Introduction

Critical Issues and Challenges Facing Forensic CBT Practitioners

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Although the scientific conundrums of one generation are often made obsolete by the technological advances of the next, the area of forensic treatment may be an exception. The problem is not a lack of knowledge regarding the components of effective treatment: Instead, the problem is one of their dissemination into practice. Scholars have noted that quackery marks the correctional treatment landscape (Gendreau, Smith, & Theriault, 2009; Latessa, Cullen, & Gendreau, 2002) with nonscientific and “commonsense” theories of criminal behavior (e.g., offenders lack discipline; offenders need to get back to nature) leading to subsequent programs (e.g., boot camps; wilderness adventure) that do not reduce recidivism. Perhaps worse, a variety of bizarre forensic “interventions” that escape scientific evaluation altogether pop up (e.g., dog sled racing; aura focus therapy; see Gendreau et al., 2009, for a list) and make forensic treatment appear similar to the patent medicines of the nineteenth century that claimed to cure a variety of ills but were often no more than opium dissolved in alcohol.

What makes correctional quackery a serious matter of concern rather than a source of comic relief is the sheer size of the criminal justice population and the scope of the financial and human costs. In the United States alone, there are over 2 million people in jail or prison, and an additional 4.8 million on probation or parole (Bureau of Justice Statistics, 2012) at an annual cost of approximately $70 billion (Pew Center on the States, 2009), and incalculable human suffering on the part of victims. In order to make an impact on such a large and significant social problem, there is a correspondingly large need for competent forensic professionals utilizing sound assessment and treatment practices.

The Complexities of Clinical Work in Forensic Contexts

Effecting change through clinical intervention is not an easy endeavor in the best of settings. There are at least two specific aspects of clinical work with justice-involved clients that make it particularly challenging. The first is the behavior of the clients themselves. By
definition, a forensic client is a person who has committed a criminal act and this, by extension, means they have caused harm to someone else. This makes forensic clinical work a perpetrator-based enterprise. It is a normal human condition to have personal reactions to human tragedy, and forensic practitioners are no different. The degree to which this occurs depends on the practitioner and can range from negligible to extreme. At the low end of the reaction continuum, practitioners can remain relatively unaffected regarding a client’s character or behavior and can be clear-headed in formulating a clinical opinion. At the other end of the continuum, clinicians can have excessively negative reactions to the nature or behavior of the client and possibly fall prey to such clinical events as compassion fatigue (Joinson, 1992), which can significantly compromise clinical judgment.

A second professional challenge in working with justice-involved clients relates to the goals of treatment and the consequences of treatment failure. In general psychotherapy, the clinical goal is often symptom relief. For example, depressed clients seek relief from low mood in order to have better and more enjoyable life functioning. The consequences of failing to effect change may be disappointing to such clients and clinicians, but less than optimal outcomes result in relatively limited harm to others. In contrast, clinical tasks with justice-involved clients may not be geared toward symptom relief but rather to a broad class of rule-violating behaviors (Bonta, 2002). Practitioners identify and attempt to therapeutically modify the factors responsible for antisociality such that risk potential for future rule violation behavior is reduced. Practitioners working with justice-involved clients often have a realization, typically based on historical behavior, that clients have the potential to commit future antisocial acts. It may be determined, for example, that criminality is linked to criminal thinking. Thus, the goal is to modify antisocial thoughts with the understanding that future criminal conduct is less likely to occur. Unlike in general psychotherapy, suboptimal treatment performance with forensic populations can result in an unchanged criminal risk profile, the consequences of which are future criminality and victimization. The fact that justice-involved clients are notorious for being resistant to treatment and chronically fail to complete interventions offered to them (Olver, Stockdale, & Wormith, 2011; Wormith & Olver, 2002) only adds to the professional challenges.

Effective forensic practitioners are not born – they develop certain competencies that set them apart from less capable practitioners. There is no clear information articulating the essential features of a good forensic practitioner; however, information exists on generic clinicians that can serve as a guide for forensic clinical work. Welfel (1998) identifies three areas of competence linked to the degree of clinical effectiveness with clients:

1. **Knowledge** – expertise in understanding the theory, research, and application of information in the field of practice.
2. **Skill** – understanding of therapeutic procedures and the application of those procedures to clients.
3. **Diligence** – attentiveness to the clients’ needs.

