

the Behavior Therapist

special issue **Forensics**

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Bradley A. White

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Introduction to the Forensics Issue

*Raymond Chip Tafrate, Central
Connecticut State University*

Bradley A. White, Virginia Tech

FORENSIC PSYCHOLOGY is not a niche area—it's mainstream. In the United States, approximately 1 in 33 adults are under some type of justice-related supervision. Among the general population, this makes justice involvement as prevalent as common psychological problems such as panic disorder and generalized anxiety disorder (National Institute of Mental Health, 2014). The majority of individuals in this large population are serving their sentences in the community, with almost 5 million currently being supervised in the country's parole and probation systems (Bureau of Justice Statistics, 2014b). Furthermore, among the 2 million people incarcerated in the United States (Bureau of Justice Statistics, 2014a), 90% will be released and returned to the community.

Justice-involved clients are typically seen across a range of settings such as prisons, jails, detention centers, probation and parole departments, day-reporting centers, halfway houses, transitional housing programs, and court-mandated community programs. Although forensic environments are the most common location for assessment and treatment activities, such individuals are also routinely encountered at substance abuse rehabilitation programs and community mental health centers, and they frequently appear in general outpatient psychotherapy or counseling for help with collateral issues (e.g., relationship difficulties, anger dysregulation, and vocational maladjustment). Thus, even those conducting traditional psychotherapy in private practice settings are likely to encounter justice-involved clients.

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INSTRUCTIONS for AUTHORS

The Association for Behavioral and Cognitive Therapies publishes *the Behavior Therapist* as a service to its membership. Eight issues are published annually. The purpose is to provide a vehicle for the rapid dissemination of news, recent advances, and innovative applications in behavior therapy.

- Feature articles that are approximately 16 double-spaced manuscript pages may be submitted.
- Brief articles, approximately 6 to 12 double-spaced manuscript pages, are preferred.
- Feature articles and brief articles should be accompanied by a 75- to 100- word abstract.
- Letters to the Editor may be used to respond to articles published in *the Behavior Therapist* or to voice a professional opinion. Letters should be limited to approximately 3 double-spaced manuscript pages.

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The criminal justice system is also facing a rapidly changing social and political landscape. In the United States, budget woes and social justice concerns have curbed the nation's appetite for mass incarceration in favor of treatment and greater use of community supervision. Partly in response to prison overcrowding and concerns about neglect of inmate health needs, a national movement is under way toward "decarceration" (reducing the number of individuals incarcerated) through various means, including reclassification of drug offenses and community diversion and sentencing policies. Some scholars anticipate the scope of this movement—and its impact—will rival psychiatric deinstitutionalization of the 1960s as the next massive challenge to the U.S. public mental health system (e.g., Harcourt, 2011). Due to such forces, correctional agencies are increasingly being asked to do more than temporarily control or sanction the population under their authority—they are expected to positively influence the behavioral trajectories of their clients and reduce risk of reoffending. There is a growing recognition that incarceration without effective treatment does little to deter or rehabilitate those who offend. Indeed, for many, incarceration has a *criminogenic* effect, increasing likelihood of crime after release. The stark reality is that, within 5 years, approximately 75% of those released from prison are rearrested, more than half within the first year of release (Durose, Cooper, & Snyder, 2014).

One bright spot in the forensic treatment literature is that CBT interventions appear to be the most effective approach for reducing criminal behavior (Andrews et al., 1990; Landenberger & Lipsey, 2005; Lipsey, Chapman, & Landenberger, 2001). A related positive development includes initiatives to train probation officers to incorporate cognitive-behavioral principles into their supervision sessions (Bonta et al., 2011; Rugge & Bonta, 2014). Advances have also been made in forensic evaluation (Andrews, Bonta, & Wormith, 2004; Hoge & Andrews, 2002; Kivisto, 2015; McCallum & Eagle, 2015; Mills, Kroner, & Morgan, 2011) and in the development of materials and handbooks on evidence-based practice for forensic practitioners (e.g., Bonta & Andrews, in press; Grigorenko, 2012; Salekin, 2015; Tafrate & Mitchell, 2014; Tafrate, Mitchell, & Simourd, in press). At the same time, there is still much room for progress in determining how to best prevent, assess, and treat a range of antisocial behaviors that

lead to immeasurable human suffering worldwide, and how to facilitate effective dissemination and implementation of such knowledge in ways that positively impact real-world practice and policy. Forensic clinical science is a dynamic area open to new discoveries, and thus calls our field's best and brightest. ABCT members are well positioned to contribute to scientific progress in this vital area.

Relatedly, tremendous interest and growth in the forensic area has also been taking place in academia. Consider that university criminal justice programs have become increasingly common across the country, with some criminology programs now starting to eclipse psychology in terms of numbers of enrolled students. A forensic focus has likewise burgeoned in related disciplines, like social work. Among professional psychological organizations, such as Canadian Psychological Association and Australian Psychological Society, forensics is one of the most popular specialty areas. Among ABCT members in particular, the Forensic Issues and Externalizing Behaviors Special Interest Group (SIG) has been growing rapidly, and many psychology students and young professionals are actively pursuing or considering a forensic career path, or placing their scholarly focus on an overlapping area (e.g., externalizing behaviors, substance abuse, anger dysregulation, intimate partner violence). For those interested in learning more about, or joining, the ABCT Forensic Issues and Externalizing Behaviors SIG, please see the text box at the end of this special issue, which provides a full description and contact information.

This special issue features eight articles (plus a humorous end piece) highlighting a handful of critical areas of current interest and controversy regarding forensic treatment. Forensic psychology is a vast landscape, and we regret that we could shed light on only a slice of what some may see as a curious "dark side" of clinical work. Therefore, a range of highly relevant topics such as forensic assessment, eyewitness testimony, working with law enforcement personnel, treatment of special populations (e.g., indigenous clientele), and certain common problems in forensic contexts (e.g., anger dysregulation) remain relatively unexplored in this issue.

Contributors to this special issue include a mixture of leading scientific experts and practitioners from the United States, Canada, and New Zealand. The first article, by Delk, Wydo, Mitchell, Kroner, and White (this issue; 2016), provides a primer on forensic psychology to help

bridge the gap for readers who may come from traditional clinical backgrounds or otherwise have less familiarity with forensic treatment. This primer sets the stage for getting the most out of the subsequent articles. The second article, by Mitchell, Wormith, and Tafrate (this issue; 2016), presents an overview of the Risk-Need-Responsivity model that has generated the most empirically supported principles for working with justice-involved clients and guides much of the forensic assessment and treatment work conducted around the world. The authors also suggest a constellation of critical treatment targets that go well beyond mental health symptoms. The third article, by White, Olver, and Lilienfeld (this issue; 2016), tackles important myths and misconceptions about the enigmatic condition of psychopathy, including what it is, and is not, and raises the prospect of treatability. The fourth article, by Jeglic, Hanson, and Calkins (this issue; 2016), describes the impacts of incarceration, registration, and current treatments on those convicted of sexual offenses, as well as future research directions. The fifth article, by Gardner, Moore, Birkley, and Eckhardt (this issue; 2016), provides an overview of the history of intimate partner violence (IPV) intervention, questioning the traditional model that has dominated IPV treatment.

The latter part of this issue is devoted to emerging trends. First, Dumas and Ward (this issue; 2016) consider the use of a positive psychology perspective in the treatment of justice-involved individuals (Good Lives Model). Next, Owens and Tafrate (this issue; 2016) examine the integration of motivational interviewing into forensic practice. Third, Sheppard and Chapman (this issue; 2016) explore unique adaptations for using dialectical behavior therapy in criminal justice environments. Finally, our Lighter Side article by Hoffman and McKay (this issue; 2016) toys with the idea that the signs and symptoms of chronic criminality, at least on a surface level, appear to be the polar opposite of those found in people suffering from anxious and obsessive-compulsive spectrum problems.

There are several overarching messages we hope all readers will take away from this special issue. In particular, a somewhat paradoxical yet dialectical reality is that: (a) persons with mental illness are overrepresented at all levels of the criminal justice system, making justice-involved individuals a critical population for dissemination and implementation of our best-supported

interventions for mental disorders, and (b) in contrast to popular notions, mental illness is not a strong predictor of criminal behavior, thus reduction of criminality and future recidivism depends upon conceptualizing a separate, criminogenic set of risk factors in treatment.

We wish to extend our deep gratitude to Mary Jane Eimer for her recognition of forensic psychology and externalizing behavior problems as an important growth area for ABCT, and for her consistent behind-the-scenes support. Much thanks to Brett Deacon (editor of *tBT*) for his willingness to devote a whole issue to this topic, and for his balanced style of flexibility and attention to detail. Finally, we thank the authors, who were willing to step away from their busy careers and contribute their time and expertise to this special issue. Our hope is that this issue will bring greater awareness to this growing area, and also serve to establish ABCT as a place for forensic professionals, both scientists and practitioners, to share their important work!

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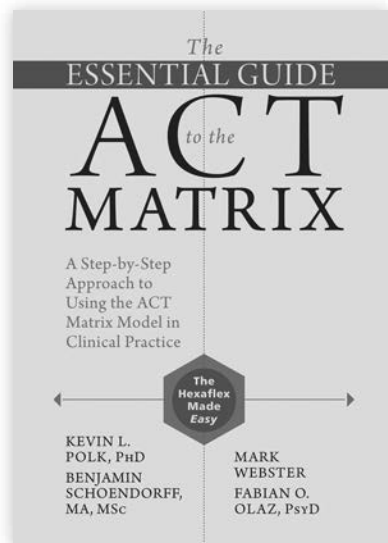
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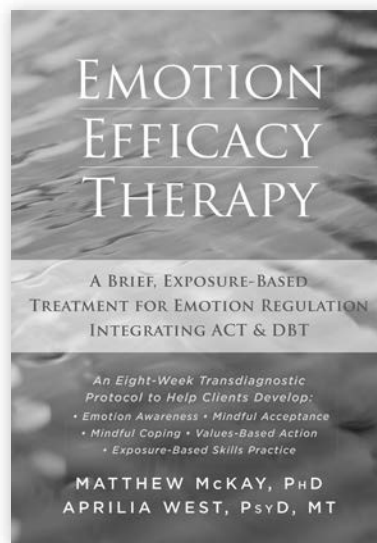
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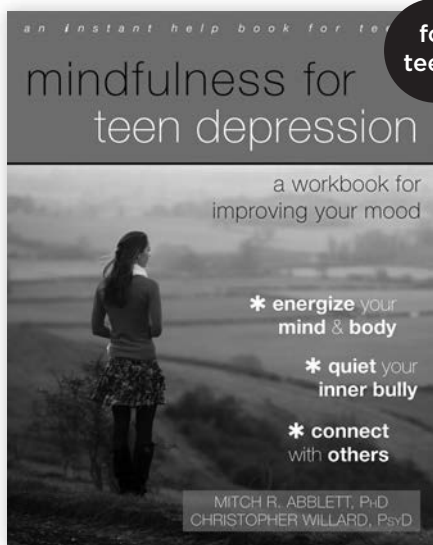
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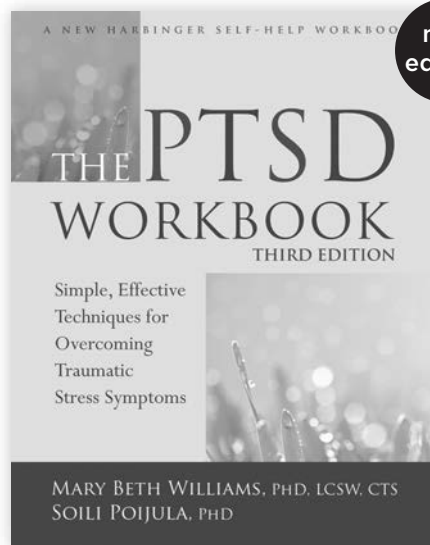
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A Forensic Treatment Primer

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AS IN OTHER SPECIALTY practice areas, the field of forensic psychology contains an extensive scientific knowledge base that can take years to become familiar with, understand, and appreciate. Psychologists trained in the application of CBT principles to anxious and depressed populations will find that modifications in assessment, case formulation, and treatment are required in order to be effective with justice-involved clients. The unique aspects of forensic work are in part driven by the challenging clinical cognitive and behavioral patterns associated with justice-involved clients, and in part by the larger institutional and cultural context within which forensic treatment is delivered. This context includes a criminal justice system that has become a major mental health care provider that is marked by significant racial and ethnic disparities, increasingly serving girls and women, and undergoing substantial changes. In this article, we provide a brief overview of both the clinical and cultural landscape of forensic practice for readers who may be less familiar with this area to help you get the most out of this special forensic issue of *the Behavior Therapist*.

The Forensic Landscape

Varied Roles of Forensic Psychologists

The American Board of Professional Psychology (ABPP) recognized “Forensic Psychology” as a specialized practice and established the American Board of Forensic Psychology (ABFP) in 1978. Despite common perceptions, it is a myth that forensic psychologists typically engage in criminal profiling, or that they routinely use polygraphs to detect deception—a good thing, since both criminal profiling (Kocsis, 2015) and polygraphy lack significant empirical support (Iacono, 2008; Meijer, Verschuere, Merckelbach, & Crombez, 2008). So what do forensic psy-

chologists do? The discipline of forensic psychology is indeed broad, and encompasses various applications of psychological research, theory, and practice to the legal system or legal issues (Fulero & Wrightsman, 2009) and incorporates some unique activities that may be unfamiliar to those from traditional psychology backgrounds. The American Psychology-Law Society (APA Division 41) is an excellent resource for those seeking additional information. Herein, we provide a brief overview and highlight some issues relevant to working with justice-involved clients.

Common services that psychologists perform in forensic contexts include a number of activities that are not a focus of this special issue. Such activities include screening and selection of law enforcement applicants, various court-related assessments (e.g., competency, mental status, risk, threat, and custody), and expert testimony. For example, the United States Court of Appeals recognizes psychologists as expert witnesses with regard to mental illness (*Jenkins v. United States*, 1965), with the three most common court-ordered evaluations concerning a client’s competency to stand trial (based on the 1960 “Dusky standard” of one’s ability to understand nature of proceedings and assist in one’s own defense), mental status at the time of the offense (based on the 1843 M’Naghten rule, in cases invoking the insanity or diminished capacity defense, of whether, as a result of a “severe mental disease or defect,” one was unable to appreciate the nature and quality of the wrongfulness of one’s acts), and potential dangerousness upon release (which typically combines use of actuarial risk assessment tools and clinical judgment to imperfectly predict likelihood of future offending). Psychologists and other social scientists are involved in nearly every aspect of law enforcement, from training of

criminal investigative techniques and officer preparedness, to jury selection and sentencing guidelines. Forensic psychological research is often used to inform and update the judicial system on relevant topics such as the effects of the death penalty on crime rates (Fagan, 2006), jury selection and decision making (MacCoun, 1989), and inaccuracies of eyewitness testimony and memories of abuse (Laney & Loftus, 2016; Loftus, 2013). Forensic psychologists also provide consultation on a wide variety of topics, from handling of individual cases to implementing broader systems reforms within criminal justice agencies and programs. More central to this special issue, psychologists also play critical roles in delivery and evaluation of intervention programs for incarcerated individuals.

In correctional facilities, psychologists and other mental health providers have multiple duties that vary by their roles, functions, and job descriptions. Suicide and sexual assault prevention and intervention are high priorities in jails and prisons, and clinical staff are often called upon to educate and train nonclinical staff on the warning signs and necessary interventions. Other competencies typically include conducting initial intake evaluations, managing inmates in segregation, crisis intervention, conflict resolution, confrontation avoidance, and hostage negotiation. Psychologists practicing in correctional environments often have specialized roles, such as administrative chiefs who manage the budget and supervise clinical work, staff psychologists who attend to day-to-day assessment and treatment operations, and treatment specialists who manage programs targeting specific problems (e.g., substance abuse, sex offender treatment). Psychologists in these settings may also supervise clinical work of master’s-level practitioners and interns.

Forensic Treatment: Addressing Criminality in a Coerced Population

Reducing future criminality, not just mental illness. In practice, mental health counselors and psychotherapists typically focus on diagnosable mental disorders, and it is the symptoms associated with those disorders and their impact on quality of life (in terms of client distress and functional impairment) that are viewed as problems to be resolved. In contrast, the primary emphasis of forensic treatment is the prevention of future criminality. A foundational concept highlighted throughout this special issue is that focusing treatment on mental health needs alone (e.g., depression,

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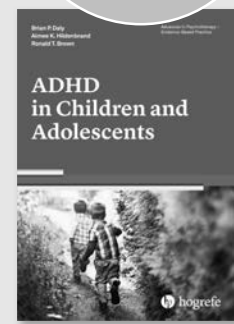
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anxiety) is unlikely to reduce recidivism (Guzzo, Cadeau, Hogg, & Brown, 2012). Although mental health problems may warrant attention for the sake of the client's general functioning and well-being, because criminal behavior and reoffending are the outcomes of most concern, forensic interventions primarily target specific risk-relevant factors that are statistically linked to criminal behavior as opposed to exclusively targeting mental health problems.

Forensic intervention often does not depend upon a clinical diagnosis of a mental disorder. While antisociality is the psychological construct most often associated with criminal behavior, it varies on a continuum and reflects only one set of factors influencing criminality. (A related but distinct construct is psychopathy; see White, Olver, & Lilienfeld, 2016, this issue.) Justice-involved clients often manifest some symptoms of DSM-5 antisocial personality disorder (e.g., failure to conform to social norms with respect to lawful behaviors; American Psychiatric Association, 2013), yet often do not meet full diagnostic criteria. Nevertheless, treatment can be implemented to tackle cognitive, behavioral, and lifestyle characteristics that can increase an individual's risk for reoffense (see articles in this issue by Dumas & Ward, 2016; Gardner, Moore, Birkley, & Eckhardt, 2016; Jeglic, Hanson, & Calkins, 2016; Mitchell, Wormith, & Tafrate, 2016; and Sheppard & Chapman, 2016).

Coercive referral mechanisms. As a group, justice-involved clients do not typically show up for treatment voluntarily. Referrals almost invariably involve some form of external coercion. Pretrial clients are advised that attending counseling may help get their charges reduced or dismissed. Probationers are warned that, without successful program completion, they may face incarceration. Prisoners are compelled to participate in treatment in order to obtain a more favorable appearance before a parole board. Although such coercive mechanisms may not be strictly compulsory, the threat or promise of external consequences can nevertheless lead the client to feel forced to participate. In many ways, justice-involved clients can be strikingly similar to unmotivated mental health clients in the community. For this reason, in forensic treatment, a significant amount of time and clinical effort often must be devoted to engaging clients and in fostering their internal motivation to make changes in life areas most linked to crimi-

nal behavior (see Owens & Tafrate, 2016, this issue).

Practitioner empathy. Practitioners working in traditional mental health settings may have little difficulty empathizing with their clients. Justice-involved clients, on the other hand, have often committed deplorable criminal acts that have recklessly endangered or significantly harmed innocent third parties. Some clients may readily acknowledge engaging in physical assault, sexual abuse, drug dealing, conning, and theft. They may justify their actions, express no remorse for their behaviors, minimize its negative impact on others, and even blame those they have victimized. Thus, it comes as no surprise that developing and maintaining empathy for and motivation to work with such individuals can be an ongoing challenge, especially when they present with a low level of motivation to change. Yet, as with traditional mental health clients, effective treatment with justice-involved individuals requires practitioner empathy, compassion, and the establishment of an effective working alliance.

Identifying behavioral and cognitive treatment targets. A common complaint among practitioners is that justice-involved clients entering treatment have difficulty identifying or acknowledging areas in need of change; often presenting at intake with minimal symptoms and a lack of subjective distress. In some cases, clients may find their current destructive patterns enjoyable, largely harmless to themselves, and worth continuing (e.g., "Why do I have to stop smoking weed on probation? I'm not hurting anyone."). Even when awareness of negative consequences exists, some clients will see the cause of their difficulties as a function of other people or external circumstances, rather than their own behavior (e.g., "If I grew up in suburbia like you did, I wouldn't have to sell drugs."). From their perspective, change ought to lie in other people and institutions, rather than themselves (e.g., "She just needs to get off my back and let me be when I'm pissed off. Then I wouldn't have protective orders.").

For practitioners new to the forensic area, justice-involved clients may seem somewhat bewildering in terms of the nature of their distorted beliefs and cognitions. In some cases, the cognitive profiles of such individuals are a mirror image of clients suffering from anxiety and depression (Kroner & Morgan, 2014; Mitchell,

Tafrate, & Freeman, 2015; Seeler, Freeman, DiGiuseppe, & Mitchell, 2014; Walters, 2014). For example, while clients suffering from anxiety and depression often overestimate and exaggerate potential dangers, are overly concerned about others' opinions, and harshly blame and judge themselves when things do not go well, justice-involved clients have a tendency to underestimate danger, challenges, or difficulties in favor of overly optimistic and self-serving predictions, and have a lack of concern for the opinions of others and how their actions negatively affect others.

Conceptualizing cognitions that are relevant for justice-involved clients can be approached effectively by taking into consideration the empirical literature that has developed around the assessment of criminal thinking patterns (i.e., thinking patterns that facilitate criminal and self-destructive behavior). At the core of this literature are seven criminal thinking assessment instruments that have been developed for adults: the Psychological Inventory of Criminal Thinking Styles (PICTS; Walters, 1995), Criminal Sentiments Scale-Modified (CSS-M; Simourd, 1997), Measure of Criminal Attitudes and Associates (MCAA; Mills, Kroner, & Forth, 2002), Texas Christian University Criminal Thinking Scales (TCU CTS; Knight, Garner, Simpson, Morey, & Flynn, 2006), Measure of Offender Thinking Styles (MOTS; Mandracchia, Morgan, Garos, & Garland, 2007), Criminogenic Thinking Profile (CTP; Mitchell & Tafrate, 2011), and Criminal Cognitions Scale (Tangney et al., 2012). Each instrument measures multiple thinking patterns and can be useful in risk-need-responsivity (RNR) based approaches to reducing recidivism (see Mitchell et al., 2016, this issue).

The focus on intermediate beliefs is a useful starting place for conceptualization and treatment within a cognitive therapy framework, because such thinking patterns can be reliably assessed, and criminal thinking instruments are freely available and easily administered and scored. In addition, an emerging literature has developed on schema-focused therapy for justice-involved clients with antisocial and aggressive personality patterns, which may be of interest to some readers (Bernstein, Arntz, & de Vos, 2007; Keulen-de Vos, Bernstein, & Arntz, 2014).

Consequences of treatment failure. Another difference between clinical work with traditional mental health clients and justice-involved clients is the ramification

of unsuccessful treatment. If treatment with a depressed or anxious client is unsuccessful, the impact of that treatment failure is going to be felt most acutely by the client through continuation of his or her symptoms. In contrast, the costs of treatment failure with justice-involved individuals may result in an unchanged criminal risk profile, the consequences of which are future criminality and victimization that can result in (re)incarceration, and cause suffering for others and the larger community (Mitchell, Simourd, & Tafrate, 2014). Incarcerations, and reincarcerations, are a common consequence of treatment failure and, as discussed in more detail later, have a negative impact on the life trajectories of justice-involved individuals and their families.

What about girls and women? An important question for forensic psychologists is whether what is known largely from a literature on boys and men can be assumed to apply equally to girls and women, especially as rates of girls and women entering the juvenile and criminal justice system have dramatically increased over the past decade (Garcia, 2015). Some

gender differences in antisociality are clear. For instance, boys and men are, on average, more physically aggressive than girls and women (Loeber & Hay, 1994). Developmental trajectories of antisocial and delinquent behavior differ by gender. Girls typically engage in more indirect than direct forms of aggression in later childhood, and compared to men, violence in women is more often aimed at close relatives or dating partners (Loeber, Capaldi, & Costello, 2013). Girls and women with persistent conduct problems are also more often impaired than boys in terms of neuropsychological anomalies, mental illness, substance use disorders, and enmeshment in violent relationships (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Giordano, Cernkovich, & Lowery, 2004; Lewis et al., 1991).

