Forensic CBT: A Handbook for Clinical Practice is a superb collection that will be of immense value to practitioners who work with this challenging group of people. Leading contributors from the CBT approaches have written excellent chapters that will be immediately helpful, striking just the right balance between scholarship and practical application. There is an awareness of the specific challenges in working with offenders—distrust, lack of motivation, history of problems, lack of social support, stigmatization—and importantly, how to overcome them. I highly recommend this important volume to anyone working in the forensic area.

Robert L. Leahy, Director, American Institute for Cognitive Therapy, New York, NY, USA

“This handbook is long overdue as it fills a glaring void in forensic and correctional treatment. With its application of CBT to an array of offenders and their conditions, it elucidates the ‘forgotten R’ (responsivity) in the RNR model of effective correctional intervention.”

Stephen Wormith, University of Saskatchewan, Canada

“Incisive, comprehensive, scholarly, and practical – Tafrate and Mitchell’s Forensic CBT is an impressive body of work, with contributions from leaders in the field integrating innovations in applied research and clinical practice for cognitive behavioral approaches with forensic clientele.”

Mark Olver, University of Saskatchewan, Canada

With the current correctional population in the United States approaching 2 million—and a probation population of more than 5 million—there is an increasing demand for effective behavioral and emotional health services from forensic practitioners. Forensic CBT: A Handbook for Clinical Practice represents the first authoritative resource on the utilization of Cognitive-Behavioral Therapy (CBT) strategies and techniques for a wide variety of justice-involved clients.

Contributions from leading experts in the major schools of CBT offer practical guidance on the treatment of antisocial personality patterns, anger, interpersonal violence, substance abuse, and sexual aggression. This practical guidance is supplemented by an assortment of worksheets, handouts, and exercises for practitioners to use with their clients. Coverage is also included on the use of modified CBT strategies for female, juvenile, and culturally diverse forensic populations; as well as emerging areas of forensic practices. Forensic treatment is presented from a wide spectrum of CBT approaches including Beck and Ellis, Acceptance and Commitment Therapy, Schema Focused Therapy, and criminal thinking models.

Forensic CBT is an invaluable resource for practitioners working with juvenile and adult offenders in various criminal justice settings, both within institutions and in the community.

Raymond Chip Tafrate is a licensed psychologist and Professor and Chairperson of the Criminology and Criminal Justice Department at Central Connecticut State University. His most recent books are Anger Management for Everyone (2009) and Understanding Anger Disorders (2006).

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Forensic CBT
Forensic CBT

A Handbook for Clinical Practice

Edited by

Raymond Chip Tafrate
and Damon Mitchell

WILEY Blackwell
...for it had ever been my opinion, that no man was past the hour of amendment, every heart lying open to the shafts of reproof, if the archer could but take a proper aim.

Oliver Goldsmith, *The Vicar of Wakefield*, 1766

This book is dedicated to those practitioners who routinely work with some of society’s most marginalized members. All too often, their efforts to alleviate human suffering and enhance safety in the communities in which we all live go unacknowledged.
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Preface

The origins of this book began with a simple observation from our work as consultants to criminal justice agencies and programs: Among practitioners there existed a high level of interest in cognitive-behavioral therapy (CBT), but a relative scarcity of CBT resources in the forensic arena. We wondered why we were unable to find an authoritative and comprehensive source of expert guidance, clinical wisdom, and inspiration for practitioners working with one of the most complex and challenging clinical populations. Where was the manual outlining the cognitive targets? Where was the handbook containing user-friendly forms and worksheets to be used with justice-involved clients? How does CBT in prisons or community corrections differ from interventions typically delivered in mental health settings? What does forensic CBT actually look like?

We hypothesized that one of the reasons for this scarcity of practical resources was an unfortunate disconnection between the psychology and criminology literatures that has developed over the last half century. For example, a rich empirical literature on offender attitudes exists that primarily focuses on thinking patterns as variables that predict program behaviors and recidivism, with much less attention dedicated to treatment issues. In contrast, a plethora of CBT programs from psychology emphasize methods and strategies for altering thinking and behavior but tend to highlight patterns central to anxiety and depression rather than antisocial patterns. It is interesting to note that the cognitive revolution in criminology predates the Ellis and Beck models but has never fully bloomed into a broad array of empirically supported treatment programs.

