Utilizing questionnaires to assess outcomes and therapeutic alliance in penitentiary resocialization as a component of strengthening readiness for resocialization

Abstract: The aim of this article is to demonstrate the possibilities of using tools to measure outcomes and therapeutic alliance in resocialization work. The starting point is the Multifactor Model of Offender Readiness, which allows capturing internal and external factors influencing the offender’s readiness to engage in resocialization interventions, ultimately leading to effective resocialization. This concept also incorporates solutions proposed by S.D. Miller and B.L. Duncan, who created tools that allow gathering information about the individual’s functioning in a very simple, accessible way for the participant. Based on this information, one can systematically assess the progress (or lack thereof) made by the individual. These tools also enable the determination of the quality of the therapeutic alliance, as while its presence does not determine effectiveness, its absence may reduce the efficiency of the interventions conducted. In the final part of this article, preliminary research results regarding the potential application of the described tools in resocialization work with first-time incarcerated individuals are discussed.

Key words: Multifactor Offender Readiness Model, Outcome Rating Scale, Session Rating Scale, resocialization outcomes.
The concept of readiness for change – the Multifactor Offender Readiness Model (MORM)

In resocialization, we have been searching for answers to the question of “what works, for whom, and how” for years. These analyses have led theorists and practitioners to various conclusions, forming the basis of contemporary resocialization theories. However, what is common among them is the belief that addressing the problem of criminality and preventing it cannot be achieved without considering numerous factors on both the side of the potential offender and the environment, as well as the interaction between them.

In other words, multifactorial theories, including the increasingly popular Multifactor Offender Readiness Model (MORM), are the most accurate. The concept of readiness, in a narrow sense, refers to the degree to which an individual is motivated to change problematic behavior. In a broader sense, readiness relates to “preliminary changes in attitude resulting from dissatisfaction with behavior or lifestyle, the ability to discuss problematic aspects of behavior, initial changes, and long-term efforts put into changes until new behavior or lifestyle becomes ingrained” (Carey et al., 1999, p. 245). In the subject literature, readiness is not a straightforward concept and refers to different aspects – either entering resocialization interventions, the ability to benefit from them, or changing problematic behavior. It is important to distinguish them because each is conditioned by slightly different factors.

When discussing readiness to enter interventions, it can be understood “as the presence of certain characteristics (states or tendencies) located both in the client and in the therapeutic situation, facilitating engagement in interventions and, as a consequence of this input, having the ability to reinforce the therapeutic process of change” (McMurran, Ward, 2010, p. 78). Importantly, these factors are dynamic and have been captured by T. Ward and colleagues in the Multifactor Offender Readiness Model, allowing for the understanding of various dependencies.

The resocialization process in this concept occurs in several stages. Initially, the aim of interventions is to increase the offender’s readiness to enter proposed resocialization interventions so that they recognize it as the best available way to bring about change in their lives. Subsequently, the program facilitator can significantly increase engagement by building the motivation of the convicted individual and utilizing therapeutic alliance. The final stage involves achieving changes in criminogenic needs and, after completing the program, introducing new habits and skills into daily life. This serves as evidence of the effectiveness of the interventions and, on the other hand, is a stage where occasional support is still provided to the offender, reinforcing achievements and preventing relapses. MORM also draws from the transtheoretical model of change, which divides the ongoing
process into several stages through which an individual passes, acquiring new skills to live in accordance with social and legal norms (Muskała, 2021, p. 69–82).

T. Ward has categorized a constant list of factors conditioning readiness to enter interventions into internal and external factors. Through preparatory actions, cognitive, emotional, and volitional skills of the convicted individual can be positively influenced, strengthening their sense of agency. Preliminary minor changes in behavior or personality factors can be achieved (Chojecka, 2016, p.357–379). However, preparatory efforts should also consider external factors to increase the competence of the facilitating staff, introduce evidence-based resocialization programs, and collaborate in their implementation with the local community to prevent further social exclusion and increase the chances of participating in socially accepted reference groups. To reinforce internal and external factors, we have various methods (Chojecka, Muskała, 2021), and their mere presence is not enough to modify readiness factors; active utilization is necessary.