In light of the rapid influx of girls and women into the justice system, some scholars have argued that antisocial developmental pathways are sufficiently gendered such that gender-responsive programming is required to optimize reduction of recidivism in girls and women (Bloom, Owen, & Covington, 2003; Garcia, 2015; Van Diemen & King, 2013). Nevertheless, thus far there

is little empirical evidence that gender predicts criminogenic risk factors (Andrews et al., 2012) or to treatment outcomes for prevention/treatment programs (Gobeil, Blanchette, & Stewart, 2016; Pardini, 2016). Treatment needs may not be as gender-specific as some proponents of gender-responsive programming have argued (e.g., creating a safe and respectful treatment environment; addressing trauma, maltreatment, or mood difficulties; Bloom et al., 2003; Day, Zahn, & Tichavsky, 2014), and these factors may not directly relate to recidivism reduction per se (Andrews et al., 2012). The evidence base on gender-responsive programming is also limited, and findings vary depending upon subpopulation (e.g., Day et al., 2014) and study methodology (e.g., Gobeil et al., 2016).

While some gender differences certainly exist in the emergence, nature, and persistence of antisocial behavior, there is also substantial individual variability within each gender, overlap between genders in risk and maintenance factors, and limits to the evidence base. These factors leave unresolved, for now, the question of whether any particular gender-specific modifications to intervention could



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improve outcomes, and suggests current practice emphasize empirically established delinquency- and recidivism-prevention interventions, regardless of client gender.

Ethical Concerns

Although the legal system and forensic psychology have in common the goal of preventing and managing criminal behavior, there is a historic gulf in approaches and guiding principles. The legal system is adversarial and emphasizes punishment, surveillance, and control for the benefit of society, versus a therapeutic/rehabilitation focus for the sake and benefit of the individual client. The apparent duality raises important questions about just how psychologists can effectively and ethically function in forensic settings (Dickie, 2008).

The Specialty Guidelines for Forensic Psychologists (APA, 2013) address critical ethical dimensions of forensic work, including practitioner competence (e.g., knowledge of legal and professional standards, laws, precedents that govern legal proceedings, and scientific foundations for legal opinions and testimony), professional relationships (e.g., avoiding therapeutic-forensic role conflicts; referring and consulting as necessary; providing expert testimony only on issues for which they have adequate foundation), informed consent (including the potential need for representation by counsel), and privacy (including confidentiality, and attaining collateral and third-party information). We will highlight a couple of these ethical considerations. For more details, interested practitioners are encouraged to consult the *Specialty Guidelines for Forensic Psychologists* (www.apa.org/practice/guidelines/forensic-psychology.aspx) and Bush, Connell, and Denney (2006).

Limits to confidentiality. Several unique ethical issues arise regarding privacy and confidentiality in forensic contexts. In custody settings (described further later), mental health providers as staff members are expected to report threats to the safety of the prison. Public safety and institutional security concerns may limit inmates' rights to privacy and confidentiality, as well as limits to what the clinician can do to protect those rights. Furthermore, the "client" of the forensic practitioner may be the individual via his or her attorney, but more often is the legal custodian (e.g., state department of criminal justice) or the court. Because of the legal ramifications for the individual being assessed or treated, it is crucial for the practitioner to know who

the client is, who will have access to reports, and ensure that the individual with whom he or she is working is aware of these facts, including the limits to their rights to privacy and confidentiality (i.e., disclosure, even where consent is not required as in a court-ordered evaluation). It is often prudent to assume nonconfidentiality, to exercise caution in obtaining and communicating information about defendants in order to protect Fifth Amendment rights against self-incrimination and Sixth Amendment right to legal counsel, to restrict reporting to the psycholegal matter at hand, and avoid inclusion of potentially prejudicial information.

In community settings (defined later), written reports documenting justice-involved clients' attendance, participation, and progress are often required by the referring court or criminal justice agency. Reports on forensic clients need to be written without jargon, for use by wide variety of professionals participating in intervention and supervision. Practitioners may also be expected to be in regular telephone contact with a probation or parole officer, and to provide information on a client's employment status, violations of protective and noncontact orders, and drug test results. For these reasons, working in the community with justice-involved clients involves complex practitioner roles, blending considerations of facilitating behavior change in the context of monitoring and community safety.

Dual relationships. Forensic practitioners have an obligation to clarify their roles and avoid multiple relationships that could pose a conflict of interest or be perceived as biased. Because forensic evaluations occur with an adversarial context and require an impartial, critical stance on behalf of the examiner (e.g., utilizing collateral and corroborated information rather than relying on mere self-report), practitioners generally should avoid functioning as forensic evaluator and therapist for the same individual, which allows the therapist to maintain confidentiality and trust, and to serve as ally and advocate for the individual. Nevertheless, ethical dilemmas can arise, such as when a therapist is required to report institutional infractions (e.g., possession of contraband), blurring the lines between clinician and security guard. The dual objectives of security and rehabilitation can work in closer harmony when the custody and behavioral health staff are conceptualized as part of a multidisciplinary treatment team in which treatment and

risk management are recognized as complementary objectives, when all parties are aware of the rights (and limits thereof) of the justice-involved individuals, and when staff roles and boundaries are understood and respected. In addition to operating in accordance with professional guidelines, practitioners are encouraged to consult with supervisors, professional peers, and experts when potential ethical conflicts arise.

The Context of Forensic Practice

Custody Settings

Impact of custody on treatment delivery. Clinical practice may differ based on the treatment setting. Custody settings include state and federal prisons, jails (which are distinct from prisons in that individuals are awaiting trial or serving only short sentences), and juvenile detention centers. Custody levels in these institutions range in security from a "camp" which has no secure perimeter, low and medium security, to high and maximum security, with multiple walls and fences, as well as a greater staff-to-inmate ratio. There are a variety of factors that impact an inmate's assigned security level, such as sentence length, history of escape attempts, violence risk, and institutional adjustment. Regardless of security level, prisons can be dangerous places, and practitioners in these environments need to take precautions, stay vigilant, and be ready to respond to emergencies (e.g., disturbance or riot).

Additionally, some correctional institutions may not have traditional professional office arrangements. Sessions are sometimes conducted at the cell door, in the "chow hall," a visitation/interview area separated by glass, or multipurpose rooms within the facility that afford limited privacy and where conversations can be overheard and a client's status as a "mental health patient" is visible to all staff and inmates. Even where professional space exists, offices are often equipped with large windows so that staff-inmate interactions can be monitored for safety purposes. This arrangement can be distracting and limit privacy, since other inmates and security staff can see who is in treatment. Another consideration is that clients who are assigned homework, as part of treatment, will typically be bringing the assignment back to a small cell shared with one or more other people, or they can be housed in a single large room with a hundred bunk beds, affording even less privacy and freedom from distractions. In custody settings,

practitioners will need to be sensitive regarding the content of a given session or assignment, shifting topics depending on the degree of privacy afforded in a given situation.

The prison treatment environment also poses some unique challenges with regard to session scheduling and client transportation. The custodial client is, in theory, always available for appointments. Yet in practice, there are certain periods allotted for inmate movement, when clients may move from their cells or dormitory to other locations on the prison grounds for work, school, or to attend counseling. Practitioners are often responsible to physically retrieve inmates for scheduled sessions, and to respond by radio during headcounts. Appointments may be canceled due to lockdowns, custody staffing shortages, and a host of other administrative situations that are outside of the client or practitioner's control.

In correctional settings, termination of care may be dictated by reasons other than

the successful attainment of treatment goals. Little or no warning may be given about a client's transfer among units or institutions, leading to an unplanned or premature ending of an intervention. Furthermore, the sheer passage of time in a prison environment can make former problems areas seem like historical factors that no longer impact daily living, which can affect motivation for treatment. For instance, 3 years of incarceration-induced sobriety may lead a client to believe that his substance abuse problem has been solved and that intervention upon release is therefore unnecessary.

Finally, treating prison inmates requires adjustments at all levels of assessment, case conceptualization, and treatment planning. For example, assessment instruments that were normed on community populations may need to be adjusted, rewritten, or normed on forensic populations (e.g., Wydo & Martin, 2015). Professionals in custody settings cope with constant challenges to the core conditions of therapeutic

change such as trust, confidentiality, and voluntary participation in treatment activities.

Impacts of incarceration. Although most justice-involved individuals reside in the community, incarceration rates in the U.S. are the highest in the world. The financial costs alone of mass incarceration are staggering. In 2014, the annual cost per U.S. federal inmate was \$30,619.85, exacting a significant financial toll on society, exacerbated by high rates of recidivism (Federal Register, 2015). Incarceration itself has not been shown to be an effective means of reducing recidivism, and it may even promote future criminality (Cullen, Jonson, & Nagin, 2011; Mears, Cochran, & Cullen, 2015).

Incarcerated individuals face serious financial and social hardships post-release that put them at risk for deleterious outcomes, including rearrest. During reentry, there may be difficulties obtaining employment, finding housing in a neighborhood



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When are Exams Conducted? Exams are conducted in different places, but are typically done at the APA (Denver 1st week in August 2016) and ABCT (New York last week in October 2016) annual conferences. This year exams can also be conducted at the ABPP conference in Chicago in early May 2016. Other exams can be arranged in other locations on a case-by-case basis.

or dwelling without strong antisocial influences, and developing prosocial structured leisure activities. Notably, a history of incarceration is predictive of stress-related physical illnesses (Massoglia, 2008; Schnitker & John, 2007), engagement in harmful health behaviors such as poor diet and smoking (Porter, 2014), and higher mortality rates from drug use, violence, and suicide (Zlodre, & Fazel, 2012).

The serious impacts of incarceration are also shared by the children of incarcerated parents. As of 2010, there were 2.7 million children with a parent in prison or jail (Western & Pettit, 2010). Family member incarceration during childhood is classified by the Centers for Disease Control and Prevention as one of a handful of adverse childhood experiences (ACEs) that significantly predicts child mortality and morbidity. Children experiencing the incarceration of a parent or other family member have much higher rates of mental health problems, serious injuries, poorer educational outcomes, increased dependence upon public assistance (Miller & Barnes, 2015; Wakefield & Wildeman, 2011), and higher rates of antisocial behavior (Murray, Farrington, & Sekol, 2012). It also increases risk for chronic health ailments (e.g., cardiovascular disease; Gjelsvik, Dumont, & Nunn, 2013) through early adulthood (Lee, Fang, & Luo, 2013), even increasing heart attack risk much later in life (White, Cordie-Garcia, & Fuller-Thomson, 2016).

Awareness of these deleterious impacts of incarceration can aid practitioners in better understanding the context of their clients. It also illustrates myriad opportunities for psychological service provision to justice-involved individuals and their families. These costs also highlight the importance of reducing criminal behavior as a primary treatment goal.

Prisons as repositories for the mentally ill. Prevalence studies consistently report higher rates of mental illness at all levels of the criminal justice system than are found in the general population (see Prins, 2014). There are now more mentally ill persons in correctional institutions than in psychiatric hospitals (Cohen, 2008). As recently reviewed by Barringer and Canada (2014), two primary explanations have been offered for overrepresentation of persons with mental illness in the criminal justice system. The first is criminalization of persons with mental illness, ostensibly resulting from deinstitutionalization policies and strict commitment laws, combined with inadequate community mental health ser-

vices and unavailability of state psychiatric hospital beds, resulting in jails and prisons serving as the de facto mental health providers of those whose untreated mental illness attracts police attention.

Although such policy changes have certainly contributed to an overall increase in rates of incarceration of mentally ill individuals who otherwise might have been placed in inpatient facilities, the empirical association between mental illness and criminality itself is weak, and diversion and treatment programs focused on treating symptoms of mental illness generally fail to reduce recidivism (see Mitchell et al., 2016, this issue). The criminalization hypothesis also overlooks historical policy trends of social welfare reduction and expansion of law-and-order/tough-on-crime criminal justice policies that increase arrests, convictions, and lengths of incarceration (e.g., mandatory minimums, three-strike laws) that likely also lead to overrepresentation by those with mental illness. The second explanation for this overrepresentation regards common causes: people with mental disorders come into contact with the criminal justice system for reasons similar to those without mental illness, including social disadvantage and environmental risk factors (e.g., poverty, homelessness, neighborhood and family crime exposure, incarceration; Barringer & Canada, 2014; Prins, 2014).

In any case, persons with mental illness are clearly overrepresented throughout the criminal justice system, making forensic contexts a critical target for dissemination and implementation of our best-supported interventions for treatment of mental disorders. At the same time, exclusive treatment focus on mental illness does little to reduce risk of reoffending, making risk reduction a separate critical treatment priority.

Community Settings

As noted earlier, the largest proportion of the forensic population is not physically confined in a jail or prison: it comprises the millions of individuals who are living in the community under some form of criminal justice supervision. Justice-involved clients supervised in the community include probationers (who are typically serving their entire sentence in the community), parolees (who are released from prison early and serving the remainder of their sentence in the community), and pretrial defendants (arrestees who are permitted to reside in the community on bond/bail while awaiting trial).

Community settings that specialize in services for justice-involved clients include

day reporting centers, drug courts, halfway houses, and transitional housing programs. Some facilities are operated directly by government agencies while others are run by not-for-profit or private organizations. At day reporting centers, clients are typically mandated to report several days per week for periods as brief as 30 days or as long as several months or more. Day reporting centers often provide treatment, educational, and employment services as well as drug and alcohol monitoring. Halfway houses and transitional housing programs typically provide similar services, as well as housing and meals, and stays can be as long as a year. As mentioned in the introduction, justice-involved clients will also end up in traditional outpatient settings where they pay for services or use insurance to reimburse treatment providers.

Racial and Ethnic Disparities in the Criminal Justice System

While reform movements have made overt race-based discrimination unconstitutional, the racial and ethnic divide persists at marked levels across the criminal justice system. The chasm is highlighted by recent incidents of police violence and associated racial tensions, and by ongoing profound racial and ethnic disparities in rates of arrest (Lytle, 2014), pretrial detention, conviction (Wu, 2016), sentencing (Mitchell, 2005), and incarceration (Nicosia, MacDonald, & Arkes, 2013; Primm, Osher, & Gomez, 2005). For instance, the most recent U.S. Census (United States Census Bureau, 2014) indicates that the largest groups in the population to be 77.5% White, 13.2% Black, and 5.4% Asian (without respect to Hispanic origin), yet the Federal Bureau of Prisons (2016) indicates that 58.9% of inmates are White, 37.6% are Black, and 2% are Asian (without respect to Hispanic origin). Hispanics and Native Americans are likewise overrepresented. This minority overrepresentation is sometimes called disproportionate minority contact (DMC). Reasons for DMC are complex but likely reflect intentional and unintentional discrimination, socioeconomic disparities (e.g., educational opportunities, poverty, unemployment) that contribute to differential rates of offending, as well as disparities in how racial and ethnic groups are handled by the criminal justice system, including policing, arrest, criminal laws and policies that differentially focus on certain groups, classes, and geographic areas that can further exacerbate the divide (Mears, Cochran, & Lindsey, 2016; Schlesinger, 2005). These concerns only scratch the surface with regard to sociocultural issues in forensic settings.

Forensic Psychology: Different Labels, Terminology, and Acronyms

Forensic psychology may seem a foreign landscape to those from traditional clinical psychology backgrounds. It has its own vocabulary. First, a variety of terms are used to describe people receiving services in juvenile and criminal justice settings, including: *juvenile delinquent, offender, sex offender, probationer, parolee, prisoner, inmate, and sexually violent predator*, to name just a few. Most of these terms emerged decades ago, persist to this day in legal contexts, and are mirrored in the forensic psychology literature for continuity with legal contexts and convenience. Nevertheless, labels like “offender” may strike some as derogatory or dehumanizing, and several longer but arguably less pejorative labels have recently emerged that more explicitly separate the individual from the behavior or context, such as *court-mandated client, justice-involved individual, and forensic patient*. As with diagnostic labels, important questions remain for the field regarding the potential explicit and implicit impacts of labels on stigma, stereotypes, and self-concept.

Second, many labels are used to describe the professionals and staff who deliver services in criminal justice settings, and whose functional roles may overlap, including: *forensic psychologist, correctional counselor, therapist, clinician, case manager, probation officer, parole officer, social worker*, etc. Third, there is variation in how services are described: *treatment, intervention, rehabilitation, programming, and supervision* are some examples. Even the term “forensic psychology,” as it is used here, can more broadly refer to any interface between legal and psychological matters, or more narrowly, such as pertaining to the role of gathering evidence to share via evaluation or expert opinion for a criminal or civil proceeding. Thus, professionals interacting with the system should take special care to ensure accurate communication and avoid the jingle-jangle fallacies of assuming the same term means the same thing across contexts (jingle fallacy) or that two differently labeled things regard different constructs (jangle fallacy).

Conclusions

Practitioners across many settings are likely to encounter clients who are justice-involved. The uniqueness of these clients and their context suggests that this is not

just an “add-on” area of practice. In order to make an impact on such a large and significant social problem, there is a considerable need for competent CBT practitioners who are familiar with the characteristics of forensic environments and systems, and who possess knowledge of the recent scientific advances in assessment and treatment. The forensic area definitely requires a learning curve. It is our hope that this special issue will provide a foundational knowledge base for working effectively with justice-involved individuals.

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Implications of Risk-Need-Responsivity Principles for Forensic CBT

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ALTHOUGH YOU MAY NOT SPECIALIZE in forensic work, justice-involved clients often end up in traditional outpatient settings. The purpose of this brief article is to provide an overview of the most empirically supported principles for working with justice-involved clients, and highlight aspects of the Risk-Need-Responsivity model that may be less familiar to practitioners, but are nonetheless essential for being successful with this client group.

Case Example

You have a new case. Jaden is a 20-year-old whose presenting problem seems to be depressed mood. When you enter the waiting room to meet Jaden, he looks up and

makes eye contact, but nonverbally communicates a sense of irritation as if being unfairly put upon by the prospect of attending counseling. As the intake interview unfolds it becomes clear that there is a coercive element to the nature of the referral. Jaden's parents have expressed concern that he has gotten on the "wrong path" in the past year. They have urged him to get counseling and have threatened to kick him out of the house unless he starts to make something of himself. Jaden's symptoms suggest a moderate level of depression: sleeping late every day, lack of energy, and an absence of optimism and game-plan for the future.

A few notable events occurred in the past year. First, Jaden failed out of college. He started hanging out with a new group of friends who routinely drank and smoked pot until the early hours of the morning. Once Jaden started spending time with these new friends, his class attendance became sporadic. Also, he decided college classes were not for him; they were too boring and he craved excitement. After dropping out of college, Jaden attempted a string of part-time jobs, ranging from construction to restaurant work. These jobs ended badly because of disagreements with coworkers and supervisors. In terms of his work experiences, Jaden complains that he did not like having to show up at certain times, do things that weren't enjoyable, or be told what to do. He seems to have a pattern of impulsively quitting in the face of disagreements. Finally, Jaden reveals that he is on probation for breaking into houses and stealing electronics with his friends, which seemed exciting in the moment. He hopes that attending counseling will help get his parents and his probation officer off his back. He casually mentions that his probation officer will be contacting you for

updates on his progress. Jaden is a justice-involved client (JIC)!

As the first session comes to a close, a few questions quickly race through your mind:

- Does the fact that he is justice-involved change the focus of treatment?
- Should his depressed mood be the primary treatment target?

The Primary Goal of CBT With JICs Is to Reduce Reoffending

If Jaden's therapist were to focus treatment solely on alleviating his mental health¹ symptoms (e.g., depressed mood, low energy) it would most likely help him feel better, but might also result in Jaden having more energy with which to continue or even escalate his pattern of hanging out late with his friends, using substances, and committing larcenies. More importantly, alleviating Jaden's mental health symptoms would have no impact on his likelihood of engaging in future criminal behavior. Furthermore, if he gets arrested again over the course of, or following, treatment, Jaden will not complete his probation successfully and will likely face a period of incarceration—an experience that typically alters peoples' life trajectories for the worse, not the better. Strange as it may sound, given these possibilities, it would be best to think beyond his mental health symptoms and put an equal, if not greater, focus on reducing Jaden's risk for criminal behavior. Stranger still, as we briefly review next, evidence suggests that reducing reoffending has little to do with reducing his mental health symptoms.

Mental Health Symptoms and Reoffending

Major mental disorders are common in correctional populations, with prevalence rates exceeding those found in the community (Steadman, Osher, Robbins, Case, & Samuels, 2009). This observation has led many practitioners to assume that mental health symptoms have a causal relationship with criminal behavior, and that alleviating such symptoms will also reduce risk of

recidivism. Yet, an emerging body of research indicates that mental health symptoms, even those of psychosis, rarely precede criminal or violent activity (Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Skeem, Kennealy, Monahan, Peterson, & Appelbaum, 2016). Indeed, a meta-analysis comparing predictors of recidivism in nonmental-health-disordered versus mental-health-disordered JICs found that the same set of criminal risk factors predicted general and violent recidivism for both groups (Bonta, Law, & Hanson, 1998). More strikingly, mental health symptoms did not predict recidivism. A more recent meta-analysis by Bonta and colleagues of the predictors of recidivism in mental-health-disordered JICs supported these conclusions: Criminal risk factors predicted general and violent recidivism, whereas mental health symptoms, including diagnoses of psychosis or mood disorders, were unrelated to recidivism (Bonta, Blais, & Wilson, 2014). While there are certainly individual cases in which a JIC's mental health symptoms relate directly to their offending behavior, as a general guideline, it appears to be criminal risk factors, rather than mental health symptoms, that drive criminal behavior.

A related issue is the potential impact of treatment on reducing reoffending. While it may seem intuitive that targeting mental health symptoms will reduce offending, the treatment outcome literature with mentally disordered JICs strongly suggests otherwise. A recent review found that while providing mental health treatment was associated with a subsequent reduction in psychiatric symptoms, it was not associated with a decline in reoffending. In fact, only treatment that specifically addressed criminal risk factors was associated with reductions in recidivism (Morgan et al., 2012). Although there are still too few studies on the ingredients of effective intervention with mentally disordered JICs, mounting evidence suggests that treatment must target criminal risk factors in order to have an impact on criminal behavior, and that we cannot expect treatment of mental health symptoms to impact risk of recidivism itself (Skeem, Steadman, & Manchak, 2015).

The Risk-Need-Responsivity (RNR) Model and Its Companion Risk Domains

Practitioners will be more effective in reducing reoffending if they adopt a *risk-reduction* goal rather than a mental health symptom reduction goal. The good news is that most practitioners are already familiar with the philosophy of the risk-reduction approach as it applies to other areas, such as heart disease (e.g., family history of heart disease, high cholesterol, smoking, diabetes, hypertension, obesity, poor diet, increased age, lack of physical activity; Centers for Disease Control and Prevention, 2016). A risk-reduction approach to heart disease can be likened to going through life with a shopping cart: the more factors in the cart, the more risk. In terms of intervention, the goal is to remove those factors from the cart, fill it with healthier options, and avoid putting more risk into the cart in the future—reducing a person's risk profile as much as possible. A risk-reduction approach to recidivism is analogous, but the items in the shopping cart are different. Over the last 25 years, a theoretically sound and empirically supported risk-reduction model of antisocial and criminal behavior has emerged and is firmly ensconced in the field of corrections. The Risk-Need-Responsivity (RNR; Andrews, Bonta, & Hoge, 1990) model and its companion listing of the “Central Eight” risk domains for criminal behavior (Bonta & Andrews, in press) now guide much of the assessment and rehabilitation work conducted with offenders around the world.