The knowledge competency may be unique in that it will shift from clinical specialty to specialty (e.g., the specific knowledge base for effective forensic practice will be different from that of health or neuropsychology) while the skill and diligence competencies are more likely to cut across clinical specialties. Below we focus on the unique knowledge competencies that are relevant to forensic practice.
Knowledge in three specific areas may serve as the foundation for effective clinical practice with forensic clients. The three areas concern an awareness of: (i) criminal risk variables; (ii) the Risk-Need-Responsivity (RNR) model of offender assessment and rehabilitation; and (iii) the offender treatment effectiveness literature. Practitioners fluent in these areas will be better equipped to provide effective treatment to justice-involved clients, which hopefully translate to better clinical outcomes.

Criminal risk variables

The first core forensic knowledge area relates to the primary factors responsible for anti-social conduct, often referred to as criminal risk variables. Justice-involved clients have multiple problem areas and it can be difficult to determine what problem assumes clinical priority. Information on the relative importance of certain risk factors can assist in the treatment planning process. Although there is extensive literature available on general criminal risk factors, research evidence from meta-analytic literature reviews exists on the predictors of criminal behavior among adult male (Gendreau, Little, & Goggin, 1996), juvenile male (Cottle, Lee, & Heilbrun, 2001), juvenile female (Simourd & Andrews, 1994), adult sex (Hanson & Bussiere, 1998), and mentally-disordered (Bonta, Law, & Hanson, 1998) offenders. Andrews, Bonta, and Wormith (2006) have identified those risk factors most closely linked to recidivism, and have referred to them as the Central Eight (see Box 1.1).

The Risk-Need-Responsivity (RNR) model

The second area of core knowledge concerns the RNR model of offender assessment and rehabilitation developed by Andrews, Bonta, and Hoge (1990). While the RNR model may be unfamiliar to practitioners who come from traditional mental health backgrounds, it has come to be important in the practice and research literature around correctional assessment and treatment. We recommend that practitioners unfamiliar with the model start with Andrews and Bonta’s The Psychology of Criminal Conduct (2010) before jumping into the large base of conceptual and empirical work on RNR that appears in scholarly journals. Each component of the model is briefly described below.

**Box 1.1** The ‘Central Eight’ Criminal Risk Variables

1. History of antisocial behavior (early and continuing involvement in antisocial acts).
2. Antisocial personality (adventurous, pleasure seeking, poor self-control).
3. Antisocial cognition (attitudes, values, beliefs supportive of crime).
4. Antisocial associates (close association with criminal peers and relative isolation from prosocial others).
5. Family/marital (lack of nurturing relationship; poor monitoring of behavior).
6. School/work (low levels of performance and satisfaction in school or work).
7. Leisure/recreation (low levels of involvement and satisfaction in prosocial pursuits).
8. Substance abuse (abuse of alcohol or drugs).
The Risk component concerns the dosage of clinical services and contends that services be titrated to the degree of presenting problem; with the presenting problem defined as risk to reoffend. Specifically, higher risk cases should receive proportionally more services than lower risk cases. The Need component relates to the targets of clinical services and suggests that clinical attention be placed on the specific factors giving rise to the client’s antisocial behavior. Moreover, the Need component distinguishes between criminogenic (those more strongly related to criminality – attitudes, companions, etc.) and noncriminogenic (those weakly related to criminality – self-esteem, social status, etc.) and suggests clinical attention focus on criminogenic needs. The Responsivity component relates to providing clinical services that are tailored as best as possible to the unique learning styles of the client. Research on the RNR model has revealed that adherence to RNR principles is linked to better clinical outcomes for justice-involved clients in terms of lower recidivism (Andrews & Bonta, 2010; Andrews & Dowden, 2005; Latessa, 2004).

