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An Explorative Single Case Study of the Therapist's Perspectives on Power, Emotions and Identity Changes in Cognitive Behavior Therapy against Men's Violence in Sweden

Abstract

This study starts from Retzinger (1995), Retzinger & Scheff (2000) and Scheff & Retzinger's (2000, 2001) micro-sociological perspective on social bonds. The general aim is to test a new model of operationalized sub-indicators that allows for a simplified ability to analyze the relationship between power relations and the social bond between therapist and clients in cognitive behavior therapy (CBT) for violent men. CBT-therapy often achieves positive effects by giving clients the knowledge and ability to talk about their problems instead of using aggression and drugs as defenses. The therapists make in this case much effort to balance the relationship between them and the clients, but there is still a tendency that therapy alienates them from each other and prevents the development of a solidarity social bond, which, assuming that the theoretical premise is true, is the prerequisite for a client to build a positive self-image and become reintegrated into society.

Key words: social bond, shame, violence, therapy, alienation, solidarity

Introduction

This study attempts to improve the understanding of the relationship between institutionalized power on cognitive behavior therapy for men with violence and drug problems and the quality of the social bond between therapist and client. The concept 'therapy' is generally inclusive and includes training where clients receive skills to better manage long-term problems as aggression and drug problems. The theoretical starting points are Scheff (2003, 1999), Retzinger & Scheff (2000), Scheff & Retzinger (1997, 2000, 2001) and Retzinger's (1995) further development of Lewis's (1971) fundamental work on shame and defense-mechanisms. Retzinger and Scheff have played a major role in understanding of the emotional content of social bonds and developed a successful method to read and interpret verbal, nonverbal and paralinguistic cues in communication. The validity of their method is not in question, but the method is time-consuming and technically complicated, and not designed for use outside a research context. The newly developed model presented here corresponds with the central aspects of Scheff's & Retzinger's theories but has been operationalized in a new way in which the power aspect, missing in Scheff, is highlighted (i.e. Barbalet 1998). Therapists using the model are made aware of the impact they have on the client's self-esteem and their opportunities to influence clients positively in the context of therapy. The level of sub-indicators I have developed under the general categories of balance – isolation/ over differentiation and balance – engulfment/underdifferentiation (i.e. Scheff 2003) refers to a pragmatic approach to highlight what is affecting the quality of the social bond between therapist and client. Isolating and engulfing relationships both contribute to alienation between interacting parties and prevent the build-up of the joint and solidarity social bonds that are central to a positive self-image and the clients' reintegration into society. Although power is relational where clients have power of their own to influence therapists, the therapists perspective is still an important starting point as this type of research has not been carried out before. Later clients will be interviewed with the same model.

The theoretical approach to the understanding of the relationship between feelings of shame and low self-esteem refers to Gilligan (2003), Brown (2004), Harper et al. (2005), Mills (2008), Wei & Brackley (2010) and their findings of a relationship between a traumatized childhood and an increased sensitivity to situations as adults reminded of a traumatic childhood. All therapy generally reminds clients about their childhood and activates shame and defenses against hurtful feeling related to it. The newly developed model's theoretical premise is that therapies dominated by unacknowledged shame and where the social bond is not balanced, result in an isolated and/or engulfing social bond that alienates therapist and client from each other. Therapy therefore tends to reproduce clients' often already poor self-esteem. Pride building therapy embedded in a stable and solidarity social bond develops the good sides of identity and reconstructs gradually the self-image of the client. The therapist's knowledge of this allows them to manage factors that otherwise tend to determine the outcome of therapy. The model (i.e. Fig. 1.[1]) intends to highlight the dynamic interplay between the organizational characteristics of therapy and the social bonds between the therapists and clients that therapy produces. Scheff & Retzinger (2001) generally focus on the micro-sociological relationships, therefore it is important to focus on the power of relationship as it can provide us with new knowledge on how it affects the quality of the social bond. The model contributes to the illumination of mechanisms (Sayer 1992) which – in accordance with the theoretical premises – might contribute to or prevent effective therapy and helps to develop an understanding of the mechanisms that can result in unintended effects in the treatment of violent men. For a detailed discussion of the theoretical framework see P.M. Jansson & S. Saxonberg (2013) forthcoming.