The Risk-Need-Responsivity Principles

The acronym RNR refers to three core principles around which efforts to work with JICs should be based. The *risk principle* states that the extent of practitioners' efforts and resources should correspond with the magnitude of a JIC's risk for reoffending. Specifically, more time and energy should go to the highest risk JICs and the least intensity to those with the lowest risk. Although this principle seems intuitive, there is a long history of criminal justice practitioners devoting their time to treatment-receptive, cooperative, low-risk JICs who are unlikely to reoffend regardless of intervention. Implicit in the risk principle is the assumption that higher risk JICs can be distinguished from lower risk JICs. Fortunately, a whole cottage industry has been built around the assessment of JICs, in particular the prediction of recidivism. The resulting plethora of risk assessment tools

¹ As is common in this literature, the terms mental health symptoms and mental disorders are used as generic labels for the variety of symptoms and disorders commonly seen in treatment settings, such as depression, anxiety, and psychoses. In the current context, these terms do not refer to substance use disorders or antisocial personality patterns, which are considered criminal risk factors.

have been developed based on established risk factors, such as the Central Eight, discussed below.

The *need principle* states that the intervention and programming efforts should target a JIC's "criminogenic needs" (also referred to as "risk-relevant factors"). Criminogenic needs are dynamic (modifiable) risk characteristics correlated with antisocial and criminal behavior, and recidivism, in contrast to static (unchangeable) risk factors based on historical or demographic characteristics. As a JIC's criminogenic needs change, his or her probability of engaging in further criminal behavior changes accordingly. While the need principle seems intuitive, there is a long history of criminal justice practitioners focusing almost exclusively on JICs' "noncriminogenic" needs, including issues such as low self-esteem, depressed mood, and anxiety that are routinely the primary focus with nonforensic clients seen in traditional mental health settings. As with the risk principle, implicit in the need principle is the assumption that practitioners distinguish criminogenic from noncriminogenic JIC needs.

The *responsivity principle* is more complicated, with at least two different components and multiple implications. Until recently, it had been dubbed "the neglected R" (Cohen & Whetzel, 2014). The *general responsivity principle* states that practitioners should, where possible, use behavioral and cognitive-behavioral approaches in their work with JICs to lower their risk of reoffending. This principle might seem obvious to CBT practitioners who are aware of CBT's track record for mental health outcomes more generally, but this principle was developed in part as a response to the long history of psychodynamic and nondirective-based therapies that have also prevailed historically in forensic settings.

The *specific responsivity principle* states that practitioners should tailor their approach, and style of interaction, with a JIC's individual cognitive, personality, mental health, motivational, and demographic (e.g., age, gender and race) attributes. Responsivity characteristics can impede efforts to address criminogenic needs and therefore require attention at the outset. Examples include being actively psychotic, not having adequate accommodations, and having a physical disability such as being visually or hearing impaired.

The specific responsivity principle might also seem intuitive to evidence-based practitioners, since it parallels in

some respects the patient characteristics "leg" of the "three-legged stool" of evidence-based practice (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Spring, 2007). However, criminal justice agencies have a long history of treating all JICs in the same manner when it comes to rehabilitation. Contrary to popular misconceptions, RNR is not a "one size fits all" or "cookie cutter" modality of treatment. In fact, the responsivity principle emphasizes the complex dynamic between practitioners and JICs (Wormith, Gendreau, & Bonta, 2012). In order to achieve optimal success with each case, practitioners must be sensitive and flexible regarding the manner of treatment delivery and the order in which treatment targets might be addressed.

RNR principles are embedded within a comprehensive model of forensic assessment and treatment (Andrews, 2001; Bonta & Andrews, 2007). In fact, an accurate acronym depicting the comprehensive nature of the RNR model would look something like: RTHC-RNR-ASBP-DRS-CCLM—an alphabetic mouthful! While a detailed review of all the elements of this

overarching RNR model is beyond the scope of this article, the hallmarks of it are summarized in Table 1, decoding the acronym. For more detailed discussions, interested readers are referred to Bonta and Andrews (2007; in press) and Andrews (2001). In sum, an RNR-informed treatment offers a comprehensive framework for intervention, one that honors the individuality of JICs, and places CBT as a preferred mode of intervention (Wormith et al., 2012).

RNR was spawned from a long history of research on JIC intervention, beginning with failed experiments of the 1960s, through the optimistic efforts of the 1970s and 1980s, to meta-analyses of the 1990s and 2000s. For example, Andrews and colleagues demonstrated that appropriate treatment (RNR adherence) that was randomly assigned to JICs across 80 different studies reduced recidivism by about half, while inappropriate treatment (offering non-CBT-based interventions that addressed noncriminogenic needs to low risk JICs) had no impact on recidivism (Andrews et al., 1990) and forensically ori-

Table 1. Hallmarks of the RNR Approach

Overarching Principles: RTHC	
R	Respect for the person
T	based on a general personality and cognitive social learning Theory
H	frame treatment as Human service delivery, not retribution or deterrence
C	the overarching goal is Crime prevention (preventing recidivism)
Risk-Need-Responsivity Principles: RNR	
R	match treatment to level of JIC Risk
N	target JIC's criminogenic Needs in treatment
R	treatment should be informed by general and specific Responsivity factors
Assessment Principles: ASBP	
A	Assess risk, need, and responsivity with validated tools
S	assess JIC Strengths and utilize them to aid in reducing risk
B	assess a Breadth of criminogenic and noncriminogenic needs
P	use Professional discretion when deviating from RNR principles
Program Delivery Principles: DRS	
D	JICs need a sufficient Dosage of treatment—enhance treatment retention
R	Relationship skills—approach JICs with a collaborative, empathic spirit
S	Structuring skills—emphasize structured interventions
Organizational Principles: CCLM	
C	deliver treatment in the Community rather than institutional settings, where possible
C	provide Continuing care after JICs are released into the community
L	agencies providing services should maintain Linkages with community resources for their clients
M	agencies providing services should use these principles to inform hiring, training, and Management of staff and services

ented CBT treatment was equally effective for both youth and adults. At least four meta-analyses have demonstrated the efficacy of CBT with JICs (Hoffman, Asnaani, Vonk, Sawyer & Fang, 2012), including specialized groups, such as those convicted of sexual offenses (Lösel & Schmucker, 2005) and domestic violence (Babcock, Green, & Robie, 2004).

The Central Eight Risk Domains of Criminal Behavior

The application of RNR to the delivery of services to JICs presupposes a thorough knowledge of both the static and dynamic factors that are related to criminal behavior and recidivism, and a means by which these factors may be accurately measured. Hundreds of empirical studies and dozens of meta-analyses have been conducted to build this knowledge base and to evaluate the many instruments that have been created to assess these factors, including research with adult (e.g., Gendreau, Little & Goggin, 1996), adolescent (Lipsey & Derzon, 1998), mental-health-disordered (Bonta et al., 1998), and sexually violent JICs (Hanson & Morton-Bourgon, 2005). The multitude of identified risk factors were honed and grouped into a systematic, empirically supported verified group of factors, or domains, that were labeled the Central Eight (Bonta & Andrews, in press), which are presented in Table 2. Initially, these risk factors were grouped into two tiers: The “Big Four,” which are those risk factors most strongly linked with reoffending — history of antisocial behavior, antisocial associates, antisocial cognition, and antisocial personality patterns — and the “Moderate Four”: school/work, family/marital circumstances, leisure/recreation, and substance abuse. However, the “Big” and “Moderate” distinction has fallen out of favor to some extent, as the relative strength of these factors seems to vary across different JIC groups. Regardless, the assessment of these eight domains is best captured in two risk/need instruments, the Level of Service/Case Management Inventory (LS/CMI) for adults (Andrews, Bonta & Wormith, 2004) and the Youth Level of Service/Case Management Inventory (YLS/CMI) for adolescents (Hoge & Andrews, 2002).

Returning to Jaden, keeping him from having further criminal justice involvement will mean formulating his case in terms of risk, need, and responsivity factors. Ideally this would include assessing his risk level with a validated tool. If that is not possible, clinical assessment of his Cen-

tral Eight would help indicate some major areas of concern. His current antisocial companions, poor performance/satisfaction with school/work, aimless use of leisure time, and substance abuse come to the forefront as potential treatment targets. His depressed mood, in turn, would be conceptualized as a responsivity factor—the associated symptoms (e.g., lack of energy, pessimism, low mood) can interfere with his ability to work on the risk-relevant areas of his life. His apparent lack of interest and low motivation in attending treatment in the first place also functions as a responsivity factor. Addressing his symptoms of depression and enhancing his motivation may be necessary in order to pursue active interventions around altering social networks, finding meaningful employment, creating prosocial activities, and reducing the use of substances. As noted earlier, however, addressing depressive symptoms is considered an adjunct to, not a replacement for, addressing criminogenic needs.

Five Implications of RNR for CBT and the Case Example

1. An Optimistic Outlook: Most Risk Factors for Criminal Behavior Are Changeable

RNR has, at times, been perceived as a deficit-driven perspective as opposed to a strengths-based perspective. By extension, this implies that RNR is philosophically pessimistic, overemphasizing client failures and problems in the assessment process, and targeting avoidance goals in the treatment process (Ward & Stewart, 2003). This contrasts with positive psychology models that emphasize client strengths, approach goals, and skills development (see Dumas & Ward, 2016, this issue). If RNR actually emphasized deficits at the expense of strengths, and avoidance goals at the expense of approach goals, imagining a cognitive-behavioral assessment and treatment informed by RNR would indeed be a grim and uncreative endeavor: The assessment process might consist of merely adding up the number of static risk factors a JIC has amassed; and the treatment process might consist of establishing a set of avoidance goals based on the Central Eight, such as *stay away from high-risk companions*, and *stop smoking pot*.

Yet RNR is neither an inherently deficit-based nor strengths-based model. It is a risk-based model that provides a set of principles to *inform* assessment and treat-

ment, one that emphasizes CBT as the modality most likely to be successful in working with JICs (Andrews & Bonta, 2010). Conceptualizing and delivering CBT in a manner informed by the RNR principles can be optimistic, oriented around approach goals, and compatible with developing and working with JIC strengths (Andrews et al., 2011; Wormith et al., 2012).

We see RNR as optimistic because: (a) it is preventative in the sense that, if we reduce Jaden’s risk profile, we can prevent further justice-involvement and its negative sequelae, and (b) it is oriented around risk factors that Jaden can change, rather than the factors that are static. Seven of the Central Eight have a dynamic component (the exception is criminal history). We have found that even for criminal history, this lone (but certainly not least important) static factor can be addressed in treatment in a manner that is neither pessimistic nor deficit-oriented. When approached with the right spirit and tone, initiating discussions with JICs about their criminal history and its impact on their lives can be useful in enhancing motivation to address dynamic risk areas and identifying goals in line with their underlying values, both of which are consistent with strengths-based work.

For example, from an RNR perspective, Jaden is not conceptualized as someone destined to reoffend because he has a history of criminal activity, failure in education and employment, a group of criminal companions, criminal thinking patterns, unproductive use of his leisure time, and substance abuse. Instead, he is conceptualized as a person whose criminal trajectory can be altered if treatment can improve the unique constellation of risk factors most relevant to his life.

2. Emphasize Approach Goals: Addressing Risk Doesn’t Just Mean Avoiding Risk

The terms *reducing risk* and *targeting risk factors for change* both carry connotations of interventions built around the JIC avoiding risk factors. Yet, CBT informed by RNR principles does not simply involve providing clients with a checklist of people, places, and situations to avoid. CBT informed by RNR may include the development of new skills, competencies, routines, habits, and thinking patterns (Andrews et al., 2011). In fact, application of the need principle may direct practitioners to specific approach goals that will assist JICs in acquiring skills that will combat risk

factors and, in so doing, reduce the overall risk profile. Six of the seven dynamic factors have an approach dimension with readily identified positive targets, including fostering prosocial attitudes and values, making achievements in school or work, participating in prosocial activities, acquiring and spending time with prosocial acquaintances, developing positive family or marital relationships, and demonstrating an overall prosocial lifestyle. The lone exception is in the substance abuse domain, where the primary objective is to reduce consumption and associated harm. But even this criminogenic need is often addressed by focusing on approach behavior or capitalizing on strengths in the other six criminogenic need areas (e.g., developing or reestablishing sober networks, activities, and endeavors). Working on skills that are unrelated to criminogenic risk (e.g., self-esteem, creativity, low mood) can still be addressed at a later point, once the JIC's risk of reoffending has been reduced.

Improving a JIC's functioning on any given risk factor may involve a blend of approach and avoidance goals. For example, Jaden's history indicates that poor attitudes and performance in education and employment are one of his risk factors. In trying to reduce his risk for reoffending, a practitioner may want to try any or all of the following: (a) engaging in a discussion about what kinds of employment opportunities would be of interest to him, (b) identifying the educational or vocational training needed to be competitive for that type of work, (c) identifying and restructuring his attitudes about work, and (d) coaching him around appropriate behaviors in the workplace. These are all approach goals that are consistent with strengths-based formulations of forensic treatment and rehabilitation. They are also consistent with RNR in that they help Jaden acquire the skills needed to reduce his likelihood of reoffending.

3. Individually Tailored Treatment:

Case Formulation and Treatment

Cannot Be a "One Size Fits All"

Approach

While the general responsivity principle directs the practitioner toward a CBT approach, the specific responsivity principle reminds the practitioner that the success of our interventions will be influenced by the unique circumstances of a particular JIC. In practice, this means that while two JICs may share a common risk factor, how it is addressed in treatment may differ

because of the way the risk factor is manifested in their lives.

For example, one of Jaden's relevant risk factors was criminal companions. If we examine his case further we find that in the past year he has spent a great deal of time with a small group of peers who have some self-destructive attitudes and habits, especially with respect to alcohol/drugs and school/work. What made his companions a particular risk factor for Jaden was that their plans and views were already appealing to him, and within this peer group he could easily justify dropping out of college and impulsively quitting various jobs when work became difficult. However, for another JIC, criminal companions may be a relevant risk factor because she is seeking the approval of a group of peers, and goes along with their criminal activities because she believes it will make her more likeable. In the latter case, her participation in antisocial conduct is a by-product of her concern about what her friends might think. While both JICs share a common treatment target of criminal companions, the approach for Jaden might start with a dis-

cussion around his existing attitudes and values and the role of his friends in reinforcing those attitudes; the approach for the latter client might start with her concerns about what her friends think of her and the impact of those concerns on her decision-making.

4. Risk Factors Are Synergistic: They Interact in Ways That Can Amplify or Reduce Each Other

When we go to the grocery store with a shopping list, we remove the listed items from the shelves, and place them in the cart, where hopefully, each individual item stays in its own bag or container, an entity unto itself. The baking soda is not expected to mix with the vinegar and produce a foamy explosion. Like shopping items, risk-relevant factors (i.e., criminogenic needs) are also presented in the form of a list. One consequence is that they may be perceived as individual entities, occupying a sealed container that does not interact with the other risk factors on the list. Unlike items on a shopping list, criminal risk factors can influence each other, and in ways that amplify risk for reoffending

Table 2. The Central Eight Risk Domains for Recidivism

Domain	Description
History of Antisocial/Criminal Behavior	Patterns of antisocial/criminal behavior beginning in childhood and continuing into adulthood
Antisocial Personality Characteristics	Signs and symptoms of antisocial personality, dissocial personality, and psychopathy
"Criminal Thinking"/Antisocial Cognition	Beliefs and attitudes that facilitate antisocial, criminal, and destructive behavior
Antisocial Companions	Close association with, and approval seeking from, criminal companions; absence of prosocial friends
Family/Marital Dysfunction	Marital or family relationships that ignore, reinforce, or model antisocial behavior; lack of positive family bonds
Poor Performance/Satisfaction with School/Work	Negative attitudes and low levels of performance and satisfaction in school/work
Unproductive Leisure/Recreational Pursuits	Enjoyment of antisocial and risky activities; low levels of connection and enjoyment related to prosocial pursuits
Substance Abuse	Abuse of alcohol/drugs; positive attitude toward substance use

(Andrews et al., 2011). For example, Jaden believes that life is about seeking excitement. His attitude toward the quiet tenor of college classes and the responsibilities required at a job is one of boredom and intolerance. He spends the better part of his considerable free time with friends who drink heavily and use drugs. His friends reinforce his unproductive beliefs about school and work, and the substances he consumes with them worsen his already poor school performance and marketability as an employee. These unsatisfying experiences in school and work may trigger his excitement-seeking attitudes, his sense that he doesn't fit in with traditional school or work activities, and encourage him to spend more time with his risky friends. Thus, the various risk factors impact each other in an interrelated, destructive system. Hence, combinations of risk factors can be multiplicative, rather than simply additive.

On the optimistic side, a positive change in one of these risk factors can reduce the other risk factors. For example, if Jaden were to try volunteering, part or full-time, with an organization he believed was important, he might receive social reinforcement, find his participation personally satisfying, and, therefore, spend less time with his friends, and have less time to engage in substance use. He would also be exposed to a new group of peers at the volunteer organization, who express more prosocial attitudes and who model productive lifestyles. Developing friendships with this new peer group would reduce his time and activities with his former friends, and reinforce a new lifestyle. The implication is that practitioners do not have to focus their efforts on changing all the risk factors relevant to a particular case. A strategic focus on one or two can create a positive ripple effect in the JIC's life (Mitchell, Tafrate, & Freeman, 2015). This strategy of substituting risky behaviors with protective ones is also reminiscent of a classic behavioral principle, the differential reinforcement of incompatible behavior.

5. Enhance Motivation: Practitioners Should Be Prepared to Work on Enhancing JIC Motivation and Building the Working Relationship

One of JICs' common responsibility characteristics is their lack of motivation to change. Unfortunately for practitioners, JICs are almost always coerced into treatment and programming. Sometimes the coercion is overt, such as by the court or, in Jaden's case, his family. Sometimes the coercion is more subtle, such as when an

incarcerated JIC volunteers for a rehabilitation program because it will be seen positively by a parole board. Whether through overt or covert coercion, practitioners must contend with JICs who are initially uninterested or poorly invested in changing the risk-relevant areas of their lives, and who may, in fact, see themselves as being treated unfairly by their families, the criminal justice system, or both. JICs may also be suspicious of the intentions of practitioners. This is a stark contrast to the client who voluntarily seeks out help for depressed mood or anxiety. In such cases, clients are seeking change, looking to the practitioner for help, and ready (and perhaps eager) to build a working relationship.

One implication for a RNR-informed CBT is that practitioners may need to spend more time at the beginning of treatment than they are accustomed to, enhancing JICs' motivation and building the working alliance (Andrews et al., 2011; Tafrate & Luther, 2014). Actively intervening around a risk-relevant life area when the JIC is not ready, or even opposed to the idea of change, is unlikely to be productive. As discussed by Owens and Tafrate (2016, this issue), when pressured to change, JICs may become more defensive, insist that change is unnecessary, and become adversarial toward the practitioner, adopting a stance that treatment is being done "to them" rather than "with them" in a collaborative endeavor. We recommend that practitioners strongly consider integrating motivational interviewing skills into their work with JICs, especially in the early phase of treatment, when resistance is likely to be at its highest (Miller & Rollnick, 2013). MI is particularly advantageous in the early stages of treatment because it enhances engagement and collaboration, discourages practitioners from adopting a confrontational or advice-giving style, and also slows practitioners down in terms of jumping too quickly into interventions for which the JIC is not yet ready. Its use in this context has been recommended for practitioners adopting an RNR framework (Andrews et al., 2011).

In working with Jaden, it would be important to resist the temptation to offer suggestions intended to help him change his social network, how he spends his leisure time, or improve his employment situation. As discussed by Tafrate, Mitchell, and Simourd (in press), since risk-relevant factors are embedded within a person's lifestyle (e.g., ongoing routines, relationships, and destructive habits), JICs will need time to explore and consider the

impact of such factors on their own lives. Early stages of treatment with Jaden would focus on establishing a good working relationship, exploring what he values most, and evoking his own motivations for making specific lifestyle changes.

Concluding Comments

While clinical work with JICs is challenging, the pessimism that has traditionally surrounded forensic treatment is unjustified and counterproductive. Treatment can reduce criminal behavior, especially if the modality is cognitive-behavioral, and if treatment targets the domains empirically linked with reoffending (Dowden & Andrews, 2000; Hanson, Bourgon, Helmus, & Hodgson, 2009; Lowenkamp, Latessa, & Smith, 2006). For practitioners who work with clients like the one presented in the case example, that means shifting the focus from mental health symptoms to the Central Eight risk areas, developing "approach" as well as "avoidance" goals around targeted areas, and working to build motivation in a client who may initially have been coerced into the office. Mental health symptoms are not unimportant, but their reduction will not necessarily reduce future criminal behavior. Addressing risk areas that drive repeated involvement with the criminal justice system is the most empirically supported approach to curbing recidivism and improving life trajectories of JICs. The substantial financial costs of the correctional system, and more importantly, the cost in human suffering that victims experience and wasted opportunities for a more productive life that JICs experience, make reducing reoffending via targeted intervention with criminogenic risks an essential goal in therapeutic work with JICs.

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Psychopathy: Its Relevance, Nature, Assessment, and Treatment

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Why Care About Psychopathy?

Fascination with individuals who chronically violate the rules and demonstrate reckless disregard for others dates back to antiquity. In the Book of Deuteronomy, Moses (c. 600 B.C.) described “a wayward and defiant son, who does not heed father or mother and does not obey them even after they disciplined him.” In his portrayal of personality types, the Greek philosopher and student of Aristotle, Theophrastus (c. 300 B.C.), described *The Unscrupulous Man* as “a cheat, rascal, a borrower who never repays, thief, incorrigible.” French physician Philippe Pinel (1745-1826) later used the terms *la folie raisonnante* (moral insanity) and *manie sans délire* (insanity without delirium) to describe patients who behaved in irresponsible and immoral ways despite intact rationality and intellect. Other historical conceptualizations include American psychiatrist Benjamin Rush’s (1746-1845) notion of *innate preternatural moral depravity*, British psychiatrist Henry Maudsley’s (1835-1918) description of “some few who are congenitally deprived of moral sense,” German psychiatrist Emil Kraepelin’s (1893-1915) proposition that congenital defects lead to *moral degeneration*, and German-American psychiatrist Karl Birnbaum’s (1878-1950) introduction of the label “*sociopathic*” to emphasize societal influences on the development of antisocial traits (although the term “sociopath” has since been confused with “psychopath”).

Contemporary conceptualizations of *psychopathic personality*, often known simply as *psychopathy*, derive largely from the vivid case studies provided by American psychiatrist Hervey Cleckley in his classic 1941 monograph, *The Mask of Sanity*. Psychopathy is now seen as a constellation of affective (e.g., callousness, guiltlessness), interpersonal (dishonesty, grandiosity), and behavioral traits (impulsivity, irresponsibility) that exist not only in forensic and clinical settings, but that also

vary dimensionally in youth and adults in the general population (e.g., Guay, Ruscio, Knight, & Hare, 2007; Murrie et al., 2007). Some authors have argued that psychopathic traits are one of the strongest dispositional risk factors for antisocial behavior, including physical and sexual aggression, behavioral problems during incarceration, and criminal recidivism across age ranges and contexts (e.g., Forsman, Lichtenstein, Andershed, & Larsson, 2010; Guy, Edens, Anthony, & Douglas, 2005; Lynam, 1997; Reidy et al., 2015; Yang, Wong, & Coid, 2010); although as we describe later, the nature of this association is somewhat controversial. Psychopathy has also been found to be associated with poorer response to treatment in some studies, but not in others (e.g., Skeem, Monahan, & Mulvey, 2002).

As a result of its potential impact on individual functioning and criminological risk, as well as questions about its malleability, psychopathy has received considerable attention in both clinical and forensic contexts. Beyond mental health and legal settings, there has been growing interest in, and controversy concerning, *successful psychopathy* in the general population (Widom, 1977), including whether certain levels or features of psychopathy facilitate success in certain vocations or avocations, such as politics, business, and high-risk sports (Lilienfeld, Watts, & Smith, 2015). Even in community contexts, psychopathic traits may be associated with elevated but more subtle forms of antisocial behavior (Czar, Dahlen, Bullock, & Nicholson, 2011) such as proactive relational aggression, in which others’ relationships or social status are intentionally harmed by means such as gossip or humiliation without provocation, for sake of instrumental gain (White, Gordon, & Guerra, 2015). Psychopathic traits in such contexts are also associated with more prosocial acts when an audience is present, but lower levels of anonymous and altruistically motivated prosocial acts (White, 2014). Yet important questions remain regarding how to define “successful

psychopathy” (Gao & Raine, 2010). In addition, it is unclear whether successful psychopathy reflects a more mild version of unsuccessful psychopathy, a distinct configuration of psychopathic traits, or an attenuated expression of core psychopathic traits tempered by protective factors (Ishikawa, Raine, Lencz, Bihrlé, & Lacasse, 2001; Lilienfeld et al., 2015).