Mental health symptoms are classified less criminogenic in the RNR model. They are related to recidivism, but not as strongly as the Central Eight. Therefore, practitioners must not assume that addressing their client’s depression, anxiety, or low self-esteem will have an appreciable impact on the client’s likelihood to recidivate. In fact, a recent study found that for forensic clients with both significant mental health symptoms and criminogenic risks/needs, focusing solely on the mental health components produced limited effects on recidivism (Guzzo, Cadeau, Hogg, & Brown, 2012). Forensic clients high on both mental health problems and criminogenic risks/needs will require good mental health treatment and interventions that directly address criminal risk factors. This suggests that like co-occurring mental health and substance use disorders, treatment for mentally disordered justice-involved clients should target both problem areas. In cases in which the mental health symptoms are particularly severe, alleviating psychological distress is important so that justice-involved clients can later work on criminogenic needs, but alleviating distress does not replace the importance of intervention around criminogenic needs.

Treatment effectiveness with offenders

Familiarity with the “what works” literature on forensic treatment is the third area of core knowledge. Energetic debates about the effectiveness of offender treatment have raged for years in the forensic literature. The lightening rod of interest in this area can be attributed to Robert Martinson (1974), who after reviewing the correctional treatment literature concluded “nothing works.” As was pointed out previously, the clinical outcomes of interest in forensic settings are most often focused on rule-breaking conduct and thus the determination of treatment benefit is focused on a very specific criterion, namely future criminality (i.e., recidivism).

After Martinson’s (1974) report, the field of forensic rehabilitation saw the development of a generation of manualized cognitive-behavioral therapy (CBT)-based programs as well as the first meta-analyses of offender rehabilitation programs. Both of these developments supported the potential for CBT to be effective with justice-involved clients. In a little over a decade after the Martinson report several manualized group treatments based on CBT principles were introduced, including: Aggression Replacement Training (Goldstein, Glick, & Gibbs, 1998), Moral Reconation Therapy (Little & Robinson, 1986), and Reasoning and Rehabilitation (Ross, Fabiano, & Ross, 1986). The three programs have different foci but were all specifically developed for offenders, can be delivered by trained facilitators rather than psychologists, and
have been found to reduce recidivism (Milkman & Wanberg, 2007; Wilson, Bouffard, & MacKenzie, 2005). The first meta-analysis of offender rehabilitation programs found a moderate effect on reducing recidivism – e.g., well-run treatment programs decreased reoffending by 30%, while simple custody (in the absence of treatment) results in an increase of recidivism by 7% (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). Subsequent meta-analytic reviews of the offender treatment literature have occurred over the years, confirming the main findings of the Andrews et al. study, and suggesting an average reduction in recidivism of 10% (McGuire, 2002). As in the general psychotherapy literature, attention has focused on the types of treatment related to the best change outcomes among offenders, and CBT has been found to be the therapeutic modality of choice (Landenberger & Lipsey, 2005; Lipsey, Chapman, & Landenberger, 2001).

The growing literature on the relative effectiveness of CBT with justice-involved clients has not gone unnoticed by criminal justice agencies. In the National Institute of Corrections (NIC) and Crime and Justice Institute’s (CJI) Implementing Evidence-Based Practice in Community Corrections: The Principles of Effective Intervention, CBT is specifically highlighted in Principle 4: “Provide evidence-based programming that emphasizes cognitive behavioral strategies and is delivered by well trained staff” (NIC & CJI, 2004, p. 5). Interest in using CBT-based interventions with offenders has more recently been extended into the field of probation and parole with efforts made to train supervision officers to use CBT skills in their sessions with offenders (see Rugge and Bonta, Chapter 7).

CBT, Criminology, and Offender Thinking Targets

Cognitive-behavioral therapy is well established in several human services disciplines but it has been surprisingly slow to be used in forensic practice. Indeed, the correctional quackery movement (lack of utilization of empirically supported treatments for offenders) suggests that it may be an uphill battle for CBT to become more commonplace amongst practitioners. While the relative effectiveness of CBT with justice-involved clients has been established, a practitioner may wonder how CBT in forensic settings is different from CBT in traditional settings. For example, what are the most important cognitive targets for intervention and are they the same as those found with traditional mental health clients? Unfortunately, confusion exists in that two literatures have emerged regarding the specific thinking patterns proposed as essential in guiding problematic behaviors. One, for CBT and mental health problems, is based on the models of Ellis (1957, 1962) and A. T. Beck (1963, 1967); the other, which came out of criminology, is connected to the work of Sykes and Matza (1957).

