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Cognitive Behaviour Therapy in Forensic Setting: An Overview

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ABSTRACT

The increase in need of treatment services in prison has been in great demand. The augmented number of crimes ranging from petty crimes to serious heinous crimes in last two decades brought in the requirement of mental health facilities in prisons at the surface level. Growth in prison facilities and prisoner populations has outstripped the slower growth in mental health services, and become the need of an hour to appoint the trained and experienced therapist to reduce the rate of recidivism. Psychotherapy one of the facility in forensic setting, has been proved as an efficient method in recidivism. Among the various therapies administered on offenders, Cognitive Behavioural Therapy (CBT) includes numerous programs like anger management therapy, moral reconation therapy, reasoning and rehabilitation, soft skill training, substance abuse training, relapse prevention therapy etc. are considered as the important component of the mental health facilities in the prisons, correctional and observation homes with an aim to increase the community re-entry of the offenders. CBT in prison focuses on cognitive functioning and behaviour especially on developing skills for living in harmony with the community and engaging in behaviours that contribute to positive outcomes in society. In the light of the available applications of CBT on forensic population, the heed of this article is to provide an overview of the effectiveness in crime reduction and training the offenders for becoming an acceptable member of the society.

Keywords: *Mental health facilities, cognitive behaviour therapy (CBT), recidivism, community re-entry.*

Psychotherapy is considered as one of the forms of the treatment which is employs the systematic use of a therapeutic relationship between therapist and patient where the former tries to bring in the changes within the latter. This is considered a totally distinct approach from the pharmacological where psychiatrist tries to bring the changes in behaviour or to produce change

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in feelings, thinking of the individual by prescribing medicines. Psychotherapy has been defined in many ways but most acceptable definition defines it as the "Psychotherapy is an interpersonal, relational intervention used by trained psychotherapists to aid clients in problems of living and coming out of the problems in the end". The advantage of this definition is that it highlights how the quality of the interpersonal relationship forms the basis for therapeutic efficacy, and how it focuses on bringing out the changes as an end result of the interaction. All the ways in which psychotherapy has been defined, interpersonal relationships, communication is a key and intrinsic component of psychotherapy. This communication predominantly involves the use of spoken language along with few non-verbal communications and gestures e.g. body sculpting,drama, music, art and play. Moreover, psychotherapists includes a range of techniques based on experiential relationship building, dialogue, communication and behaviour change and that are designed to improve the mental health of a client or patient, or to improve group relationships (such as in a family).

In the process of psychotherapy, therapist generally view change as a by-product of empathic listening and beneficial presence which are the prominent feature of this process wherein the clients are less likely to explicitly intervene to effect intended changes. Despite the diversity of techniques employed in psychotherapy, the following are beneficial functions that most, if not all effective psychotherapies have in common like developing a therapeutic relationship, generating positive expectations, facilitating cognitive and experiential learning, facilitating emotional arousal and catharsis, engendering a sense of mastery and finally the application of new skills developed.

Levels of Psychotherapy

To speak of the varying levels in psychotherapy, suggests that intended changes for patients may be superficial, intermediate or deep. Psychoanalysis, with its ambitious goal of reconstructing character pathology by dealing with deep, hidden psychic issues from the past, and its frequency and duration of meeting with the patient, is taken as the deepest extent of psychotherapeutic exploration. The corollary is that techniques that rely less on psychoanalytic methods (e.g. exploration of the unconscious by free association, interpretation of the unconscious conflicts and transference) and forms of psychotherapy in which patients are seen less often or for shorter periods of time are assumed to have only modest effects. Thus, activities such as the unburdening of problems to a sympathetic listener, ventilation of feelings to a supportive helper, rational discussion of problems with the aim of arriving at practical solutions and having more information are presumed to fall short of what could be achieved through deep exploration and analysis.

In a different sense, the level of psychotherapy could be used to indicate the level of training and sophistication of the practitioner. This ranges from 'level 1' of basic counselling, through an intermediate 'level 2' practised by many psychiatrists, psychologists, social workers and nurses,

to specialist 'level 3' treatments. The assumption here is that the 'level 3' specialists have better skills and can deal better with more difficult clinical situations.