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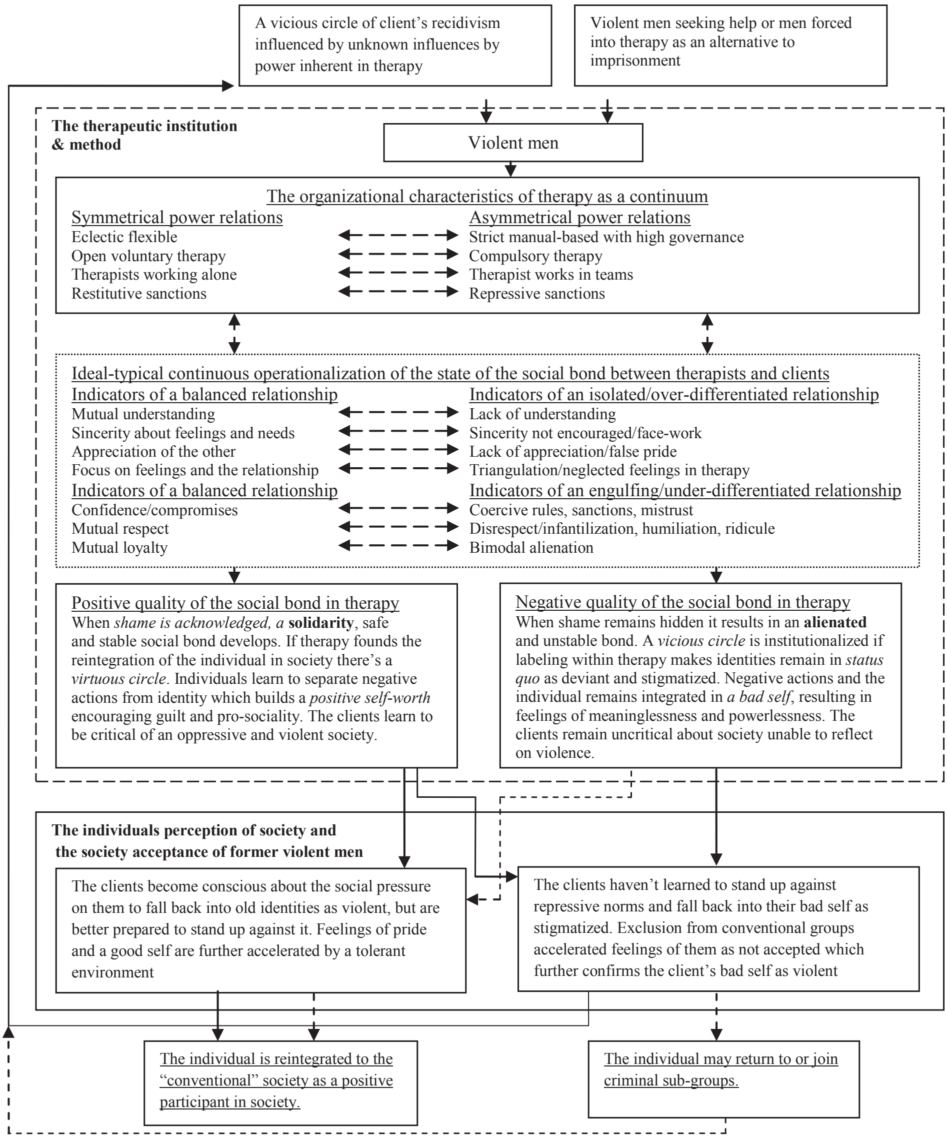
[1] This model is elaborated in P.M. Jansson & S. Saxonberg (2013) *Are asymmetrical power relations a hidden obstacle to successful rehabilitation of violent men? An explorative study on the methodology to investigate shame. Aggression and violent behavior,* http://dx.doi.org/10.1016/j.avb.2013.08.02



Jansson, P.M., & Saxonberg, S., *Are asymmetrical power relations a hidden obstacle to successful rehabilitation of violent men? An explorative study on the methodology to investigate shame, Aggression and Violent Behavior* (2013), http://dx.doi.org/10.1016/j.avb.2013.08.002

Fig. 1. Ideal typical model of the tensions between different kinds of emotional content in therapy for men with violence problems

The Organizational Characteristics of Therapy as a Continuum

The power imbalance between therapists and clients relates to the quality of the social bond which makes it important to focus on the interaction. Therapy is generally *Eclectic, flexible* or *strict manual-based with high governance:* This dimension is important to consider as the manual-based therapy is less flexible to adapt to unique client needs than is the eclectic. Therapy is either *open voluntary* or *compulsory:* Clients who are compulsory remitted to the therapy have no choice but to adapt, which can make the adjustment mistaken for a real change and may remind them of negative childhood experiences, reducing trust between therapist and clients. *Therapists are working alone or in teams:* team work increases the power of the therapists and could make the clients feel less autonomous. *Restitutive or repressive* sanctions: it is important to consider if sanctions are manifestations of authoritarian power and if punishments have the client's best interest in mind.

Indicators of Pride and Shame in Therapy

According to Scheff (1990, 2003), Retzinger (1995), Retzinger & Scheff (2000), Scheff & Retzinger (1997, 2000, 2001), Scheff (2003), a relationship between two parties can be either balanced or isolated/engulfing and either produce the feelings of shame or pride. Balanced relationships are characterized by pride of belonging to the relationship and isolated/engulfing relationships are related to shame as not belonging to it or being compelled to belong to it.

Based on the category <u>balance and isolation/differentiation the following *subcategories* have developed following focus on the therapist's perspective</u>: *mutual understanding* means that parties understand each other's feelings and thoughts. *Lack of understanding* results when emotions are not focused and when parties do not share the same experience. *Sincerity about feelings and needs* exists when parties are honest with their feelings and thoughts toward each other. *Sincerity is not encouraged* when hidden conflicts and motives produce *face-work* where clients and therapists do not 'meet' each other as individuals but as roles. *Appreciation of the other* is present when therapy emphasizes the client's strengths and positive aspects even though the client is dominated by his own 'bad' experiences. *Lack of appreciation and false pride* occurs when parties emphasize more positive qualities about themselves than what is true in order to compensate for the other's lack of respect. *Focus on feelings and the relationship* exists when parties realize that the quality of the relationship is a prerequisite for the effect of therapy and when therapists see the relationship as valuable and not only as a *professional tool. Triangulation and neglected feelings in therapy* will be the result when clients are allowed to talk about other things and persons as a defense against the pain of talking about their own feelings and experiences.