The role of therapeutic alliance in the process of change

Why does the concept of a therapeutic alliance appear in the context of resocialization? Is this not a mixing of concepts, or perhaps even reducing resocialization to psychotherapy?

As E.S. Bordin argues, the creator of the concept of the “working alliance” between a person seeking change and a change agent can occur in many places, including beyond psychotherapy. The concept of the alliance in action seems applicable in the relationship between student-teacher, local community-leader, and with a slight adjustment in the child-parent relationship (Bordin 1979, p. 252). If so, the effectiveness of resocialization, understood as a process serving the change of behaviors inconsistent with social and legal norms, may depend on the quality of the alliance connecting the ward and the conducting influence.

The therapeutic alliance is understood as a “form of agreement between the therapist and the patient regarding therapeutic goals and tasks” (Afolabi, Adebayo 2017, p. 212). In Bordin’s concept, an additional essential element is the development of a bond between the participant and the facilitator (Bordin 1979, p. 253). Importantly, while goals and tasks can be determined at the beginning of the change process, the bond develops during work and undergoes various fluctuations. Therefore, it is essential for the facilitator to monitor the quality of the bond at different stages of the resocialization process because, as noted by L. Cierpiałkowska and J. Kubiak, “if the alliance collapses, and efforts to rebuild it do not bring positive results, the patient most often terminates therapy, often with a sense of misunderstanding and disappointment” (Cierpiałkowska, Kubiak, 2010, p. 92).
One way to prevent falling out of the system of interventions (interrupting therapy) is to use interventions based on feedback—“feedback-informed treatment.” This is a necessary element of evidence-based practice, and the impact of such routine evaluative practices allows the assessment of the effectiveness of conducted interventions. It also increases efficiency and reduces the likelihood of dropping out of interventions or even worsening the condition of the client (Bertolino et al., 2012, p. 12). Among the tools for assessing results and the therapeutic alliance are the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) by B.L. Duncan and S.D. Miller (Duncan et al., 2003, p. 3–12). The session evaluation tool is based on Bordin’s alliance concept, containing four elements, and the respondent’s response is marked on a 10-point scale. The tool has been translated into several languages, including Polish, and is available in several versions—for individuals above 13 years old, for children between 6 and 12 years old, and for users under 6 years old. It is filled out at the end of the session, and the participant can refer to the relationship with the facilitator, goals and topics discussed, methods used, and provide an overall assessment of the meeting. All results from individual scales are summed, and the norms for this tool indicate that people who rate the relationship below 36 points are more prone to dropping out of the system of interventions or that interventions will not bring any results (Bargmann, Robinson, 2012, p. 7). However, Bargmann and Robinson point out that a score of 36 or more does not necessarily indicate a formed therapeutic alliance but may indicate that the client does not feel confident enough in the relationship with the facilitator to provide honest responses (Bargmann, Robinson, 2012, p. 15). Thanks to the alliance assessment tool, we can react appropriately to alarming signals, modifying methods or goals, which can increase the success of conducted interventions. As S.D. Miller indicates, forming a therapeutic alliance is not a guarantee of success, but the lack of an alliance and a negatively assessed relationship with the facilitator are correlated with the results of conducted interventions, so it is worth considering this element (Miller, Duncan 2004, p. 19). Furthermore, the SRS is a tool created not for researchers and theorists but for people working directly with clients. It is easy to fill out, interpret, and allows for real-time response to assessments. As research results show, the ability to assess the session by the participant increases readiness to participate in the next meeting, and not using the SRS tool generated weaker effects of interventions (Miller et al., 2006, p. 14).

Although the relationship between the therapeutic alliance and the effectiveness of various helping actions has been studied worldwide for many years, this issue is still insufficiently addressed in Poland. The research of L. Cierpiatkowska and J. Kubiak, as well as the efforts undertaken by T. Prusiński to adapt the Alliance in Action Scale (WAI), draw attention to the need to conduct research among residents of resocialization and penitentiary institutions. The strength of the therapeutic alliance significantly influences the results of the change process and is
a better predictor “than the individual characteristics of the patient and therapist. This is an important premise for clinical practitioners and therapists, showing that regardless of the procedures and strategies used in addiction treatment, the quality of contact with the patient is essential” (Cierpiałkowska, Kubiak, 2010, p. 108).