Cognitive-Behavioral Therapy (CBT) in Forensic Setting

Cognitive-behavioural (CB) theory and approaches emerged from two paths: cognitive theory and therapy and behavioural theory and therapy. The development of behavioural therapies in the late 1950s and 1960s provided the foundation of the behaviour component of cognitive-behavioural therapy.

Behavioural therapies and Cognitive-restructuring approaches seemed to develop in parallel paths, over time the two approaches merged into what we now call *cognitive-behavioural therapy* (CBT). Bandura's work on behavioural modification, social learning theory, and how internal mental processes regulate and modify behaviour provided an important bridge in the merging of behavioural and cognitive approaches (1995,1996).

Following the work of Ellis and Beck (A. Beck, 1963, 1970, 1976), the different approaches to cognitive therapy and cognitive restructuring were joined with the elements of behavioural therapy. Examples of this blending (coming together) include coping-skills training and self-instructional training (Meichenbaum, 1975, 1977). Other blending approaches include problem solving, assertiveness and other social skills training, and managing relationship stress. Most cognitive approaches see the process of treatment as starting with helping the client to identify automatic thoughts and cognitive distortions and then addressing the long-term underlying core beliefs that are associated with them (J. Beck, 1995; Dobson and Dozois, 2001; Freeman et al.,1990; Leahy, 1997).

Contemporary CBT, is an integration of the key components of behavioural and cognitive therapy. It is common to see cognitive restructuring as the cognitive part of CBT and social skills training as the behavioural component of CBT. An important combining element of CB approaches is the principle of *self-reinforcement.* This concept simply states that cognitive and behavioural changes reinforce each other. When change in thinking lead to positive behaviour outcomes, the outcomes strengthen both the behaviour and the cognitive structures that lead to those outcomes. In turn, the changes in thinking reinforced by the changes in behaviour further strengthen those behavioural changes. It is not just the reinforcement of the behaviour that strengthens the behaviour; it is the reinforcement of the thought structures leading to the behaviour that strengthens the behaviour.

Effective cognitive-behavioral programs of all types attempt to assist offenders in four primary tasks: (1) define the problems that led them into conflict with authorities, (2) select goals, (3) generate new alternative prosocial solutions, and (4) implement these solutions (Cullen and Gendreau, 2000).

Generally, cognitive-behavioral therapies in correctional settings consist of highly structured treatments that are detailed in manuals (Dobson and Khatri, 2000) and typically delivered to groups of 8 to 12 individuals in a classroom-like setting. Highly individualized, one-on-one cognitive-behavioral therapy provided by mental health professionals is not practical on a large scale within the prison system (Wilson, Bouffard, and Mackenzie, 2005).

Goals of CBT: Clinical setting versus Forensic setting

The major types of therapies predominantly used in clinical setting are psychoanalytic therapy that focuses on bringing out the repressed and subconscious and unconscious thoughts, feeling, unfulfilled desires to the surface and conscious level; Cognitive-Behavioural Therapy focuses on modifying the cognitive distortions and maladaptive behaviours of the client especially in the case of depression. On the other hand Interpersonal or systemic therapy is the means to bring about change, with the aim of helping patients to improve their interpersonal relationships or change their expectations about them. And lastly, Existential or gestalt philosophy aims to help client to establish what it is that matters to him/her, so that s/he can begin to feel more in tune with him/herself and therefore more real and alive. In general, psychotherapy aims to provide the solution to the problems that are faced by the clinical population. In clinical setting, psychotherapies targets and works for removal of distressing symptoms of the client, altering disturbed patterns of behaviour along with improved interpersonal relationships. It also aims to teach the better coping with stresses of life and lastly focusing on the personal growth and maturation. The desired changes in the client can be achieved in many ways i.e there are various types of psychotherapies that targets the specific types of the problems encountered by the client.