Under the category of <u>balance and engulfment/under differentiation</u> the following subcategories are developed: *confidence and compromises* will result when there is trust, allowing for compromises. *Mistrust* results in *coercive rules and sanctions* with rewards/penalties that regulate the relationship. *Mutual respect* exists when therapists respect the clients' right to control their own autonomy. *Disrespect* is characterized by *infantilization,* where clients are reduced to diagnoses/disorders or to the negative actions they had committed. Overprotective therapists together with normative statements point out that clients have a lower value. *Mutual loyalty* dominates when the therapist and the client see their relationship as more important than the relationship with their respective group. *Bimodal alienation* prevails when confidence in each other is revealed to each others' groups and when the parties primarily live up to the expectations of their own group.

Method

In contrast to the ideal type of case study that is heuristic and inductive this study is deductive and has been preceded by work on the development of a theoretical model for understanding of emotions relevant to the effect of therapy. This does not follow the typical form (Chadderton & Torrance 2011) since it does not account for the case in the complex context of the treatment facility's history and relationship to other institutions. This sets limitations on how the social practice can be understood in its entirety. The meaning therapists ascribe to their practice and what they do is focused but not on the perspective of reality itself (i.e. inductive) but through a deductive model that is applied to therapy producing data. The focus is on here and now and their *rationale* behind their work which is necessary for a focus on the theoretical core aspects. The therapist's description of the therapy content gives us a secondary access to the social reality which they construct together with clients. Clients' reality is described indirectly through therapists' statements about the therapy which is a limitation to the understanding of the power of the relationship, but a necessary starting point, as this type of research has not been carried out before, for further studies it would be good to interview clients as well. Individual therapists' unique qualities and experience are not the focus, but the *gestalt* of them as a collective whole, which means that the quotes are inserted in the text to demonstrate both the variety and the common among them.

Selection of a Single-case

The sample has been strategically guided by a therapy method, for violent men, assumed to generate an unbalanced power-relation between therapist and clients. This case is characterized by therapists having power over clients by organizing their therapy. The sample challenges the theoretical preconceptions/hypothesis that therapy dominated by governance and control generates statements from therapists about therapy that points at an isolated/overdifferentiated and engulfing/under differentiated relationship. The therapeutic focus is here cognitive. It challenges the theoretical preconceptions that unacknowledged shame produces an isolated or engulfed relationship between therapists and clients.

A compulsory Swedish treatment center has been selected where clients are remitted for treatment instead of prison[2]. The treatment is carried out under the supervision of a correctional unit. The treatment uses knowledge from completed psychiatric examinations and medical history from correctional and social services[3]. Most of the clients have aggression and/or violence problems along with drug problems and diagnosed psychiatric disorders. Treatment is essentially manual-based Cognitive Behavior Therapy (CBT) and conducted through group therapy sessions, lectures on topics relating to their clients' problems, supplemented with components from the manual-based Aggression Replacement Therapy (ART) and Motivational Interviewing (MI). CBT-therapy is forward-looking and supports the clients to think about the future and learn constructive actions in typical problem situations and not to focus on past experiences and life history as in psychodynamic therapies (PDT). The manual is used as a framework for treatment and is often evidence-based, i.e. with a proven positive effect on the behavior you want to treat, given that all steps are followed about what to do and within what timeframe and how the client's progress should be evaluated. ART is originally a structured program (Goldstein 1987) that combines both techniques from cognitive therapy and behavioral therapy. ART is an educational and training approach to replace the antisocial behavior by actively teaching the desirable behaviors and consists of a 10-week, 30–35-hour intervention, administered to groups of 8–10 youths three times a week. ART includes anger management, development of social skills and moral reasoning. Motivational interviewing (Miller & Rollnick 2009) consists of five steps designed to change the client's behavior. In the three first stages the clients learn to think about the change. In the two later stages, clients are actively doing things to change or maintaining the changes they have been able to make. In MI there is important to identify where the clients are in the recovery process, thus interventions that do not match the persons' readiness are likely to create resistance.

Four active CBT-therapists work at the treatment site. Therapist 1 is the therapy manager with basic cognitive psychotherapy training step 1 and extensive experience. Therapists 2 and 4 have basic training step 1 as CBT-therapists but limited

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[2] The study follows the ethical standards developed by the Swedish Science Council (http://www.codex.vr.se/texts/HSFR.pdf) and has been processed by the University local research ethics committee (FEN).The research has not been assessed to touch sensitive issues or vulnerable research participants as it focuses on the daily therapeutic work practices and content and no regional ethics committee approval is required for a study of professional therapists (SFS 2003:460). Informed consent was obtained from each participant in advance of the data collection and each participant was informed that they could withdraw at any time. Participants are anonymized and data is processed confidentially so that no unauthorized person can access it.

