–39.

Zanarini, M. C. (2003). Zanarini Rating Scale for Borderline Personality Disorder (ZAN-BPD): a continuous measure of DSM-IV borderline psychopathology. *Journal of Personality Disorders*, 17, 233–242.

Zigmond, A. S., & Snaith, R.P. (1983). The hospital anxiety and depression scale. Acta *Psychiatrica Scandinavica*, 67(6):361-370.

Zimmermann, G., Favrod, J., Trieu, V. and Pomini, V. (2005). The effect of cognitive behavioural treatment on schizophrenia spectrum disorders: a meta-analysis. *Schizophrenia Research*, 77, 1–9.

Empirical Paper

CIRCLES OF SUPPORT AND ACCOUNTABILITY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE NATURE OF THE RELATIONSHIP BETWEEN VOLUNTEERS AND THE CORE MEMBER

Abstract

Introduction

Circles of Support and Accountability (CoSA) is a community volunteer based restorative justice initiative that aims to support newly released individuals who have committed sexual offences (called core members) to reintegrate back in to society and commit to living an offence free life. Research suggests that CoSA can make a positive impact on reducing recidivism, however less is known about the mechanisms underpinning the model.

The aim of this research was to add to our understanding of the processes within CoSA by conducting a qualitative analysis of the nature of the relationship that exists between volunteers and core members.

Method

Interpretative Phenomenological Analysis was used to interpret the subjective experiential claims of six CoSA volunteers regarding the nature of the relation they had with their core member.

Results

The analysis identified four main themes which reflect participants' experiences of their relationship with their core member and the meaning they attach to this experience. These themes related to how they experienced and made sense of themselves in the relationship, the other in the relationship, issues within the relationship, and also how they experienced making sense of the relationship itself.

Conclusion

The study offers insight into the relational processes that underpin the CoSA model and how volunteers make sense of and experience these processes. The findings can be best understood in the context of the role that social capital plays in promoting desistance and supporting the core member to sustain an offence free life and add to our overall understanding of the processes involved in CoSA.

> It is better to lead from behind and to put others in front, especially when you celebrate victory when nice things occur. You take the front line when there is danger. Then people will appreciate your leadership.
>
> - Nelson Mandela

Introduction

Circles of Support and Accountability (CoSA or 'circle') is a community-based, restorative-justice initiative that supports the rehabilitation and re-integration, back in to society, of individuals who have committed sexual offences (Hannem, 2013). Typically reserved for newly released high and medium risk offenders (known as 'core members'), a circle involves trained volunteers supporting an offender to desist from offending and lead a meaningful life in the community (Hoing, Bogaerts, & Vogelvang, 2015). The 'inner circle' of volunteers consists of between three to six individuals who meet with the core member weekly over a period of 12-18 months, normally becoming less frequent during the latter half of the circle. The volunteers provide social and practical support for the core member, as well as holding them accountable for their behaviour and their commitment to an offence free life. Volunteers receive training in advance of the circle, covering topics such as boundaries, risk, sex offending and manipulation. In addition, volunteers are also introduced to models of offender rehabilitation, such as the Good Lives Model (Ward & Gannon, 2006), and trained in using exercises, such as the Wheel of Life in order to assist them to explore with the core member their goals for the future (Bates, Williams, Wilson & Wilson, 2016). The inner circle is supported by an "outer circle" of professionals and often includes representatives from Probation, Police and Multi-

Agency Public Protection Arrangement (MAPPA) staff. The circle is managed by a circle coordinator who supervises the volunteers and acts as a link between the inner and outer circles. Figure 1 outlines the organisation of a circle in diagrammatic form.

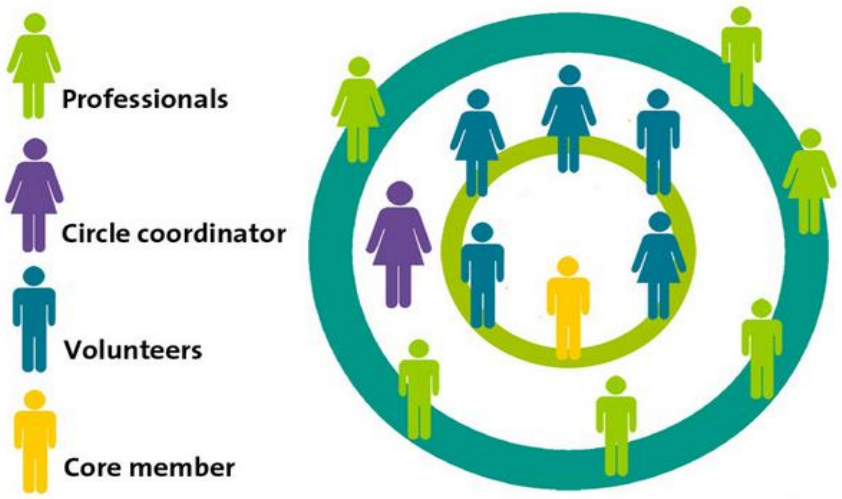


Figure 1. Circles model (adapted from R. J. Wilson & Picheca, 2005, by Netherlands Probation Service, 2012).

Origins of CoSA

First established in Canada in 1994, CoSA was set up by members of the Christian faith, before being brought to the United Kingdom (UK) in 2002 by the Quakers. While some of the religious influences are no longer explicitly present in CoSA, it retains strong links with the Christian church, from which it still gets many of its volunteers (Wilson, McWhinnie, Pichea, Prinzo, & Cortoni, 2007).

In 2017, there were 163 circles run in the UK, involving 16 separate organisations and 583 active volunteers (Circles UK, 2016). CoSA have now been established across Europe and world-wide, with programmes running in countries such as the Netherlands, France, Belgium, Spain, Latvia, the United States, Australia and New Zealand. Due to the growth and success of CoSA, the UK have begun to take a

leadership role in promoting the programme and helping to establish it in new countries (Bates, Williams, Wilson, & Wilson, 2014).

Theoretical Underpinnings of the CoSA Model

Attempts to explain how and why CoSA appear to make a contribution to reducing recidivism amongst sexual offenders have been drawn from a wide range of disparate and diverse areas, including theories of sexual offending (Ward & Beech, 2006), restorative justice (Hannem & Petrunik, 2004), desistance theory (Farrall 2004), the Risk-Need Responsivity model (Andrews & Bonta, 2006), the Good Lives Model (Ward & Gannon, 2006), social capital theory (Kreuter & Lezin, 2002), re-integrative shaming (Braithwaite, 1989), and theories related to relapse prevention (Laws, 1989). It is beyond the scope of the present study to detail how each of these areas contributes to our understanding of CoSA, and instead a brief account of one of the more specific attempts to present a unified theoretical model will be discussed.

There have been a number of studies that have offered general theoretical explanations to suggest how CoSA may work (e.g., Saunders & Wilson, 2003; Wilson, McWhinnie, & Wilson, 2008; Hannenm & Petrunik, 2007), but Hoing, Bogaerts and Vogelvang's (2013) Revised CoSA Intervention Model probably represents the closest to achieving an integrated model to explain the underlying processes. The proposed model includes aspects of restorative justice and desistance theory, as well as elements of social capital theory and relapse prevention. Central to the model are four circle strategies that are suggested to be key to a circle's effectiveness, namely inclusive strategies, change-promoting strategies, risk-reduction strategies, and process-oriented strategies. Additional mediators of circle effectiveness are suggested to include volunteer diversity, a positive climate of trust and openness, a careful selection of the

core member, and effective coordination between the inner and outer circles (Hoing, et al., 2013). The authors sum up their suggested model by asserting that the "core effective feature of COSA is probably the inclusion of the core member into the social structure of a small group" (p. 290), also adding that the fulfilment of the core member's 'need to belong', is probably what best explains why Circles may be effective (Hoing et al., 2013).

Effectiveness of CoSA

There have been a number of studies that suggest that CoSA can make a positive contribution towards reducing recidivism. Two Canadian evaluations reported reductions in general and sexual recidivism for core members when compared to control groups. Wilson, Picheca and Prinzo (2007) compared the recidivism rates of 60 core members to 60 matched controls at 55 months post-release and reported recidivism rates of 7% versus 16.7% for sexual offences, and 28.3% versus 43.3% for general offences respectively. However, these differences were not of statistical significance. In a second Canadian study, Wilson, Cortoni and McWhinnie (2009) matched 44 core members with 44 controls, and over a period of 35 months they reported that the core members had engaged in 83% less sexual offending and 71% less general offending. Wilson et al. (2009) reported that the differences between the core member group and the control group were significant for both sexual and general reoffending, although the statistical rigour of the analysis and the resulting significance of the findings have been questioned by Elliott and Beech (2013). Duwe (2012) conducted the only randomised control test (RCT) of CoSA to date, matching 31 core members with a randomised control group. Despite the small sample size, the study found that core members had lower rates of recidivism, as well as time to recidivism,

compared with controls, although this was for any offence rather than specifically a sexual offence. In the UK, Bates, Saunders, and Wilson (2007) examined 16 circles that were run over a four-year period and found that over half of the core members engaged in behaviours that resulted in them being reported to the police. The design of this study did not involve a control group and therefore no conclusions regarding the contribution of the circle to the core members desistance from offending could be made. In another UK study, Bates, Macrae, Webb, and Williams (2012) conducted a follow-up descriptive study of 60 core members for an average period of 36 months and found that 75% were concluded to have had a positive outcome, 'in that the Circle intervention was either ongoing in some form or had completed its objectives' (Bates et al., 2012, p. 363), with only one core member being reconvicted for a sexual offence. This study also did not have a control group and the short follow-up period meant that it was not possible to compare reconviction rates with those reported in the wider literature. In a similar UK study, Bates, Williams, Wilson and Wilson (2014) looked at core member outcomes over a 10-year period for a regional CoSA organisation. 71 core members were matched with a comparison group with the study reporting a significantly higher incidence of violent and contact sexual offences for the comparison group compared to the CoSA cohort.

While recidivism has been the primary outcome variable of interest for CoSA research, a number of studies have also looked at changes in core members' level of risk (Bates & Wager, 2012; Earnshaw, 2014) and psychosocial variables (Bates et al., 2012; McCartan et al., 2014). In the two reported studies that assessed core members' level of risk, reductions in the domains of Inapproriate Sexual Attitudes and Overconfident Hostile Sexualisation were recorded, while the studies that examined

changes in psychosocial variables reported improvements in the domains of positive attitudes and motivation. Similar to the outcome studies that focussed on recidivism, the small sample sizes, lack of a control group and methodological rigor mean that the results of these studies must be interpreted with some caution. Two studies included an analysis of CoSA from an economic perspective, with both reporting significant return on investment (ROI). Comparing CoSA operating costs with costs associated with rearrests and incarceration, Duwe (2013), in a US study, reported a ROI of 82% and savings of US$1.82 for every US$1 spent. Elliot and Beech (2013), using a hypothetical cohort of 50 core members and 50 controls, estimated a less substantial saving, reporting the net benefit of CoSA over reconviction to be £23,494 per year, per 100 offenders, equating to a cost-benefit ratio of 0.02. They conclude that although their estimated cost saving is low, it is in line with other criminal justice interventions, where the goal is often to at least break even (Elliot & Beech, 2013). While both studies clearly demonstrate that CoSA is at least marginally cost effective from a ROI standpoint, it is suggested that there would also be a potential saving, although more difficult to qualify, in terms of potentially less victims.