Ellis’s rational emotive behavior therapy (REBT) is firmly rooted in stoic philosophy and is often encapsulated by the quote from Epictetus “men are not disturbed by things but the views that they take of them” (Gill, 1995). The goal is to teach clients to become less reactive to life’s daily hassles and inconveniences through a philosophical shift. In terms of relevant cognitive targets, Ellis hypothesized that demandingness (insisting that other people or the world conform to one’s own terms), awfulizing (exaggerating the consequences or level of hardship associated with difficult or challenging situations), low frustration tolerance (the tendency to underestimate one’s ability to deal with discomfort or adversity), and self or other rating (blaming or condemning other people or oneself “in total” for limited and specific things that they do), as the major culprits leading to disturbed functioning (Walens, DiGiuseppe, & Dryden, 1992).

Beck’s Cognitive Therapy (CT) is connected to philosophical work on how humans construct and experience reality. This model includes several levels of cognitive processes. At the
most basic level are core beliefs and schemas, which tend to be global and overgeneralized conceptions about the self, other people, and the world. These beliefs are formed in early childhood and often remain below the level of conscious awareness. Core beliefs influence the next level of thinking, which consists of attitudes, rules, and assumptions, and form the basis for how an individual thinks, feels, and behaves across different situations. Lastly, automatic thoughts are quick evaluative thoughts that spring up in response to different stimuli and form the stream of consciousness that humans can learn to identify with minimal effort. In the early stages of treatment, the emphasis is on modifying automatic thoughts by testing them against observable data from the real world (J. S. Beck, 1995). Traditionally, Beck and colleagues have proposed specific categories of cognitive distortions to be modified in treatment (J. S. Beck, 1995; Leahy & Holland, 2000). Some examples include fortune telling (predicting the future negatively), mental filter (focusing on the negatives instead of seeing the whole picture), all or nothing thinking (situations are viewed in only two categories instead of a continuum), overgeneralization (making sweeping negative conclusions that go beyond a specific situation), and personalizing (attributing a disproportionate amount of blame to oneself rather than considering other factors).

In both the traditional CT and REBT models, how people think about events is proposed to exert a powerful influence over feelings and actions. Over time, patterns of thought develop and with years of repetition these thoughts become automatic and inflexible. The first step in treatment is to develop an awareness of the thinking patterns associated with excessive emotions and problematic behaviors. Distorted and irrational thoughts are then challenged, based on logic or evidence, and new thinking that will bring about emotional and behavioral change is developed and practiced in day-to-day life (Leahy & Holland, 2000; Walen et al., 1992).

While many of the interventions that have emerged from the CT and REBT traditions have established themselves as some of our most empirically supported treatments for a wide variety of disorders (for a meta-analytic review see Butler, Chapman, Forman, & Beck, 2006), the extent to which the belief patterns targeted by these traditional CBT models underlie criminal behavior has not been well established. For example, a curious finding emerged from a doctoral dissertation that focused on irrational beliefs and convicted felons. On two separate self-report paper-and-pencil tests that measured irrational beliefs, the felon group (at pretest) reported fewer thinking errors than other populations, including college students who had previously taken the same instruments (Swanston, 1987). Were the offenders to be considered the standard for rational and healthy thinking? Was the felon group dishonest in completing the questionnaires? Or, are the existing cognitive models derived primarily from work with prosocial anxious and depressed patients missing the mark when it comes to justice-involved clients?

Surely, most chronic offenders do not harshly criticize or blame themselves when they receive negative feedback, as CT would suggest is the pattern for depressives? Similarly, many offenders may be unlikely to make the error of awfulizing or overestimating danger in ambiguous situations, as REBT proposes is common for those suffering from anxiety. In fact, offender thinking may be just the opposite; showing a lack of concern for how one’s actions affect others and a tendency to underestimate danger and risk in favor of overly optimistic predictions regarding likely outcomes (Yochelson & Samenow, 1976).