[3] The treatment site has room for 37 male clients from 18 years upwards and treats mainly young men between 18–25 years. The treatment has a duration of 6–8 months with the possibility of prolongation in special circumstances. The step-one trained therapists are supported in the daily work by therapy assistants working with daily care. At the treatment center there are also a psychiatrist, a psychologist and a nurse, who deal with the prescription of medication and general investigations of clients' health.

experience. Therapist 3 is the managing director and has a basic psychotherapy training step 1 as *gestalt* therapist and extensive experience[4].

Data Collection Procedure

The data collection was conducted in two phases. In the first phase two individual interviews were conducted, each of 1,5 hour, each with therapist 1 and therapist 2, based on themed semi-structured questions with open responses. The interviews were transcribed and sent to therapist 1 (head of therapy) and therapist 2 to allow them to complete data. Thereafter, *member-check* by follow-up individual interviews with therapist 1 and 2 was conducted for 1,5 hour respectively, focusing on the *lose ends* of the initial interpretations. These interviews were compiled in the form of preliminary analysis results.

The second phase consisted of a group interview of 1,5-hour with therapist 3 and 4. The preliminary results from phase 1 were the base for a deeper and clarifying discussion of the therapy content in accordance with *writ large* (Cresswell 2007), in which therapists reflected on the accuracy of the preliminary analysis. The saturation in data which group interviews with the remaining two therapists generated formed the basis for the final coding. My coding of therapists' statements in relation to the theoretical model was verified by a *blind intercoder reliability design* (Cresswell 2007) where a researcher, without knowledge of the original coding, coded transcribed data in accordance with predefined sub-indicators. The percentage data that were coded in the same way were 70% consistent. After discussions we reached an *intercoder agreement* with a consistency rate of about 80%.

Analysis Method

Qualitative deductive-oriented content analysis has been used to systematically analyze the interviews in relation to a level of theoretically derived *sub-indicators.* According to Patton (1990), content analysis, inductively identifies and categorizes basic patterns or themes that emerge in an empirical material, it can also be used to systematically categorize content based on predetermined categories. Common to both approaches is the condensation method (Cresswell 2007), that reduces long interview answers to pithy excerpts and quotes. According to Hsieh and Shannon (2005), *directed content analysis* is a successful method to explore the applicability of coding schemes derived from theory and empirical research. In comparison to conventional naturalistic category and concept-generating strategies, the theoretical preconceptions could be a problem that must be dealt with by making room for new categories that do not fit into the theoretical framework. The space for this depends

[4] The difference between step-one and licensed therapists step-two therapists in Sweden is that there are stricter requirements on licensed psychotherapists and psychologists in training concerning record keeping and confidentiality.

on the design and in this study no new delineated category emerged alongside the theoretical preconception.

Step 1 in the analysis used the interview material from all interviews and condensed it into *meaningful units*. These units were picked from each transcribed interview and capture the essence of the larger piece of text without final analytical coding. In step 2 statements from the therapists were interpreted in accordance with the given figure of a continuum between a solidarity and alienated social bond i.e. a balanced or isolated/engulfing social bond. The therapist's statement was related to the organizational power aspects that are assumed to influence the social bond between therapist and client.

Results and Analysis

Organizational Power Aspects of the Therapy

Based on the individual characteristics of the case, the following 'organizational' areas have been seen as central as they represent power structures that the therapist and the treatment are influenced by.

Eclectic or Manual-based

According to therapists the therapy is, in addition to the general knowledge, gained in the training to CBT-therapist, grounded in evidence- and manual-based therapy techniques. Aggression Replacement Therapy with Motivational Interviewing are two of the methods used. Therapist 1: 'Manual-based treatment, ART remade for adult individuals, supplemented by other cognitive and behavioral features as well as motivational interviewing [...] you have to rely on evidence, [...] you should not get involved with something that you know does not have a structure, where there is not a manual or a thoughtful structure behind.'

Open or Compulsory

According to therapists, clients that are detained, choose between treatment or incarceration. Therapy has a compulsive character as violations from referrals correctional rules lead to discharge. Newly enrolled clients may not leave the building for the first 3 weeks and are by correctional service rules required to be there for at least 3 months. Therapist 4: 'Those from prison must be here at least 3 months [...] when you come here as red [...] they must not leave the house without staff permission.' Operations are in this case carried out with supervision from the criminal justice system. Therapist 3: 'Those who are here from the prison are in some sense detainees [---] anyone who commits anything serious [...] take drugs is kicked out.' Therapist 1: '[...] we are always loyal to the rules, for example, relapses are reported to the correctional unit.' Clients, not detained, may leave treatment when they want to but are subject to the same regulations as the others. As clients progress, treatment may grant more freedom. Therapist 2: 'In the beginning, it is more strict and then it opens up [...] I think they will be controlled when they need it [...] but it can also come in the end again when they start to get worried [...] about being discharged.' To sum up, the therapy is compulsory for detained clients and more flexible to others, but in reality, the rules are the same for everyone.

Therapists Working Individually or in Teams

Therapists work in teams and the clients' situation and problems are discussed at least once a week, while lectures and group therapy are conducted individually by the therapists. All information that clients provide to a therapist during treatment are according to agency rules and procedures, notified to the other therapists. Therapist 1: 'If a client tells me something, I must pass it on.' The therapists team work is based on loyalty to each other and they always check what clients are saying about them: Therapist 1: '[...] back up your colleague and then if it's something you have to deal with, talk about it [---] their way to bond might be to divide and ruin as well.'