A recent systematic review investigating the effectiveness of CoSA concluded that, to date, studies have failed to demonstrate that participation in a circle reduces the likelihood of an offender being reconvicted for a sexual offence (Clarke, Brown, & Vollum, 2017), although a number of studies have reported results that approach significance, with a case being made to consider these results 'socially significant' (Wilson et al., 2007). In their systematic review of CoSA outcomes, Clarke et al. (2017) state that the lack of significant findings does not mean that CoSA is ineffective, but may instead have more to do with a lack of methodically robust

studies. Study design, short follow-up period, small sample size and intervention dosage (i.e. length of time a core member is part of a circle) are cited as possible contributors to the lack of a strong evidence base. They also cite practical issues, such as the fact that by simply taking part in a Circle a core member is more closely monitored, therefore making recidivist behaviour more likely to be detected and also making any attempt to create a matched control group very difficult. Similar observations of challenges (and past failings) of CoSA effectiveness studies were made by Elliot and Zajac (2015) in their evaluability study of CoSA interventions in the US. The authors describe CoSA as currently inhabiting a 'programmatic middle ground', where it is trying to balance maintaining its unique identity with having to evidence its effectiveness, acknowledging that there are many obstacles and difficulties to effectively evaluating CoSA outcomes.

Elliot, Zach and Meyer (2013), in providing a critical analysis of CoSA research to date, suggest that current evaluations should only be considered an estimate of CoSA's potential effectiveness and that 'at this time there is not enough evidence to confidently state that CoSA is proven to be effective in reducing sexual recidivism' (Elliot et al., 2013, p.7). In their analysis of the evidence base supporting the use of CoSA, they identified similar methodological shortcomings, referring to imperfect matching of samples, inconsistent statistical analysis, and lack of statistically significant results as being the main areas of concern.

Aim of the research

The current evidence base, while suggesting that CoSA may make a positive contribution to a reduction in rates of reoffending, falls somewhat short of providing conclusive evidence for its overall effectiveness. While an obvious solution to this

would appear to be the pursuit of further RCTs, there are currently a number of significant obstacles to this type of research, including ethical concerns over withholding treatment, low base rates of reoffending, stakeholder resistance, access to sufficient sample sizes, and long enough follow up-periods with robust data collection methods (Clarke et al., 2017; Hanvey, 2011).

Within the field of criminology, possibly fueled by a motivation to control crime and reduce reoffending rates, it is suggested that research has been dominated by a quantitative discourse that seeks to answer the imponderable question of 'what works', in favour of the question of 'how does it work' (Ward & Maruna, 2007). Tewksbury, DeMichele and Miller (2005), in their analysis of 726 articles from five leading criminology journals over a five-year period, found that just 6% of the studies were qualitative versus 72% being quantitative. The authors of the study in bemoaning their findings highlight the important (and often forgotten) role that qualitative research plays in the development of theory, as well as providing an accessible means to communicating with policy makers and practitioners, that is not grounded in complex statistical analysis (Tewksbury et al., 2005). It is therefore argued that, within criminology research, a more eclectic line of enquiry is warranted (including one that promotes a phenomenological approach), in order to further develop our understanding of offending behaviour.

In the case of CoSA, it is suggested that theory development is still in its infancy and that, at this stage, a more subjective and realist-driven research agenda can make important contributions to our understanding of the processes involved. The aim of this research, therefore, is to explore the lived experiences of CoSA volunteers and

in particular the nature of the relationship they have with the core member, and how they experience and make sense of this relationship.

Method

Participants

Six participants agreed to take part in the research. Three were male and three were female. Their ages ranged between 24 and 83. All participants were White British. Participant's names have been changed to pseudonyms and their ages have been rounded to the nearest decade to ensure anonymity. The key demographics are presented in Table 1 below.

Table 1: Key demographic and main reason for volunteering of participants

Participant	Age	Religious or Secular	No. of Circles Completed	Reason for Volunteering
James	70	Religious (lay person)	3	Expression of faith/personal values
Paul	80	Religious (priest)	5	Related to his role within the Church
Denise	80	Religious (sister)	3	To contribute to reducing reoffending
Claire	30	Secular	1	To gain experience relevant to career ambitions
Mary	20	Secular	1	To gain experience relevant to career ambitions
Andrew	60	Religious (lay minister)	3	Expression of faith

Data Collection

Participants were recruited via a regional CoSA organisation and responded to a request that included an information sheet (see Appendix A) seeking participants to take part in the study. The inclusion criterion for the study was that participants had completed at least one full circle in the past 24 months.

Prior to the commencement of the interviews, participants were briefed on the purpose of the research and given a copy of the information sheet. Participants were further informed of procedures surrounding anonymity and confidentiality, as well as the importance of not disclosing the identity of any core members. Informed consent was obtained through participants signing a consent form (see Appendix B).

Semi-structured interviews (see Appendix C for interview schedule) were carried out and recorded using a digital audio recording device. The interview schedule aimed to support participants to explore the nature of the relationship they had with a core member as well as how they experienced this process and what meaning they attach to it. Interviews resulted in between 60 and 74 minutes of data and were transcribed semi-verbatim.

Analysis

The qualitative approach employed in this study was Interpretative Phenomenological Analysis (IPA; Smith, 1996). IPA has its theoretical foundations in phenomenology, hermeneutics and ideography (Smith & Eatough, 2007) and is focussed on attempting to understand the lived experiences an individual has of a particular event, and the psychological meaning they attach to these experiences. The process is interpretative in that IPA acknowledges that the researcher takes an active role involving a double hermeneutic process whereby they make sense of how

participants have made sense of their own lived experiences through "identifying what *matters* to participants, and then exploring what these things *mean* to them, given their context and our own interest" (Larkin, 2015, p. 12).

The analysis undertaken, including the steps and strategies used to perform IPA are outlined below, and were informed by the recommendations by Larkin (2015) and Smith et al. (2009).

Before commencing the coding of the transcripts, the researcher familiarised himself with the data by reading and re-reading the interview transcripts in detail several times. Following this, a process of free coding involved the memoing of initial thoughts and exploratory comments alongside the transcribed interviews (Smith et al., 2009). This facilitates useful reflections by researchers regarding their own preconceptions and how these might influence their interpretation of the data.

After this, a detailed line-by-line analysis was conducted in order to identify: (a) objects of concern, which comprise of things that are important and matter to the participant; and (b) experiential claims, which describe what meaning the participant attaches to these objects of concern (Larkin, 2015).

The third level of analysis involves the emergence of an interpretative account of the participant's world and the identification of emerging themes and patterns. These themes and patterns serve to highlight patterns of both convergence and divergence within and across accounts and facilitates the development of superordinate themes.

To enhance the validity and credibility of the analysis, the coding and emergent themes were reviewed and discussed with the researcher's academic supervisor and a researcher, independent of the study, who has expertise in conducting IPA research.

The researcher also made use of peer supervision via a student IPA group, whereby sections of anonymised transcript were independently coded by peers and then discussed, facilitating the exploration of alternative perspectives relating to the transcript.

Ethical Approval

Permission to carry out the research was given by Circles UK, a Ministry of Justice funded organisation that works to support the development and effective operation of Circles of Support and Accountability across England and Wales (see Appendix D). Ethical approval for the study was also granted by the Science, Technology, Engineering and Mathematics Ethical Review Committee at the University of Birmingham (see Appendix E).

Reflexive Account

A reflexive diary was kept throughout the research process in order to enhance my ability to understand my own positionality and how this may influence how I approached this research. This account is written in the first person.

I first became interested in CoSA after attending a presentation at a conference by one of the circles organisations in the West Midlands area. At the time, I had started to become aware of strengths-based approaches to offender rehabilitation, as well as the field of restorative justice. Having had a long history of volunteering in the homeless sector myself, I had also witnessed first-hand the value of high-quality volunteer-service user relationships, founded on mutual trust and respect. This led me to become curious about the relational aspect of CoSA and how the competing roles of support and accountability might be balanced by volunteers. Throughout my training as a Forensic Clinical Psychologist, I have also been deeply influenced by supervisors,

the literature, as well as my own clinical experience regarding the positive impact of therapeutic alliance on outcomes. Having previously conducted research using IPA, I felt that this would be a useful vehicle for CoSA volunteers to tell their story about the unique relationship they have with core members.

The interview process was a very positive experience and at times I got the sense that participants enjoyed the process of looking back and reflecting on their relationships with core members and I was repeatedly drawn back to something that was said near the beginning of my first interview about the core members being human beings and not just their offences. The analysis was challenging and at times felt like I was 'drowning' in the data, but referring back to the with the recommended IPA step-by-step processes assisted me greatly.

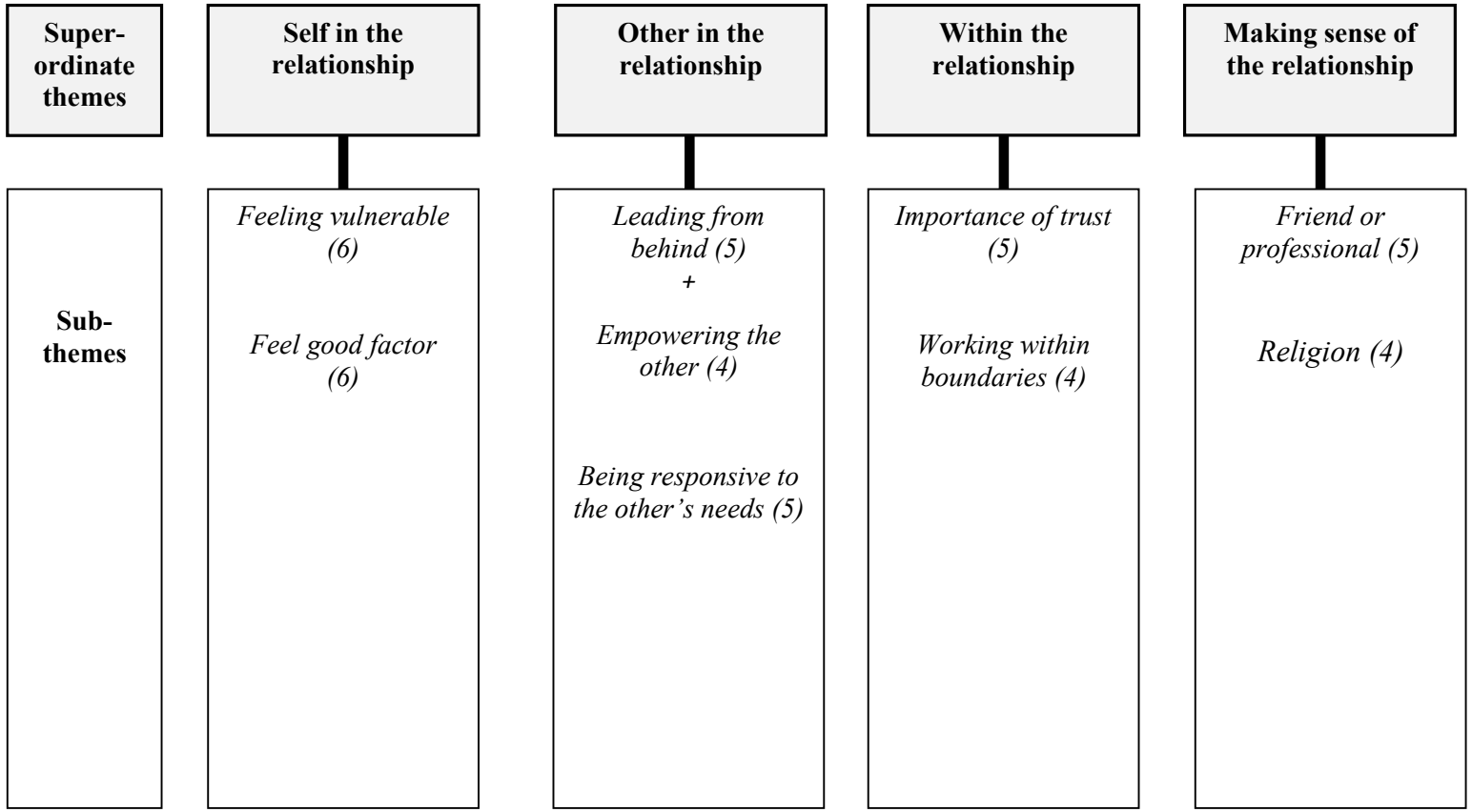
The experience of completing this research has been a wholly positive one and has filled me with admiration and respect not only for the volunteers and the difficult work that they do, but also for the core members whom they "*lead from behind"* on the path to desistance.