As the major focus of this article is on effectiveness of the CBT in on forensic population, when same approach is targeting the offenders (juveniles, adult, violent, sexual, female offenders, substance abusers etc.) to bring down the rate of recidivism, it has been found to be the most effective therapy. The end product of this therapy helps the offender for community re-entry with less chances of reoffending. CBT involves building attitudes and skills that are required to be morally responsible and to develop empathy along with allowing the offenders to develop insight for the welfare and safety of others (Little, 2000, 2001; Ross and Fabiano, 1985; Wanberg and Milkman, 1998). CBT in forensic setting employs the programs such as Aggression Replacement Training(ART), Criminal Conduct and Substance Abuse Treatment, Strategies for Self-Improvement and Change (SSC), Moral Reconation Therapy(MRT), Reasoning and Rehabilitation, Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C) etc. that targets the maladaptive behaviour and finally leading to adaptive behaviour. The outcome of these programs must include an approach that focuses on making the offender to understand his/her responsibility toward others and the community by laying an emphasis on empathy building, victim awareness, victim empathy, social conditioning especially in juvenile offenders and developing attitudes that show concern for the safety and welfare of others. It also includes helping offenders inculcate the belief that when a person engages in behavior that is harmful to others and society, they are violating their own sense of morality (Wanberg and Milkman, 2006).

Using the above mentioned programs as an important part of the therapy, therapy as a whole targets on following mental health problems are most commonly linked to offending behaviour:

a) Personality disorder: particularly of the antisocial variety, but often combined with other personality disorders, commonly borderline and narcissistic types,
b) Anger and associated problem.
c) Substance abuse and increasingly poly-substance abuse: Individuals may regularly take a wide range of substance; often the pattern of use depends on availability.
d) Sexual offending; the range of offences referred for psychological intervention commonly includes rape and paedophilia.
e) Post traumatic disorder.
f) Compulsive behaviour, individuals who engage in compulsive behaviour such as shoplifting and gambling are often in conflict with the law.

How it is useful in forensic fields

Six cognitive- behavioural programs are widely used in the criminal justice systems namely Aggression Replacement Training(ART), Criminal Conduct and Substance Abuse Treatment, Strategies for Self-Improvement and Change (SSC), Moral Reconation Therapy(MRT), Reasoning and Rehabilitation (R&R and R&R2), Relapse Prevention Therapy (RPT) and Thinking for a Change (T4C).

The following section will describe about the target areas under each program and expected outcome of each. Aggression Replacement Training(ART) focuses on providing training to youngsters with prosocial skills to use in antisocial situations as well as skills to manage anger impulses that lead to aggressive and violent actions by social skills training(the behavioral component) teaches interpersonal skills to deal with anger-provoking events; anger control training (affective component) to imparting the training to reduce their affective impulses to behave with anger by increasing their self-control competencies and lastly (cognitive component) moral reasoning raise the young person's level of fairness, justice, and concern with the needs and rights of others. For the offenders who are convicted for committing the crime under the influence of drugs, substance abuse or poly substance abuse Strategies for Self-Improvement and Change (SSC) proves to working best with them. It includes three phases: challenge, commitment and ownership to change with aim to develop the self -awareness within the offenders. In the process of treatment, if the therapist finds that for some offenders there are chances of relapse, then those offenders are suggested for Relapse Prevention Therapy (RPT). The aim of RPT is to prevent and manage the relapse in case of addiction and drug abusers. Offenders are trained on self-management and self-control of their thoughts and behavior. This approach views addictive behaviors as acquired habits with "biological, psychological, and social determinants and consequences" (Marlatt, Parks, and Witkiewitz, 2002).