In an effort to bridge the gap between those psychologists working from traditional CBT mental health backgrounds and those from criminology, we organized a panel titled CBT for Criminal Justice Populations: Lessons Learned from the United States and Canada for the 2010 World Congress of Behavioral and Cognitive Therapies, in which the presenters discussed their application of one or more of the existing CBT models to the problems of forensic clients. Over coffee later, we informally discussed the need for a forensic CBT handbook, and through an act of serendipity, were approached by an editor from Wiley that day who had noticed our panel in the catalogue and asked if we might be interested in putting such a volume together.

As the book began to take shape, scholarly presentations and informal discussions about how to apply CBT to justice-involved clients continued at professional meetings of the Association for Behavioral and Cognitive Therapies and Canadian Psychological Association.
The ideas and treatment models presented at those meetings comprise some of the chapters of this volume. In addition, we reached out to leading forensic researchers and treatment experts from around the world and were pleasantly surprised at their overwhelmingly positive response and willingness to contribute to this book.

Our primary goal in assembling this text is to create an authoritative and comprehensive resource on the use of CBT for a wide variety of justice-involved clients. The development of the content was guided by two objectives. The first was to present a diverse array of models within the CBT umbrella rather than a single CBT approach. For example, how might forensic treatment look from a traditional CBT perspective as compared with an acceptance-based or schema-focused approach? In order to accomplish this first objective, contributions were solicited from leading experts in the major schools of CBT. The second goal was to present the material in a manner that would be useful to practitioners. Toward this end, contributors were provided with an outline of specific practical clinical concerns to discuss and reviews of research were generally relegated to brief subsections of chapters. The inclusion of worksheets, exercises, and other clinical materials was encouraged.

**Organization of the Present Volume**

This book is divided into five parts. The first presents six approaches to the treatment of antisocial patterns. Such a considerable portion of the book is devoted to this single clinical construct because it is a day-to-day pressing concern for practitioners who work in forensic settings, but one about which practical information to guide treatment is lacking. Practitioners working in more traditional environments will also encounter individuals with antisocial patterns and will find the material in this part of the book useful for conceptualizing and treating such cases. Although the authors in Part I are considering antisocial patterns from their unique approaches, all were asked to discuss a core set of topics: (i) setting the treatment agenda and enhancing motivation; (ii) identifying and conceptualizing relevant thinking targets and/or core beliefs; (iii) strategies for disputing, challenging, accepting, and/or defusing problematic thoughts or beliefs; and (iv) strategies for reinforcing new thinking and behavior patterns with exposure, in session activities and/or homework. Chapter 2 tackles the antisocial pattern from a traditional CBT perspective, conceptualizing treatment from the point of view of cognitive therapy (CT) and rational emotive behavior therapy (REBT). Chapter 3 presents an acceptance and commitment therapy (ACT) group intervention developed for use with incarcerated populations. In contrast, Chapter 4 describes conceptualization and individual treatment from a schema-focused model. Chapters 5, 6, and 7 discuss treatment from the perspective of criminal thinking models, which are informed by the Risk-Need-Responsivity (RNR) model as well as traditional cognitive and social learning principles. The approaches in Chapters 5 and 6 are both based on the use of empirically supported criminal thinking instruments as a means of identifying treatment targets. The training of probation officers in the use of CBT techniques, detailed in the Chapter 7, underscores the interest of criminal justice agencies in CBT and the dissemination of CBT into forensic case management practices.