Results

The analysis identified four superordinate themes which reflect participants' experiences of their relationship with a core member and the meaning they attach to these experiences. The first superordinate theme 'Self in the relationship' refers to participants' internal experiences of being in the relationship and conveys their thoughts and feelings based on these inner experiences. The second superordinate theme 'Other in the relationship' encapsulates how participants experienced the core member in the relationship and how they made sense of this relationship. The third superordinate theme 'Friendship or professional' conveys participants' attempts to make sense of their experiences in terms of how they view their relationship with the core member. Finally, the superordinate theme 'Within the relationship' speaks of participants' awareness and meaning-making with regard to elements of the relationship itself.

The themes identified are reflective of participants' sense-making and are presented alongside commentary and supporting quotations outlining both convergence and divergence in participants' experiences. Figure 2 below illustrates the structure of the superordinate themes and corresponding sub-themes; the number of participants whose narrative contributed to each theme (in parenthesis).

Figure 2: Structure of superordinate themes and corresponding subthemes



Self in the Relationship

This superordinate theme provides an understanding of how participants experienced themselves in the relationship and how they made sense of this.

Feeling vulnerable. All six participants provided experiential claims relating to feeling vulnerable in their relationship with the core member.

Claire. Here, Claire narrates her experience of being fearful and feeling vulnerable with regard to her personal safety and how she might react to something the core member might say.

> *I had big concerns about how I could help him. About safety, I'll be honest as well, because we didn't know, as I said, anything about him. There was quite a bit of fear really, initially.*
>
> *...because there is still that fear of is he going to say something he shouldn't, is he going to reveal something that's going to make me feel uncomfortable?*

Claire emphasises how vulnerable and scared she felt when first meeting the core member. She attempts to make sense of her experience in the context of not knowing and balances concerns for her personal safety with concerns about not knowing how to help the core member. Claire also makes sense of her feelings of vulnerability as being related not only to the unknown, but also to a lack of control over what the core member might do or say and how this might impact on her. She appears to struggle to make sense of her experience of being concerned about her personal safety, tempering this with "*I'll be honest"*. Claire's narrative conveys a sense of struggle that her desire to fully accept the core member as a human being is being countered by concerns over his past offences and what this might mean for her personal safety.

Paul. Paul describes a heightened sense of threat and vulnerability with regard to the core member. He described not wanting to be "*groomed*", as well as the need to be remain vigilant.

> *...be on your guard on the sense he could be grooming you. Just be aware that he could be grooming you, and be on your guard with that one [...] Don't be groomed. Don't be groomed. Be on the alert, and that's exactly what was that. You don't like doing it, no, you have to abide your instincts about your intuition on whatever it is, and call as you see it. That's what I did*. […] *You don't take things at face value, in a sense. How to put it ... Expect them to be honest. To be as truthful as he knows how, put it that way...Just be alert of what might be going on there.*

Implicit in Paul's narrative is a sense that he feels vulnerable to being manipulated within the context of the relationship and in order to counter this he feels that he must be alert and suspicious of the core member's intentions. Paul's stance is therefore one of suspicion and mistrust, where he is uncertain of the other person's intentions and is unable to take everything he sees at face value. Paul experiences being vulnerable as a tension within the relationship, and he appears to feel uncomfortable with having to be on the lookout for signs that he might be being manipulated. Paul repeats the warning, as if as a reminder to himself "*don't be groomed, don't be groomed"*.

Feel good factor. The participants shared experiential claims that they experienced positive outcomes as a result of their relationship with the core member. All six participants described how they benefitted personally from the relationship and how they felt rewarded.

Andrew. Andrew describes a contrasting picture of the core member before and after his relationship with him and with a sense of pride highlights the positive change that he has witnessed. His interpretation conveys a sense of feeling that he feels that the shared success is his reward for his hard work.

> *I mean, the first one, I am now ... I have not stopped seeing him. I have carried on, I was there yesterday. I've seen this guy that was a prisoner in his little council, old people's bungalow, and last night we had an hour and a half, sharing a cup of tea and a chat, and I checked his mail which I've tended to do. Tend to read through, say junk that, you don't need this. Then he was smartly presented and he was going off to be the committee member for his local working man's club. That's the difference, that is the difference that I've seen this chap. If anybody said that CoSA isn't rewarding ... if it's done right and you get the right result, it's very rewarding.*

Andrew's narrative also highlights the supportive nature of his relationship and seems to challenge any potential dissenting voices with regard to how rewarding the relationship can be. For Andrew, the practical aspects of support and the simple tangible evidence that he is making a difference to the life of the core member is his reward. He adopts a 'knowing' stance, stating the reward is only forthcoming when CoSA is done "*right*", and in this sense positions himself as someone who knows how to do it right. Andrew repeats the word "*difference"* as if to emphasise the positive impact that his relationship has had on the core member's life.

James. James' narrative evokes a sense that he feels the need to excuse himself for feeling good as a result of making a positive contribution to the core member's life. His use of the word "*selfish*" suggests that he views his role in the relationship as someone

who gives as opposed to receives. In doing this, he adopts an apologetic narrative tone, possibly anticipating disapproval on some level.

> *Well, I suppose I've taken out of it – it sounds selfish in a way – because someone has started to smile and wasn't, and I feel responsible, then I feel good. And if someone is happier I feel good. Not a lot more than that really.*

James's final comments appear to minimise his experiencing the relationship as being reciprocal, which further suggests that there may be some underlying reluctance to accept that as a volunteer he has as much to gain from the relationship as he brings to it.

Claire. Similar to James, Claire's narrative creates the sense that helping someone was an extremely positive experience, and one that off-set areas of her personal life where she was experiencing difficulties. When she describes her work situation and contrasts it with her experience of helping the core member, she conveys a real sense of disillusionment with her job, but also a sense of fulfilment as a result of her role with CoSA.

> *I thought, we've helped you. This is really good. It didn't matter what had gone on during my day or how terrible my work had been. Going to that meeting and knowing you'd spent just an hour really helping somebody was enormous. It completely just erased everything else that I was worrying about during the rest of the day, because my job was a nightmare. It was sat in front of a computer. It was numbers. It was completely different, so sitting in front of somebody and knowing you were helping someone, it just helped me massively. It really did.*

Claire's account provides a personal insight into how she experienced her relationship with the core member as something very positive. She adopts a narrative

stance of gratitude and places emphasis on how much she took from the relationship, using words such as "*enormous*" and "*massively*". Claire, in her description of the hour she spent each week helping the core member, highlights the experience as one that was overwhelmingly positive and crossed over to many other areas of her life.

Other in the Relationship

This superordinate theme provides insight into how participants experienced the 'other' in the relationship. Their narratives convey that they made sense of their role as one of subtle leadership, but also that the core member's needs were primary in the relationship. Within all participants' meaning making of the other in the relationship, there is also a real sense of the person's autonomy and personal agency being respected.

Leading from behind. All but one of the participants described themselves as having adopted some form of a leadership role in their relationship with the core member. Their narratives create a sense that they perceived this leadership role as one of empowering the other and facilitating personal development for the core member.

Claire. Claire conveys an image of the relationship as a safe space from where the core member could explore and push beyond the boundaries of his comfort zone. Within her meaning-making, there is a sense that she views her role as inspiring the core member to challenge himself. Her use of the word "*push*" creates a powerful image of her behind the core member gently encouraging him to move forward with her support always being present.

> *Every week he'd come back and say, well, I tried this. I did this. It was nice to know that he was genuinely really trying. Even though he was absolutely terrified, he tried. Then we'd try and push him a little bit further every single week. After, I*

think, about six months we said, Okay, how would you feel about we're going to go out? We're not going to stay in this little nice little cosy room. We're going to go outside. You could just see the fear. He didn't want to do it, but he knew he needed to move forward, and we made a point of saying, Look, this is what you've done so far that you didn't think you could do, how about we do it? We came up with a plan with him.

Claire's narrative also evokes the sense of a shared journey, where the collective support of the volunteers is empowering the core member on his journey of desistance towards an offence-free identity. She very much adopts an inclusive stance by her use of the collective "*we*", and one gets a true sense that she sees her role as one of enabling as opposed to being directive.

***James*.** Within James' narrative, he uses the metaphor of a flower and makes sense of his role in the relationship as facilitating growth and change in the other. The flowering metaphor is especially powerful in conveying the non-directive approach that James takes towards the core member.

The word that immediately jumps to mind, and it might be inappropriate, but anyway it just jumped is flowering. […] He used to compose songs and he used to do a bit of writing, so he said or I said or whatever, I said, "Is that something you have done recently?" and he said, "Not really". And I said, "Maybe you'd like to try" and he did and he came along and he brought his poem and I thought this is really good. Then he would do it each time and it grew. So, that is an example of the flowering.

...then he'd get out of the car and go and stand in the shop and watch, then he'd go into the shop and so on. So, that was the flowering.

James also adopts a narrative tone here that is very much a suggestive and encouraging one, whereby avenues of change are presented to the core member as choices. In this sense he conveys a sense that he is behind the core member supporting him to make choices as opposed to being out in front taking a more directive role.

Mary. Mary provides a direct example of how she supported and empowered the core member to accomplish a task that previously he would not have been able to do, and in doing so positions herself as adopting a leadership style that again is facilitative and non-directive. Her account provides insight into her sense-making in that even small tasks were extremely difficult for the core member, something that is evidenced by her repeating the word "*massive*" when recounting his achievements. Again, similar to other narratives, within Mary's meaning-making, there is a sense that she interprets her role in the relationship as being one of sharing in the achievements of the core member, as well as empowering him to push beyond his comfort zone.