Restitutive or Repressive Sanctions

The treatment is, according to the therapists, conducted instead of doing time in prison and surrounded by rules and sanctions for clients that escape from the treatment site or take or use drugs during furlough. The regulatory framework is least forgiving to clients who are remitted by the prison administration. Therapist 1: 'When serious stuff is committed, there is only one way to do it, but when it comes to less serious things, there may be half-truths and vague situations in the hallway.' Therapist 3: 'If a client does something wrong [...] so it is up to us to make use of the holistic approach [...] but everything is reported [...] if anyone takes drugs then he always is kicked out, but the door is not closed forever.' Reporting to the correctional unit is not negotiable and the sanction is repressive as criminal justice has authority to enforce the punishment which cannot be challenged by the treatment site.

The therapist and client tend to be alienated from each other because the relationship is based on an asymmetric power relationship. Manuals reduce the scope for the personalization of therapy and it is compulsory for those who are remitted by the prison system. The therapy uses repressive sanctions to rule violations and those who are detained could be discharged. The therapists work as a team and are loyal to each other. The organizational aspects of power subordinate the clients, which makes it difficult to distinguish between an adaptation and a real change by clients.

The Tension between Solidarity or Alienated Relationships between Therapist and Client

The developed sub-indicators within each area increase knowledge of what the key elements are in therapy. The tension between the *balanced* <u>or</u> *isolated/ overdifferentiated* respective *engulfed/underdifferentiated relationship* is used to investigate whether the therapy results in a *solidarity* or an *alienated* social bond between therapist and client.

The Balanced or Isolated Relationship

The social bond between therapists and clients can be *balanced* or *isolated/ overdifferentiated* i.e. there is a distance between therapists and clients in terms of *mutual understanding, sincerity, appreciation and focus on feelings* and *the relationship.* The relationship is then presumed to be dominated by *lack of understanding, sincerity* and by *lack of appreciation* and *triangulations.*

Mutual Understanding or Lack of Understanding

The therapists mean that the cognitive focus is an effect of the CBT approach. CBT focuses on the client's past experiences and motivations behind the violence and drug use, which will counteract the moralizing of client's past behavior. New knowledge gets the clients to understand the risks associated with their way of life. Therapist 2 stresses how important it is to: '[...] not only see the client's as a behavior, here it is extremely important not to moralize anything. To form your own opinion without forgetting what they have been capable of.' The therapist stresses how important it is for the understanding of client's emotional experiences to have experienced the same thing, as it's easier to relate to the client's via emotions. Therapist 2 says, 'It can be about something emotional that you can relate yourself to [...].'

Therapists work with knowledge-oriented lectures and seminars to increase clients' knowledge of drugs and violence, but are aware that a lack of dialogue reduces the understanding of each other. Therapists believe that, because they have not used drugs themselves, there is a difficulty to understand how drugs affect clients. Therapist 2 says: '[...] it is difficult to understand how strong a craving for drugs may be [...] and what you are willing to do.' The therapists believe that there is an advantage to not have the same pre-understanding as clients as they represent an alternative to their lifestyle. Therapist 3: 'If you have an extensive pre-understanding you pull much out of anything and other things than what you actually hear [---]. Often conflicts arise when therapist over-interpreted the client.' Therapist 4 confirms this: 'Not having the same experience is good because we know of another life, too.' The therapists emphasize the importance of confirming that the drug has been a help. Therapist 2: 'I understand that the drug filled an important function for you.' The therapists have difficulties in understanding how to help clients to understand their powerlessness in repeating the same negative behaviors over and over again.

The cognitive focus on the clients' experiences and motifs of violence and drug use gives therapists less understanding of the emotional part. The therapy uses one-way communication through lectures to enhance clients' understanding of their problems which threaten the understanding when not accompanied by a dialogue. Misunderstanding is a consequence when therapists do not share the experiences of violence and drugs and can relate emotionally to clients to reach attunement. Therapists, although without personal experience of drugs, are anxious to confirm that the drug was important for the client and that it is sad to give it up. Despite the therapists' attempts to increase their understanding of clients, the therapy is dominated by a lack of understanding of emotions, which isolates therapists and clients from each other.

Sincerity About Feeling and Needs or Sincerity Not Encouraged/Face-work

The therapists believe it is important to be honest with the intent of CBT-therapy. Therapist 1 highlights the importance of this: 'The CBT has something called the rationale, I describe CBT and how it works [...] and do not have a hidden agenda or ulterior motives. It is important for myself to weed out the crap and speak plainly.' Meanwhile, therapists are careful to stress that they do not discuss the therapeutic model with clients in case it does not work. Therapist 2: 'No, you cannot, I would never do that, I would rather stop using it.'

Hidden conflicts, brought up in group therapy, are typical in areas sensitive to the clients to talk openly about. Therapist 2 provides an example: 'There may be something about the abuse that they do not want to talk to others about and you have to respect that.' The therapists stress that hidden conflicts also arise when therapists' do not confront clients and when they are afraid to take up a fight.