Part II concerns the treatment of four problem areas that are commonly targeted by the courts for mandated treatment and for which clients rarely seek help voluntarily: (i) anger, (ii) interpersonal violence (IPV), (iii) addictions, and (iv) sexual aggression. The goal in constructing this section was to obtain two unique CBT approaches for each problem area. Contributors were asked to include discussion of the same core set of topics mentioned earlier (e.g., setting
the agenda, identifying relevant thinking targets). Chapters 8 and 9 present two approaches to the treatment of pathological anger. The anger episode model presented in Chapter 8 is rooted in traditional CBT, while the contextual anger regulation model presented in Chapter 9 is aligned with an acceptance-based approach. Chapters 10 and 11 offer two alternatives to the Duluth model, which has dominated IPV treatment. A new theory of IPV, Instigating-Impelling-Inhibiting (I²), and an accompanying treatment model, are the subject of Chapter 10, while Chapter 11 presents the violence reduction program, which is a couples-based approach rooted in the General Aggression Model. Two approaches to the treatment of substance abuse are the focus of Chapters 12 and 13. A six-pronged REBT-based approach is provided in Chapter 12, while an eclectic approach that incorporates treatment of criminal behavior and problem substance use with an emphasis on building empathy and social responsibility is described in Chapter 13. Chapters 14 and 15 both concern CBT for sex offenders but with different emphases. The Rockwood model presented in Chapter 14 integrates a strengths-based perspective into sex offender treatment, while the Recidivism Risk Reduction Therapy (3RT) presented in Chapter 15 integrates the RNR model.

Part III is devoted to the use of modified CBT strategies for female, juvenile, and culturally diverse forensic populations. Chapter 16 highlights the differential needs of justice-involved women and discusses how to conduct gender-responsive treatment. Chapter 17 provides an overview of an array of evidence-based CBT programs for juvenile offenders and at-risk youths, including programs that emphasize family involvement. Chapter 18 considers the impact of cultural differences on treatment delivery and responsiveness. The treatment of offenders who identify from Indigenous cultural backgrounds in Australia is used to highlight the importance of integrating cultural perspectives into CBT practice.

The chapters in Part IV are intended to highlight potentially useful but underdeveloped areas of practice and emerging trends. Chapter 19 presents an efficient and clinically practical method for conducting ongoing assessment and documenting treatment progress. Chapters 20 and 21 provide overviews of two treatment models that have permeated forensic practice over the past 10 years: motivational interviewing (Chapter 20) and the good lives model, a strengths-based approach (Chapter 21). Both chapters emphasize strategies for integrating their respective models into CBT. Treating prisoners suffering from depression and post-traumatic stress disorder using a new schema-based model, centered on schemas related to interactions with others, as opposed to the self, is presented in Chapter 22. Part V consists of the final chapter, which presents five recommendations for applying CBT to justice-involved clients that were distilled from the rich clinical chapters preceding it, and also discusses directions for the evolution of forensic CBT.

Labels and Language

There are many terms used to describe individuals who receive services in criminal justice settings: offender, probationer, parolee, prisoner, justice-involved client, court mandated client, inmate, and patient to name just a few. Similarly, many terms are used to describe professionals who deliver those services: counselor, therapist, clinician, practitioner, case manager, etc. Often the setting where treatment is delivered or the preference of the provider will dictate the terminology that emerges. Readers will find an array of terms used throughout this book. Authors were asked to be consistent through their chapters in the terminology they chose, but were free to use the terms they thought fit best with their own work and settings.
In Gratitude

Bringing together the various authors and perspectives presented in this volume was a large undertaking. Our burden was eased by the willingness of a great many talented psychologists, researchers, and professionals from around the world who shared their clinical expertise. We are thankful for the considerable time and effort they spent preparing their chapters and their cooperation and responsiveness to our editorial feedback. Through this experience we have gained many new colleagues and our understanding of forensic practice has been vastly enriched.

We would also like to express our gratitude to Andrew Peart, our acquisitions editor at Wiley, for getting this book off the ground. He achieved a wonderful balance of being on top of the details while also being easy-going and flexible. We appreciated his enthusiasm and support throughout this project. We would also like to thank Olivia Evans, Robert Hine, Mahabunnisa Mohamed, Gnanambigai Jayakumar and the rest of the production team at Wiley for helping to shape this book into its final form.

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Raymond Chip Tafrate
Damon Mitchell
July 2013
Introduction

Critical Issues and Challenges Facing Forensic CBT Practitioners

Damon Mitchell, David J. Simourd, and Raymond Chip Tafrate

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 out-
comes 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 realiza-
tion, 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 inter-
ventions 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