In the field of criminology, at around the same time as the development of CBT, a model of dysfunctional thinking tailored specifically for offenders, which has come to be known as neutralization theory, emerged from Sykes and Matza’s (1957) work with juvenile delinquents. They proposed that five cognitive techniques allow offenders to neutralize (minimize
self-blame and disapproval from others) their actions. Neutralizations such as denial of responsibility (delinquent acts are due to outside forces), denial of injury (minimizing harm caused by one’s actions), denial of the victim (victim is seen as the wrongdoer deserving retaliation or punishment), condemnation of condemners (cynicism directed at those responsible for upholding society’s norms), and appeal to higher loyalties (loyalties to smaller antisocial groups take precedence over larger society), provide justifications following a criminal act and also set the stage for continued criminal activity. The authors acknowledged that these patterns exist to some degree across society but suggest that they are stronger and more prevalent among justice-involved clients. The theory has since been expanded to include a variety of adult offenders as well (see Maruna & Copes, 2005, for a review).

Several other cognitive conceptualizations from the criminology literature have been applied to offender thinking. Mylonas and Reckless (1963) identified self-justification, loyalty, belief in luck, and a tendency to exaggerate society’s shortcomings as important attitudes possessed by justice-involved clients. Expanding upon the work of Sykes and Matza (1957), Scott and Lyman (1968) proposed their theory of accounts, which describes and classifies people’s descriptions of their misconduct. They distinguish between excuses (in which a person acknowledges engaging in misconduct but denies responsibility for it) and justifications (in which a person accepts responsibility for the behavior but denies that it was wrong). A common theme running through the criminology literature on offender thinking is the importance of excuse making – to minimize responsibility for criminal conduct – as the leading cognitive treatment target. Indeed, intervention programs with offender populations seem to place special emphasis on challenging thinking that minimizes accountability. Having offenders take personal responsibility for their actions seems to be a cognitive focal point (Maruna & Mann, 2006). Thus, rationalizing, minimizing, justifying, blaming others, and seeing oneself as a victim are all viewed as important cognitive targets. In several recent reviews it has been suggested that an overemphasis on excuse making in the offender treatment literature, has resulted in too little attention being paid to other, perhaps more important, cognitive patterns that contribute to offending behavior (Henning & Holdford, 2006; Maruna & Copes, 2005; Maruna & Mann, 2006; Mitchell, Tafrate, Hogan, & Olver, 2013).

Although both CBT and neutralization theory and its offshoots developed around the same time and emphasized the role of thinking patterns, almost two distinct literatures have emerged – each rarely referencing the other (Maruna & Copes, 2005). This may partially explain why neither seems to adequately address the cognitive patterns that facilitate criminality. As noted earlier, antisocial cognitions are a major risk factor for criminal behavior. However, practitioners with mental health backgrounds may find that attempts to restructure client thinking around the traditional cognitive targets of CT and REBT are a poor fit with chronic offenders. On the other hand, criminal justice practitioners influenced by the criminology literature may place too much emphasis on offender responsibility and favor confrontation over collaboration in attempts to alter thinking patterns. Neglected in both approaches, and in clinical practice, is the empirical criminal thinking literature, which identifies and measures the thinking patterns that facilitate the antisocial and self-destructive conduct observed in justice-involved clients. Drawing from sources in criminology and psychology, including traditional CBT, neutralization theory, psychopathy, and differential association theory, existing criminal thinking instruments assess multiple thinking patterns, varying from as few as three to as many as eight (the instruments developed in this area are discussed in more detail by Kroner and Morgan in Chapter 5, and by Walters in Chapter 6. Although there are several criminal thinking instruments
available, and despite the importance of criminal thinking in the RNR model described above, criminal thinking “has been largely overlooked in the mainstream assessment and treatment of offenders” (Simourd & Olver, 2002, p. 429).

We believe it is time for greater integration of the CBT, criminological, and psychological literatures that are geared toward forensic practice. This book reflects an attempt to better connect these disparate bodies of knowledge. Such integration holds promise for finding better solutions for addressing a broad range of antisocial behaviors that lead to a staggering amount of human suffering worldwide. We hope that in the chapters that follow, forensic practitioners find a rich foundation of clinical wisdom to guide their work and avoid the quackery noted earlier. As readers will find, there is reason to be optimistic that a future generation of forensic practitioners can conquer the conundrums that have historically overshadowed quality forensic clinical work.

References


**Suggestions for Further Learning**

**Book**


**Journal articles**