According to B.L. Duncan, the greatest impact on making changes comes from extratherapeutic factors, such as individual resources, troubles, motivation, support, the change itself, and even random events (Duncan, 2017, p. xvii). The effects of therapy, including feedback, therapeutic alliance, the applied model, techniques, and the so-called therapist effect, occupy an important but small place in the change process – Duncan estimates it at 13% (Duncan, 2017, p. xvi). This thinking is close to the creators of the Multifactor Model of Offender Readiness, in which – as in B.L. Duncan’s work – more attention is paid to extratherapeutic factors influencing the offender’s readiness for change.

Another concern relates to the therapeutic alliance in the context of resocialization work. This is a situation where support and control coexist, which can hinder effective assistance. This role mixing is characteristic of all relationships where the resocialization or therapy process results from a court decision but also applies to wards subject to more informal pressures – such as a family probation officer, social worker, teacher, or even a parent/life partner. As J.L. Skeem, J.E. Lauden, D. Polaschek, and J. Camp argue, in this situation, a different approach is needed to the role of the therapeutic alliance, subjecting it to different analyses (Skeem et al. 2007, p. 397–410). Tools applied in work with voluntary clients are not enough (Martin et al., 2000, p. 438–450). The response to this deficiency is the Dual-role Relationship Inventory (DRI), whose creators emphasize the more complex nature of such a relationship. Besides the possible lack of motivation to engage in proposed interventions, the facilitator’s role involves not only control over the participant but also the pursuit of goals that are neither the ward’s nor the therapist’s goals (Wysocka 2019, p. 18). This triangular relationship arises because society is the client, and the goal of the actions is at least to limit the risk of re-entering into conflict with the law. Sometimes society expects maximum goals, such as positive changes in the personality of the convicted individual. In light of this, it was essential for the authors of the DRI to identify the components of the therapeutic alliance. They accomplished this based on focus group studies and quantitative research among probation officers and mentally ill patients. The results allowed them to distinguish two types of relationships: authoritarian (despotic) and authoritative (Gochyyev, Skeem 2019, p. 354). The concept by J.L. Skeem and colleagues involves three dimensions of the alliance: caring and fairness, trust, and toughness (Skeem et al., 2007). The tool developed during the research consists of 30 questions and is internally consistent. It not only allows for the examination of the quality of the alliance but also predicts the violation of probation conditions by the convicted person (Skeem et al., 2007, p. 406). To increase the reach of the concept and the tool’s applicability in the daily work of
probation officers, the Dual-role Relationship Inventory-Short Form was created. In this form, both the probationer and the officer are asked nine questions, three for each subscale, and responses are marked on a Lickert scale from 1 (never) to 7 (always). Studies conducted among convicts show that a strong bond with a probation officer acts as a protective factor, reducing the risk of recidivism (Kennealy et al., 2012, p. 502).

Partial evaluation in the process of resocialization

Why make partial evaluations in the resocialization process?

In contemporary resocialization theory and practice, there is an increasing emphasis on the need for interventions based on scientific evidence, known as evidence-based practice (EBP). One component of EBP is Measurement-Based Care, described as the “use of systematically collected data to assess client progress and make decisions about ongoing care” (Scott, Lewis, 2015, p. 50).

It is essential to recognize that evaluation is a complex and process-oriented activity that unfolds over time, comprising various activities and phases. The direct outcome of evaluation is the evaluative assessment of what has been the subject of evaluation. (...) since there can be multiple evaluation criteria, there may be more than one assessment based on them (Szarfenberg, 2010, p. 27).