What Psychopathy Is Not

Beyond the obvious confusion stemming from the unfortunate prefix “psycho” (psychopathy is just one form of personality psychopathology, and most psychopaths are not *psychotic* or otherwise irrational or disoriented), many erroneous beliefs exist about psychopathy (Berg et al., 2013; Skeem, Polaschek, Patrick, & Lilienfeld, 2011). We will cover a few of the most common misconceptions.

Psychopathy Is Not Synonymous With Violence

It is true that psychopathic individuals commit some of the most heinous crimes, and that certain notorious serial killers, like Ted Bundy and John Wayne Gacy, manifested marked psychopathic traits. But others, like Charles Manson, displayed more symptoms of psychosis than psychopathy. And of course, violence is influenced by a host of factors (e.g., historical, economic, and ideological). Although the most widely used measure of psychopathy (Psychopathy Checklist-Revised; Hare, 2003) emphasizes antisocial features (e.g., juvenile delinquency, recidivism, criminal versatility), not all psychopathic individuals exhibit violent or other antisocial tendencies, or end up in prison (Lilienfeld, 1994), even though they may show other socially undesirable characteristics, such as being superficial, smug, and unempathic.

Psychopathy Is Not Equivalent to Antisocial Personality Disorder

Psychopathy is not synonymous with antisocial personality disorder (ASPD; APA, 2013), a heterogeneous DSM diagnosis characterized by a chronic history of antisocial, criminal, and in some cases violent behavior (Cox et al., 2013). Despite earlier editions of the DSM suggesting psychopathy and ASPD are synonymous, ASPD measures and diagnostic criteria focus on antisocial behaviors seen in approximately half of incarcerated samples, whereas psychopathy occurs less often, and measures of psychopathy emphasize distinct personality traits

(described later) that are not observed in most individuals with ASPD (Skeem et al., 2011).

Psychopathy is not unalterable. The conventional belief that psychopathy is innate and unalterable is increasingly challenged by evidence of the interplay of constitutional and environmental influences in this condition (e.g., Waldman & Rhee, 2006). Genes appear to play a significant role in the development of psychopathy, probably by influencing children's information, or affective-processing styles (e.g., difficulty learning from punishment, low emotional reactivity), but there are unlikely to be any specific genes for psychopathy (Viding & McCrory, 2012). Furthermore, twin studies (e.g., Larsson, Andershed, & Lichtenstein, 2006) suggest that only about half of the variability in psychopathic traits reflects heritable factors, and the other half reflects *nonshared environmental influences*—nongenetic factors that make siblings dissimilar from one another, such as birth order, differential parenting, stressors (e.g., injuries, illness, trauma), having different peers, and microbiomes (the community of microorganisms that inhabit our bodies; Peterson et al., 2009). Environmental variables also appear to influence the expression of genetic risk for psychopathy. Particular evidence for the impact of the environment comes from the apparent response of psychopathic traits and associated behaviors to parenting styles (Viding & McCrory) and to treatment, as discussed later.

What Is Psychopathy?

Cleckley's (1941) modern characterization of psychopathy emphasized the confident, well-adjusted, personable presentation (hence, the reference to the word "mask" in his title) of a subset of psychiatric inpatients he was seeing. As with other forms of personality pathology, these individuals revealed their severe underlying deficits over time, which included shallow affect, egocentricity, and irresponsibility, rather than emotionally dysregulated, explosive, violent, or cruel tendencies. Others working with incarcerated individuals have similarly conceptualized psychopathy as marked by superficial emotions, but they placed greater emphasis on callousness, lovelessness, impulsivity, as well as hostile alienation from and exploitation of others (McCord & McCord, 1964).

Measuring Psychopathy

In forensic settings, the most frequently used measure for the assessment and diagnosis of psychopathy is the Hare Psychopathy Checklist–Revised (PCL-R; Hare, 2003), which relies on a semistructured clinical interview and corroborative information (e.g., criminal records) to assign values on a 20-item symptom-based rating scale. Scores range from 0–40 with a research-based diagnostic cutoff for psychopathy of ≥ 30 (or 25 when rated via file only; Wong, 1988). Two broad dimensions have been derived via factor analysis that account for much of the covariation among the items on the PCL-R and its variants (Harpur, Hare, & Hakstian, 1989). Factor I encompasses core affective (callousness, lack of remorse) and interpersonal (grandiosity, superficiality) features; whereas Factor II encompasses unstable lifestyle (irresponsible, impulsive) and antisocial behavior (early behavior problems, criminal versatility). Subsequent three-factor (Cooke & Michie, 2001) and four-factor (Hare, 2003) models further parse Factor I into separable but correlated affective and interpersonal features. The PCL-R has been extended downward to adolescents as the Psychopathy Checklist: Youth Version (PCL: YV; Forth, Kosson, & Hare, 2003).

The time and expertise required to conduct the PCL-R interview has led to the development of briefer self-report questionnaires, particularly in research settings (Lilienfeld & Fowler, 2006). Such measures include the Levenson Self-Report Psychopathy Scale (LSRP; Levenson, Kiehl, & Fitzpatrick, 1995), Self-Report Psychopathy Scale (SRP-III; Paulhus, Hemphill, & Hare, 2012), the Psychopathic Personality Inventory–Revised (PPI-R; Lilienfeld & Widows, 2005), and the Triarchic Psychopathy Measure (TriPM; Patrick, 2010).

Influenced by the classic writings of Karpman (1941), Levenson and colleagues (1995) developed the LSRP, a now well-validated self-report measure to differentiate psychopathy subtypes. They conceptualized *primary psychopathy* as encompassing interpersonal characteristics such as selfishness, uncaring, and manipulateness, combined with general intelligence, emotional stability, and seemingly adequate outward adjustment. In contrast, *secondary psychopathy* encompasses impulsivity, emotional dysregulation, anxiety, self-defeating tendencies, and general psychopathology.

The SRP-III (Paulhus et al., 2012) is the second revision of a scale developed by Hare and colleagues as a self-report counterpart to the PCL-R for use in community samples. The current version was revised to fit the four-facet structure of the PCL-R. It contains 64 items and produces a global psychopathy score, as well as four subscales, with Callous Affect and Interpersonal Manipulation subscales reflecting PCL-R Factor 1, and Erratic Lifestyle and Antisocial Behavior subscales reflecting Factor II.

The PPI-R (Lilienfeld & Widows, 2005) is an adult 154-item self-report measure usable for community, clinical, and forensic settings that offers a total score as well as eight factor-analytically derived content scales, most of which often, although not always (Neumann, Malterer, & Newman, 2008), load onto two higher-order factors. The first of these higher-order dimensions, Fearless Dominance, comprises the Social Influence, Fearlessness, and Stress Immunity scales and is associated with assertiveness, poise, stress resilience, and thrill-seeking; although it is largely unassociated with PCL-R total scores, it is modestly associated with its interpersonal facet. The second, Self-Centered Impulsivity, comprises Machiavellian Egocentricity, Rebellious Nonconformity, Blame Externalization, and Carefree Nonplanfulness scales and is associated with impulsivity, ruthless narcissism, manipulateness, and hostile attribution bias; it correlates highly with PCL-R Factor II. The Coldheartedness scale does not load highly on either PPI-R higher-order factor, and is associated with lack of deep social emotions including empathy and guilt; it correlates moderately with PCL-R Factor I (Marcus, Fulton, & Edens, 2013). The PPI-R is standardized for community samples in the United States, offers norms for male offenders, and can detect positive and negative impression management and careless responding.

More recently, Patrick, Fowles, and Krueger (2009) introduced an increasingly popular triarchic model of psychopathy, which attempts to reconcile competing historical models by conceptualizing psychopathy as encompassing three interrelated phenotypic dispositions of boldness, meanness, and disinhibition. Each domain is captured in a 58-item self-report questionnaire (TriPM; Patrick, 2010). *Boldness* comprises emotional resiliency, confidence, social assertiveness, and venturesomeness. It is based largely on the Fearless Dominance factor of the PPI-R and intended to capture the "mask" features of

Cleckley's (1941) conceptualization of psychopathy, as well as a lack of behavioral inhibition. *Meanness* comprises lack of empathy and affiliative capacity, contempt toward others, predatory exploitativeness, and empowerment through cruelty or destructiveness, thus overlapping with Callous Unemotional traits in youth (see discussion below, "Psychopathy in Children?"), as well as the Coldheartedness scale of the PPI-R. *Disinhibition* entails impulsiveness, weak restraint, hostility and mistrust, and difficulties in regulating emotion, and relates strongly to the Self-Centered Impulsivity factor of the PPI-R. An important distinction between the PPI-R and TriPM, on the one hand, and many other psychopathy measures, on the other, is their inclusion of the Fearless Dominance/Boldness dimension, which is less well represented within such measures as the LSRP and SRP-III, as well as the youth-based APSD described later (Patrick & Drislane, 2015).

Definitional Controversies

There is still ongoing debate on the role and relevance of certain psychopathy features in defining the personality syndrome. For example, although Cleckley (1941) noted a lack of extreme meanness in prototypical psychopaths, the triarchic model accords a central role to meanness. Hence, the place of meanness within the psychopathy construct requires clarification.

Similarly, although some scholars have argued that adaptive features, such as boldness (as assessed largely by the PPI-R Fearless Dominance dimension), are largely or entirely irrelevant to psychopathy (e.g., Miller & Lynam, 2012), others have argued that they play a key role, accounting in large measure for Cleckley's (1941) "mask" of superficially healthy functioning (Lilienfeld et al., 2012; Venables, Hall, & Patrick, 2014). Adding to the confusion, boldness measures tend to be moderately to highly correlated with total scores on some psychopathy measures, but not with total scores on measures derived from the PCL-R, probably reflecting the PCL-R's emphasis on maladaptive (e.g., antisocial and criminal) behavior (Lilienfeld et al., in press).

Others have argued that disinhibition is merely a secondary correlate or consequence of psychopathy rather than a core component (Cooke, Michie, Hart, & Clarke, 2004). Because the PCL-R includes items assessing prior antisocial behavior, there is also ongoing debate regarding how much psychopathy per se adds to the pre-

diction of future violence beyond preexisting history of violence (e.g., Hare & Neumann, 2010; Skeem & Cooke, 2010a, b).

Notably, the construct of psychopathy has also been deconstructed in terms of Big Five (or Big Three) normal-range personality traits, with the aforementioned psychopathy measures typically reflecting low Agreeableness (i.e., high antagonism, including suspiciousness and deceptiveness) and low Conscientiousness (i.e., low constraint, including impulsivity and non-traditional values). Some measures also reflect the more psychologically adaptive traits of low Neuroticism, high agentic Extraversion, and high Openness, depending upon how psychopathy is conceptualized and operationalized (Lilienfeld, Watts, Smith, Berg, & Latzman, 2015).

Psychopathy in Children?

Certain psychopathic features appear to emerge early in development and have been measured in children as young as 2 to 3 years of age (Kimonis, Frick, Boris, et al., 2006). The most widely used measures of psychopathic features in youth have been the PCL:YV (Forth et al., 2003) and the Antisocial Process Screening Device (APSD; Frick, O'Brien, Wooton, & McBurnett, 1994). Both are 20-item adaptations of the adult PCL-R, although the PCL:YV follows the PCL-R format of requiring a semi-structured interview and review of records, whereas the APSD is based upon parent or teacher report or adolescent self-report. Factor structures of these measures largely mirror those of the PCL-R (Kotler & McMahon, 2010), although these factors tend to be more positively correlated with negative emotionality (e.g., depression, anxiety) in youth than in adults (Sevecke & Kosson, 2010).

Other instruments have been developed, such as the 50-item Youth Psychopathic Traits Inventory (YPI; Andershed, Kerr, Stattin, & Levander, 2002), a self-report measure that contains items designed to tap each of 10 core psychopathic traits identified in nonincarcerated adolescent samples in a manner similar to the PCL, without requiring the administration training and time of the PCL:YV. A modified version of the YPI, the Child Problematic Traits Inventory (CPTI; Colins et al., 2014), developed for children ages 3 to 12, excludes the YPI and PCL behavioral dimension (e.g., rule-breaking, antisociality, impulsivity) to avoid confounding measurement of traits with behavioral symptoms of conduct disorder.

An alternative approach by Frick and colleagues emphasizes callous/unemotional (CU) traits, such as shallow emotions, lack of guilt or remorse, disregard for others' feelings, and lack of concern regarding one's own performance in important activities. CU traits tend to be associated with relatively high levels of antisocial behavior (Christian, Frick, Hill, & Tyler, 1997), including early onset and persistence of serious conduct problems (Moffitt, 2006; Patterson, 1996), repetitive deceitfulness, rule violations, physical cruelty, and property destruction (Frick, Ray, Thornton, & Kahn, 2014), as well as fearlessness (e.g., Pardini, Lochman, & Powell, 2007). Youth with elevated conduct problems and CU traits are less responsive to others' distress (Kimonis, Frick, Fazekas, & Loney, 2006), show deficits in fear recognition (Dadds et al., 2006), and are more prone to proactive aggression (Marsee & Frick, 2007), compared with other youth. Such findings have led to expansion of the six items originally forming the CU subscale on the APSD to form a separate 24-item Inventory of Callous-Unemotional Traits (Frick, 2004; Kimonis et al., 2008). Others researchers (Willoughby, Waschbusch, Moore, & Propper, 2011) have constructed CU scales by combining selected items from commonly used symptom inventories, such as the Child Behavior Checklist (Achenbach & Rescorla, 2000).

To acknowledge that youth with elevated CU traits comprise a unique subgroup among those with serious conduct problems, while attempting to minimize potential harm in labeling such youth, the latest edition of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; APA, 2013) added the specifier "With Limited Prosocial Emotions" to the diagnosis of conduct disorder to designate those with CU traits. A clinician-rated *Clinical Assessment of Prosocial Emotions* (Frick, 2013) is currently under development to facilitate determination of the corresponding DSM-5 CD specifier.

Ethical Implications

Important ethical concerns remain regarding the potential negative impact, including stigma and negative juror impressions, of labeling children and adolescents with a term that implies the presence of pre-psychopathic features (Edens, Mowle, Clark, & Magyar, 2016). Moreover, the downward extension of psychopathic traits to children has been controversial on

scientific grounds. Although rank-order estimates suggest moderate stability of CU traits across later childhood into adulthood, there is significant individual variability in trajectories over time (Pardini & Loeber, 2008), and some children with CU traits appear to “grow out” of this pattern (Edens, Skeem, Cruise, & Cauffman, 2001). Those examining CU tendencies in early childhood sometimes use the term “behavior” rather than “traits” to emphasize their temporal instability during this developmental period (Waller et al., 2015).

Etiology

A review of the etiology of psychopathic traits is beyond the scope of this article. Nevertheless, research suggests that callous behaviors can develop early (e.g., Waller et al., 2015), with some evidence for moderate to high heritability (Viding & McCrory, 2012). There appear to be at least two alternative pathways that reflect either largely innate (“primary psychopathy”) or environmental (“secondary psychopathy”) influences (Karpman, 1941; Kimonis, Frick, Cauffman, Goldweber, & Skeem, 2012). Some prominent etiological models of psychopathy are primarily “bottom up,” emphasizing the role of emotional disturbances in shaping psychopathic deficits. For example, some posit that deficits in the capacity to process fear and closely related emotions give rise to the core features of the condition, such as guiltlessness, callousness, and superficial charm (e.g., Blair, 2008; Kiehl, 2006; Lykken, 1957). In contrast, other major etiological models are primarily “top down,” emphasizing the role of higher cortical processes, such as insufficient attentional allocation to extraneous cues, in shaping the core features of the condition (Moul, Killcross, & Dadds, 2012; Patterson & Newman, 1993). Still other recent models posit a mix of bottom-up and top-down etiological influences (e.g., impaired integration model; Hamilton, Racer, & Newman, 2015).

Do Psychopathic Traits Worsen Treatment Outcomes for Youth?

Behavioral interventions for conduct problems in children, particularly parent management training, are well-established (Michelson, Davenport, Dretzke, Barlow, & Day, 2013), yet about 40% to 50% of youth do not show substantial benefit (Ollendick et al., 2015). There is reason to be concerned about treatment outcomes for youth with elevated CU traits in particular, as such youth appear to be at greatest risk for chronic and severe disruptive

behavior problems. However, there is ongoing debate concerning whether CU traits attenuate treatment effectiveness (Hawes, Price, & Dadds, 2014), or merely reflect the fact that such youth start with higher levels of conduct problems but improve at the same rate in treatment as those without CU traits (Waller, Gardner, & Hyde, 2013). A recent comprehensive review (Hawes et al., 2014) of parenting interventions for youth with CU traits suggests that parent training is effective in reducing behavioral problems in these youth, particularly when emphasis is placed on positive reinforcement and promotion of parental warmth. Other research suggests that a warm and responsive parent-child relationship may enhance conscience development (Somech & Elizur, 2012). Furthermore, there is preliminary evidence that emotion recognition training may serve as a useful adjunct to parent training for youth with CU traits (Dadds, Cauchi, Wimalaweera, Hawes, & Brennan, 2012).

Are Adult Psychopaths Untreatable?

Turning to adults, there is surprisingly little evidence to support the common skepticism regarding the treatability of psychopathy or the presumption that psychopathy adversely moderates the effectiveness of treatments for adult antisocial behavior (Skeem et al., 2002). The roots of doubt appear to stem largely from an earlier intervention study that reported increased criminal recidivism among psychopathic individuals who had participated in a radical “therapeutic community” (Rice, Harris, & Cormier, 1992). In this program, devised by Canadian psychiatrist Elliot Barker and authorized by the Canadian government (Barker & Buck, 1977), patients in a maximum security hospital were mandated to participate without voluntary consent. They were stripped of their clothing, locked in “total encounter capsule” rooms for days on end, administered psychedelic drugs, fed through tubes in the wall, offered minimal contact with professional staff, and received no attempts to alter criminal attitudes or teach social or problem solving skills—certainly a far cry from modern-day ethical evidence-based approaches.

Countering the pessimism regarding treatability, growing evidence suggests that individuals with elevated psychopathy are best seen as high-risk cases that are in need of intensive treatment (Skeem et al., 2011). Although early optimistic reviews (Salekin,

2002) have been limited by methodological concerns, including a lack of well-designed studies (D’Silva, Duggan, & McCarthy, 2004; Harris & Rice, 2006), more recent reviews (Caldwell, McCormick, Umstead, & Van Rybroek, 2007; Polaschek, 2014; Salekin, Worley, & Grimes, 2010) at least partially support the treatability of psychopathy.

Recent Treatment Advances

Some new experimental intervention approaches feature the application of computerized cognitive/affective remediation paradigms in attempts to target hypothesized psychopathy-specific deficits (e.g., Baskin-Sommers, Curtin, & Newman, 2015; Schönberg et al., 2014). These approaches are intended to alter specific cognitive-affective dysfunctions, such as perceptual insensitivity to others’ emotions (Schönberg et al.), failure to utilize contextual information (for psychopathic, high-Factor I individuals), or the inability to regulate affective reactions (for externalizing, or high Factor II/low Factor I individuals; Baskin-Sommers et al., 2015). Preliminary support has been obtained, for instance, for deficit-matched cognitive training based on offender subtype. Specifically, Baskin-Sommers and colleagues found improved attention to context among psychopathic men, and improved affect regulation among externalizing men. The results underscore the importance of cognitive factors and the potential incremental value of novel computerized interventions in developing specific cognitive and affective information processing skills that might, in turn, curb antisocial behavior. Nevertheless, it is too early to tell whether these computerized interventions will translate into long-term gains in real-world settings.

A larger body of research from high-intensity violence-reduction programs, broadly adhering to risk-need-responsivity (RNR) principles (discussed further by Mitchell, Wormith, & Tafrate, 2016, this issue), offers some clarity regarding what potentially works with psychopathic offenders. Emerging evidence suggests that effective programs must provide high-intensity services for high-risk offenders (risk principle), prioritize criminogenic needs to be targeted for risk-reduction services (need principle), deliver services in a flexible and clinically engaging manner (general responsiveness), and be attentive to the unique needs of each client (specific responsiveness). When these core compo-

nents can be harnessed, positive risk-relevant changes have been linked to reductions in sexual (Olver & Wong, 2009) and violent (Olver, Lewis, & Wong, 2013; Wong, Gordon, Gu, Lewis, & Olver, 2012) recidivism after controlling for baseline risk and individual differences in psychopathy.

Wong proposed a two-component model for the treatment of psychopathy that prioritizes services, in part based on the structure of psychopathic traits (see Wong et al., 2012; Wong & Hare, 2005). Component 1 is essentially a responsibility prong, in which service providers manage the interpersonal and affective features of psychopathy (i.e., Factor I traits). For instance, psychopathic offenders tend to engage in disruptive behavior within groups, pit staff against one another and push boundaries, intimidate co-patients, fail to accept responsibility, and show a lack of empathy or emotional connectedness toward others. Since Factor I features appear to be linked to decreased therapeutic progress (Olver et al., 2013), increased dropout (Olver & Wong, 2011), and weaker working alliances, particularly the therapeutic bond (DeSorcy, Olver, & Wormith, 2016), Wong and colleagues recommended managing Factor I through containing treatment-interfering behaviors rather than trying to treat and change Factor I per se. For example, service providers can maintain open lines of communication, present a united front, maintain clear boundaries, avoid power and control battles with challenging clients, and engage in routine consultation and support. Such strategies are essential in maintaining psychopathic client engagement in treatment and avoiding program dropout.

Component 2 (criminogenic component) essentially corresponds to the risk and need principles, and entails delivering high-intensity risk-reduction services targeting criminogenic needs (i.e., dynamic risk factors) associated with PCL-R Factor II. The criminal lifestyle features of psychopathy correlate highly with measures of criminogenic needs (Olver & Wong, 2009; Simourd & Hoge, 2000; Wong & Gordon, 2006), and Factor II bears particularly strong links to recidivism. Many of the features of Factor II are dynamic in principle (e.g., impulsivity, irresponsibility, lack of goals, poor behavior controls, parasitic lifestyle), and conceptually share much in common with treatment foci of correctional programs. The criminogenic needs of psychopathic offenders are not different than those of nonpsychopathic individuals;

they tend to be more severe and probably larger in number (Wong & Gordon). Comprehensive and integrated cognitive-behavioral programs targeting general and specific criminogenic need domains are likely to yield larger net gains and potential for recidivism reduction (Wong & Hare, 2005; Wong et al., 2012). For possible gains to be realized, of course, psychopathic clientele need to be retained and engaged in treatment. In summary, service providers are advised to manage, rather than to try to alter, the characteristics associated with Factor I, and to actively target the criminogenic features associated with Factor II (see also Harkness & Lilienfeld, 1997).

Conclusions

Behavioral and cognitive-behavioral therapists have long focused on internalizing problems, particularly anxiety-related disorders. We believe that the time has come to examine further the opposite end of the spectrum, which may be just as maladaptive, albeit in ways that differently impact individuals and those around them. Countering the prevailing pessimism about this client group, a growing literature suggests that, although psychopathic traits may increase risk for chronic and severe conduct problems, the affective, interpersonal, and behavioral patterns that comprise psychopathy may prove to be amenable to cognitive-behavioral approaches. An analogy to borderline personality disorder may be helpful in this context. Borderline was once viewed widely as an untreatable condition, but such views have receded in the wake of major therapeutic advances (Linehan, 1993). Similarly, the treatability of psychopathy, once assumed to be a quixotic or even pointless venture, is increasingly coming to be regarded as a promising new frontier. At the same time, important conceptual and practical questions await further investigation with regard to the nature and development of interventions for psychopathy, creating exciting opportunities for future research.