A sincere relationship gives the client a harder but better treatment. Therapist 2: 'Lack of sincerity does not result in a good treatment. Sincerity leads to a harder treatment, but you get something emotionally out of it.' When clients learned to put difficult things into words without aggression and fear they achieve more sincerity about what they are talking about. The therapists emphasize the importance of self--therapy to get in touch with emotions that help them to interpret the clients.

For therapists, sincerity is about clients being able to talk about experiences of abuse in childhood and feelings that come up during therapy. Sincerity is countered by clients' emotional fear and that treatment's duration is too short and that there is a lack of expertise to talk about all the feelings. Therapist 2 says that: 'It is always possible to talk more about feelings [...] but I think this should be moderate. [...] Everything does not have to come up to the surface, life is not enough to ponder [...].'

The therapists know that clients censor or lie in group therapy about experiences such as abuse or when they have been violent against women, as it would result in a low status in the group. Therapist 1 says that: 'Some crimes clients are cautious to talk about in the group and it is often violence […] violence against women'. It is common that clients are dishonest when they violated rules at the treatment center, since it may result in discharge. Therapist 1: 'Rules that we have to obey sometimes force clients to lie. Since psychiatrists and psychologists are part of the treatment, it is difficult for clients to succeed with manipulative behavior.' Therapist 3: 'It's then very difficult to play the game unnoticed.'

Therapists strive to be sincere about the intent of CBT-therapy, which contributes to a balance but there is also a tendency for isolation when therapists are not sincere about the therapy shortcomings. The relationship becomes sincere when clients through CBT-therapy learn to put words to what they feel instead of using aggression as defense. Therapists in self-therapy find it easier to get in touch with emotions, which adds to their ability to interpret clients. The client's sincerity about what they experienced in childhood is counteracted by the fact that therapists do not delve enough into emotions as they argue that it is harmful. Clients who committed rule violations become manipulative because they risk discharge. The lack of sincerity overall isolates the parties from each other.

Appreciation of the Other or Lack of Appreciation/False pride

Therapists appreciate clients when they are responsive to their small progress of i.e. being drug-free and sleeping at night. Therapist 1 says that you must be: '[...] more considerate for the client's situation, what is a change, a change could from the client's perspective be a huge change.' Therapists still believe that they miss many of the clients' small but important steps.

False pride is triggered by power struggles where therapists want to regain authority over clients. In a power struggle you tend to raise yourself as a moral example, with education, work, house, home, family and all they lack. Therapist 1: 'Pointing out how wrong the client is. Then it is a power struggle [---] clients that are very power-oriented inevitably provoke such acts among us.' Therapist 2: 'What gives you the right to say this about me? I am here to work for you […]. Throwing the ball back, you should not make clients ashamed but sometimes you have to do it in an ok way.'

Therapists show appreciation for clients' small progress which balances the relationship, but not in power struggles, as false pride is used to regain power over clients, which increases the distance between them. There is equal evidence that therapists show appreciation of clients so that clients' bad aspects are highlighted.

Focus on Feelings and the Relationship or Triangulation/Neglected Feelings in Therapy

The escape from feelings by triangulation is highlighted by therapists as aggression become evident when clients feel guilt and shame for what they have done to others or release hurtful feelings from childhood. Emotions also come up when clients feel uncertain about standing on their own feet before discharge. Therapist 1: 'They come in contact with something that has been difficult, painful, [...] sexual abuse [---] anger comes up because they are angry at those who have done so to them [...] and that they enjoyed the [---] there may be an extreme shame in admitting that.'

The therapists do not protect clients from talking about their hurtful experiences in group therapy unless they expose that they committed abuse to others or are suicidal. If the emotions clients intend to raise are more than what therapy can cope with, therapists intervene.

The therapists mean that clients are keen to triangulate away from a focus on themselves when it becomes emotional. Therapist 1: 'When clients triangulate problems outside themselves, the focus become deflected away from what should be done in the therapy [...] it may be a defense of the clients' that he wants to avoid what you are talking about right now.' Therapists attempt to direct them back to what should be included in the treatment. When clients feel guilty that they let their children, and their families down, abused parents, siblings and children, they generally blame others or use aggression or self-injurious behavior such as threatening to discharge themselves from the treatment. Therapist 1: 'They can become hostile and somewhat menacing [...] it can also be a defense against break down and crying. One must be alert to what is happening. Rarely do they jump on one and hit you, it has never happened to me. Some can be really angry when you come too close.' Clients also defend each other in group therapy, by shifting the focus to other issues, as they are afraid to come into contact with something they feel bad about.

Therapists mean that professionalism prevents them from getting too close to the clients and joining in friendly relations. Therapist 3: 'We must be prepared to be really close, there are those who over the years thought that I was unprofessional, you have to go close, but as a therapist I have to be aware that clients' are non independent. I cannot go in and make friends with them in real life [...] friendship becomes too complex [...] they always come back to the unequal relationship.' The therapists emphasize that therapy will make them self-reliant and not *vice versa*. The therapist also manifest an instrumental approach to clients as treatment is a commercial transaction in which we make money on the clients.