In resocialization, adopting a comprehensive evaluation strategy proves useful, where assessment is integrated into the helping process from the initial design of the support plan to the final interaction with the participant. “It serves as a tool for continuously gathering information and modifying interventions (...), thereby increasing the likelihood of achieving all set goals at a high level and in a broad scope” (Brzezińska, 2005, p. 239)

As the process of resocialization is not a simple action where the application of a single stimulus can result in the formation of a specific habit (behavior), but rather a complex, multifactorial, and multi-stage set of actions, the aim is to “strive to limit its probabilistic nature and try to determine its effects to the maximum extent” (Opora, 2011, p. 69). Among the many variables influencing the success of the resocialization process, the control of effects is also crucial. According to R. Opora, periodic control should assess the implemented interventions (Scott, Lewis, 2015, p. 49; Brzezińska, 2005, p. 231).

Using professional tools that allow for partial evaluations during conducted resocialization interventions has many benefits, including providing information about progress, establishing specific goals, reducing the likelihood of deterioration in the participant’s condition, and positively influencing the final outcomes of the interventions. These tools can also provide information about various symptoms of problematic behaviors, the level of functioning and life satisfaction of the
participant, readiness for change, and information about interventions, including therapeutic alliance and the assessment of individual sessions.

Utilizing tools for progress assessments gives participants insights into the progress or modifications made within symptoms, effectively reinforcing the willingness to make changes, thereby increasing the effectiveness of the resocialization process. Intervention leaders gain real-time information, allowing them to adjust the program to participants’ actual needs and intervene when progress is too small or absent.

Among the numerous tools for assessing progress in resocialization (Evans et al., 2002, pp. 51–60; Burt, 1980; M.J. Lambert, 2013, pp. 42–51; Kirkpatrick et al., 2018, pp. 1–12; Masden et al., 2008, pp. 1450–1460), you can also find the previously mentioned Outcome Rating Scale by S.D. Miller and B.L. Duncan. According to the authors, filling out and interpreting this questionnaire takes only one minute. Questionnaires that take more time for implementers to complete are rarely used. Additionally, as M.J. Lambert and colleagues pointed out in the intervention system, there is no place for expensive and time-consuming procedures for studying changes occurring in participants (Lambert et al., 2001, p. 160).

As shown by the results of J.L. Whipple and colleagues’ research, it is worthwhile for intervention facilitators to use information from the participant’s progress assessment. However, much more effective are interventions based on information from both outcome assessment and tools supporting the facilitator (clinical support tools). These tools include the alliance assessment questionnaire, the stage of change assessment questionnaire, and the questionnaire assessing social support perceived by the participant. Through a comprehensive approach to evaluation and using the obtained results during sessions, therapists influenced, firstly, longer participation of participants in interventions (on average by 4.5 sessions compared to the control group), and secondly, they increased the effectiveness of therapy – 49.2% of participants improved or recovered, compared to 25.2% who received support without feedback and the use of any tools supporting the change process (Whipple et al., 2003, p. 63). Research by S.D. Miller and colleagues confirms these results. Clients who filled out the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) during sessions coped better and stayed in interventions longer. Importantly, while high scores on the therapeutic alliance scale do not statistically affect therapy outcomes, the lack of analysis of this variable (i.e., not collecting information using the SRS tool) resulted in a threefold lower readiness of the participant to attend the second meeting and significantly lower therapeutic process outcomes (Miller et al., 2006, p. 14).

The Outcome Rating Scale (ORS) was developed based on a more extensive tool, the Outcome Questionnaire 45.2, authored by M. Lambert and colleagues (Lambert et al., 1996). Filling out the questionnaire takes approximately 5 minutes, and it consists of 45 questions addressing the intensity of psychiatric symptoms, interpersonal relationships, role functioning, and quality of life.
Responses are given on a 5-point Likert scale (from “0” never to “4” always), where the total score represents the sum of all responses. A higher score indicates more disturbed functioning of the participant, with a score of 63 points or more considered clinically significant). The Outcome Rating Scale (ORS) is a tool that allows measuring the progress of the participant in personal (well-being, symptoms), interpersonal, and social spheres, enabling an overall assessment of life satisfaction (fourth scale). The tool is designed for self-reporting, and at the beginning of each session, the facilitator requests marking on four scales (10 cm) the point that corresponds to the current assessment of the situation. By transferring the results to a collective chart, both the participant and the facilitator can continuously monitor progress. Any lower scores become a starting point for a discussion about what happened in the preceding session, what requires support, and what the session should focus on to meet the real needs of the participant. Utilizing the tool for outcome assessment during sessions serves the facilitator in at least a dual role – allowing for more precise monitoring of the participant’s progress, making adjustments to content and methods when progress is minimal, and primarily serving as a control function for the facilitator. In the midst of planned activities and goals to achieve, it ensures that the actual needs of the participant are not overlooked. Furthermore, the use of the tool introduces a consistent operating pattern, building a sense of predictability about what will happen. It also reinforces a sense of self-efficacy, a crucial element supporting the process of change for many socially maladjusted individuals.