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ABCT > Election Results



Sabine Wilhelm, Ph.D.
President-Elect, 2016-2017



Simon Rego, Ph.D.
Representative-at-Large, 2016-2019

The membership also passed two bylaws proposals:

1. Article III: Membership
2. Article V: Voting

Sex Offender Treatment: The Need for Cognitive Behavioral Therapists

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R. Karl Hanson, *Public Safety Canada*

Cynthia Calkins, *John Jay College of Criminal Justice*

SEX OFFENDERS—AMONG THE MOST reviled of all offenders—are primarily managed through punishment and surveillance. The U.S., whose criminal justice system is more punitive than that of other industrialized nations, uses a variety of restrictive measures for sex offenders. For example, federal U.S. legislation requires states to implement registration and notification laws (i.e., The Sex Offender Registration and Notification Act [SORNA], which is part of the Adam Walsh Child Protection and Safety Act of 2006 [P.L. 109-248]) wherein released sex offenders have to register for a specified period of time (between 15 years to life) on publically available searchable Internet-based state registries. Although the information available varies from state to state, SORNA requires a minimum of a current photograph, home address, employment address, license, and detailed information pertaining to the crime (Adam Walsh Act, 2006). Residence restrictions statutes, which prevent sex offenders from residing and loitering in close proximity to areas where children congregate (e.g., schools, day cares, parks and school bus stops), have also been enacted by many jurisdictions across the U.S. (Levenson & Cotter, 2005b; Meloy, Miller, & Curtis, 2008). Although the definition of close proximity varies (500 to 2,500 feet), many of these laws have the effect of banishing registered sexual offenders to rural settings where there are few public services and distances between civil institutions are large. Among the most controversial of the laws targeting sex offenders are Sexually Violent Predator (SVP) statutes, currently enacted in 20 states and at the federal level. SVP statutes allow for the indefinite postsentence civil commitment of offenders deemed to be especially dangerous (Calkins, Jeglic, Beaty, Zeidman & Perillo, 2014).

Unlike the U.S., Canada has not adopted postsentence civil commitment or public sexual offender registries. Canadian sexual offenders, however, can be confined indefinitely through the Dangerous

Offender provision of Canada's Criminal Code (CCC §753). The Dangerous Offender provision is intended to incapacitate individuals whose current offense does not justify a life sentence but are deemed to be at high risk for serious personal injury offenses. In 2015, there were approximately 600 individuals under sentence in Canada as Dangerous Offenders (30 to 50 new cases per year), of which 71% were sexual offenders (Public Safety Canada, 2016). In contrast to the Dangerous Offender provisions that are applied at the time of sentencing, "810 orders" can be used to place sexual offenders deemed high risk at the end of their sentences on a new community supervision order without committing a new offense (CCC §810.1). Although 810 orders are administered by the police (not corrections), they can be used to create supervision conditions similar to probation, including residency restrictions, electronic monitoring, and mandatory psychological treatment.

In Canada, treatment for sexual offenders is primarily organized and paid for by the government (corrections or forensic mental health). The nature and quality of such treatment services varies considerably across the country, with the most well-developed programs found in the major urban centers and areas with greater correctional services. Whereas there is a reasonable likelihood that convicted sexual offenders in Canada will receive custody and community supervision, there is much less certainty that they will receive appropriate, sexual offense specific treatment.

Although punishment for sexual crimes is morally justified, punishment and surveillance are not the most effective ways to promote rehabilitation and reduced offending (Andrews & Bonta, 2010). Many policies for managing sexual offenders are designed for "stranger danger" offenses committed in public spaces, which in actuality are a small minority of all sexual crimes (Cohen & Jeglic, 2007). In contrast, most sexual offenses are committed by someone known to the victim (Colombino,

Mercado, Levenson, & Jeglic, 2011; Greenfield, 1997; Snyder, 2000) in residential settings like homes and apartments (Colombino et al., 2011). Further, 95% of offenses are committed by individuals who are *not* on a sex offender registry (Sandler, Freeman, & Socia, 2008). Research on the effectiveness of sex offender registries and residence restrictions have, at best, been mixed (Colorado Department of Public Safety, 2004; Freeman, 2012; Prescott & Rockoff, 2008; Sandler et al., 2008; Schram & Milloy, 1995; Socia, 2012; Tewksbury, Jennings, & Zgoba, 2012; Vasquez, Maddan, & Walker, 2008; Zevitz, 2006; Zgoba & Bachar, 2009). A number of studies have shown that these laws destabilize sex offenders (Jeglic, Mercado, & Levenson, 2012; Lasher & McGrath, 2012; Levenson & Cotter, 2005a, 2005b; Levenson & D'Amora, 2007; Mercado, Alvarez, & Levenson, 2008; Zevitz, 2006) and, as such, may inadvertently increase the risk of recidivism. In sum, there is little evidence that policies based on punishment and surveillance of known offenders are the most effective in reducing the public health burden of sexual victimization.

There are, however, other options. For psychologists, the obvious starting point is to provide interventions that help offenders identify and change beliefs, habits, and offense behavior patterns. As previously stated, many jurisdictions already require sexual offenders to receive treatment. Given the nature of their offenses, it is easy for lay people to attribute psychological problems to sexual offenders. Most individuals who commit sexual offenses do not, however, display deviant sexual interests. Indeed, the motivations for committing sex crimes are as varied as the offenses themselves. Therapeutic approaches that are evidence-based and that allow clinicians to focus on the precise factors that trigger offending offer much more promise for promoting successful rehabilitation than efforts to simply contain and monitor sex offenders.

Sex Offender Treatment

Currently, there is no single approach to treating sexual offenders. Furthermore, there are no interventions distinctly designed for sexual offenders that would currently meet the criteria for a well-established treatment (Dennis et al., 2012; Grønnerød, Grønnerød, & Grøndahl, 2015; Långström et al., 2013). Although sexual offenders who receive treatment tend to be less likely to reoffend than untreated sexual

offenders, and despite ethical and practical constraints on study designs with correctional populations, all reviewers bemoan the lack of solid studies upon which to base conclusions (Dennis et al.; Grønnerød et al., 2015; Långström et al.; Schmucker & Lösel, 2015). Consequently, many of the interventions commonly provided to sexual offenders are only indirectly informed by research evidence.

Most sexual offender treatment is delivered within correctional settings, and, to a lesser extent, private clinics and mental health centers. In forensic mental health settings, sexual offenders may be assigned DSM/ICD diagnoses (most often paraphilias and personality disorders), and then treated with a combination of counseling and sex-drive reducing medications. Although there are case studies suggesting that sex-drive reducing medications may be helpful in reducing recidivism, there are no well-controlled studies of medical interventions (Khan et al., 2015; Långström et al., 2013), and the use of these medications with sexual offenders remains strictly “off-label.”

Within corrections, interventions for sexual offenders typically take the form of structured group sessions, in which therapists motivate offenders to come to terms with their past transgressions (sexual and otherwise) and prepare themselves for productive lives as law-abiding citizens. On average, offenders who attend sexual offender group treatment programs are less likely to reoffend than offenders who are not offered treatment (Schmucker & Lösel, 2015). The overall effect is small, however, corresponding to sexual recidivism rate differences of 10.1% for the treatment groups compared to 13.7% for the comparisons groups (Schmucker & Lösel). Nevertheless, given the consequences of recidivism, even small reductions are important, if they are real. Unfortunately, the meta-analytic results are difficult to interpret because the treatment effects decrease as the rigor of the study designs increases (Beech, Freemantle, Power, & Fisher, 2015). The only replicable intervention for sexual offenders that has demonstrated positive treatment effects in strong research designs is Multisystemic Therapy (MST), a form of family-focused intervention designed for juvenile delinquents. Although MST has shown positive results with youth who have committed sexual offenses (Borduin, Schaeffer, & Heilblum, 2009; Letourneau et al., 2013), it cannot be used with the vast majority of sexual offenders, who are adults.

All is not lost, however. Sexual offenders are offenders, and the same interventions that work to decrease general offending in nonsexual offenders also work to reduce general and sexual offending with adult sexual offenders (Hanson et al., 2009). The most effective rehabilitation interventions are those that follow the Risk, Need, and Responsivity (RNR) principles developed by Andrews, Bonta, and Hoge (1990; Andrews & Bonta, 2010; see also Mitchell, Wormith, & Tafrate, 2016, this issue). Simply put, effective correctional interventions provide a dose of intervention proportional to offenders’ recidivism risk (Risk principle), address the life problems associated with rule violation (Need principle), use cognitive behavioral interventions, and deliver the program in a form and language congruent with the offenders’ culture and learning style (Responsivity principle). There is strong evidence that programs that follow the RNR principles result in meaningful reductions in recidivism (Andrews & Bonta, 2010; Dowden & Andrews, 1999, 2000; Gutierrez & Bourgon, 2012). It is important to remember, however, that the RNR principles are not a program per se. Instead, the RNR principles are intended to guide program development.

Although the RNR model is currently the dominant framework for offender rehabilitation in the U.S. and Canada, it has been criticized for its focus on offenders’ deficits (i.e., criminogenic needs). Consistent with the pendulum swing towards positive psychology, Ward and colleagues have proposed a model of correctional intervention that emphasizes offenders’ strengths and their capacity for self-determination—the Good Lives Model (Ward & Gannon, 2006; Ward & Stewart, 2003). This model interprets offending as ineffective, unskilled strategies for obtaining intrinsic goods, such as relatedness, creativity, physical health, and mastery (see Dumas & Ward, 2016, this issue). Even though many elements of the Good Lives Model are appealing, it has yet to establish research credentials. We are not aware of any studies of the Good Lives Model that examine sexual recidivism as the outcome. Even for intermediate goals, such as retention in treatment, the Good Lives Model has yet to show improvements over treatment as usual (Barnett, Manderville-Norden, & Rakestraw, 2014; Harkins, Flak, Beech, & Woodhams, 2012).

So why have the outcomes of sex offender treatment studies not been as promising as we have hoped? One possible

explanation concerns the quality of the interventions themselves. To date, the majority of sex offender treatment research has focused on the “what” of treatment—the Risk and Needs principles of the RNR model—with minimal consideration of the “how”—the Responsivity principle.

As with any psychological intervention, the success of sexual offender treatment largely depends upon its delivery. Very little is known, however, about those who deliver sex offender treatment. What we do know is that working with offending populations, and sex offenders in particular, can be difficult. Because the treatment is generally provided by correctional institutions or community mental health centers, and often paid for by the offenders themselves, there may be little financial or lifestyle incentives for experienced and skilled therapists to work in this area. Further, studies of sex offender service providers have found increased levels of stress, burnout, and vicarious traumatization as a consequence of working with this population (Farrenkopf, 1992; Kadambi & Truscott, 2004; Moulden & Firestone, 2007). Although some therapists find the work challenging and rewarding (Scheela, 2001), others describe the frustration of working in correctional settings where punishment and containment is valued over rehabilitation (Ellerby, 1998). This demoralization can impact the quality of treatment delivery and also results in high levels of therapist turnover. Consequently, there are many therapists in the sex offender field who have inadequate training and supervision. In the U.S., there has been a movement to require sex offender treatment provider certification to ensure minimal qualifications, but many of these qualifications are vague and often only require minimal background training and license-eligible degrees. Currently, few front-line service providers in Canada and the U.S. hold doctoral degrees, and in some cases treatment is being delivered by those with only a corrections background—parole and probation officers—whose orientation may be more punitive than therapeutic. Many sex offender treatment providers only have high school or bachelor’s degrees, and only minimal, on-the-job training in the techniques and foundations of behavior change. Although one study found that clinicians working with sex offenders were familiar with evidence-based practices, the study also found that the delivery of the techniques was flawed (Moon & Shivry, 2008).

There has been some effort in the sex offender treatment field to standardize interventions by developing treatment manuals. However, many of these manuals are not based upon current research, and in some cases they are rigidly scripted. Although manualization promotes treatment adherence and replicability (Wilson, 2007), manuals are not a panacea to address issues such as staff burnout, turnover, and therapists with little background and training in basic principles of behavior change. One of the main criticisms of manualized interventions for sex offender therapy has been the one-size-fits-all mentality. Sex offenders are not, however, a homogeneous group. Research suggests that there are differences in treatment needs based on characteristics of the offender and offense (Robertiello & Terry, 2007). Evidence from the RNR model suggests that, in order for treatment to be effective, each offender requires a proper assessment so that the intervention can be tailored to the person's unique criminogenic needs. A well-trained therapist could accomplish this by using a case-formulation-based approach, wherein they would develop an understanding of the offenders' learning history, factors that precipitated the offense, and the contingencies maintaining the offending behavior. A case conceptualization would then be formed and the treatment plan would be developed based on this conceptualization. This formulation-based approach is not mutually exclusive from a manualized treatment approach—and a skilled clinician would be capable of addressing individual treatment needs using evidence-based practice while the client still benefits from the group therapy environment (Ward, Nathan, Drake, Lee, & Pathé, 2000). However, without adequate training, support, and supervision, it is unlikely that many clinicians could successfully navigate this approach.

Although responsivity can have many facets, one area in the sex offender field that is garnering increasing attention is the therapeutic alliance, or the relationship between the therapist and the client (Serran & Marshall, 2010). The importance of the alliance process has been well documented in the general therapy literature (see Fluckiger, Del Re, Wampold, Symonds, & Horvath, 2012). In contrast, Serran and Marshall note a relative void in research examining process issues in sex offender treatment. Marshall and his colleagues reviewed factors related to the therapeutic alliance in sex offender treatment and concluded that many of the same therapist

characteristics and behaviors needed for change in general psychotherapy were also needed when working with sex offenders, including warmth, genuineness, respect, and humor (Fernandez, Marshall, Lightbody, & O'Sullivan, 1999; Marshall et al., 2002; Marshall et al., 2003; Marshall, 2005). There are also, however, challenges to the formation of the alliance that are unique to working with sex offenders, including mandated treatment (or the perception that treatment is mandated), therapists' reactions to the sex offenders and their crimes (e.g., countertransference), limitations of disclosure, denial and minimization of crimes, the focus on obtaining admission of crimes using polygraph testing, and inequitable power distribution between the therapist and the client (see Jeglic, 2015, for review). Although these issues may present challenges to the therapeutic relationship, the most recent research suggests that formation of a functional therapeutic alliance is possible even with high-risk sex offenders and those with psychopathic features (Blasko & Jeglic, 2014; Walton, Jeglic & Blasko, 2016).

The Role of CBT in Sex Offender Treatment

There have been strong historical links between behavior therapy and the treatment of sexual offenders. Most of the pioneers who developed the sexual offender interventions now widely used (William Marshall, Gene Abel, Richard Laws) began their professional careers as behaviorists, with strong belief in the power of conditioning and an affinity for gadgets. The early forms of sexual offending treatment focused almost exclusively on sexual deviancy, as measured by phalometric assessment (direct monitoring of penile responses when the client is exposed to diverse erotic stimuli). Behaviorism in the 1960s asserted that everything important was learned, so why can't sexual deviants relearn normal sexual interests? Thus began several decades of innovation in behavioral techniques intended to control unwanted sexual attractions, such as satiation, guided masturbation, aversion therapy, and covert sensitization (for a history see Laws & Marshall, 2003; Marshall & Laws, 2003). Although these techniques provided short-term control over sexual impulses, there was little to support their long-term efficacy. Gradually, therapists came to appreciate that sexual offending is influenced by diverse psychological factors (Mann, Hanson & Thornton, 2010), and

most individuals convicted of sexual offenses do not display deviant sexual interests. In the 1980s, as the broader field of behavioral treatment became increasingly cognitive, the leading organization for advancement of professional standards and practices in sex offender evaluation and treatment in the U.S., the Association for the Behavioral Treatment of Sexual Abusers (ABTSA), dropped the "Behavioral" from its name to become simply the Association for the Treatment of Sexual Abusers (ATSA; <http://www.atsa.com/>).

The interest in cognitive-behavioral treatment, however, has remained strong, both for sexual offenders and general offenders. This is largely due to the research on the RNR model where programs utilizing cognitive behavior therapy (CBT) techniques have increased success at targeting criminogenic needs (Andrews et al., 1990). Although current paradigms of sex offender treatment rely heavily on the principles of CBT in general, there are some specific criminogenic needs that are particularly well suited to CBT strategies.

A recent meta-analysis of 46 studies found that attitudes that support offending behavior were significant predictors of recidivism among sex offenders (Helmus, Hanson, Babchishin & Mann, 2013). For child molesters these may include thoughts that children can be sexually provocative and that sex with children does not harm them. Among rapists, attitudes supportive of offending behavior are often referred to as "rape myths" and include beliefs such as women who dress a certain way are asking to be raped and that women who are raped deserve it. Cognitive therapy techniques can be used to identify, challenge, and change these thinking styles, attitudes, and cognitive distortions. For instance, thoughts and beliefs supportive of offending behavior can be identified in a group setting using more general examples or the offenders' own beliefs. The therapist then works with the group to uncover the distortion, label it, and challenge it. The group can then come up with more reasoned and rational responding. Similar to traditional cognitive therapy, the goals of such exercises would be for the offenders to practice and become adept at individually identifying and challenging their own thoughts and beliefs that are supportive of offending behavior to reduce their risk of future offending (Moster, Wnuk, & Jeglic, 2008).

Problem-solving skills deficits have also been linked to sexual reoffending (Mann et al., 2010). For example, Nezu and colleagues (2005) found that child molesters

had significantly more problem-solving skill deficits compared to the general population across a number of domains, including having a negative problem-solving orientation (i.e., feeling helpless and hopeless about one's ability to solve problems, using avoidant and impulsive problem-solving strategies), and utilizing a less systematic approach to facing life's challenges. All of these deficits can be targeted using CBT approaches to develop skills in problem identification, brainstorming, weighing pros and cons to assess costs and benefits of options, and the development of actions plans. The group modality can be particularly helpful in aiding the sex offenders in identifying problem-solving deficits and developing solutions. Therapists can provide guidance using techniques such as psychoeducation, group-based problem-solving exercises, and homework assignments (see Nezu, D'Zurilla, & Nezu, 2005).

A more recent focus of sex offender treatment has been on self-regulation. Self-regulation has been broadly defined as the ability to manage sexual and emotional states. Although further research is necessary, there is evidence that the inability to regulate emotions, such as anger, or deviant sexual arousal is linked to recidivism among sex offenders (Reid, Beaugard, Fedina, & Frith, 2014). Dialectical Behavior Therapy (DBT; see Sheppard & Chapman, 2016, this issue) may be particularly well suited to address these deficiencies, as three of its core modules (mindfulness, distress tolerance, emotion regulation) all deal with self-regulation. Although still to be rigorously tested, some authors (see Shingler, 2004) have postulated that the sex offender field could benefit from DBT strategies, and that mindfulness techniques in particular could be used to help manage deviant arousal (Singh et al., 2011) and treat disturbed emotion regulation (Gillespie, Mitchell, Fisher, & Beech, 2012).

Conclusions

There is still much room for growth in the research and practice of sex offender treatment. Although we remain optimistic that treatments can be developed that reduce recidivism among convicted offenders, we are far from having established, evidence-based practice standards. One promising area for development is the quality of treatment delivery. Although challenging, sex offender treatment can also be tremendously rewarding, as the ultimate goal of successful intervention is

keeping our communities safe. The sex offender field is fertile ground for well-trained CBT practitioners who want to use their advanced skills and case formulation approaches to make a difference. Sexual offender treatment has traditionally lacked well-trained service providers, and we believe that skilled CBT practitioners have an important role to play in the future of the field.

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POSTDOCTORAL FELLOWSHIP IN THE IMPLEMENTATION OF COGNITIVE THERAPY IN COMMUNITY BEHAVIORAL HEALTH. The Aaron T. Beck Psychopathology Research Center of the University of Pennsylvania is seeking applicants with previous training in Cognitive Therapy (CT) or Cognitive Behavioral Therapy (CBT) and knowledge of implementation science to join the Beck Community Initiative, under the direction of Torrey A. Creed, Ph.D. Since 2007, the Beck Community Initiative has served as a model for the successful implementation of CT in community behavioral health settings, increasing access to evidence-based treatment for economically, culturally, and ethnically diverse urban populations. The emphasis of the fellowship will be the implementation of CT in services for individuals seeking recovery from substance abuse, but responsibilities may also include working with providers across a wide range of treatment settings to support adults or children in their recovery from anxiety, depression, anger, recent incarceration, homelessness, and other common behavioral health issues. Primary responsibilities will involve the systematic use of implementation strategies to integrate CT into current practice settings, including engagement of agency staff, delivery of workshops, group supervision, integration of CT into the treatment milieu, and ongoing support for sustained practice of CT. Participation in research, program evaluation, grant writing, IRB activities, planning and execution of specialized training, and other academic and administrative endeavors are also part of the experience. Applications from post-doctoral level or license-eligible individuals are sought for this position.

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Please send a CV, a statement of interest, and two letters of recommendation to Torrey Creed, Ph.D. at tcreed@mail.med.upenn.edu.

History, Comparative Outcomes, and Future Directions for Intimate Partner Violence Intervention Programs

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INTIMATE PARTNER VIOLENCE (IPV) has been broadly defined as physical, sexual, or psychological harm engaged in by a current or former romantic partner (Fanslow, McMahon, & Shelley, 2002). Although it has amassed many years of study, IPV remains a pervasive societal problem with a substantial public health and economic impact. Indeed, it has been estimated that across a lifetime, 35.6% of women and 28.5% of men will have been the victim of physical violence, sexual violence, and/or stalking-related behavior by an intimate partner (Black et al., 2011). The estimated economic impact of more than \$8 billion annually in the U.S. alone reflects the direct and indirect monetary costs of IPV (Max, Rice, Finkelstein, Bardwell, & Leadbetter, 2004; National Center for Injury Prevention & Control, 2003). In addition, public health concerns are prevalent for both genders, with IPV victimization placing both men and women at significant increased risk for mental health symptoms (Hines & Malley-Morrison, 2001; Lawrence, Orengo-Aguayo, Langer, & Brock, 2012), and male-to-female IPV resulting in the most pervasive negative physical health consequences (Archer, 2000; Holtzworth-Munroe, Bates, Smutzler, & Sandin, 1997).

Given the significant personal and economic impact of IPV, the intent of this article is to present an overview of the history and comparative outcome data for intervention programs for perpetrators of IPV. We hope this review will serve as a call for critical dialogue and a new wave of research. A focus on IPV risk factors is proposed as a promising future direction.

History of IPV Interventions

Given the noted prevalence and impact of IPV, it is not surprising that the last decade witnessed a significant increase in arrests for domestic violence (Hirschel,

2009). This increased volume of arrests directly led to a variety of diversionary programs that served as an alternative to incarceration. For instance, women's advocates, in collaboration with legislatures and justice system representatives, worked to develop the first diversionary programs for batterers (Barner & Carney, 2011; Gondolf, 2010); early examples of such programs are EMERGE in Boston, AMEND in Denver, and RAVEN in St. Louis (Rothman, Butchart, & Cerda, 2003). These programs focused primarily on improving victim safety and holding offenders accountable for their actions. Such programs were grounded in a feminist analysis of IPV, and the feminist framework foundational to these programs (developed ostensibly by Pence and Paymar in 1993 in Duluth, Minnesota) took on the moniker of the *Duluth Model*. Duluth Model-based interventions maintain the feminist framework that domestic violence is a criminal act perpetrated by males onto female intimate partners.

Over time, a number of states formally enacted legislation designating the Duluth Model curriculum as the required and exclusive batterers' program for court-mandated individuals (Barner & Carney, 2011; Gondolf, 2010). Presently, even in those increasingly rare situations in which there is no legislative requirement, sociopolitical factors have fueled the criminal justice system's continued adoption of Duluth Model programs, and thus, it has evolved to become the most prominent model for batterers across the U.S. (Barner & Carney, 2011; Corvo, Dutton, & Chen, 2008; Gondolf, 2010; Smedslund, Dalsbo, Steiro, Winsvold, & Clench-Aas, 2007).