Therapists believe that it is easier to get close to clients when accustomed to therapy, but you have to focus on what has not been done when they had been through 3–5 treatments before. Therapist 4: 'More often, they are easier to open, when they are therapy experienced.' While therapist 3 means that: 'It is easier that they end up in the same track, harping on what they always nag about, sitting fixed [...] when I try to quickly find out what it is that they have not reached [...] I have a more critical eye if I have a client who went through 3–4 treatments in the past [...] if we take violence as an example, you want to sweep it under the abuse carpet.'

The focus on feelings and the relationship is countered by clients triangulating from painful areas that remind them of what they have done to others or release hurtful feelings from childhood. Clients divert the conversation from them, show aggression, or threaten with self-harming behaviors. Here the therapists show great awareness and balance the relationship despite the client's defenses by not conceding emphasis on the client's problems. Still emotions in therapy often remain untreated because of the professional belief that it is unprofessional to get too close to clients, making them more dependent than they already are. The focus on key areas is facilitated when clients have been to therapy before, as it points out that there are unsolved problems. The professional distance results in less processed emotions and isolates therapists and clients from each other.

The Balanced or Engulfed Relationship

The sub-indicators below are intended to give us more knowledge about whether the social bond between therapists and clients are *balanced* or *engulfed/ underdifferentiated,* i.e. if the therapists do not leave any room for the clients to be themselves and express individual needs, which is the consequence when the therapy is dominated by *coercive rules, disrespect* and *bimodal alienation* instead of *confidence, mutual respect* and *mutual loyalty.*

Confidence/Compromises or Coercive Rules, Sanctions, Mistrust

The therapists believe that they cannot rely on clients because of what they have done, and their behavioral problems justify rules and control. Therapist 3 says however: 'We must be aware so that they do not just adapt without making any real change. Therefore it is important not to use too much control.'

Therapists state that the therapy is framed by the Prison Service rules for detainees, which means that clients must be enrolled for at least 3 months of treatment and if they violate such rules, they are discharged. Therapist 3: 'We have our rules that we believe work out well, for example, when you come here as a new one you should be «red» for two weeks and you cannot leave the house without staff permission.' The therapists are, however, keeping the door open for clients that have been discharged to come back to therapy again.

The manual-based CBT-therapy, according to therapists, has generally definite steps that organize the clients' life. Responsibility schemes and rewards to clients who manage, teach them about what is necessary to live in a community. The rewards confirm clients' progress and show that there is confidence in them. Therapist 1: 'Clients have their commitments which they should meet and the better they handle it, the more benefits they will get access to. It is like life in all respects [...] there is a little room to violate some of the rules depending on the unique individual you are. There is a little flexibility, yes.' Therapist 2: 'These guys have not got any positive rewards in their lives but often have been rewarded for negative actions [...] but it's still a reward in their eyes.' The compromises are limited to allowing clients to change groups in therapy if it benefits them. Therapists treat, at the same time, therapy as an alliance where responsibility builds up the good self-esteem and self-respect of the client. Therapist 1: 'The reason why clients want to change is important. If they feel that it hurts, clients want to change but this is often when we should move forward instead [...] if someone in a group has never been a criminal before, never stolen or anything, it might not be so good that he is in group therapy along with criminals.'

The confidence in clients is limited because of what they have done and their behavioral disorders, creating a need for rules and control. Probation rules for detained clients are rigid which contributes to the therapy engulfing the client. The manual-based CBT-therapy controls clients' behavior through rewards directing them to a more normalized status. Underdifferentiation makes it difficult to discern the client's real change from adaptation to conditions in therapy. Compromises are impossible when clients make serious violations but there is room for changing therapy groups and the like. Overall, this dimension is dominated by a strong engulfing element which restricts the possibilities increasing trust between therapist and client.

Mutual Respect or Disrespect/Infantilization, Humiliation, Ridicule

Therapists do not believe that they compel clients to give up aspects of their identities as they cannot do anything about client's disorders. Therapist 1 says: 'Many clients have some form of disability, emotional problems, we do not think they can get rid of sides of their personalities, it is more about grinding off, rounding off the edges so they become more dynamic, and adaptive. A narcissistic person will always be narcissistic, but may be less exploitative and arrogant when he notices that it has implications regarding shaping a slightly better self-image.'

Therapists want to maintain their respect for the clients by making a difference between behavior and personality. To do so it takes both education and intuition. The therapists do not want to know about previous investigations of clients, to give them an opportunity to manifest themselves again. However, therapists are ambivalent as they take great notice in existing reports of disorders and diagnoses. Therapist 3 says: 'I do not want to know much, I know very little about the clients and I think it is important for my staff also [...] so that each client has still to manifest himself in a new way.'

Therapists state that clients become infantilized when they are reduced to diagnoses. Diagnoses are also incentives for clients to make ADHD their identity, to gain access to legalized drugs. Therapist 3 stresses otherwise: 'We have not seen the whole problem of these multi-diseased people. We have put the abuse label on their foreheads, and told them that they just have to stop abusing and everything will be fine. We do not see the entire client.' Therapist 4: 'If you look at health care, they use previous investigations of clients, and medical reports, they use this more than we do.' Therapist 3: 'Is not the real problem that we have ignored these clients and their problems? We have not taken their disorders seriously. There has been a kind of moralizing. Clients have been told to get themselves together. We have not bothered about the disorder and believed that the client is able to do this anyway. You should be normal.'