*Go to the Post Office, was one. Which seems really small and insignificant but for him was a massive, massive deal. We'd get him to go to the Post Office, and he'd take a photo or get something so we knew that he'd been, and he could tell us about it. It was one where he went to the Post Office and he was sat in his car and was feeling quite anxious about it, and he was watching who was going in and out. I'd text him I think on the day, because he had a set date to do it, and I'd text him to see how he was feeling and everything, and then he text after he'd done it. So we started to do that with him in the middle, setting these targets of where to go***.**

This extract demonstrates not only the task-setting role that Mary sees herself as having, but also the supportive role that she plays in the carrying out of the tasks. As well as playing a supportive role, Claire conveys an acknowledgement of the inequality in the relationship, as well as her role in keeping the core member accountable. In her description of him taking a photo or getting something at the Post Office "*so we knew he had been there",* there is a sense that for her the nature of the relationship may be something more than simply being supportive.

Being responsive to the other's needs. Most of the participants provide a narrative that describes how they developed a deep understanding of the core member, which then helped them to support him in a way that was responsive to his needs.

Claire. Within Claire's experiential claim is the sense that only through getting to know the core member could she be responsive to his needs. At the beginning of this excerpt, Claire conveys a feeling of hopelessness and not knowing how to help the core member. This is shortly followed by a realisation that she can in fact help, with the repeated use of "*actually*" serving to highlight the moment as a significant event in the relationship. Claire also adopts a minimising stance in describing her contribution as "*simple*" and further emphasises this with the repeated use of the word *"just".*

> *What on earth can I do? After he'd revealed that about himself, thought, actually, I can help you more than I realised I could. Just with simple things like just support, just, Okay, he said that a certain ... He used to get really anxious about a certain time of day, or certain things used to make him anxious. Okay, you know what, I'm going to give you a call in the morning just to make sure you're all right, because I*

understand that it's difficult for you. I just felt like I could do something, that I actually had a purpose in the circle, whereas I didn't feel I did before.

When Claire provides this narrative of how she helped the core member, she conveys an overwhelming sense of not only compassion but also a deep understanding of what the core member needed in terms of support. Claire narrates a process of doing something that is both simple but highly personable and meaningful for the core member and the experiential impact of the act clearly had an effect on her in terms of an increased sense of purpose.

Paul. Within this excerpt, Paul's narrative very much conveys a sense that it is only through knowing the core member and recognising his needs that one can contribute fully to the relationship. Similar to Claire, his tone at the beginning communicates feelings of hopelessness (and maybe frustration) at not knowing how to help. This is emphasised by the repeated questioning of what the core member's needs are. Within Paul's meaning-making is the message that only by knowing and understanding the core member one can truly begin to help him.

What does he need? What does he need? What is his needs? And let's see what his needs are. In a sense that what his needs is, and that's what I'd be cluing into. Sometimes that's not easy, to get a handle on the needs. Because if you touched on needs, you have to be careful and sensitive in the sense ... the vulnerabilities. They might react and close up shop, so you have to ... it's a slow, easy, gentle way of doing it. […] You build a road. The things he said, the things he shared, I sense this, this, this about you, is that part of who you are, what's going on? Something

like that. In that sense, I'm checking into his needs. And by and large, they usually respond to that.

Paul presents himself as searching sensitively for information relating to the core members' needs and in doing so positions himself in a helping role in the context of the relationship. He describes a process that must be completed carefully, all the time being respectful towards the core member, and conveys this image with the use of words like "*slow*", "*easy*" and "*gentle*". Using a metaphor of a road, he creates an image of building a road from his understanding of the core member's needs to one that facilitates the subsequent journey towards recovery and desistance.

Within the Relationship

Throughout their narratives, participants made experiential claims relating to aspects that occurred within their relationship with the core member. This superordinate theme relates to how participants experienced and made sense of aspects of the relationship that were pertinent for them. Trust was something that all participants spoke about, describing it as an essential element of the relationship. All participants also provided accounts of how they experienced boundaries within the relationship and the meaning they attached to these.

Trust. Trust was described by all participants as being a key ingredient of their relationship with the core member. For most, trust was something they experienced as being bi-directional and their narratives convey a sense that in order for the relationship to work both sides needed to trust each other. For Claire, Mary and James, the disclosure by the core member of his index offence was a key moment in terms of building this trust in

the relationship and in some ways contributed to him being humanised and maybe perceived as less threatening.

Claire. Within Claire's narrative, she provides insight into how she struggled initially to trust the core member and had real concerns for her own personal safety. Implicit in her account appears to be a deep fear of the unknown and within her meaning making she conveys a real sense of not feeling safe. The use of *"really, really"* also serves to emphasise how nervous she was.

> *Nervous. Really, really nervous. I didn't know what his offence was at this stage, so I didn't know what we'd have to deal with. I didn't know anything about him at all.*

Claire appears to feel the need to justify her feeling scared and being concerned for her safety and evokes a sense that trust was not present at this stage of the relationship.

As the relationship progressed, however, Claire provides a contrasting narrative that conveys a real sense of trust and feelings of safety.

> *Once we'd gotten over that, the formality of it all and started to relax and think, you know what, he isn't a danger. We're safe, then we could start talking about likes and dislikes, and trying to find some common ground. […] It became more of the beginnings of a potential friendship… It's very much a two-way thing because he needs to trust us just as much as we need to trust him.*

Within Claire's meaning-making, there is a sense that for her feeling safe is the foundation upon which trust and the relationship with the core member can be built. In this narrative, Claire adopts an accepting and humanising stance, where the person behind the offence is recognised.

Paul. In contrast to Claire, Paul's narrative indicates that for him it was not his trust of the core member that was most important, but whether the core member was trusting of him. When Paul provides this narrative, one gets a sense of mistrust directed towards the core member. Within his meaning making there is reference to nearly an expectation of dishonesty and impression management on behalf of the core member.

> *You don't take things at face value, in a sense. How to put it ... Expect them to be honest. To be as truthful as he knows how, put it that way. At the same time, he might be, what's the word ... glossing up the thing and trying to make it look not as bad as it was from his own perspective.*

In this excerpt, Paul appears to be making sense of his need for the core member to trust him.

> *I think it gives them a sense that this one understands me. He understands me. And they'll be more forthcoming, than if I wasn't on to this one. It gives them a sense that they can start trusting me. I'd say he started to trust me maybe the first time in his life that he started to trust somebody. On a different level than he used to do before. I'd say before, any relationship they had would be built on bluff. This not become bluff, this one knows me, and I sense he knows me more and he trusts me, I sense he's building that trust… That was the worst. The saving grace was in the fellow's ... right, I would give him the benefit of the doubt, I would work with that.*

Here, Paul also describes how it is important to have an understanding of not only the details of the core member's offence but also some of his strengths, which Paul refers to as his "*saving graces"*. Paul makes reference to feeling a need to communicate his understanding to the core member and that this then allows the trust to be built. Within his

meaning-making, there is a sense that Paul feels that others may not have taken the time to understand the core member, and therefore were never truly trusted by him. When Paul provides this narrative, he also conveys a sense of privilege in that he may be the first person that the core member has really trusted.

Andrew. Similar to Peter, within Andrew's narrative, there is a feeling of suspicion and a sense that the core member can never be fully trusted. Andrew's meaning-making conveys a sense that he is unprepared to completely look beyond the offence and his use of the word '*listed offender'* evokes a feeling of permanency. In contrast to Claire's narrative, which spoke of '*a potential friendship'*, the implicit theme within Andrew's narrative appears to be about a motivation to gain the trust of the core member in order for this to this to become a factor that promotes desistance.

> *I think that that is one of … if they got friends people that they trust, and that trust them, as far as you can of course because these are listed offenders, then that is an element that would stop them offending. That would put a resistance. This model of the steps, it might just stop them from going to step two to step three, or step one ... he might just be thinking, gosh, Andrew wouldn't like it if he knew I'd done this.*

In adopting this position, it is suggested that Andrew's stance is more one of accountability, as opposed to being supportive. In this sense, he adopts a narrative that is free from emotion and explicitly outlines how he perceives his role in the relationship as being one of promoting desistance, and how trust increases the likelihood that this will occur.

Boundaried nature of the relationship. By its very nature, relationships within CoSA are boundaried. All CoSA volunteers receive training on boundaries, including

guidance on disclosure of personal information and what constitutes a 'safe' and appropriate relationship with a core member. All participants acknowledged the presence of boundaries, with some participants appearing to struggle more with them than others

Claire. Of all the participants, Claire found the boundaried nature of the relationship the most difficult. Within this excerpt, Claire refers to finding the imbalance in the sharing of personal information a challenge. The experiential impact of this is clearly evident when she describes wanting to balance things by sharing some information about herself, but not being able to, due to the need to maintain boundaries. Her narrative conveys a real sense of struggle and tension between wanting to do what feels natural but being constrained from doing so.

> *That made it difficult again, because he'd made this big breakthrough and said actually, he trusted us with this, but we were still holding back from him. I found that quite difficult at first, because I thought he's been honest. I thought, I can't do that. I can't share with you.*

In her description, Claire chooses a narrative tone that appears to suggest that the boundaries that are preventing her from sharing herself with the core member are an external imposition and not one that she has elected to create herself. In this sense, her stance is one that seeks to absolve her from any responsibility for the imbalance and boundaried nature of the relationship.

Mary. Within Mary's narrative, boundaries were viewed more positively and her interpretation of them conveys a sense that she viewed them as protecting her. In contrast to Claire, Mary interprets boundaries as something that are internally generated and

therefore adopts a less apologetic stance when sharing her experience of boundaries in the relationship.

> *I think you're kind of guarded in a way obviously because of the situation you're in, so I suppose there is that barrier in terms of how much you want to give […] so it was very much I like to have that barrier between, knowing that I lived close and things like that. So I think that was in the forefront of my mind anyway, and I always have that barrier of not giving too much away.*

However, like Claire, within Mary's meaning-making of boundaries there is a sense that they are not consistent with her normal way of being, and therefore she must remain alert to committing a boundary-crossing by not "*giving too much away"*. Mary's account and her repeated use of the word "*barrier*" creates a powerful image of a physical barrier between her and the core member, behind which she keeps her true self protected.

Paul. Similarly, within Paul's meaning-making of boundaries in the relationship, he conveys a sense that he views them positively and that they are protective.

> *I don't give in to him. I might say will you do that, no do that yourself. In other words, I'll keep my distance, I will decide when I'll see him and when I won't see him, and so forth. He can't come see me any time in that sense he's not getting over-dependent on me.*

Here, Paul also chooses a narrative stance that seeks to communicate a sense that the boundaried nature of the relationship was not only protective for him but also for the core member and fulfilled a role of keeping the relationship healthy.

James. For James, who adopts a more detached and unemotional tone in his narrative, boundaries are something that are explicitly discussed with the core member as

being part of the relationship. Within this narrative, James conveys a sense that it is the boundaries that define the relationship and this demonstrates his desire to maintain some distance from the core member.

> *So, I think I'd prefer to be more upfront and say, we are in a relationship which is for a particular purpose and these are the boundaries and… So, that my sort of hunching movement.*

In the following excerpt, James positions the relationship in the context of him being there to help the core member and in doing so continues to employ an impersonal and detached tone. Within his meaning-making, he appears to convey a sense that the relationship is anything but a friendship, but is in fact something that is purposeful, positioning himself as the helper and the core member as the one in need of help.