The Duluth Model is based upon societal-level constructs, such as viewing IPV as broadly reflective of male attitudes and beliefs toward women, and these constructs are then applied at the level of the

individual, in the form of batterers' intervention programs. Since the sociological constructs of male privilege and related patriarchal attitudes and beliefs are seen as the underlying mechanism by which IPV emerges, the resulting interventions for male perpetrators of IPV focus on attitudes and beliefs toward, and about, their female intimate partners. Typically, psychoeducational in nature, Duluth Model-based interventions thus seek to present, in generally didactic formats, the view that male abusive behavior is the direct result of culturally reinforced gender-based socialization (Pence & Paymar, 1993; Yllo, 2005).

Although interventions based on the Duluth Model are currently the dominant approach to IPV offender treatment, an often-cited concern that arises when one seeks to understand IPV from a Duluth Model perspective is that empirical findings indicate men and women actually engage in IPV at near-equal rates (Archer, 2000; Ehrensaft, Moffitt, & Caspi, 2004). Therefore, investigators have long argued that the foundational Duluth Model constructs do not sufficiently attend to female-to-male IPV (Dutton & Corvo, 2006; Dutton & Nicholls, 2005; Felson, 2002; Straus, 2009). Further, it has been suggested that the Duluth Model's exclusive focus on patriarchal beliefs: (a) continues despite limited empirical support (Dixon & Graham-Kevan, 2011; Dutton & Nicholls; Sugarman & Frankel, 1996), (b) fails to adequately consider and address a range of psychological issues and risk factors (e.g., exposure to abuse, problematic anger, emotional control, and other related variables) found in perpetrators of IPV, and (c) is a major obstacle to the development of more effective batterers' interventions (Dutton & Corvo, 2007).

Alternative IPV treatments to the Duluth Model have been introduced. When not limited by state regulations, interventions based on the principles and methods of cognitive behavioral therapy (CBT) are gaining increasing acceptance. The CBT model most broadly "considers IPV as a learned behavior and focuses on the therapeutic modification of faulty cognitions and intense emotions and in teaching communication skills and emotion control techniques to prevent future violent behavior" (Eckhardt, 2007, p. 371). This model takes intervention beyond beliefs related to patriarchal attitudes and socialization to include additional risk factors that have been shown to be associated with IPV in sound empirical research. Such factors include cognitive distortions and

early maladaptive cognitive schemas, psychological consequences of trauma and childhood maltreatment, emotion dysregulation, and deficits in interpersonal skills (e.g., Dutton, 1986; Feazell, Mayers, & Deschner, 1984; Sonkin, Martin, & Walker, 1985; Smyth, Gardner, Marks, & Moore, in press). These CBT approaches view behavior change as occurring within the context of a collaborative therapeutic relationship that includes active treatment components such as the alteration of distorted cognitions, exposure, enhanced problem solving, and relationship skills training. Over the past two decades, a variety of promising CBT programs for IPV have emerged (Hamberger, 1997; Murphy & Eckhardt, 2005; Stosny, 1995; Wexler, 2006).

It is important to note that despite some clear differences in underlying treatment targets and methods, both Duluth Model interventions and more traditional CBT programs for IPV are often labeled as “cognitive behavioral,” and some scholars suggest that they both pursue the ultimate goal of violence reduction via modification of cognitive processes (Smedslund et al., 2007). Although some authors state their view unequivocally that Duluth psychoeducational models are philosophically incompatible with CBT (Dutton & Corvo, 2007), the differences can most often be seen in the content of the “cognitions” to be modified (i.e., patriarchal attitudes vs. beliefs related to abandonment, trust, emotions). Further adding to the conceptual confusion, it is not uncommon for IPV interventions to reflect a hybrid integration of feminist and cognitive-behavioral models, and researchers have increasingly noted the difficulty in distinguishing between the two models as distinct entities (Babcock, Green, & Robie, 2004; Eckhardt et al., 2013).

Murphy and Ting (2010) have suggested that the methods used to enact change more clearly differentiate these two models. Along this line, while Duluth Model interventions are didactic, educationally oriented, and focus consistently on patriarchal attitudes and behaviors, CBT model interventions are more psychopathological process oriented, with a potential focus on a wider array of psychological issues (emotional distress, trauma, substance abuse, etc.) that are theoretically relevant and empirically related to IPV. These distinctions reflect a philosophical difference. From a Duluth Model perspective, the therapeutic-based CBT framework pathologizes batterer behavior, and supposedly shifts accountability for abusive

behavior away from the offender’s choice to act violently, promoting instead the notion that abuse stems from immutable internal mental disorders and personality traits. Duluth Model proponents (e.g., Pence & Paymar, 1993) suggest that while batterers may in fact require additional/secondary treatment, the batterers’ intervention itself needs to remain primarily focused on gender egalitarianism (in all its manifestations) and on personal responsibility.

This perspective has consequences for real-world IPV treatment programs. For example, despite evidence supporting the bi-directionality between general relationship dysfunction and IPV (Murphy & O’Farrell, 1997)—and similar strong evidence linking anger and IPV (Birkley & Eckhardt, 2015; Norlander & Eckhart, 2005) and emotion dysregulation and IPV (Gardner & Moore, 2008, 2014a, 2014b; Shorey, McNulty, Moore, & Stuart 2015)—interventions that focus on these specific variables are either discouraged or overtly forbidden in states with Duluth Model-based “Batterer Intervention Program” guidelines (Dutton & Nichols, 2005). This arbitrary restrictiveness is particularly problematic, as sociopolitical/legislative requirements have limited the intervention curriculums for batterers, resulting in a paucity of alternative approaches in real-world settings that might have better impact (Dutton & Nichols).

With this in mind, two scientifically responsible questions then arise: What do the data tell us about intervention efficacy of existing programs for IPV? And, is there room to consider alternative interventions?

Efficacy of IPV Interventions

While a comprehensive review of the literature is beyond the scope of this article, we briefly discuss the state-of-the-science with regard to IPV intervention efficacy. Over the last 15 or so years, a number of systematic reviews of the empirical research have consistently found, at best, small effect sizes for psychological interventions for IPV (Babcock et al., 2004; Carter, 2010; Corvo et al., 2008; Eckhardt, Murphy, Black, & Suhr, 2006; Feder, Wilson, & Austin, 2008; Levesque, Velicer, Castle, & Greene, 2008). This lack of compelling outcomes has led a number of investigators to suggest that, for IPV intervention, “institutionalizing a ‘one size fits all’ model” (Buttelle & Carney, 2004, p. 100) is not consistent with empirical findings. Similarly, other investigators have sug-

gested that “no single treatment approach for domestic violence has robust empirical support” (Stith, Smith, Penn, Ward, & Tritt, 2004, p. 306), and that little evidence exists that violence is reduced by the most common IPV interventions (Corvo et al., 2008). Following directly from such reviews, Gondolf (2009) noted that intervention programs for IPV face substantial challenges, given that empirical evidence indicates little effect compared to placement on probation only. This is consistent with the conclusions of Babcock and colleagues (2004), who stated: “Given what we now know about the overall small effect size of batterers’ treatment, the energies of treatment providers, advocates, and researchers alike may be best directed at ways to improve batterers’ treatment” (p. 1048).

Despite these rather pessimistic conclusions about the treatment outcome data, two recent reviews of the literature present a somewhat more nuanced, and possibly more hopeful, picture. In the first review (Arias, Arce, & Vilarino, 2013), investigators also found that overall, the treatment of IPV perpetrators is generally not efficacious. However, this average finding was qualified by the fact that some studies showed positive effect sizes (larger than ≥ 0.20), whereas others found negative effects. When looking at potential moderators that might account for these different results, only the *type of intervention* (i.e., psychotherapeutically oriented CBT interventions focused on the treatment of psychopathology) and the *duration of intervention* (i.e., long-term) were significant. Arias and colleagues (2013) concluded that inconsistent results suggest that some batterers are helped from treatment while others are not, with no clear empirical way of predicting outcomes for any specific individual. In turn, this further suggests the clear need for future studies to carefully consider moderators that impact treatment outcome.

In the second recent review of the intervention literature, Eckhardt and colleagues (2013) also found that, in the majority of studies using randomized designs (and in contrast to those with methodologically weaker quasi-experimental designs), both traditional gender-themed and CBT batterer intervention programs do not demonstrate differential effectiveness relative to a no-treatment control group. Similar to the findings of the Arias et al. (2013) study, Eckhardt et al. (2013) emphasized that their conclusions reflect group-level effects, and that there will be some individ-

ual successes and some failures within the context of nonsignificant group results.

While we cannot at this time identify who is likely to respond or not respond to which intervention, it is important to note the overall conclusion regarding the current effectiveness of batterer intervention programs. It appears that the probability an IPV perpetrator receiving a traditional intervention program will not engage in future IPV is about the same as an individual not assigned to such a program. These conclusions have led many in the field to question whether intervention programs for IPV waste valuable resources and create a false sense of security among victims who expect the abusive partner to change as a result of attending such a program (Jackson et al., 2003).

Future Directions:

Focus on Relevant IPV Risk Factors

Given the pessimistic conclusions regarding traditional IPV treatment effectiveness, the question must be asked if the bulk of current IPV treatment programs have been built upon flawed conceptual foundations. In a recent comprehensive review that included the questions of male patriarchy and power/control as a primary motive for IPV, Langhinrichsen-Rohling, McCullars, and Misra (2012) concluded that: (a) there is minimal if any difference between men and women perpetrating violence as a vehicle for power and control, (b) there were few if any gender differences in the perpetration of IPV, and (c) for both men and women, self-defense, retaliation for emotional pain, anger, and jealousy were the most common motives for IPV. While perhaps an unpopular conclusion among Duluth Model supporters, empirical findings do not currently support patriarchal attitudes (which would predict a vastly higher level of male to female perpetration than the literature suggests) and/or power and control as central risk factors for the perpetration of IPV. As such, while the sociopolitical zeitgeist may make this proposition challenging, the time is clearly ripe to develop, evaluate, and disseminate alternative intervention programs. One promising new direction is to incorporate what we know about criminal recidivism risk into future alternative IPV treatment programs (for a discussion of criminal risk-reduction models, see Mitchell, Wormith, & Tafra, 2016, this issue). In the remaining sections of this article, we discuss several examples of emerging treatment

models based on evidence regarding various IPV risk factors.

Instigating, Impelling, and (Dis)Inhibiting Factors

IPV scholars have identified a wealth of risk factors for IPV perpetration, as evidenced by numerous meta-analyses and qualitative reviews of this literature (e.g., Schumacher, Feldbau-Kohn, Slep, & Heyman, 2001; Stith, Rosen, McCollum, & Thomsen, 2004). However, little progress has been made in integrating and demonstrating possible functional interconnections among these risk factors or methods to alter them that would prove useful to practitioners. The I³ Model of IPV is a recently developed meta-theory for systematically integrating our understanding of risk factors related to IPV etiology to better guide research on IPV risk reduction (Finkel, 2007; Finkel & Eckhardt, 2013). The I³ Model is an integrative approach that is centered on a simple yet clinically important core assumption—the probability of IPV perpetration increases when environmental triggers and aggressive urges overcome an individual's ability to counteract these urges. The model gets its name from the first letters of the three process categories in which IPV risk factors are classified: Instigation, Impellance, and Inhibition.

Instigating factors are situational influences that normatively produce an urge to behave aggressively (e.g., verbal or physical provocation by a romantic partner; Finkel, DeWall, Slotter, Oaten, & Foshee, 2009). *Impelling* factors are those that, on their own, do not cause aggression, but when coupled with a strong source of instigation, amplify the urge to behave aggressively (e.g., high trait anger; positive attitudes toward aggression). *Inhibiting* factors, on the other hand, are those that mitigate aggressive urges and reduce the likelihood that someone will behave aggressively (e.g., using effective emotion regulation techniques such as reappraisal). However, situational factors may act against an individual's inhibitory faculties; these disinhibiting factors decrease the likelihood that someone will successfully resist an urge to behave aggressively (e.g., alcohol intoxication).

The main IPV conceptual model drawn from the I³ Model is known as *perfect storm theory* (Finkel, 2014; Finkel & Eckhardt, 2013), which posits that the greatest likelihood for IPV occurs when instigation and impellance processes are strong and inhibitory processes are weak. Several prior

investigations have found empirical support for this three-way “perfect storm” interaction across diverse samples, measurement and assessment techniques, and aggression paradigms (for a review, see Finkel, 2014).

The advantage to using I³ Theory in clinical decision-making rests on its interactional framework. The model suggests that practitioners could predict, with greater accuracy, whether a given interaction between intimate partners will be violent versus nonviolent if they can discern the strength of instigation, impellance, and inhibition. In other words, knowledge of these three processes, and of the interplay among them, may be both *necessary and sufficient* for predicting IPV perpetration and, therefore, of designing interventions for IPV perpetrators. Eckhardt, Crane, and Sprunger (2014) outlined a CBT-focused approach for the assessment and treatment of IPV perpetrators based on the I³ Model that capitalizes on each process dimension: reduction of provoking situations via psychoeducation and stimulus control techniques (*instigation*); use of empirically supported treatments to reduce problematic anger and other intense emotions as well as accompanying cognitive distortions (*impellers*); and development and training of self-regulatory skills as well as modification of problematic substance use (*inhibition/disinhibition*).

Experiential Avoidance and Emotion Regulation Deficits

Based on research demonstrating a relationship between experiential avoidance, deficits in emotion regulation, and IPV (Gardner & Moore, 2008, 2014a; Liu & Roloff, 2015; Moore, in press; Smythe et al., in press), mindfulness- and acceptance-based behavioral therapies have recently been presented as another alternative IPV intervention model. In particular, early research has supported the efficacy of *contextual anger regulation therapy* (CART), a mindfulness- and acceptance-based intervention based on the Anger Avoidance Model (Gardner & Moore). The Anger Avoidance Model posits that the significant relationship between the early aversive histories and IPV perpetration is mediated by deficits in emotion regulation, particularly in the presence of even a moderate degree of anger. As such, violent behavior is seen as an interpersonal behavior with the function of avoiding or escaping from difficult emotions, in particular anger, but including jealousy, rejection, and hurt. Importantly, anger avoidance may actually offer

an area of rapprochement between proponents of the Duluth Model (Gondolf, 2007) and those who argue for a broader psychological approach to IPV (Dutton & Corvo, 2007).

The Duluth Model suggests that anger control will not stop IPV if the batterer's intent is to control or dominate one's partner (Pence & Paymar, 2003), and as noted earlier, in fact provides an "excuse" for such behavior. In addition, the Duluth Model further suggests that IPV reflects instrumental behavior, with a fundamental goal of dominance and control (emanating from patriarchal attitudes). The Anger Avoidance Model suggests the possibility that, while IPV may have the topographical features of control or dominance, the actual *function* of IPV may very well be a type of situation-modification emotion regulation strategy (Gross, 2002). That is, the offender may in fact be attempting to change the stimulus functions of his or her partner by direct efforts to dominate/control, but in the service of his or her own emotion regulation needs, and not necessarily based upon patriarchal beliefs. Thus, the control/dominance interpretation of perpetrators behavior noted by Duluth Model proponents may be seen as being accurate descriptions of behavior, but quite possibly with a different underlying explanatory function (Gardner, Moore, & Dettore, 2014). Following directly from the Anger Avoidance Model, CART seeks to develop client capacity to fully *experience* and *tolerate* yet not *act upon* (by attempting to avoid or escape via aggressive behavior) intense feeling states, such as anger. Clients are taught to engage in behaviors more likely to help achieve long-term desired outcomes in relationships, even when experiencing anger or other intense emotions. CART has demonstrated positive preliminary findings with clients who have engaged in IPV (Gardner & Moore, 2014a; Gardner, Moore, & Pess, 2012).

Substance Use

The robust association between substance use and IPV perpetration is largely absent from many IPV interventions and court-mandated programs. Studies of violent couples indicate that when one partner has been drinking, IPV episodes are more frequent, severe, and more likely to lead to mutual violence (Murphy, Winters, O'Farrell, Fals-Stewart, & Murphy, 2005; Testa, Quigley, & Leonard, 2003; Testa et al., 2012). Laboratory studies demonstrate that alcohol intoxication increases negative interaction behaviors among violent cou-

ples (Leonard & Roberts, 1998) and aggressive verbalizations during simulated relationship conflicts, especially among violent men prone to anger (Eckhardt, 2007). This cross-method convergence of findings has led to the conclusion that alcohol use is a contributing cause of IPV (Leonard, 2005). Given the well-established link between alcohol and IPV, it seems reasonable to presume that effectively addressing this risk factor (alcohol or drug use) in the context of IPV would result in a concomitant reduction in aggressive behavior.

Relationship Dysfunction

In one of the few studies to examine IPV perpetration among women seeking treatment for substance use disorders, Schumm, O'Farrell, Murphy, and Fals-Stewart (2009) examined IPV among women with alcohol use disorder who participated in *behavioral couples therapy* (BCT). IPV was shown to be significantly reduced among women and their romantic partners at 1- and 2-year follow-up from BCT as compared to the year prior to BCT. Notably, these reductions in IPV were not observed for women who relapsed with regard to alcohol abuse. While BCT was not developed as an IPV intervention, it is important to further evaluate the efficacy of dyadic interventions in the treatment of IPV among those who do not report or seek treatment specifically for severe IPV. In terms of potential mechanisms, cognitive behavioral approaches to IPV treatment within the dyad allow for the conjoint practice of cognitive restructuring and adaptive emotion regulation and anger management strategies (e.g., time-out, distraction; Babcock, Jacobson, Gottman, & Yerington, 2000; Stith et al., 2004), and identification within the couple of specific risk processes associated with past aggressive interactions (e.g., types of provocations, substance use).

Treatment Dropout

In a meta-analysis of attrition for forensic programs not specifically focused on IPV, Olver, Stockdale, and Wormith (2011) found that program noncompleters had a 23% higher risk of recidivism than program completers. Other researchers examining outcomes of forensic programs in both institutional and community settings have reported similar findings, and have expressed concern that noncompleters pose a significant public safety risk (Beyko & Wong, 2005; McMurran & Theodosi, 2007; Nunes & Cortoni, 2006). Regarding IPV, the majority of men man-

dated to attend intervention programs do not complete them (Daly & Pelowski, 2000), which raises similar concerns about dropout impacts on IPV treatment outcomes.

Due in part to treatment resistance observed among IPV offenders, particularly in response to confrontational models of intervention, the use of motivational interviewing (MI; Miller & Rollnick, 2013) techniques is gaining momentum in batterer interventions, and these techniques are linked to reduced recidivism (Stuart, Temple, & Moore, 2007). MI assumes that most individuals who engage in maladaptive behaviors are aware of associated disadvantages but feel a degree of *ambivalence* regarding the discontinuation of their behavior. In the context of IPV, ambivalence to change is often observed in the earlier stages of the change process and may result from the conflicting motivation to discontinue violent behavior while continuing to justify aggressive behaviors or remaining uncertain about one's ability to remain nonviolent (Murphy & Eckhardt, 2005). The confrontational style of traditional (e.g., Duluth-oriented) interventions may provoke the client to justify and defend their aggressive behaviors, which stands in stark contrast to the spirit of MI that emphasizes therapeutic collaboration and client autonomy (Miller & Rollnick, 2013). Nevertheless, an emerging literature suggests a connection between the integration of MI techniques into existing IPV interventions and improved treatment outcomes. (For broader discussion of the integration of MI with forensic models, see Owens and Tafrate, this issue.)

Several studies have evaluated the effects of a brief motivational enhancement treatment (BME), a rapid form of MI delivered over a short period of time, on the behavior of IPV perpetrators. IPV perpetrators randomly assigned to stages-of-change intervention had lower physical IPV rates than those assigned to a traditional Duluth Model intervention (Alexander, Morris, Tracy, & Frye, 2010). Other researchers have reported that partner-abusive clients randomly assigned to a two-session BME intervention reported greater readiness to change, decreased attributions of blame for abuse, increased group participation, greater outside help-seeking behavior, and decreased violent recidivism over control procedures (Kistenmacher & Weiss, 2008; Musser, Semiati, Taft, & Murphy, 2008; Woodin & O'Leary, 2010). Crane and Eckhardt (2013) reported increased treatment compliance and ses-

sion attendance among partner-abusive men randomly assigned to receive a *single-session* pre-intervention BME session. Such techniques may aid in establishing therapeutic rapport and enhancing the client's expectation of benefiting from an intervention program, especially among clients with characteristics that may interfere with the change process, including dysfunctional anger and frequent binge drinking (Birkley & Eckhardt, 2015; Crane, Eckhardt, & Schlauch, 2015; Shorey, Brasfield, Febres, & Stuart, 2010).

Final Thoughts

As a society, we need to place increased investment in further development and evaluation of treatments for IPV offenders. While the Duluth Model was a useful starting point in the development of empirically supported interventions for IPV perpetrators, recent evidence suggests that alternatives to this approach are desperately needed. Indeed, the sociopolitically based standards stemming from a Duluth approach that have been adopted by many states function to impede progress in improving IPV interventions by placing restrictions on type of treatment delivered without reference to the empirical literature (e.g., prohibiting couples therapy, anger management, affect regulation, or substance abuse treatment). These ideologically driven restrictions interfere with the ability of clinical researchers to develop, or courts to recommend, interventions based upon the demonstrably most relevant risk factors for IPV perpetrators. These restrictions are a disservice to those who might benefit from alternative, evidence-based options to reduce aggressive behavior. Empirical evidence clearly demonstrates the complex and multifaceted nature of IPV perpetration. It is time that as a society, we rely on sound empirical evidence to reform clinical practice mandates, and consider the full range of treatment options that may decrease IPV recidivism and further promote victim safety and wellbeing.

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The Good Lives Model of Offender Rehabilitation

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THE QUESTION OF HOW BEST to address criminality and the offender-client has existed for decades and resulted in the production of numerous explanatory and rehabilitation theories (e.g. Eysenck, 1964; Gottfredson & Hirschi, 1990; Maruna, 2001). More recently, the answer to this question has shifted from a penal emphasis to a focus on risk-management and dynamic criminal risk factors or criminogenic needs (Andrews & Bonta, 2010; Gendreau, 1996; also see Mitchell, Wormith, & Tafrate, 2016, this issue). However, despite empirical support for *risk-management-based* rehabilitation models, such as the Risk-Need-Responsivity model (RNR; Andrews & Bonta, 2010), their comparative neglect of desistance variables (those leading to cessation of criminal behavior; e.g., offender's personal agency, developing an alternate noncriminal identity) and therapeutic process factors (e.g., focusing on the client's values, fostering intrinsic motivation, recognizing the greater context of the client's difficulties) is a significant limitation. In response to these concerns, *strength-based* rehabilitation approaches, such as the Good Lives Model (GLM; Laws & Ward, 2011; Ward, 2002; Ward & Maruna, 2007), have been developed. In essence, strength-based models seek to identify individuals' personal priorities and core commitments, and to formulate intervention plans that help them to achieve these goals while also reducing their risk for further offending.

The GLM provides a comprehensive theoretical basis for the implementation of interventions in forensic and clinical settings. Since this theory was originally developed as a rehabilitation model for a sex-offender population, the majority of the literature focuses on the efficacy of this approach with sex offenders (e.g., Ward, 2002; Ward & Gannon, 2006). However, the model is broad in orientation and its basic principles and strategies easily translate to treatment for other, nonsexual offending populations (Whitehead, Ward, & Collie, 2007). Similar to third-wave CBT treatments such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl,

& Wilson, 1999), the GLM principles use values clarification as an important step in assisting offenders with determining what they believe is a meaningful life. Principles from Motivational Interviewing (Miller & Rollnick, 2013), which are known to enhance the therapeutic alliance and increase motivation (Tafrate & Luther, 2014), also integrate well into the GLM (see Owens & Tafrate, 2016, this issue). Practitioners focus on revealing and capitalizing on the offender's values and life priorities and, further, helping the individual to find prosocial ways in which to achieve desired outcomes. In fact, an advantage of the GLM is that, because individuals are working towards the attainment of more fulfilling and prosocial lives, motivation for therapeutic engagement is intrinsic to the model—something lacking in risk-management intervention frameworks.