The research conducted by S.D. Miller and B.L. Duncan also allowed determining the Reliable Change Index (RCI) at a level of five points. This means that if the participant surpassed the cutoff threshold (set at 25 points) between the first and last measurement using the ORS tool, and the difference between the results was at least 5 points, we can speak of a clinically significant change. This change is not attributed to the imprecision of the tool or the respondent’s mood fluctuations (Miller, Duncan, 2004, p.12–13). As indicated by the authors of The Outcome and Session Rating Scales, “most changes in effectively conducted therapy occur sooner rather than later, and the longer the change does not appear, the greater the likelihood of dropping out of interventions and/or achieving weak results. Clients who achieve higher scores (ascending on the chart) are making positive changes, while those whose scores decline experience a worsening of their situation” (Miller, Duncan, 2004, p. 22).

Numerous studies (Miller et al., 2003, p. 91–100; Campbell, Hemsley, 2009, pp. 1–9; Bringhurst et al., 2006, p. 23–30) confirm the validity and reliability of the ORS tool, emphasizing that its internal consistency may arise from the fact that the areas examined correlate with each other. Therefore, it is better to view the tool as a general measure of distress rather than four separate scales (Miller...)

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et al., 2003, p. 95). A. Campbell and S. Hemsley point out that in the course of their research, a high level of correlation was observed between the personal scale and overall well-being. This suggests that they measure the same thing, and thus, three scales would be sufficient, not affecting the loss of significant information, making the tool even easier to use for practitioners (Campbell, Hemsley, 2009, p. 6–7). As shown by the results of S.D. Miller and colleagues’ research, the introduction of tools into interventions that require less time to complete and interpret, and do not disrupt the process but rather serve as a starting point for sessions, is more willingly adopted than longer tools (after a year, the completion rate of ORS was 89%, whereas the longer OQ-45.2 was only 25%) (Miller et al., 2003, p. 97).

Using tools with offenders that provide information on progress gives facilitators the chance not only to track and modify interventions but also to provide offenders access to “practically confirmed” programs (instead of evidence-based practice, we talk about practice-based evidence (Miller et al., 2006, p. 17), tailored to the specific offender’s needs.

### Use of ORS/SRS in work with first-time prisoners

In Polish resocialization practice, tools allowing us to measure the effectiveness and efficiency of resocialization are rarely, if at all, utilized. There are likely several reasons for this, with a few prevailing.

The first is the difficulty in determining what this effectiveness is. Operationalizing this concept would require both theorists and practitioners to define the goals of the interventions. However, this proves challenging because the involved parties in the resocialization process—society, in particular—may have different expectations. Society may expect the offender to be isolated or prevented from returning to crime, or to fulfill various roles while adhering to moral and legal norms. Legislators expect the instigation of “a willingness to cooperate in shaping socially desirable attitudes”2 in the convicted individual. Meanwhile, those conducting resocialization interventions have a range of goals to choose from, depending on the resocialization work area. In simplified terms, their aim is to engage the individuals in various activities to maintain order in the institution. On the other hand, the goal is for convicts, upon leaving the facility/prison, not to return to crime and/or the institution. Participants in the resocialization process may also have various goals that do not necessarily exclude each other—some want to survive the period of imposed sanctions, others aim to improve their qualifications (hopefully, education and vocational), while still others may use this

time to rebuild relationships, and perhaps some to change their previous lifestyle. In such a situation, how can goals be precisely defined and their measurement methods determined?