> *Yeah, but I suppose I'm saying I do want to keep a sort of a boundary and I don't want to pretend that I really think you're a great guy when in fact I don't. I can be nice to you because you've got a problem and I'm here to try and help if I can and so on.*

Making Sense of the Relationship

For most participants, the relationship they had with the core member was unique and unlike any other relationships in their lives. This superordinate theme describes how they made sense of the relationship and while each participant experienced the relationship differently, there was commonality in how they contextualised their experiences relative to other relationships in their lives.

Friend or professional. A common theme present in participants' sense-making was an attempt to understand the relationship in the context of whether it was more similar

to a ‘friendship’ or a ‘professional’ relationship. Some participants appeared to struggle to decide where along this continuum the relationship was, which probably reflects the dynamic nature of it and how the dual roles of support and accountability co-existed side by side.

Denise. Within this excerpt Denise refers to not knowing the core member’s surname and her narrative appears to convey a certain distance between them, something that is not present in her friendships. Denise also appears to adopt an apologetic stance, one that may serve as an attempt to lessen any potential negative impact as a result of her experiential claim. Her interpretation conveys a sense that she views her relationship with the core member as very different from her friendships, and places the desire to maintain contact firmly with the core member. Denise chooses a narrative that highlights the differences the relationship has to a friendship and in doing so positions it more towards a professional relationship.

> *Right, right, well I suppose … This is very bad, but friends I would generally remember their surnames, I don’t remember his surname, and apart from the fact that he wants to keep in touch by this sort of six-monthly meal, I don’t know that it would be particularly appropriate for me to get into touch with him.*

In the account below, Denise further distances the relationship from one of friendship and presents it in the context of being one-sided. Within her meaning-making, there is a sense that she views the relationship as being one way and her use of language conveys a feeling that friendship is not something that she is actively seeking from the core member.

It's just to say that I wouldn't call him a friend because I don't know him well enough, but it's to say that I'm sufficiently interested, that when I see something that I think could be helpful for him, I would do something about it.

Finally, in this next excerpt, Denise makes sense of the relationship and places it again very much in the professional realm, likening it to a doctor-patient relationship. In doing so she evokes a sense that within the relationship, there is an expectation and an obligation on her to provide help, something that serves to further distance it from being a friendship.

I haven't practised that much as a doctor but I would put the core members in the same category if you like as patients.

Andrew. Similar to Denise, Andrew attempts to make sense of the relationship in the context of a friend or a professional relationship, but unlike Denise, within his meaning-making, he interprets it as being more like a friendship. Both provide different experiential claims that serve to highlight how they see their relationship as being more professional or friendship-like. Andrew chooses a narrative that describes him helping the core member beyond what would be expected in a professional relationship and, in contrast to Denise, conveys a sense of closeness as opposed to professional distance.

I think it's a friend relationship, it's a friend relationship...Professional, I don't go anywhere. If it's a professional, that means you wouldn't do things that ... I don't think I would go down to the graveyard with them.

When Andrew provides this narrative outlined below, he portrays conflicting thoughts about the relationship and how he makes sense of it. On the one hand it feels like

a friendship, but through his use of the car metaphor below he portrays a relationship where the power is not equal and one where there is distance between both parties.

> *It's a one-way street. You're in the driving seat the whole time, and you're hoping he's sitting along with you and will drive around. But it's strange in that sense. What are examples ... In a friendship, you don't mind to get close. But then you don't encourage getting close. You try to get close. This, no. In that sense, it's a friendship but maybe professional, too. In that sense professional. You don't get too close or let them get too close.*

Andrew narrates his difficulty in making sense of the relationship and conveys an overwhelming sense that he is struggling with closeness and what this means for the relationship. His account paints a vivid picture of the push and pull nature of the relationship, as he attempts to manage both the friendship and professional aspects of it, and at times appears to be torn between the two.

James. For James, he too sought to make sense of the relationship along the continuum of friend or professional, concluding that he feels much closer to the professional, but still evidencing some struggle in his meaning-making by tempering his interpretation of the relationship as being "*friendlier professional"*

> *I'd be much closer to the professional rather than the family, much, much closer. A friendlier professional.*

Paul. Similar to other participants, for Paul it is also the one-way nature of the relationship that differentiates it from a friendship. Paul clearly articulates what makes the relationship unlike a friendship and for him this that in a normal friendship he gives

something of himself to the relationship, whereas in his relationship with the core member he holds something back.

A friend ... I share myself, I commonly don't. I don't share myself.

Religion. Four of the six participants came from a Christian background and chose to provide narratives that contained a religious underpinning, when describing and making sense of their experience of CoSA and the relationship they had with the core member. Within these narratives, there was a common theme that by volunteering participants were living their faith and doing 'God's work'. It appeared that their Christian faith was so central to how they experienced and made sense of their relationship with the core member, that it was important to include this as a theme. Common across many participants' experiential claims was a sense that they had less choice regarding how they felt towards the core member, because as Christians they were expected to, as Andrew put it, "*love the unloved*".

Andrew. In the following extract, Andrew's narrative evokes a strong sense that he experiences his relationship with the core member in the context of his Christian faith. In doing so, he adopts a narrative tone that positions his relationship very much as being part of his Christian duty. Within his meaning-making, there is a sense that he does this less out of choice and more to do with it being a vocation. Through his narrative, he also appears to adopt a position that evokes a sense of power in relation to the core member, as illustrated by his reference to 'saving' him.

I do all sorts of fringe ministries where you've got to love the unloved. This is part of my Christian calling, my call to save is from the Lord, and this is just right up that street because as soon as you say offenders, I'm working with offenders, that

would put people taking one step back. And if you think I'm trying to help ex- sex offenders, they take a pause and two steps back.

When Andrew describes the prospect of people being shocked by him working with "*offenders",* there is a sense that, for him, not only is it important to be doing God's work but also to be seen that he is doing this.

In the following excerpt, Andrew goes on to describe a very compassionate view of his relationship with the core member, but this is then contrasted by his more impersonal interpretation of this being his "*brief*". Implicit in his narrative is a sense that his relationship with the core member may be somewhat of a microcosm for his relationship with God.

I always treated him just as I would anybody else. Very openly, very warmly. I loved him right from the start. I can't say it was anything, because that's my brief.

Denise. Similar to Andrew, Denise's narrative conveys a strong sense that she made sense of her relationship with the core member in the context of her faith.

Well I suppose there's a basic, hopefully, as the Quakers would say, there's something of God in everybody. […] I don't know, I'm thinking a bit about the Christian side of it, that we're told to love everybody but you don't have to like everybody. […] So any help that we can do to bring them back into mainstream community, that's my goal

Denise, in her meaning-making of the influence of her faith on the relationship, differentiates loving someone from liking them, and in doing so conveys a sense of personal agency as well as acknowledging a limit to what she is expected to do as a

Christian. This contrasts with Andrew, whose narrative conveyed more a sense of obligation and need to follow his *"brief"*.

James. James also describes how his Quaker faith influenced his work with CoSA, but adopts a narrative tone of anticipating judgement, feeling the need to justify it with explaining that he also does it because he enjoys it.

> *Then I stopped that ages ago and became a Quaker etc. etc. And as a Quaker there's a lot of emphasis on putting your faith into practice, which I do because I enjoy it, not because I feel I want to save the world or anything.*

Discussion

This qualitative study employed Interperative Phenomonological Analysis (IPA) to explore how six volunteers with Circles of Support and Accountability (CoSA) experienced their relationship with core members they worked with.

Summary of Main Findings

The analysis identified four main superordinate themes within the data, which reflected participants' experiences and how they made sense of the relationship they had with a core member. The narratives of the participants describe a mutually beneficial and trusting relationship where both sides felt valued and respected. The unique nature of the relationship was also evidenced in participants' attempts to make sense of it and understand it in the context of their professional and personal relationships.

Theoretically, it is suggested that the findings of the study, including how they contribute to our understanding of CoSA, are most suitably grounded in the wider context of the social bond or 'informal social control' theory of desistance (Farrington, 1992; Sampson & Laub, 2003). Within the desistance literature, there is an acceptance of the important role social relations can play in supporting a cessation in offending behaviour (Sampson & Laub, 1990). While the underlying mechanisms that explain the relationship between social bonding and desistance are less well understood, there appears to be consensus that desistance does not simply occur due to the presence of social connections, but is in fact mediated by the perceived strength, quality and interdependence of these ties (Maruna, 1999; West, 1982).

Loneliness and social isolation have been identified as important risk factors for the maintenance of sexual offending (Marshall, 1989, 2010), as well as being associated

with higher levels of aggression in individuals who have committed sexual offences (Blake & Gannon, 2011; Ward et al., 2000). Amongst criminal populations, individuals who have committed sexual offences are recognised as having the greatest difficulties forming meaningful relationships with others (Ward et al., 2000), with a number of studies reporting that individuals who have committed sexual offences often perceive their social networks to be inadequate (Blake & Gannon, 2011). A key component of Gobbels, Ward and Willis's (2012) Integrative Theory of Desistance from Sex Offending (ITDSO) is the reintegration phase, whereby an individual re-joins society following a period of incarceration. CoSA is recognised as one of a number of practices that aim to address this problem of social support for newly released individuals who have committed sexual offences. While essential human capital needs such as housing and financial support must be met, research has highlighted the importance of social capital in promoting long-term desistance (Farrall, 2004; Farrall & Calverley, 2009). Social capital has been referred to as an individual's social connectedness along with their social ties, and their involvement in a set of relations of trust that assist their participation in civil society (Brown & Ross, 2010). Human capital, on the other hand, refers to the skills, knowledge and abilities that an individual possesses (Coleman, 1990), and in the context of desistance would include things such as an individual's thinking style and attitudes towards their offence, along with their motivation to change (Farrall, 2002, 2004).

The re-entry phase of the ITDSO also emphasises the need for the individual to maintain a commitment to change, with Ward and Maruna (2007) suggesting that this is best presented in the form of approach rather than avoidance goals (i.e., achieving a desired outcome versus avoiding an undesirable outcome), because desistance represents

simply more than an avoidance of offending behaviour. Further support for this preference of approach over avoidance goals is found in the most recent version of the Good Lives Model of offender rehabilitation (GLM; Ward & Maruna, 2007), known as the Good-Lives Desistance Approach (Ward & Laws, 2011). Ward and colleagues suggest that most individuals who commit sexual offences are not criminals (apart from their sexual deviance), and that the focus of rehabilitation should therefore not be to address their criminogenic needs but to improve their ability to obtain Primary Human Goods (i.e., life, knowledge, excellence in work, excellence in play, excellence in agency, inner peace, relatedness, community, spirituality, happiness and creativity; Ward & Maruna, 2007). It is suggested that, based on research evidence that highlights the important role of social capital in promoting desistance and social isolation as significant risk factor for sexual offending (Bunby & Hansen, 1997), addressing these should form a central tenet in any rehabilitation programme.

The findings of this study provide important evidence for CoSA's role in promoting and supporting the development of an individual's social capital and improving their ability to obtain the primary good of relatedness. Relatedness is recognised as being a key element of an individual's social capital, as well contributing to their happiness and well-being (Deci & Ryan, 2000). Relatedness has been defined as "an individual's level of involvement with persons, objects, groups, or natural environments and the concurrent level of comfort or discomfort associated with that involvement" (Hagerty, Lynch-Sauer, Patusky, & Bouwsema, 1993, p. 291).