Practitioners help offenders to identify their core values by asking detailed questions about the most important things in their lives and discussing their success in achieving what are called *primary human goods*, which are outcomes, experiences, or activities that are sought for their own sake, and that if attained, result in higher levels of well-being (Fortune, Ward, & Mann, 2015). Examples of categories of primary goods include the pursuit of knowledge, inner peace, friendships, and happiness (see Table 1 for a complete list and definitions of primary goods). The GLM also recognizes *secondary goods*, or the means with which individuals attempt to attain the primary goods of interest (for more detailed information on these categories see Table 1; and Ward & Stewart, 2003). One aspect of the GLM that makes this approach specific to an offender population is determining the values that underlie criminal behavior, and the way that dynamic risk factors are conceptualized as obstacles to meaningful lives, including prosocial attainment of personally valued outcomes. For instance, in many sexual offending cases, the value of agency or relatedness may be a driving factor for offending behavior and be reflected in the nature of criminal acts, such as intimacy seeking through a sexual

relationship with a child (Fortune et al., 2015). It can be assumed that values may motivate nonsexual offenses as well, such as theft or drug-trafficking as a means to achieve specific primary goods of interest such as cash or pawnable items to pay for survival-related needs like rent or food, or buying nice things for others in order to maintain a bond or feel closer to significant others (for additional examples see italicized secondary goods in Table 1).

Reducing Risk by Pursuing Prosocial Goals

A basic assumption of the GLM is that offenders are likely to desist from crime if they are able to realize prosocial and personally fulfilling ways to reach their "ideal" life (Ward, Mann, & Gannon, 2007). There are two ways risk reduction can occur. First, the establishment of the internal and external resources needed to achieve a primary good (or more broadly, implement a good life plan) in socially acceptable and personally fulfilling ways, that can directly alter criminogenic needs/risk-relevant factors. For example, learning the skills necessary to become a carpenter or welder will make it easier for an offender to develop the skills for concentration and emotional regulation, thereby reducing impulsivity, a criminogenic need. Second, the reduction of risk can occur indirectly when an offender is strongly motivated to engage in treatment because of his involvement in projects that personally engage him. For example, an individual might work hard at overcoming his substance abuse problems because he is keen to attend a mechanic training course. In actual practice, having a good life plan both directly and indirectly impacts one's dynamic risk factors.

Treatments that focus primarily on reducing risk take an avoidance orientation to rehabilitation, whereas strength-based methodologies like the GLM are guided by an approach orientation. Roskes and colleagues (2014) capture the importance of an approach orientation when considering a fulfilled life when they wrote, "*Avoidance goals are designed for surviving and approach goals are designed for thriving.*" Through the use of a strength-based intervention, offenders are better able to identify what outcomes they are working towards, allowing for more structured plans, whereby progress can be more easily and accurately assessed. Many of the outcomes found to promote desistance are also important treatment goals of the GLM, such as reframing offender-clients' identi-

Table 1. Primary Goods Definitions and Possible Secondary/Instrumental Goods

Primary Good	Life Goal	Definition	Secondary/Instrumental Goods
Life	Living and surviving	Taking care of physical health and ensuring safety.	Attending to health issues, exercising, earning a wage, living in a safe area, eating a balanced diet, <i>drug selling</i> .
Knowledge	Learning and knowing	Acquiring understanding of the social and physical environment, other people, and oneself.	Attending college, undertaking vocational courses, doing training, self-study, therapy, reading, <i>surfing offender chat rooms</i> .
Excellence in play and work	Being good at play and work	Striving to meet high standards of performance on work tasks and in leisure contexts.	Practicing a musical instrument, attending work-related training courses, developing a career plan, sports training, art lessons.
Excellence in agency	Personal choice and independence	Formulating important goals and deciding how to address important issues on one's own.	Expressing personal views to friends, revealing preferences to partner, choosing own training course, <i>controlling and manipulating others</i> .
Inner peace (emotional regulation)	Peace of mind	The experience of emotional balance and freedom from ongoing emotional conflict.	Expressing feelings to others, meditation, exercising, keeping a diary, <i>use of alcohol or drugs</i> .
Friendship	Relationships and friendships	Forming intimate bonds with other people (romantic, family, friends).	Marriage, family outings, romantic encounters, <i>sex with children, grooming children</i> .
Community	Being part of a group	Being part of a social group or network with shared values, goals, and activities.	Belonging to a sports team or social service group, <i>being part of a criminal gang</i> , joining a cultural organization.
Spirituality	Having a sense of meaning in life	Being part of something greater than oneself, a sense of purpose and wholeness.	Joining a church group, prayer, meditation, political activism, <i>being part of a religious sect</i> .
Happiness	Happiness	The desire to experience a state of fulfillment or pleasure.	Playing a game, eating a favorite food, spending time with a romantic partner, <i>risky thrill seeking activities, risky sex, taking drugs</i> .
Creativity	Creativity	The wish to make something, to do things differently, or to participate in a creative activity.	Attending an art class, gardening, writing poetry, engaging in a novel activity, <i>manipulating people</i> , walking home a different way, listening to music.

ties (e.g., changing the narrative from being a lifestyle criminal to having a criminal history) and working towards creating a path to a personally more meaningful life (Maruna, 2001).

Current Research on GLM-Style Interventions

The GLM is based on a strong theoretical foundation that goes beyond consideration of just the offending behavior and recidivism risks that must be avoided, and as such entails treatment that considers the

broader context of the individual's life goals and quality. It is a *rehabilitation* theory, and therefore evaluation of its utility should address two questions: (a) Does it provide a more comprehensive and systematic intervention framework for designing and implementing intervention

plans? (b) Do treatment plans and interventions based on the GLM rehabilitation theory result in greater levels of desistance from crime when compared to RNR-based models? Failure to distinguish between these two questions has resulted in considerable confusion within the correctional and forensic literature about its validity.

With respect to its evaluation as a rehabilitation theory, the GLM has several advantages over the RNR and risk management models, because of its seamless integration with desistance approaches to social reintegration, and its ability to integrate both well-being enhancing and risk-reducing elements. However, with respect to the *treatment efficacy and effectiveness* of programs derived from the GLM, for a broad range of offender populations, the empirical evidence is still in its infancy. Preliminary findings in sex offender samples have found that secondary goods (means to achieve primary goods) predicts recidivism (Bouman, Schene, & de Ruiter, 2009; Willis & Grace, 2008), post-release satisfaction is higher with attainment of primary goods (Willis & Ward, 2011), and similar patterns emerged in adolescent sex offenders (Chu, Koh, Zeng, & Teoh, 2015). Further, supplementing a relapse-prevention treatment with GLM principles has been found to enhance therapeutic progress with otherwise stagnant cases (Lindsay, Ward, Morgan, & Wilson, 2007). Within the client-clinician relationship a GLM approach was found to promote treatment engagement with sex offenders (Gannon, King, Miles, Lockerbie, & Willis, 2011). A GLM-style intervention has not been extensively tested against other interventions; however, forensic practitioners have indicated a qualitative preference for the GLM (Harkins, Flak, Beech, & Woodhams, 2012).

In light of the theoretical advantages of the GLM over risk management approaches, it is worthwhile continuing research with this model to evaluate its generalizability to a broad range of offender populations, and to assess long-term outcomes such as desistance, life achievements, and life satisfaction. In our view, the use of the GLM is likely to result in more comprehensive intervention plans that reduce recidivism by encouraging offenders to live personally meaningful lives, as well as less harmful ones.

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Finding the Niche for Motivational Interviewing in Forensic Practice

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BY THE END OF THE 1990s in the U.S., the seemingly disparate goals of improving public safety and controlling prison spending merged into the singular policy objective of reducing recidivism. Along with the changing political landscape, a new wave of behavioral treatment research emerged showing that reducing criminal recidivism can be achieved, and in some cases dramatically (Andrews et al., 1990; Landenberger & Lipsey, 2005; Lipsey, Chapman, & Landenberger, 2001). These beneficial treatments are being more clearly defined with the goal of turning these innovative approaches into effective, and ultimately routine, forensic practices. Although not specifically designed for criminal justice environments, motivational interviewing (MI) has established itself as an approach that is commonly integrated into contemporary forensic practice (Tafrate & Luther, 2014; Walters, Clark, Gingerich, & Meltzer, 2007). A body of literature supporting the effectiveness of MI with justice-involved clients is beginning to emerge (Anstiss, Polaschek, & Wilson, 2011; Austin, Williams, & Kilgour, 2011; Ginsburg, Mann, Rotgers, & Weekes, 2002; Skinner, Heasley, Stennett, & Braham, 2014), although significant gaps in the literature exist (McMurran, 2009).

We begin with the premise that forensic practitioners of many types (e.g., psychologists, correctional counselors, probation/parole officers, and case managers) should play an active role in facilitating behavior change among justice-involved clients—as opposed to the traditional emphasis on surveillance, drug testing, and imposing “accountability.” The purposes of this article are to briefly introduce MI and to clarify the role of MI in forensic practice.

Brief Description of MI

The main objectives in using MI in forensic practice are to promote engagement in the treatment process, and to explore and elicit clients’ inner motivation to change behaviors related to criminally relevant risk factors, with the aim of pre-

venting future criminality. The tone, or *spirit*, of MI conversations is nonjudgmental, nonconfrontational, respectful, inquisitive, and supportive, with an emphasis on client autonomy and self-direction. Discussions are collaborative and focus on clients’ reasons why change would be important as well as how they might go about it. This clinical approach is consistent with self-determination theory of human personality and motivation (Ryan & Deci, 2000), in that individuals are more likely to change after hearing themselves voice reasons and commitments to do so, and if they feel autonomous, supported, and competent in their decision making (Miller & Rollnick, 2012, 2013; Moyers, 2014). MI is built on a platform of four core counseling skills known as OARS: *open questions, affirmations, reflections, and summarizations*. These skills are used across four broad and dynamic processes: *engaging, focusing, evoking intrinsic motivation, and change planning* (Miller & Rollnick, 2013). The four processes of MI provide a practical structure for moving forward with justice-involved clients who often feel coerced into supervision, programming, or treatment.

To better understand the dynamics of MI, try this experiment: imagine that your employer has retained a new health insurance company. The new company prides itself on its prevention efforts and requires that each employee participate in a health and wellness exam that includes a lengthy questionnaire and an interview with a nurse practitioner. The purposes of the assessment are to review a range of unhealthy behaviors and to identify a specific lifestyle change each participant can make. During your interview, the nurse suggests that you eat a healthier diet (e.g., low fat, plant-based), supplies a fact sheet with foods to target, and provides a referral to a nutritionist. During the discussion, the nurse never asks you about your perspective on your eating habits, or your level of interest in adopting a new lifestyle. He seems most concerned about documenting the recommendation and making sure you

sign an acknowledgment that you have received the proper counsel.

What would your reaction to this interaction look like? For many people, the natural reaction would be to become defensive and noncompliant. Indeed, many of us would likely either minimize the seriousness of our current eating habits (“My parents have eaten this way their whole lives and are in their 90’s”), justify our current unhealthier ways (“I need to do something to relax at the end of the day and food helps me do that”), argue why the recommended change is not practical (“I don’t have time to see a nutritionist and put effort into preparing healthier meals”), or smile politely, sign the form, and ignore the nurse’s advice. Of course, by reacting this way, we would probably be viewed by the nurse as unmotivated and uncooperative, even if we had already been thinking about improving our diets!

Unfortunately, since few people react well to being pressured to change, the dynamics represented above are very similar to the types of unproductive conversations that happen countless times per day in forensic settings around the world. Justice-involved clients are told they have a problem (confrontation) and that they must get treatment (coercion). The client becomes defensive and counters with minimizations of, or justifications for, their self-defeating and risky behaviors (resistance), and the practitioner argues with logic and counterevidence (more confrontation). The client feels frustrated, self-protective, and resists change attempts. In contrast, productive conversations—consistent with MI—are more likely to emerge by listening to clients’ perspectives (*engaging*), exploring what they see as most important in terms of changing risk-relevant life areas (*focusing*), eliciting their reasons for making changes (*evoking*), and collaboratively gathering ideas for how change might happen (*planning*). For more detailed descriptions of the four processes, see Miller and Rollnick (2013) and Schumacher and Madson (2015).

Why MI in Forensic Settings?

MI Provides a Platform of Basic Skills

Forensic practitioners come to their jobs with varying skill levels. In some settings (e.g., probation and parole), practitioners might enter the field with little formal training on how to interact with clients in a collaborative, autonomy-supporting manner. In the absence of basic counseling skills, the default option for

many becomes an authoritarian or adversarial stance that increases resistance and impedes the development of a productive working relationship. Confrontational communication styles can become the cultural norm in many forensic settings because practitioners simply have not developed alternative ways of relating to justice-involved clients. Although OARS skills are not unique to MI, they are implemented in MI with a level of precision and fluency not often found in other counseling models. The OARS skills provide a foundation that aids practitioners in establishing rapport, conducting assessments, identifying collaborative goals, and guiding conversations in helpful, productive directions that foster the therapeutic alliance and promote client change.

MI Enhances Treatment Engagement

In traditional psychotherapy, clients mostly come into treatment voluntarily and without legal supervision. Also, individuals seen in traditional mental health settings often are able to identify and acknowledge their symptoms, and want their symptoms reduced or removed with the hope of improved functioning and well-being. In contrast, justice-involved clients frequently are mandated to treatment for their offending behavior, can be unaware of their risky patterns, and may possess little or no real interest in changing lifestyle factors that are most relevant to their future criminality (e.g., criminal companions, aimless use of leisure time).

Although there is support for court-mandated substance use treatment (e.g., Bahr, Masters, & Taylor, 2012; Broner, Mayrl, & Landsberg, 2005; Chandler, Fletcher, & Volkow, 2009; DeMatteo, Shah, Murphy, & Koller, 2013; Hogue, Henderson, Ozechowski, & Robbins, 2014), general reviews of offenders have found that mandating treatment is ineffective (e.g., for sex offending, violence), and not as beneficial as when individuals engage in treatment voluntarily (Klag, O'Callahan, & Creed, 2005; Parhar, Wormith, Derksen, & Beauregard, 2008). Overall, it seems that some level of intrinsic motivation is helpful in order for people to benefit from intervention. Thus, we want mandated clients to develop an interest in change akin to that of their voluntary counterparts. In essence, we should strive to create an environment where clients who feel "forced to be here" come to say they "want to make changes anyway" (Tafrate, Mitchell, & Novaco, 2014, p. 474).

MI Fosters Behavior Change

MI is meant to be a time-limited approach to help resolve ambivalence about behavior or lifestyle changes. Aside from certain brief adaptations, MI was not designed to be a stand-alone intervention (Miller & Rollnick, 2009). Nonetheless, some studies have examined MI as a single modality treatment specifically for justice-involved clients. The most encouraging evidence for the use of MI with forensic clients has emerged in the area of substance use for both adults and adolescents (Clair-Michaud et al., 2015; Harper & Hardy, 2000; Hogue et al., 2014; Miles, Duthiel, Welsby, & Haider, 2007; Sinha, Easton, Renee-Aubin, & Carroll, 2003; for review, see McMurrin, 2009), although the evidence is not unequivocal (Carroll et al., 2006).

In terms of general recidivism outcomes, Anstiss and colleagues (2011) found that male prisoners incarcerated for a variety of offenses (e.g., violent, property, drug-related crimes), but received an MI intervention at the start of their sentence, were less likely to reoffend than matched prisoners. Relatedly, Letizia and Keaton (2014) noted encouraging reductions in rates of recidivism for substance-using offenders who received MI from their community corrections staff. Outside of substance use outcomes, mixed results have been found for MI-based interventions in other areas such as for domestic violence (Kistenmacher, 2000; Marques, Voas, Tippetts, & Beirness, 1999; Woodall, Delaney, Kunitz, Westerberg, & Zhao, 2007), which may be explained by a number of factors. For some of these studies, rates of recidivism are generally low and thus there is a floor effect that limits ability to detect group differences. Additionally, it is possible that because MI is combined with other treatments, its specific effects may be lost (McMurrin, 2009).

MI Can Be Integrated With Existing Forensic Models

Recently, more focus has been placed on incorporating evidence-based treatments into criminal justice programming; one way to do this is to blend MI with established forensic models as a tool for enhancing motivation. As discussed by Mitchell, Wormith, and Tafrate (2016, this issue), an emerging literature from the Risk-Need-Responsivity (RNR) model has identified risk factors that are linked with continued criminal behavior that also can serve as essential treatment targets (Andrews & Bonta, 2010; Andrews, Bonta,

& Wormith, 2006). Thus, MI can be integrated during risk/need assessments and incorporated into ongoing discussions about changing risk-relevant life areas depending on clients' fluctuating levels of motivation (Andrews, Bonta, & Wormith, 2011). Another area for integration that is yet to be explored is to focus MI discussions on justice-involved clients' values and life priorities. The Good Lives Model (GLM), discussed in this issue (Dumas & Ward, 2016), suggests some potentially worthwhile focal points, such as promoting beneficial relationships with others, creativity, healthy living, work satisfaction, and inner peace. We argue that MI provides the interaction style most likely to encourage justice-involve clients to productively engage in treatment, while the RNR model, and potentially the GLM, are useful in identifying the most important targets for treatment.

Final Thoughts

The encouraging preliminary evidence of MI with forensic populations suggests that this is a meaningful area for future treatment development and research. In particular, MI can be flexible enough to meet the many demands inherent in forensic populations and settings for both adolescents and adults, and MI has been shown to have beneficial synergistic effects when combined with other approaches in the treatment of substance use, health behaviors, and anxiety disorders (Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Westra, Constantino, & Antony, 2016). Integrating MI with existing forensic treatment models (MI-RNR and MI-GLM) may hold the most promise for improving treatment outcomes; this integration can have a significant positive impact on the lives of those who make contact with the criminal justice system.

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Dialectical Behavior Therapy in Forensic Contexts

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THE RATE OF BORDERLINE PERSONALITY disorder (BPD) among prison inmates has been found to range between 25% and 50% (Sansone & Sansone, 2009). This disorder is associated with high rates of nonsuicidal self-injury (NSSI), suicidal behavior, and impulsive aggression, which are overrepresented among forensic patients (e.g., see Gardner, Dodsworth, & Selbey, 2014). However, most correctional treatment programs specifically address criminality and do not explicitly address features of BPD that can contribute to criminality (e.g., emotional instability, impulsive aggression, substance use, relationship instability, etc.).

Standard dialectical behavior therapy (DBT) is based in part on a dialectical philosophy whereby reality consists of polar opposites. Treatment aims to synthesize these poles, such as by balancing the patient's acceptance of her- or himself with the need to change. DBT also addresses polarized behavioral patterns (e.g., emotional vulnerability vs. self-invalidation/emotional suppression), often referred to as dialectical dilemmas, by teaching synthesis and balance of these extremes. DBT integrates these Hegelian dialectics, Western client-centered and cognitive-behavioral approaches, and Eastern Zen meditative traditions via four components: individual therapy (hierarchically targeting life-threatening behaviors, followed by therapy-interfering ones, and so on), weekly groups that teach four sets of behavioral skills (mindfulness, interpersonal effectiveness, emotion regulation, and distress tolerance), weekly therapist consultation team (to support therapist motivation and competency), and telephone consultation (availability of the therapist for in-the-moment behavioral skills generalization).

Although DBT was initially developed to treat highly suicidal patients and is most commonly associated with the treatment of BPD, standard DBT is a flexible, principle-

driven approach that can be modified to forensic and correctional settings. Indeed, DBT has been extensively adapted and expanded to a variety of other populations, such as suicidal adolescents (Miller, Rathus, & Linehan, 2006), disordered eating (Bankoff, Karpel, Forbes, & Pantalone, 2012), and substance-dependent individuals (Linehan et al., 1999; 2002). Research on standard DBT (i.e., with civil outpatients and some inpatients) has demonstrated consistent effects on outcomes such as emotional and behavioral stability, as well as suicidal and NSSI behaviors that are also relevant to correctional populations (Stoffers et al. 2012; Valentine, Bankoff, Poulin, Reidler, & Pantalone, 2015; Wilks, Korslund, Harned, & Linehan, 2016). Comprehensive reviews of BPD treatment by both the Australian National Health and Medical Resource Council and the United Kingdom's National Collaborating Centre for Mental Health have concluded that DBT has the largest evidence base for treating BPD (NHMRC, 2012; National Institute for Health and Clinical Excellence, 2009).

DBT has been tailored for the needs of persons in correctional settings, and a growing research base suggests that the application of DBT-informed programs to forensic populations holds much promise (see Chapman & Ivanoff, in press; Layden, Turner & Chapman, in preparation). In this article, we provide a brief summary of three DBT-informed programs, describe common adaptations that are made specifically for forensic treatment, and review existing research with forensic clientele.

In its original form, DBT assumes: (a) that the patients are primarily female outpatients, (b) that treatment is for BPD and is focused on the issue of emotional dysregulation and a lack of effective skills for managing emotions, and (c) that primary treatment targets are self-directed harm (e.g., suicide, NSSI). These assumptions are

usually not met in correctional contexts, where the patients are mostly male inpatients with diagnoses that can include BPD, but more commonly involve features of antisocial personality disorder (ASPD), and a range of criminal and destructive behaviors, including violence toward others as well as self. The following are examples of forensic-modified DBT programs that take into account the characteristics of typical forensic populations.

DBT-CMHIP

McCann, Ball, and Ivanoff (2000) developed a modified version of DBT for use with forensic patients at Colorado Mental Health Institute at Pueblo (CMHIP) that differs from standard DBT by taking into account the facts that the patients are typically male, often have comorbid ASPD, are in an inpatient context, and criminal behavior is a primary focus of treatment. The DBT biosocial conceptualization of the etiology of the patient's problems is modified to better suit the prevalence of ASPD features. There is a greater emphasis, for example, on impulsive and criminogenic behavioral patterns (see Mitchell, Wormith, & Tafrate, 2016, this issue), compared with the focus on emotion dysregulation in standard DBT. In addition, individual treatment in forensic environments is usually administered by clinicians with less training than found in those delivering standard DBT in mental health settings (e.g., 1 or 2 years postsecondary). Therefore, staff members are supervised by psychologists or psychiatrists, and treatment staff have much more contact with patients due to the nature of the inpatient/custody setting.

The treatment hierarchy takes into account the violent and criminal nature of the patients. Life-threatening behaviors have highest priority; these behaviors include violence toward others (which is more common than suicide attempts or NSSI among ASPD patients). Unit destructive behaviors are next in importance (e.g., bringing drugs to the unit, engaging in sexual behavior with co-patients, interfering with the willingness of co-patients to engage in treatment, etc.). Third on the hierarchy are "behaviors linked to life-threatening behaviors," which include devaluing language, or language related to alienation or disconnection from others. Essentially, these are idiographic antecedents in an individual's behavior chain leading to life-threatening behavior. As in standard DBT, therapy-interfering behavior is next on the hierarchy, followed

by quality-of-life interfering behaviors. The skills training groups largely teach the standard DBT skills (i.e., mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation), and skills acquisition is assessed via role-plays, quizzes, and exams. The emotion regulation module is modified to include issues related to ASPD, such as increasing attachment, increasing empathy, and engaging in “random acts of kindness.” The “pleasant events” include activities with a more typically masculine focus than those in standard DBT (see McCann & Ball, 1996, for specifics). This version of DBT includes an additional skills module addressing criminal behavior, addressed after the other modules have been completed. The DBT consultation team addresses correctional issues such as the potential polarization between treatment-focused and security-focused attitudes among staff.