Another reason is the lack of standards—clearly and precisely defined expectations that practitioners in resocialization must meet in their work. Who evaluates the effectiveness of their work and based on what principles? The absence of clear rules and the multiplicity of problems among participants make it difficult to carry out activities. Often, finding solutions to many difficulties faced by convicts falls outside the scope of the duties of the intervention implementer, and the flow of information and inter-institutional cooperation is still far from ideal.

The third issue, arising from the previous two, is the lack of tools to measure the effectiveness of interventions. While we have various individual scales to determine, for example, the level of demoralization in a minor or the sense of coherence in an adult, we do not have a single tool to assess the starting point of resocialization work, what steps to take, how the process progresses (partial measurement), and what results have been achieved. Criminological research conducted over the years clearly points to the multifactorial nature of legal norm violations, and consequently, the multifactorial nature of the resocialization process. At the core of the belief that factors correlated with crime can be measured is the belief that these are dynamic needs that can be modified during interventions. Therefore, determining the starting point allows planning necessary actions to reduce the negative impact of these factors, ultimately enabling measurement of whether they have achieved their intended goals. Practices based on a multifactorial approach include, among others, the Risk-Need-Responsivity Model with developed fourth-generation tools for estimating the risk of recidivism or the Multifactor Model of Offender Readiness.

In the absence of tools that can even determine small progress in the chosen sphere of the participant's functioning, the general criterion of “no return to crime is often used (…), which interests both lawyers and educators. Using it, we categorize individuals as rehabilitated or non-rehabilitated, without the possibility of grading effectiveness” (Siemionow, 2016, p. 10). Consequently, this leads to frustration among all stakeholders and the belief that “nothing works in correction” (Martinson, 1974).

The pedagogical experiment conducted from 2018 to 2020, utilizing a solution-focused approach³ among detainees experiencing imprisonment for the first time in the Detention Center in Poznań and its external branches, allowed for the introduction of ORS and SRS tools into the workflow. The application of these tools was justified for several reasons:
— firstly, it provided the opportunity to measure the subjective perception of the situation by the detainee;

³ The experiment will be described elsewhere, the text is in preparation.
secondly, the regular use of the ORS tool allowed for tracking the progress of the detainee preparing to leave the prison;

thirdly, systematic measurement provided the ability to capture negative changes in the detainee's situation and apply appropriate interventions;

the use of tools introduced certain consistent and predictable elements into working with detainees – each meeting began with filling out the ORS questionnaire and ended with completing the SRS questionnaire, which organized the course of the meeting;

by using self-reporting tools, the individual involved could assess the course of the meeting and its usefulness, and visible progress could motivate further efforts;

the tools served as a starting point for a conversation about what is important to the detainee, guiding what else they could work on;

the tools were also useful for the facilitator, providing information on which direction to make efforts to support the process of change in the detainee and what to pay attention to in order to build a therapeutic relationship correctly.

The tools ORS and SRS were used in working with fourteen inmates from the experimental group. In two cases, only one measurement was possible, as one of the inmates was transferred to another facility, and the other did not return from leave. Therefore, in the data analysis, there are instances of either 14 or 12 inmates. All participants were male inmates convicted of property crimes, and their sentences were due to end within a year of the study’s commencement.

The average number of sessions was 7.64, with nine inmates completing the full cycle of 10 sessions.

The average results for the first ORS measurement were 25.05 points, with a standard deviation of 7.36, slightly exceeding the cutoff line of 25 points.

In the last ORS measurement, the average score was 35.5, with a standard deviation of 5.91.

The effectiveness of resocialization interventions also depends on how quickly the change in the inmate's behavior becomes evident. In this study, on average, the change manifested at the 2.91 session, earliest during the second and latest during the sixth session.

S.D. Miller and B.L. Duncan indicate that the clinically significant change (Reliable Change Index) for the subjects is 4.99. Therefore, between the first and last measurement, there should be an increase of at least 5 points. The calculated RCI for this study was 6.29, resulting from a larger standard deviation than in the original authors’ research (8.58 in the author’s study, compared to 6.8 in S.D. Miller and B.L. Duncan’s study). This implies that inmates should make greater progress for a clinically significant change, not attributable to mood swings or tool/measurement errors.
The average change among the subjects was 10.93, which might inspire optimism. However, the results raise questions when compared to the recidivism rate.