Within the GLM, the primary good of relatedness is said to contain the sub clusters of goods of intimacy, friendship, support, caring, reliability and honesty (Ward & Brown,

2004). Hagerty et al. (1993) further identify four social competencies involved in establishing and promoting relatedness: (i) a sense of belonging, (ii) reciprocity, (iii) mutuality, and (iv) synchrony. While the present study is unidirectional and explores the relationship between a volunteer and a core member solely from the perspective of the volunteer, the themes identified suggest the strong presence of relatedness and social capital within this relationship. All participants experienced themselves not simply as providers of support and accountability, but also as being in a genuine relationship with the core member, where they too felt a sense of belonging and connectedness. Within the superordinate theme of 'Self in the Relationship', reciprocity was clearly identified by participants who experienced both giving and receiving (i.e., the 'feel good factor') within the context of relationship. Evidence for mutuality also appears within the superordinate theme 'Within the relationship', especially in relation to participants' narratives associated with the shared feeling of trust between them and the core member. This finding has important implications and supports previous work by Ward and Brown (2004), who suggested that a minimal degree of trust is a causal precondition for an individual entering and benefiting from a therapeutic relationship. The fourth social competency of relatedness concerns synchrony, referring to the degree a person's experiences are congruent with another's. The superordinate theme of 'Self in the relationship' and particularly the sub-theme of 'feeling vulnerable' conveys a sense of both the volunteer and the core member being in harmony with regard to how they experienced the initial 'forming' period in the relationship (Tuckman, 1965).

Participants' narrative experiences of their relationship with the core member also echo many of the characteristics of an effective therapeutic relationship (Ackerman &

Hilsenroth, 2001, 2003). Within a therapeutic relationship, the quality of the relationship (i.e., the therapeutic alliance), has been found to be one of the most significant single predictors of positive outcome, with some studies suggesting it accounts for up to 30% of the variance (Hubble, Duncan, & Miller, 1999; McNeill, Batchelor, Burnett, & Knox, 2005; Shirk & Karver, 2003). While not strictly a therapeutic relationship, it is suggested that the unique relationship that exists between volunteers and core members inhabits a space somewhere between a professional therapeutic and a friendship-type relationship. This view was supported by participants' sense-making of the relationship (one of the superordinate themes), with most concluding that it means different things at different times, as it balances the competing roles of support (friendship) and accountability (professional). When reflecting on their experiences of the relationship, participants uniformly presented a narrative that conveys a sense of a relationship that was meaningful and of a high quality.

That CoSA has so far shown promising results in terms of reducing recidivism and supporting an individual's re-entry into society supports the suggestion that it is the quality of the relationship that may be making a significant contribution towards a positive outcome. Amongst identified therapist attributes that are associated with a positive alliance and outcome are flexibility, friendliness and being empowering (Ackerman & Hilsenroth, 2003), whereas attributes seen to contribute negatively to the therapeutic alliance included inappropriate self-disclosure, belittling and being uncertain (Ackerman & Hilsenroth, 2001). The narratives presented by participants further support the suggestion that it may be the relational aspect of CoSA and the 'alliance' that forms between volunteers and core members that is fundamental to its success. Clear links can

be seen between factors identified in the literature as contributing to a positive therapeutic alliance and participants' sense-making of their relationship with the core member. These are outlined in Table 2 below.

Table 2: Relationship between factors contributing to a positive therapeutic alliance and participants' sense-making of their relationship with core members

Therapeutic Relationship Factor	Sub-theme
Flexibility	Being responsive to the others' needs
Friendly	Friend or professional
Empowering	Leading from behind
Inappropriate self-disclosure*	Working within boundaries
Belittling*	Leading from behind

* Factors contributing to a negative therapeutic alliance

Participants' narratives also convey a sense of experiencing their relationship with the core member similar to that of being a 'mentor'. How they made sense of the relationship bears strong similarities to Nellis' (2002) description of mentoring in a criminal justice context, as being a relationship that is "more formal than befriending but less formal than supervision — and more purposeful than mere volunteering" (p. 94–5). Within the sub-themes of 'empowering the other', 'leading from behind' and 'friend or professional', it is suggested that there is strong evidence for volunteers seeing themselves as fulfilling a mentoring role towards the core member. Previous research has reported findings that support the effectiveness of mentoring programmes for ex-prisoners (e.g., Lewis, 2007), and, similar to the conclusions drawn in the present study, the quality of the

friendship that developed between ex-prisoners and their mentors is recognised as being a key component in promoting future desistance (Brown & Ross, 2010).

Implications for Theory and Practice

The findings of the study present a number of implications for theory. Firstly, they support and add to the existing knowledge base that suggests that social capital may have an important role to play in promoting desistance. Secondly, the findings, in demonstrating the existence of a high-quality relationship between the volunteers and core members, align with previous research that supports the claim that the quality of the relationship is a significant predictor of positive intervention outcomes. It must, however, be acknowledged that the present study did not specifically look at the outcomes of the circles, and the suggested link between quality of the relationship and positive circle outcomes should therefore be interpreted with caution. Finally, the findings add to the current literature focussing on our understanding of what processes might underplay CoSA. The results, by shining a light on the nature of the relationship, albeit only from the perspective of the volunteer, offer some support to the claims made by Hoing and colleagues in their Revised CoSA Intervention Model, that the improvements in social capital experienced by the core member are likely to be the "most prominent theoretical effect of circles" (Hoing et al., 2013, p.271).

The findings also have a number of potential implications for practice. The narratives of the participants highlight the various relational pathways that social capital can be activated for core members, which is suggested to have the potential to inform future training of volunteers. The findings also have implications for practice in relation to how we approach the treatment of individuals who commit sexual offences in general.

Typically, prison-based sex offender rehabilitation programmes have focussed on improving an individual's human capital (i.e., their skills, knowledge, capacities and personal resources), and therefore the addressing of aspects of social capital is often left until the post-release period. While the importance of human capital in promoting desistance is accepted as being necessary, it is suggested that it alone may not be sufficient and that access to social capital is also equally important for a successful outcome. It is therefore proposed that interventions, from the beginning, should consider more direct targeting of the familial and social contexts of offending and desistance, such as the development of an individual's prosocial connections while they are still in prison. Indeed, it is suggested that both the Risk Need Responsivity Model (Andrews & Bonta, 2006) and, to a lesser extent, the GLM (Ward & Maruna, 2007) are overly focussed on the individual level of analysis, and fail to adequately address the development and mobilisation of an individual's social capital.

Methodological Considerations

There are a number of methodological limitations of the study, which should be considered when interpreting the findings. Firstly, a key limitation of the study is that it merely explored the volunteer-core member relationship through the eyes of the volunteers and, in accepting that there are 'two sides to every story', the inferences drawn from the findings may not be a true representation of how the core members experienced the relationships described. Secondly, in keeping with the IPA recommendations regarding the use of a homogeneous sample, the study drew all its participants from the one CoSA organisation, which along with the small sample size, limits the generalisability of the findings.

Future Research

While it is acknowledged that more methodologically robust evaluations must be conducted before CoSA can truly claim to be founded on sound empirical evidence, based on the findings of this study, a number of worthy qualitative future research opportunities have been identified. The present study could be replicated with core members in order to explore their experiences of the relationship they have with volunteers. This would facilitate further understanding of the relational and social capital dimensions of CoSA, as well as allowing for a comparison of meaning making between core members and volunteers.

A qualitative IPA study investigating the relational experiences of volunteers and a core member from the same circle would also further our understanding of CoSA, by facilitating an exploration of the converging and diverging experiences and sense-making in relation to specific circle events, such as the disclosure by the core member of their index offence. Research focussing on how social capital is experienced and mobilised within the CoSA model not only has the potential to inform future developments in circles, but it can also contribute to the wider greater literature base regarding the relational context within which desistance is co-produced. It is also suggested that a more in-depth understanding of the relational processes involved in CoSA, when combined with continued research focusing on outcomes, may shed light on what aspects contribute most to a positive outcome, thereby informing the future direction of the model and ultimately further reducing recidivism.

References

Ackerman, S. J., & Hilsenroth, M. J. (2001). A review of therapist characteristics and techniques negatively impacting the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training*, 38, 171–185.

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 23, 1–3.

Andrews, D. A., & Bonta, J. (2006). *The psychology of criminal conduct* (4th ed.). Newark, NJ: LexisNexis/Matthew Bender.

Bates, A. & Wager, N. (2012) Assessing dynamic risk in the community: the DRR and Circles of Support and Accountability. *Forensic Update*, 108, 5-13.

Bates, A., Macrae, R., Williams, D., & Webb, C. (2012). Ever-increasing circles: A descriptive study of Hampshire and Thames Valley Circles of Support and Accountability 2002-09. *Journal of Sexual Aggression*, 18, 355-373.

Bates, A., Saunders, R., & Wilson, C. (2007). Doing something about it: A follow-up study of sex offenders participating in Thames Valley Circles of Support and Accountability. *British Journal of Community Justice*, 5, 19-42.

Bates, A., Williams, D., Wilson, C., & Wilson, R. J. (2014). Circles South East: The First 10 Years 2002-2012. *International Journal of Offender Therapy and Comparative Criminology*, 58(7), 861–885.

Blake, E., & Gannon, T. A. (2011). Loneliness in sexual offenders. In S. J. Bevinn (Ed.), *Psychology of Loneliness* (pp. 49-68). US: Nova.

Braithwaite, J. (1989). *Crime, shame and reintegration*. Melbourne: Cambridge University Press.

Brown, M. & Ross, S. (2010). Mentoring, social capital and desistance: a study of women released from prison, *Australian and New Zealand Journal of Criminology*, 43, 31-50.

Bumby, K. M., & Hansen, J. D. (1997). Intimacy deficits, fear of intimacy and loneliness among sexual offenders. *Criminal Justice & Behaviour,* 24, 315-332.

Circles UK. (2017). *Annual Review 2016-2017*. Retrieved from http://www.circles-uk.org.uk/images/documents/review_2016-2017.pdf

Clarke, M., Brown, S., & Völlm, B. (2017). Circles of Support and Accountability for sex offenders: A systematic review of outcomes. *Sexual Abuse*, 29(5), 446–478.

Coleman, J. S. (1990). *Foundations of Social Theory*. Cambridge, MA, Harvard University Press.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry*, 11, 227–268.

Duwe, G. (2012). Can Circles of Support and Accountability (COSA) work in the United States? Preliminary results from a randomized experiment in Minnesota. *Sexual Abuse: A Journal of Research and Treatment*, 25, 143-165.

Earnshaw, K. (2014). Dynamic risk review: Overview of data. Paper presented at Circles UK Trustees Meeting, Reading, UK.

Elliott, I. A., & Beech, A. R. (2013). A U.K. cost-benefit analysis of circles of support and accountability interventions. *Sexual Abuse: A Journal of Research and Treatment*, 25(3), 211–229.

Elliott, I. A., & Zajac, G. (2015). The implementation of circles of support and accountability in the United States. *Aggression and Violent Behavior*. 25, 113-123.