Moral Reconation Therapy(MRT) addresses on the moral reasoning training to the offenders. It is for the offenders with low levels of moral development, strong narcissism, low ego/identity strength, poor self-concept, low self-esteem, inability to delay gratification, relatively high defensiveness, and relatively strong resistance to change and treatment" (Little and Robinson, 1986). Reasoning and Rehabilitation (R&R and R&R2) program is meant for the offenders who suffer from cognition and social deficits. This primary focus of the program is on imparting the training that will make them suitable for the re-entry (rehabilitation of the offender) of the offenders into the community by addresses the associated issues. This program focuses on enhancing self-control, interpersonal problem solving, social perspectives, and prosocial attitudes (Wilson, Bouffard, and MacKenzie, 2005) where participants are taught to think before acting, to consider consequences of actions, and to conceptualize alternate patterns of behaviour. The last program of the CBT is Thinking for a Change (T4C) (Bush, Glick, and Taymans, 1997) which uses uses a combination of approaches to increase offenders' awareness of self and others. It integrates cognitive restructuring, social skills, and problem solving. The program begins by teaching offenders an introspective process for examining their ways of thinking and their feelings, beliefs, and attitudes. Problem solving becomes the central approach offenders learn that enables them to work through difficult situations without engaging in criminal behavior.

EFFECTIVENESS OF CBT

Unlike CBT in clinical settings, it is gaining popularity in forensic setting too. Many researches provide the evidence of CBT with offenders and reducing the rate of recidivism in treated offenders (Pearson et al., 2002). However there exists a mix response on the effectiveness as some studies suggest that CBT do not have any appreciable effect on recidivism (Martinson, 1974) whereas some studies supports the effectiveness in recidivism by CBT (Allen, MacKenzie, and Hickman, 2001; Andrews et al., 1990; Cullen and Gendreau, 1989)

Various studies on the effectiveness on CBT in Forensic setting provides the evidence that it works in managing and transforming the cognitive distortions into the adaptive behaviour by altering/ modifying the maladaptive ones. Handful of studies suggest that when children with sexual behaviour problems received cognitive behavioural interventions (CBT), they had roughly comparable less rates of future sex offenses (2%) compared to clinical comparison groups (3%) (Lindsey et. al , 2010). Another study by Pearson ,Lipton, Cleland and Yee (2002) also used a meta-analysis to study the effect of behavioural and cognitive behavioural programs on recidivism. They examined sixty nine studies from 1968 to 1998 that earlier used behavioural approaches or cognitive behavioural approaches to reduce recidivism, although they found that both types of interventions were more effective in reducing recidivism than their comparison groups ,cognitive behavioural approaches showed grater effects on recidivism than programs solely used behavioural approaches. Specifically, programs that focused on cognitive behavioural social skills development and cognitive skills programme were the most effective in reducing recidivism**.** Furthermore study byAndrews et. al. (1990) found programs that provided

appropriate correction interventions, such as cognitive behavioural treatment, were more effective in reducing recidivism than programme that did not follow the principles of effective interventions.

Despite of the CBT's effectiveness in the forensic setting and its sustainability within the correctional, observation home still there certain risk factors are also associated on re-entry of offenders in the community such as emotional, psychological, and family disruption in childhood and adolescence; involvement with an antisocial peer group as a youth and school problems or failure; alcohol and other drug use in childhood and adolescence. Apart from these there are some more factors that make them vulnerable to accept changes such as motivational level sustain the changes, role models and reinforces in the society and expression of disapproval stands in stark contrast to the levels of interest, concern, and warmth previously offered by the society and many more.

Indigenous researches on therapy shows that most of the researches are concentrated in clinical settings but there is very limited research on the applications of therapy in forensic setting i.e in observation home, prison setting and correctional setting in India. In the dearth of the available literature on therapeutic researches on forensic setting in India, it is very important for us to extend the services to above mentioned institutions which will help prisoners for recidivism and community re- entry.

LIMITATIONS

Implementing CBT in correctional settings also has its challenges. Although it addresses explicitly cognitions interfering behaviour, common correctional challenges to therapy such as lockdowns, group consequences for the behaviour of a few, and inmate on inmate pressure to conform to behaviours inconsistent with societal norms need to be specifically addressed by CBT providers. Another challenge is the necessity to provide CBT training for all staff members that interact with those receiving treatment. Low literacy rate accompanied by dyslexia or learning difficulties or mental illness among the offenders hinders the smooth process of treatment. Limitation to behavioural homework tasks also restricts them as these people have very less opportunity to do homework out of the session which prevents to go through the complete therapeutic process.

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