Recydywa – recidivism; wskaźnik zmiany – change index; badania własne – own studies
Graph 2 – Comparison of the change index with the recidivism rate.
Source: the authors’ own study.
Looking at the chart above, it can be observed that, according to the assumptions of S.D. Miller and B.L. Duncan, the subjects exceeded the threshold for clinically significant change. Moreover, except for one case, they also surpassed the higher RCI value calculated in the own study. In the two cases mentioned earlier, it was not possible to calculate the change. Examining the individuals who returned to criminal activities and their change scores, it can be noticed that change occurs in those offenders whose change index hovers around lower values. On the other hand, those participants who made significant progress in their functioning did not return to crime (during the studied period). This could suggest, for example, that the clinically significant change threshold is higher than the one calculated by the tool’s authors and in the own study.

Speaking of therapeutic alliance, in the first measurement, the subjects rated it on average at 33.57 with a standard deviation of 6.87. Six inmates rated it above the cutoff line (36+). However, there is a doubt, raised by S.D. Miller and B.L. Duncan, that high alliance scores early in the collaboration may indicate not an actual relationship but a superficial one, where the inmate, not yet trusting the facilitator, fears revealing their assessments (Miller, Duncan, 2004, p. 19). Interestingly, from the group where the alliance could be superficial, four participants returned to crime. In this group, change indices were also relatively low, as illustrated in the chart below.
The apparent alliance can be treated as a lack of a therapeutic alliance, and this absence can influence the final outcome of interventions, as illustrated in the above chart. It is interesting, however, that in two examined cases, among the offenders who did not exceed the cutoff line during the work, there was no recidivism. This, given the small sample size, excludes generalizations but becomes an interesting topic for further analysis. It may suggest the multifactorial nature of change understood as effective resocialization.

An interesting observation can be made by analyzing one of the sessions in which a significant other of the offender participated. Both participants received the ORS questionnaire, and the significant other was to assess the offender’s level of functioning in estimated areas on the scale. The results obtained in both questionnaires differed significantly (the participant rated their situation at 37.6 points, while the significant other at 24.2), undoubtedly indicating subjectivity in assessing the situation. However, it can also be a starting point for resocialization work. The expectations of the intervention facilitator towards the offender and their future functioning may differ from the confrontation of the offender with the expectations of important people in their life. Based on the principles of motivational interviewing, discrepancies between the obtained results can be seen as a starting point for developing ambivalence, which can ultimately strengthen the offender’s motivation for change. It also points the direction for further work that the significant others may undertake. On the other hand, we often assess others according to “objective” criteria, applying an ideal measure to them, while being more lenient in self-assessment. This perspective can also be useful for negotiating meanings together, expanding the perspective, and seeking adequate, individualized solutions to help the offender find their place in the environment they will return to after leaving prison (Sztuka, 2018, p.102).

Conclusions

To conduct effective and efficient resocialization interventions, various factors must be taken into account, the presence and appropriate level of which increase the likelihood of success. These factors have been outlined by T. Ward and colleagues in the Multifactorial Offender Readiness Model. However, it is essential to remember that none of these factors, when occurring individually, significantly increases effectiveness. The goal of conducted research should be to develop sound, evidence-based practices that relate to the entire set of factors. This would enable the evaluation of the effectiveness of actions taken by both practitioners and the offenders themselves in relation to clear and measurable criteria. As Z. Bartkowicz points out, “by applying a psychological measure, we ask about absolute effectiveness: »To what extent and how beneficial are the transformations that have occurred in the rehabilitated individuals?« Assessing the effectiveness
of resocialization through the measurement of psychological evolution requires at least two diagnoses: one conducted at the beginning of the process (...) and another conducted at the end of the evaluated period of interventions. Such studies are also called expert-evaluative (Pytka, 2000) and advocated as the optimal way to determine the degree of resocialization effectiveness” (Bartkowicz, 2016, p.52). Research utilizing the tools described in this article aligns with this postulate for evaluating intervention outcomes and therapeutic alliance.

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