Elliott, I. A., Zajac, G., & Meyer, C. A. (2013). *Evaluability assessments of the Circles of Support and Accountability (COSA) model*: Cross site report. Retrieved from https://www. ncjrs.gov/pdffiles1/nij/grants/243832.pdf

Farrall, S. & Calverley, A. (2006). *Understanding Desistance from Crime: Theoretical Directions in Resettlement and Rehabilitation*. McGraw-Hill Education, Oxford University Press: Crime and Justice Series.

Farrall, S. (2004). Social capital and offender reintegration: making probation desistance focused, in S. Maruna and R. Immarigeon (eds) *After crime and punishment: Pathways to offender reintegration*. Cullompton: Willan Publishing.

Farrington, D. (1992). Explaining the Beginning, Progress, and Ending of Antisocial Behaviour from Birth to Adulthood, in J. McCord (ed.), *Facts, Frameworks, and Forecasts: Advances in Criminological Theory*, Vol. 3. New Brunswick, NJ: Transaction Publishers.

Glaser, B.G. & Strauss, A.L. (1967). *The discovery of grounded theory: strategies for qualitative research*. Chicago: Aldine Pub. Co.

Goebbels, S., Ward, T., & Willis, G. W. (2012). An integrative theory of desistance from sex offending. *Aggression and Violent Behavior*,17, 453–462.

Hagerty, B. M., Lynch-Sauer, J., Patusky, K., & Bouwsema, M. (1993). An emerging theory of human relatedness. *Journal of Nursing Scholarship*, 25, 291–296.

Hannem, S. (2013). Experiences in reconciling risk management and restorative justice: How Circles of Support and Accountability work restoratively in the risk society.

International Journal of Offender Therapy and Comparative Criminology, 57, 269-288.

Hannem, S., & Petrunik, M. (2007). Circles of Support and Accountability: A community justice initiative for the reintegration of high risk sex offenders. *Contemporary Justice Review*, 10(2), 153–171.

Hanvey, S. (2011). But does it work? Evaluation and evidence. In S. Hanvey, T. Philpot, & C. Wilson (Eds.), *A community-based approach to the reduction of sexual reoffending: Circles of Support and Accountability* (pp. 150-165). London, England: Jessica Kingsley.

Höing, M., Bogaerts, S., & Vogelvang, B. (2013). Circles of Support and Accountability: How and why they work for sex offenders. *Journal of Forensic Psychology Practice*, 13, 267-295.

Höing, M., Bogaerts, S., & Vogelvang, B. (2015). Volunteers in circles of support and accountability job demands, job resources, and outcome. *Sexual Abuse*, 29(6), 541 –562.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (1999). *The heart and soul of change: What works in therapy?* Washington, DC: American Psychological Association.

Larkin, M. (2015). Phenomenological psychology. *Qualitative Research in Clinical and Health Psychology*, 155–174.

Laws, D. R. (1989). *Relapse prevention with sex offenders*. New York: Guilford.

Lewis, S., Maguire, M., Raynor, P., Vanstone, M., & Vennard, J. (2007). What works in resettlement? Findings from seven pathfinders for short-term prisoners in England and Wales. *Criminology and Criminal Justice: An International Journal,* 7:33–53.

Marshall, W.L. (1989). Invited essay: Intimacy, loneliness and sexual offenders. *Behaviour Research and Therapy*, 27, 491–503.

Maruna, S. (1997). Going straight: desistance from crime and self-narratives of reform. *Narrative Study of Lives*, Vol. 5, 59-93.

McCartan, K., Kemshall, H., Westwood, S., Solle, J., MacKenzie, G., & Pollard, A. (2014). Circles of Support and accountability (CoSA): A case file review of two pilots. London, England: Ministry of Justice.

McNeill, F., Batchelor, S., Burnett, R., & Knox, J. (2005). *21st century social work: reducing re-offending - key practice skills*. Edinburgh.

Nellis, M. (2002). The 'tracking controversy': The roots of mentoring and electronic monitoring. *Youth Justice*. 4 :77–99.

Sampson, R.J. & Laub, J. (1993). *Crime in the making: pathways and turning points through lif*e. Cambridge, Massachusetts: Harvard University Press.

Sampson, R.J., & Laub, J. (1992). Crime and deviance in the life course. *Annual Review of Sociology*, Vol. 18, 63-84.

Saunders, R., & Wilson, C. (2003). *Circles of Support and Accountability in the Thame Valley: Interim report 2003*. London: Quaker Peace and Social Witness.

Smith, J. & Osborn, M. (2003). Interpretive phenomenological analysis. In J.A. Smith (Ed.) *Qualitative psychology: A practical guide to research methods* (pp.51-80). London: Sage.

Smith, J.A. & Eatough, V. (2006) 'Interpretative phenomenological analysis', in G. Breakwell, C. Fife-Schaw, S. Hammond and J.A. Smith (eds), *Research Methods in Psychology*, (3rd edn). London: Sage.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11: 261–71.

Smith, J.A., Flowers, P. & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Starks, H. & Trinidad, S. B. (2007). Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17(10), 1372 -80.

Tewksbury, R., DeMichele, M. T., & Miller, J. M. (2005). Methodological orientations of articles appearing in criminal justice's top journals: Who publishes what and where. *Journal of Criminal Justice Education*. 16, 265–279.

Tuckman, B. W. (1965). Developmental sequence in small groups, *Psychological Bulletin*. 63.

Ward, T. & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation*, Psychology, Crime & Law*, 10:3, 243-257.

Ward, T. & Maruna, S. (2007). *Rehabilitation: beyond the risk paradigm*. London: Routledge.

Ward, T., & Beech, A. (2006). An integrated theory of sexual offending. *Aggression and Violent Behavior*, 11, 44-63.

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, 11, 77-94.

West, D. (1982). *Delinquency: Its Roots, Careers, and Prospects*. London: Heinemann.

Wilson, R. J., & Picheca, J. E. (2005). Circles of Support and Accountability: Engaging the community in sexual offender management. In B. K. Schwartz (Ed.), The sex offender: *Issues in assessment, treatment, and supervision of adult and juvenile populations* (pp. 13.1-13.21). Kingston, NJ: Civic Research Institute.

Wilson, R. J., Cortoni, F., & McWhinnie, A. W. (2009). Circles of support & accountability: A Canadian national replication of outcome findings. *Sexual Abuse: A Journal of Research and Treatment*, 21, 412-430.

Wilson, R. J., McWhinnie, A., Picheca, J. E., Prinzo, M., & Cortoni, F. (2007). Circles of Support and Accountability: Engaging community volunteers in the management of high-risk sexual offenders. *The Howard Journal of Crime and Justice*, 46(1), 1–15.

Wilson, R. J., Picheca, J. E., & Prinzo, M. (2007). Evaluating the effectiveness of professionally facilitated volunteerism in the community-based management of high-risk sexual offenders: Part Two—A comparison of recidivism rates. *The Howard Journal*, 46, 327-337.

Wilson, R., McWhinnie, A., & Wilson, C. (2008). Circles of Support and Accountability: An international partnership in reducing sexual offender recidivism. *Prison Service Journal*, 178, 26-36.

PUBLIC DISSEMINATION DOCUMENT

CIRCLES OF SUPPORT AND ACCOUNTABILITY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE NATURE OF THE RELATIONSHIP BETWEEN VOLUNTEERS AND THE CORE MEMBER

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June 2018

SYSTEMATIC REVIEW

A SYSTEMATIC REVIEW OF THE EFFICACY OF THIRD WAVE COGNITIVE BEHAVIOURAL THERAPIES IN FORENSIC MENTAL HEALTH SETTINGS

Introduction

The rehabilitation and management of mentally ill offenders represents a significant challenge for secure mental health facilities and is also an important issue for public safety. According to the National Health Service (NHS), in 2013, Commissioners in England purchased approximately 7719 inpatient beds across secure mental health services (NHS, 2013). The average cost per annum of keeping a patient in a low secure facility has been estimated at £152,000, rising to £273,000 per patient residing in high secure (Durcan, Hoare, & Cumming, 2011). Individuals who are detained in secure care under the Mental Health Act (1983/2007) will typically have complex mental disorders linked to offending behaviour and often present with additional difficulties such as substance misuse (NHS, 2013). Considering the high financial costs associated with secure care and the complex clinical presentations of forensic patients, the importance of ensuring that the most effective and evidence-based treatment practices are in place is both an issue of ethical and fiscal concern.

Over the past decade, there has been a shift within clinical psychology to a 'third wave' of Cognitive Behavioural Therapy, characterised by a move from first order change (i.e. changing thoughts and beliefs) to second order change (i.e., changing the feelings

attached to such thoughts and beliefs; Witharana & Adshead, 2013), as well as a focus on experiential strategies.

The aim of this systematic review is to review the current evidence for the use of this third wave CBT in forensic mental health settings, with a view to assessing its current impact as well as discussing the potential benefits such an approach might bring.

Method

A systematic search for studies involving third wave CBT in forensic mental health settings was conducted using several databases (PsychINFO, EMBASE, MEDLINE and PsycARTICLES). The therapies included were Acceptance and Commitment Therapy (ACT), Dialectical Behaviour Therapy (DBT), Metacognitive Therapy (MCT), Compassion Focussed Therapy (CFT), Behavioural Activation (BA), Functional Analytic Psychotherapy (FAP), Mindfulness-based interventions (MBSR, MBCT).

Results

Of the 9 studies that met the inclusion criteria, five were DBT intervention studies, two were MCT studies, one was an ACT study, and one a CFT study. Overall, the quality of the studies that met the inclusion criteria was assessed as ‘fair’. In particular,, many of the studies had methodological weaknesses which made it difficult to generalise the results to other forensic mental health .settings.

Conclusions

The findings across the nine studies evaluated suggest that third wave therapies may be effective in forensic settings, however the evidence base is in its infancy and therefore further research is required before this can be said with more confidence. The findings also concluded that conducting research in forensic settings is not without its

difficulties and practitioners must proceed with caution and not be tempted to interpret positive findings in clinical settings as evidence for efficacy in forensic settings.

References

Durcan, G., Hoare, T., & Cumming, I. (2011). *Unlocking pathways to secure mental health care.* Centre for Mental Health.

NHS England. (2013). NHS Standard Contract 2014/15- Particulars, Schedule 2- The Services, Service Specifications.

Witharana, D., & Adshead, G. (2013). Mindfulness-based interventions in secure settings: challenges and opportunities. *Advances in Psychiatric Treatment*, 19(3), 191–200.

EMPIRICAL PAPER

CIRCLES OF SUPPORT AND ACCOUNTABILITY: AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS OF THE NATURE OF THE RELATIONSHIP BETWEEN VOLUNTEERS AND THE CORE MEMBER

Introduction

Circles of Support and Accountability (CoSA or 'circle') is a community based, restorative justice initiative that supports the rehabilitation and re-integration of individuals who have committed sexual offences (Hannem, 2013). Typically reserved for newly released high and medium risk offenders (known as 'core members'), a circle involves trained volunteers supporting an offender to desist from offending and lead a meaningful life in the community (Hoing, Bogaerts, & Vogelvang, 2015). The "inner circle" of volunteers consists of between three to six individuals who meet over a period of 12-18 months with the core member on a weekly basis, normally becoming less frequent during the latter half of the circle. The volunteers social and practical support for the core member, as well as holding them accountable for their behaviour and their commitment to an offence free life.