Humiliation of clients becomes visible in power struggles as the therapists' position of power makes it possible for them to act prestigiously and authoritatively. Therapist 3 believes however: 'If I cannot keep track of my authoritarian side, if I am power-oriented or prestigious, then I cannot work with this at all [...] because then I am going to offend people, but I can use my authority in meeting with vulnerable people in a positive way, I see no problem in it.' The therapists see the parental role in them taking care of clients' problems as a kind of lack of respect but stress also that it is a part of our human nature.

To sum up, the therapists stress – in light of their understanding that disorders are irreversible – that it is more respectful to increase the client's ability to adapt to society than to try to normalize the clients. In comparison to an understanding where it is assumed that clients can reconstruct their identity to that of normal, this lack of respect for the individual's potential to develop underdifferentiate relationship. The therapists both emphasize the importance of diagnoses and the clients possibilities to manifest themselves in a new way. The rules for the prescription of legal drugs enable clients to self-label with (eg. ADHD) diagnoses in order to continue their addiction. Clients are engulfed by diagnostics that tend to infantilize and deprive them of their unique individuality and potential to build a positive self-image. Respect is reduced when therapists use prestige to defeat the client in power struggles. The dimension is dominated by lack of respect and engulfing aspects, despite therapists' efforts to allow clients to manifest themselves in a new way.

Mutual Loyalty or Bimodal Alienation

The therapists believe that clients' fear of conflicts makes them manipulative, i.e. show loyalty to therapists by an adherence to rules which may be mistaken for loyalty. The therapists emphasize that strong loyalty to clients can be dangerous, i.e. therapists express that they like a client and defend him although he has done something wrong. Therapist 1: 'I think what you are talking about is whether the staff group is safe or not. If it is alright to take up these kinds of things, the colleagues notice it straightaway, they note that the colleague defends his client. In a good working climate you can bring it up.'

Therapists are loyal to each other and if a client says something in confidence they are obliged to notify the others. Therapists back each other up by controlling rumors and things said about them. Here there is a clear boundary as to how loyal therapists can be towards their clients. Therapist 1: 'Loyalty is often tried, such situations are common. When serious stuff takes place, there is only one way to do it but when it comes to less serious things, there can be half-truths in which we do not go any further.'

Clients' loyalty to each other could be illustrated by norms to pretend to be tough in front of therapists. Being loyal to the therapists could produce feelings of shame as it signals weakness against the masculinity norms of their own group. Therapist 1: 'That is a way to assert themselves as a person and a way that they know works [...] but a way we confront.' The therapists believe that the therapy benefit derived from charismatic therapy motivated clients as they set the norm and bring others with them.

Therapists are loyal and underdifferentiated in relation to each other and overdifferentiated in relation to clients, as a consequence of the orientation to manuals and treatment protocols. Clients' loyalty and underdifferentiation in relation to each other is most evident when expected to be 'tough'. The balance in the relationship between therapist and client is favored when a therapy-motivated client sets the norm for other clients. In this dimension there is a clear bimodal alienation from the therapists' side isolating them from the clients, but they are at the same time engulfed by each other. Clients do not tend to be engulfed by each other as they are compelled to adapt to therapists' manuals and rules.

Conclusions

The overall picture of this particular CBT-therapy, according to the therapists statements, is that it is dominated by coercive rules, making the power balance between therapists and clients asymmetric. The efforts that therapists exert within this framework are consistently outstanding and humanistic, but not enough to ensure the building of a stable solidarity social bond. The organizational aspect of power interaction, together with the new level of sub-indicators, gives us a better understanding of what influences the stability of the social bond between therapist and clients. The dimension balance – isolation is characterized by a lack of *understanding* of clients' feelings. *Sincerity* is inhibited by the group therapy which is experienced as disclosure to clients and together with the risk of discharge if clients are honest about the rule violations they committed. *The therapists try to identify every kind of small progress that clients make which is a way of showing appreciation* of the clients. *The focus on feelings* is hampered as therapists do not want to get too close to the clients, which limits the room to acknowledge shame. All in all, therapists and clients are isolated from each other in three of the four dimensions, increasing the alienation between them. In the dimension of balance – engulfment *the confidence between therapist and client is restricted because of what clients have done, their diagnoses and the strict rules set by the correctional unit. The respect* for the client's potential is moderate because the disorders are seen as irreversible. Therapists' *loyalty* to each other disadvantages loyalty towards clients. The clients are engulfed by therapy in all three dimensions, which alienates therapists and clients. CBT-therapy achieves positive effects on clients by providing them with greater knowledge and ability to talk about their problems, which they can use instead of defenses such as forms of aggression, violence and drugs. It is important to note that, although this CBT-therapy aims to build strong social bonds, it can teach clients to deal with destructive behaviors, which can be the new basis for stable social bonds. Taken together, there is a tendency that this CBT-therapy alienates therapist and client from each other and prevents the development of a solidarity social bond which, assuming that the theoretical premises are true, is the prerequisite for a client to be able to build a positive self-image, a good self, and then reintegrate as a positive participant in society.

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