There have been a number of studies that suggest that CoSA can make a positive contribution towards reducing recidivism (Wilson, Picheca, & Prinzo, 2007; Wilson, Cortoni & McWhinnie, 2009).

Aim

Within the field of criminology, possibly fueled by a motivation to control crime and reduce reoffending rates, it is suggested that research has been dominated by efforts

that seek to answer the imponderable question “what works”, in favour of the question “how does it work” (Ward & Maruna, 2007). The aim of this research is therefore to make a contribution to addressing this imbalance by exploring the experiences of CoSA volunteers and in particular the nature of the relationship they have with the core member and how they experience and make sense of this relationship.

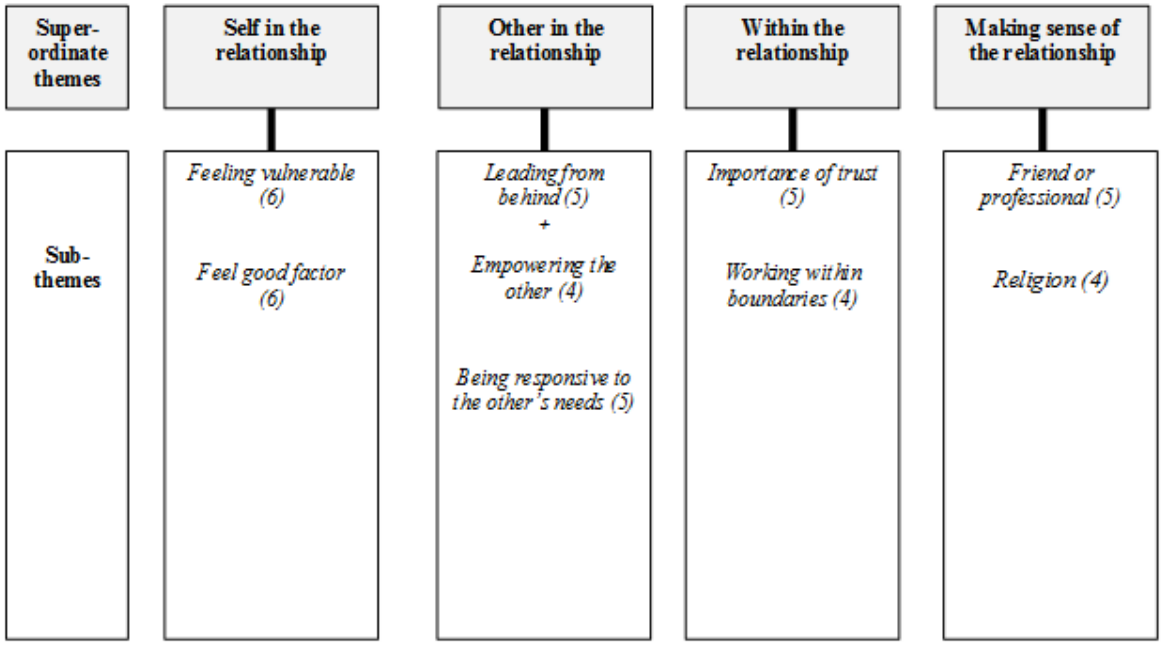
Method

The approach employed in this study focussed on attempting to understand the experiences and psychological meanings that six CoSA volunteers attached to their relationship with the core member. The six volunteers were interviewed by the researcher and the content of these interviews was analysed for common themes.

Results

The analysis identified four main themes which reflect participants’ experiences of their relationship with a core member and the meaning they attach to this experience. These themes are outlined in figure 1 below.

Figure 1. Themes identified from participants interviews



Conclusion

The narratives of the participants describe a mutually beneficial and trusting relationship where both sides felt valued and respected. The unique nature of the relationship was also evidenced in participants' attempts to make sense of it and through understanding of it, in the context of their professional and personal relationships. It is suggested that the findings of the study, including how they contribute to our understanding of CoSA, are most suitably grounded in the wider context of the role of social connection in preventing reoffending (Sampson and Laub, 1993). The results of the study can help inform practitioners and policy makers about the important role that social relationships play in supporting an individual to live and offence free life.

References

Hannem, S. (2013). Experiences in reconciling risk management and restorative justice: How Circles of Support and Accountability work restoratively in the risk society. *International Journal of Offender Therapy and Comparative Criminology*, 57, 269-288.

Höing, M., Bogaerts, S., & Vogelvang, B. (2015). Volunteers in circles of support and accountability job demands, job resources, and outcome. *Sexual Abuse*, 29(6), 541 –562.

Sampson, R.J. & Laub, J. (1993). *Crime in the Making: Pathways and Turning Points Through Life*. Cambridge, Massachusetts: Harvard University Press.

Ward, T. & Maruna, S. (2007). *Rehabilitation: beyond the risk paradigm*. London: Routledge.

Wilson, R. J., Cortoni, F., & McWhinnie, A. W. (2009). Circles of support & accountability: A Canadian national replication of outcome findings. *Sexual Abuse: A Journal of Research and Treatment*, 21, 412-430.

Wilson, R. J., Picheca, J. E., & Prinzo, M. (2007). Evaluating the effectiveness of professionally facilitated volunteerism in the community-based management of high-risk sexual offenders: Part Two—A comparison of recidivism rates. *The Howard Journal*, 46, 327-337.

APPENDICES

Appendix A

Participant Information Sheet

UNIVERSITY OF BIRMINGHAM

Participant Information Sheet

1. **Study title**
   Circles of Support and Accountability: An interpretative phenomenological analysis of the nature of the relationship between volunteers and their Core Member.

2. **Invitation Paragraph**
   You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us (via phone or email) if there is anything that is not clear or if you want more information. Take time to decide whether or not you wish to take part.

3. **What is the purpose of the study?**
   The purpose of this study is to explore your experiences as a CoSA volunteer. This study is looking at the relationship you have with the Core Member and how you make sense of this relationship. The study will explore your understanding of the type of relationship you have with the Core Member and ask you to think about what the relationship means to you. This study is keen to find out the personal meaning you attribute to the relationship also.

4. **Why have I been chosen?**
   You have been chosen because you are a volunteer for CoSA and are currently working within a circle with a Core Member. Other volunteers in a similar position have also been invited to take part.

5. **Do I have to take part?**
   It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a

decision not to take part, will not have any negative consequences for you. You are able to withdraw your consent to be included in this study up until it is due for submission and formal write up at the end of June 2017. Should you wish to withdraw your consent from the study, please contact the researcher at the bottom of this information sheet, giving you participant details and your information will be removed from the study.

6. **What will I have to do?**
   If you decide to take part, you will be asked to meet with the researcher and to take part in an interview. You will be given plenty of notice and a time and location for the interview will be arranged that is convenient for you. The interview will take between 60 and 90 minutes and will explore the nature of the relationship that you have with the Core Member and what the relationship means to you.

7. **What are the possible risks and disadvantages of taking part?**
   There are no foreseeable risks or disadvantages to participating. The individual information you provide will not be made available to anyone aside from the researchers. It will be kept confidential by the researchers. You may withdraw at any time without any negative consequences. There will not be any negative consequences if you do participate.

8. **What are the benefits of taking part?**
   By taking part in this study, you will be helping the researchers to explore and learn more about the nature of the relationships that volunteers have with their Core Members. The research will look at both the positive and negative aspects of the relationship from the perspective of the volunteer. The findings of the research will inform future training of volunteers and also help to identify areas where improvements can be made or additional support can be offered.

9. **What happens when the research stops?**
   After your part in the research, the information you provide will be entered into a computer file accessible only by the researcher) and all the interview transcripts will be assigned a research number. Any information with names on it will be kept in a locked cabinet with limited access to members of the research team. The list matching names to research numbers will also

be kept in a locked cabinet. The information will be kept for 10 years from the date of any publication that occurs using the data

10. **What if something goes wrong?**
    It is not anticipated that anything will go wrong, but you are free to withdraw your participation at any point if you feel that something has gone wrong. You can also contact the researcher to ask for your data to be withdrawn from the study, up until the time that the data is published.

11. **Will my participation in this study be kept confidential?**
    All information that is collected during the course of the research will be kept strictly confidential. When data is entered into the data base it will be assigned a research number and names will not appear in the data base. Research numbers will be used to identify individuals from that point forward. The list that connects names to research numbers will be kept in a locked cabinet. No identifying information about you or other volunteers will be included in any research document

12. **What will happen to the results of the study**
    The results of the research study will be analysed to gain an understanding of how CoSA volunteers experience the relationships they have with CMs. These results may be presented at a conference or appear in a journal.

13. **Contact for further information**

Appendix B

Participant Consent Form

UNIVERSITY OF BIRMINGHAM

Circles of Support and Accountability: An interpretative phenomenological analysis of the nature of the relationship between volunteers and their Core Member

Consent Form for Participants

I have read and understood the information sheet for the above study and have been given the opportunity to ask questions.

I understand that my participation is voluntary and that I am free to withdraw from the study up until _____ *(the specific date will be entered here on the day of the interview)*, without having to give any reason and without me being affected or this having any negative consequences on my circumstances.

I agree to provide information that will be used for research purposes only, and understand that all the information relating to myself obtained as part of the study will be strictly confidential, and that I will not be personally identified in any write-up of the results.

I agree not to disclose identifiable information in relation to Core Members

I understand that information will be stored in manual and electronic files and is subject to the provisions of the Data Protection Act.

I wish to participate in this study under the conditions set out here and in the Information Sheet for Participants.

Signed: _____

Printed Name: _____

Date: _____

Thank you very much for agreeing to participate in this study!

Appendix C

Interview Schedule

1.) Please could you tell me what about your experiences of being a COSA volunteer?
    a. What was your initial motivation for taking part?
    b. What preconceptions did you have about CoSA?
    Possible prompts: How do you feel/how did it make you feel?

2.) Can you describe the relationship that you have experienced with a CM?
    a. How did this relationship differ from relationships you have with other people?
    Possible prompts: Why do you think this was? What do you think brought this about? How did you feel/how did it (the experience) make you feel?

3.) Can you describe the types of challenges with regard to the relationship that you have faced?
    a. How did you overcome this challenge?
    b. Why do you think this challenge arose?
    c. What tensions exist within the relationship
    Possible prompts: What happens? How do you feel/how did it make you feel?

4.) Please could you describe how the relationship develops over the course of the programme?
    a. How was it different at the beginning versus the end?
    Possible prompts: What happens? How do you feel/how did it make you feel?

5.) What aspects of the relationship do you feel are most important?
    a. How do you experience _____ in the relationship?
    Possible prompts: What happens? In what way?

6.) Do you feel that you have changed as a result of your work as a volunteer?
    a. What do you feel you gain from it?
    b. What has being a volunteer taught you about yourself?
    c. In what way does it affect/influence other relationships?
    d. What do you perceive to be importance for a relationship to be successful?
    Possible prompts: What happens? In what way? What is important?

7.) Can you describe your feelings as a programme ends or is nearing ending?
    Possible prompts: What happens? How do you feel/how does it make you feel?

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