In the DBT-CMHIP model, dialectical dilemmas are adapted for incarcerated forensic patients and include issues such as freedom to participate in the program versus being coerced to participate; experiencing staff as jailers versus treatment providers; living the “con code” versus making prosocial changes. Staff dilemmas include treatment versus security; acceptance versus change; and hope versus burnout.

DBT-CM

Trestman, Sampl, Pagano, and Zhang (2008) developed and tested a modification of DBT for correctional settings called DBT-Corrections Modified (DBT-CM). Although a manual is currently unavailable, Sampl, Wakai, and Trestman (2010) describe the program as skills-focused; participants take part in 32, twice-weekly, 1-hour skills training sessions. The treatment materials (e.g., examples, illustrations) are significantly modified to reflect the context of male inmates. Within this model, individual therapy is less frequent than in standard DBT, is focused on skills coaching, and is offered after skills training is completed. Offering individual psychotherapy after skills training, rather than concurrently, reduces resource demands on the institution. The authors describe the importance of having operational staff oriented to the purpose and structure of the program, as “buy in” from correctional officers significantly affects program fidelity and effectiveness. Clinician treatment adherence is measured by an in-session observer using a form developed for this purpose.

The RUSH Model

The Real Understanding of Self-Help (RUSH) program, developed by Eccleston and Sorbello (2002), is a modification of DBT that takes into account the realities of incarceration that are not part of standard DBT treatment. RUSH was developed specifically for inmates with symptoms of BPD. The differences between RUSH and standard DBT include simplification in language and acronyms (e.g., core mindfulness is called “healthy mind, healthy body”). Skills training is sequential, starting with mindfulness followed by distress tolerance (“dealing with distress”), and then emotion regulation (“looking out for number one”), and interpersonal effectiveness (“getting the most out of yourself and your relationships”). The pronouns are either masculine or gender-neutral, and the examples are modified to be relevant to criminal behavior. Group skills training includes warmup and closing exercises, as well as competitions and quizzes throughout the program; participants compete for prizes and in the final session there is an “awards” ceremony in which staff describe their perceptions of each participant’s strengths. Individual counseling is provided on an as-needed basis and group skills training is offered twice-weekly for twenty 2-hour sessions.

Research Findings on DBT in Correctional Settings

Berzins and Trestman (2004) conducted the first review of DBT programs in correctional settings. This initial review focused on six institutions in Australia, the United Kingdom, the United States, and Canada. The programs were DBT-informed, in that they included some elements of the practice and theory of DBT. DBT was used with adult males and females, youth, sex offenders, and persons in mental health units in custody. Findings suggested that persons undergoing these DBT-informed programs demonstrated reductions in irritability, suicide attempts, and self-injury.

Since that initial review, several studies have examined DBT-informed programs within a number of different correctional settings, including males, females, and youth. All of the programs in these studies included significant modifications to DBT, commonly including adaptations in length, often ranging from as little as 8 sessions to as long as 18 months (Evershed et al., 2003; Wahl, 2012); and the inclusion of group skills only (Eccleston & Sorbello, 2002; Sakdalan, Shaw, & Collier, 2010; Wahl, 2012).

Although an integral part of traditional DBT, a significant oversight in the literature, or perhaps design of these programs, is that the DBT consultation team is rarely mentioned. For example, we could only find three studies that reported the use of a consultation team (Nee & Farman, 2005; Rosenfeld et al., 2007; and van den Bosch et al., 2012). Other relatively neglected topics of study in forensic DBT applications include adherence to fundamental DBT principles and program attrition rates. To our knowledge, only one study (van den Bosch et al.) has measured adherence to DBT; and dropout rates for these programs have ranged from approximately 11% (Evershed et al.) to 58% (Wahl).

In terms of outcomes, some studies have found significant reductions in stress, anger expression, disciplinary infractions, and rearrest rates (Eccleston & Sorbello, 2002; Sakdalan et al., 2010; Shelton et al., 2009; Wahl, 2012). Although these findings are promising, the research base is still emerging. Adherence monitoring, the inclusion of appropriate control groups, the use of randomized controlled trial designs, and the systematic assessment of patient characteristics (i.e., through structured diagnostic interviewing) are common deficits of existing studies (Chapman & Ivanoff, in press; Layden et al., in preparation). Research maximizing internal validity in these ways is difficult to conduct in real-world forensic settings. There are also additional challenges to the dissemination and implementation of DBT-informed programs in forensic settings, including a lack of material resources and adequate front-line staff training, a dearth of well-trained mental health professionals, the necessary emphasis on security (which is sometimes seen as conflicting with clinical care; see Delk et al., 2016, this issue), and difficulty scheduling and sustaining consistent treatment (e.g., due to crises or unexpected events; Chapman & Ivanoff, in press).

In conclusion, the structure and focus of DBT is a good fit to address many of the challenges found among inmates in correctional settings (e.g., self-injury; suicidal, aggressive, and impulsive behaviors). Currently, DBT-informed treatment can be considered a promising forensic intervention approach deserving of further rigorous evaluation. With a growing research base and large initiatives under way in North America, the U.K., and Australia, DBT-informed programs will likely become more common and well-integrated into correctional systems.

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A Clockwork Orange Is the New Black

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The penitentiary we've patrolled as correctional officers (COs) for so many years is practically unrecognizable nowadays. If one more inmate asks for reassurance again that their cell is locked or that they didn't hurt another prisoner's feelings we'll surely lose it. And the constant requests for more soap and wet wipes! There's no point tossing cells for contraband anymore either, as inmates are confessing to the point of absurdity—"Boss, are you SURE this Q-tip isn't really a weapon?" They also symmetrically arrange everything they have, right out in the open, where they can keep checking it's all in the perfect place.

They even stopped communicating by "fishing" (surreptitiously sending items between cells using string) due to exhaustion from tossing the message carrying weight so many times until it felt just right.¹ Ugh. We used to get headaches from the constant gangsta rap, thrash metal, and other totally annoying music the different gangs played as they kept trying to drone each other out. Believe it or not, we actually miss the noise. The Zen music they all play now to stay "even" drives us crazy. We even tried to up the tempo with some old 70s music, such as KC and the Sunshine Band. But that was too racy, prompting forbidden thoughts once inmates learned about the drugs and promiscuity of the era. It used to take a lot of effort not to bring back home to our families a demeanor of numbness—the insensitivity to violence and callous disregard for others we were "exposed" to during our daily shifts; now it's all we can

do to avoid developing symptoms of OCD ourselves.

One of the first changes we COs saw was when the inmates started asking us increasingly ridiculous questions, like should they call their makeshift knives "shanks" instead of "shivs." It was hard for us to keep our composure since at first, by accident, they had been conditioned to speak with English Cockney accents. This was a mystery until we realized that, due to recent state budget cuts, the film *Alfie*² was playing over and over again on the TV hanging outside the training room, and what we had on our hands was a case of accidental conditioning. It was very disconcerting to hear a prisoner sporting teardrop tattoos repetitively uttering the words "Blimey! Have I offended you, kanga?"³ followed by "I daresay Guv'na, I had a right nasty thought, beg your pard'n, please forgive me." Fortunately, they fixed that little glitch pretty quick, as we were coming awfully close to believing we had magically been transported to work on the set of a community theater production of *Oliver Twist*.

OK, all the bigwigs think the OCD Induction Initiative—Phase II (OCD-II) is a big success, and is going to drastically reduce recidivism, but, really? Do they actually believe that just because antisociality and OCD seem to be polar opposites, they can turn criminals into law-abiding citizens by "contaminating" them with OCD? Guess none of these so-called thought leaders ever saw *A Clockwork Orange*, or Dexter's ritualistic killings, or

know that some of the most vicious future members of Murder Incorporated were so germ phobic that the only way to run them off was to pelt them with dog poop.⁴ And, after all, it's not called "disorganized crime," is it? Seriously, isn't this almost as illogical as thinking that since SSRIs help depression, depression must be caused by a chemical imbalance? Most of the prison's psychiatrists seem to believe this! And no one is going to listen to a couple of COs.

So, how'd they do it? Phase I was easy, since we COs already had been trained in motivational interviewing (MI) and to listen for "change talk." Now, instead, we were retooled to listen for even the slightest hint of "OCD" talk connected to criminogenic needs and risk-relevant life areas. We role-played how to gradually reinforce and shape successive approximations of OCD talk into full-blown doubt. This included keying into any sign someone said they felt "responsible," complained that their "thoughts were really, really important," or that the "uncertainty was intolerable." Once we got them doubting, it was a hop, skip, and a jump to producing obsessional overvalued ideation, rituals, and magical thinking. (Just for laughs we sometimes introduced a compulsion to literally jump into the behavioral chain of a notorious prison shake-down artist, which, let us tell you, really undermined his street cred.) We learned to use erroneous biofeedback to link random thoughts around themes of selfishness, overconfidence, and uncaring with the fear of going into cardiac arrest, and then further random self-statements that had to be repeated perfectly, for an arbitrary number of times, to neutralize this fear. Once that was coupled with the sense that "if you think it, it will happen," we had the inmates reporting rampant thought-action fusion, leading to intense self-directed monitoring of forbidden thoughts. We included behavioral experiments—a particularly compelling one was to ask an inmate to think really hard about the wastebasket catching fire. Unbeknownst to the inmate, of course, was the accelerant and balled up tissues in the basket at the start of the exercise, so that when it caught fire, it seemed like a product of his mind.

Cognitive destructuring of criminogenic thinking was also awfully effective. So were our disinhibitory learning (promoting giving into fears and engaging in avoidance), ACT-perfectly protocols, and Perfect Life Plan worksheets. We even had the inmates tell us innocuous memories of times when they failed to sufficiently con-

¹ It's still strange for us to enter the cellblock and not hear the sounds of barbells being lifted. For a while some inmates were collapsing from exhaustion trying to find the perfect alignment of their hands on the barbell to ensure symmetrical muscle development. One inmate took 2 hours just to "set" before doing 10 repetitions. Now the elliptical trainers get the most use since the machines are inherently "even" in their rotations.

² A 1966 classic about a commitment-phobic Cockney chauffeur played by Michael Caine.

³ Cockney rhyming slang turns "screw," a regular nickname for a prison guard, into kangaroo, which is then abbreviated to "kanga."

⁴ Ethics forbid us to use real feces. Instead, we rely on novelty poop, like the kind used on Halloween, or that you find in the office of anxiety disorder specialists who practice CBT. Now *those* people really give us the creeps.

sider another person's perspective, and while they were speaking moved our fingers in front of their eyes the opposite way we were supposed to. (Well, that one didn't work so well.) Our ultimate intervention was exposure and ritual encouragement; we used tokens that could be exchanged for items at the commissary as reinforcers for performing compulsions. For example, an inmate would get four tokens for meticulously rechecking that the bars in their cell had no cracks or other signs of erosion.

And it seemed like almost overnight the inmates were following the letter, if not the spirit, of our institutional rules. That's because we induced a fear that the warden MIGHT be disappointed in them, which we conditioned to the image of a "W" that

could be signaled via specially designed flashlights whenever even the hint of a minor infraction occurred.

Despite our adherence to the protocol and obvious impact on outcomes, if you ask us, all we've done is create a bunch of criminals who now also have OCD!

Oops, gotta go now... The inmates are aggressively organizing a protest about their foods in the mess hall touching. And we do mean, "organizing!"

P.S.: Not long after this report was written, a crew of habitually deceptive inmates, who had received special programming to induce urges to confess, in response to even a passing thought about lying, executed a "perfect" escape plan. We have no idea how

they did it, but serious research grant money to study why they didn't fess up beforehand is available.

*IMPORTANT DISCLAIMER: The authors are not members of the socially marginalized population depicted above, thus this article may, understandably, not be considered valid by some readers.

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Forensic Issues and Externalizing Behaviors SIG

The Forensic Issues and Externalizing Behaviors Special Interest Group is dedicated to the application of cognitive-behavioral principles to the understanding, prevention, assessment and treatment of externalizing behaviors that put individuals at risk for harming others and themselves, and for criminal justice involvement. Members strive to understand and find better solutions for addressing a broad range of antisocial behaviors that lead to immeasurable human suffering worldwide, and to improve the lives of some of society's most marginalized members and the lives of those impacted by antisocial behavior. Clinical and research activities span both community and forensic contexts and encompass such issues as: antisociality, delinquency, anger, psychopathy, aggression, intimate partner and family violence, forensic assessment, oppositional and disruptive behaviors, sexual offending, addictions, recidivism, forensic treatment, policing, legal consultation, victimology, and various influences on antisocial behavior (sociocultural, dispositional, and environmental). A primary goal of the Forensic Issues and Externalizing Behaviors SIG is to provide a network for members to discuss up-to-date information related to research, application, and training on CBT principles relevant to at-risk and justice-involved individuals and their families.

Contact Information:

To be added to the Forensic Issues and Externalizing Behaviors Special Interest Group LISTSERV, or for other inquiries, please contact any of the following SIG leaders:

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Thomas Dowd Receives the Russell Bent Award From the American Board of Professional Psychology

Linda Carter Sobell, *Nova Southeastern University*

THE AMERICAN BOARD OF BEHAVIORAL and Cognitive Psychology would like to congratulate Dr. Thomas Dowd, who recently was awarded the Russell E. Bent award. This award recognizes significant and continued service and contributions to the American Board of Professional Psychology (ABPP). Dr. Dowd's contributions have certainly exceeded this standard of excellence. Tom, a long-time member of the Association for Behavioral and Cognitive Therapies, was a founding member of the American Board of Behavioral Psychology (now the American Board of Behavioral and Cognitive Psychology [AMB&CP]) in 1986. He created the specialty board, contributed to the writing of

the initial CRSPPP application for recognition of Behavioral Psychology as a specialty, and obtained affiliation with ABPP.

He has served on the B&CP board for close to 30 years. He has been elected President on three occasions and has been the B&CP representative to the ABPP Board of Trustees three times. Finally, Tom has tirelessly served B&CP in numerous other capacities over the last three decades.

In addition to cofounding the ABBCP Board, Dr. Dowd has vigorously promoted the ABPP B&CP diploma at the ABCT conventions and other venues, has trained and mentored most of our examiners and exam chairs, and served on countless

exams. Dr. Dowd is also board certified in counseling psychology.

On a personal note, I was on the board of ABCT when Tom and others came to ask ABCT (then AABT) for monetary and professional support for the behavioral specialty board. At the time, the ABCT board was uncertain about the value of such a specialty board and the vote was close. Those of us who professionally identify as cognitive and behavioral specialists owe a debt of gratitude to Tom, as it was his unwavering dedication that solidified the diplomate in Behavioral and Cognitive Psychology. The Russell Bent award could not go to a more deserving person.

The value of board certification has increased tremendously over the past few years. There is now an early career and senior option. Some hospitals and medical schools employing psychologists are now requiring board certification and others like the VA provide a pay boost. Further information about board certification in B&CP can be found at www.abpp.org/i4a/pages/index.cfm?pageID=3299 ■

Call for Submissions | Graduate Student Research Grant

The ABCT Research Facilitation Committee is sponsoring a grant of up to \$1,000 to support graduate student research. Eligible candidates are graduate student members of ABCT seeking funding for a currently unfunded thesis or dissertation research project. The grant will be awarded based on a combination of merit and need. Applications should include: (1) a 3-page document detailing significance, innovation, approach, and justification of need; (2) a budget (no more than 1 page); (3) the applicant's curriculum vitae; (4) one letter of support from a faculty advisor. Please e-mail parts 1 through 3 of the application in a single .pdf to the chair of the Research Facilitation Committee, Nathaniel R. Herr, PhD, at nherr@american.edu. Include "Graduate Student Research Grant" in your subject heading. Please ask your faculty advisor to e-mail a letter of support separately.

Applications are due July 31, 2016. Please submit:

- 3-page document detailing significance, innovation, approach, and justification of need
- 1-page budget
- Curriculum vitae
- Letter of support from faculty advisor

To submit: please e-mail all required documents to Dr. Nathaniel Herr at nherr@american.edu

The grant will be awarded October 28, 2016, with the award recipient announced at the 2016 Awards Ceremony during the Annual Convention.

For more information on the grant and application procedures and requirements, please visit the ABCT website at www.abct.org/Awards/



Why Wales Will Be More Wonderful

Mary Jane Eimer, *ABCT Executive Director*

David Teisler, *ABCT Director of Communications*

MANY OF YOU HAVE HAD THE PLEASURE of meeting Lisa Yarde, JD, ABCT's Membership Services Manager, over the years. She might have facilitated your dues renewal, or made your convention registration go easier, or found that ribbon for your committee work, or retrieved your login and password (maybe more than once, right?), or helped you update the specialties in your clinical directory listing. Some of you will know she helped you; others will just have benefitted. She will stay in the background if not flushed out; it's just her nature. Let's just say that in her 10 years here, she's likely handled all of your needs multiple times and helped make the place you all call your professional home just a little more, well, homey.

But that's just the part that touches you immediately. There's a ton more to her professional accomplishments. First, she's overseen conversions of our database twice, once from iMIS to Avectra and once from Avectra to a proprietary database. The first conversion was undertaken only after having tried to work with the company's developers to fix some problems that made life very difficult for us and for our members. The second was undertaken after working with that company's people to implement elements promised but not

delivered. In order to get to that point, she really had to immerse herself in the back end. It's the second move that's the more fascinating, though, because not only did we change databases, but she designed the new one, that is, the one you're using now. She wrote the specs for it, and oversaw its testing and implementation and all the additional refinements made after launch. Designing and implementing a database from scratch is not for the faint of heart, and that helps to explain why so few ever even try. She succeeded.

She's also been the person behind the back end of our list serve. I realize it's not the most robust list serve in the world, but it functions well and is likely the best tech buy around.

Let's see, what else does she do. Well, she coordinates the SIGs and is point of contact for all SIG leaders as well as the conduit for the posters for the SIGs' annual expo (she also coordinates the setup and helps assemble the 700 folding easels holding the 700 SIG posters, risking paper cuts as she and Tonya and a couple others race to beat the flood of eager poster presenters); she is the liaison with Membership Committee and Student Membership Committee; she is your broadcast emailer; she develops the forms so you can renew

your dues and the forms so you can register for the convention; she also works closely with the Social Media Networking Committee, especially on the Twitter aspects; she is the staff person who keeps the rest of us apprised of specials and due dates and closing dates. She writes much of the promotional copy.

Which seems a nice segue to her other professional life, as a writer. She has written two historical novels (see *On Falcon's Wings*; Amazon.com) set during the turbulent years as England and Normandy wrestle for a chunk of France at the turn of the last millennium (the one just after we got to 4 digits in the year) and has completed 5 of the planned 6 novels set in Moorish Spain (also available on Amazon; look for *Sultana*). If you like that time in Spain, but prefer blogs to novels, see <http://unusual-historicals.blogspot.com/>.

All this helps to describe why Wales will be better, because it's getting a new inhabitant in June, when she leaves Brooklyn and ABCT and heads to heathered mists to marry her betrothed. She and Ian are planning to adopt and have already started the process. Lately, she's been conducting a by-continental relationship.

We'll miss the perpetual chuckles, for nothing was ever so serious she couldn't find the humor within; and we'll miss her taste in music, which runs to weeping cellos and brooding organs; and we'll miss her ability to find the good, and the silly, in people, all the while correctly naming spades each time they came up in the deck. ■



50th Annual Convention Update



Are you aware that the Annual Convention is in October this year? We are celebrating our 50th Anniversary and returning to New York to mark this special milestone. The Annual Convention is scheduled for Thursday, October 27 to Sunday, October 30, 2016, at the New York Marriott Marquis, in the heart of Times Square.

There has been a slight increase in the general convention registration rates for the 2016 Annual Convention. The CE ticketed session's registration rates will remain the same as last year. The new general convention registration rates have been approved and are listed at the bottom of this page.

The registration process for this year's Annual Convention is changing. ABCT has enlisted the assistance of a registration partner to assist with the processing and execution of our online and on-site regis-

tration processes. We will no longer be mailing badges out in advance. Once you register, you will receive an email registration confirmation with a QR code embedded in the confirmation. This QR code will give you and on-site registration staff access to print out your badge and/or tickets quickly and efficiently. More information will be available on the ABCT website when you register for the Annual Convention.

All meetings and events for the Annual Convention will take place at the New York Marriott Marquis Hotel. ABCT has secured a block of rooms at a discounted rate for the Convention. In addition, there are additional supplemental hotel options available within blocks of the Marriott Marquis that also offer discounted room rates for ABCT Convention attendees. Here are the hotels and rates associated with each hotel:

2016 Annual Convention Registration Rates

Registration Category	Preregistration	On-Site Registration
Full Member	\$314	\$372
Student Member	\$130	\$159
Postbaccalaureate Member	\$170	\$200
Student Nonmember	\$227	\$249
Nonmember	\$615	\$670

Registration will open in mid-June
www.abct.org

Headquarter Hotel and Rate

New York Marriott Marquis
 1535 Broadway, New York, NY 10001
 (Site for all ABCT meetings and events)
 Rates: Single or double occupancy: \$339

Supplemental Hotels and Rates

Fairfield Inn & Suites New York
 Manhattan/Times Square
 330 West 40th Street, New York, NY 10018
 Rates: Single occupancy: \$279;
 Double occupancy: \$309

Four Points by Sheraton Midtown/
 Times Square
 326 West 40th Street, New York, NY 10018
 Rates: Single occupancy: \$279
 Double occupancy: \$309

Hotel Edison
 228 West 47th Street, New York, NY 10036
 Rates: Single occupancy: \$249
 Double occupancy: \$269

Manhattan Affinia NYC
 371 Seventh Ave. at 31st Street,
 New York, NY 10001
 Rates: Single or Double occupancy
 (Queen bed only): \$249

Paramount
 235 West 46th Street, New York, NY 10036
 Rates: Single occupancy: \$249
 Double occupancy: \$279
 Third and fourth person: no charge

RowNYC
 700 8th Avenue, New York, NY 10036
 Rates: Single or double occupancy
 (Queen bed only): \$239

Note: Rates do not include the 14.75% state and local taxes and the \$3.50 daily occupancy fee. Add third person rate for each additional person, plus charge for rollaway bed, if requested. Prices for parking, taxes, and other services are subject to change without notice.

Registration and Housing will open in mid-June. Additional information and the links to register and make hotel reservations will be available on the ABCT website, www.abct.org.

Preconvention Sessions

Thanks to those who submitted abstracts for the CE sessions, poster presentations, and general sessions. Under the guidance of this year's program chair, Katharina Kircanski, and the program planning committees, we will have an exciting educational experience for all attendees.

For those interested in the continuing education sessions offered on Wednesday, October 26 and Thursday, October 27, 2016, below are the list of AMASS, Clinical Intervention Trainings, and Institutes:

AMASS

Thursday, October 27, 2016 – 8:30 AM – 12:30 PM

AMASS 1: Dyadic Data Analysis: An Introduction to the Actor-Partner Interdependence Model

Robert A. Ackerman, *The University of Texas at Dallas*

Thursday, October 27, 2016 – 1:00 PM – 5:00 PM

AMASS 2: Intensive Longitudinal Methods: An Introduction to Diary and Experience Sampling Research

Niall Bolger, *Columbia University*

Jean-Phillipe Laurenceau, *University of Delaware*

Clinical Intervention Trainings (CIT)

Wednesday, October 26 & Thursday, October 27, 2016

2 Days: 8:30 AM – 5:00 PM

CIT 1: Process Focused ACT: An Intermediate ACT Workshop

Steven C. Hayes, *University of Nevada*

Thursday, October 27, 2016 – 8:30 AM – 5:00 PM

CIT 2: Child and Adolescent Anxiety Disorders: A Developmental and Family-Based CBT Model

Anne Marie Albano, *Columbia University*

Thursday, October 27, 2016 – 8:30 PM – 5:00 PM

CIT 3: The Primary Care Behavioral Health Model: An Effective Platform for Behavior Therapy

Patricia J. Robinson, *Mountainview Consulting Group*

Kirk D. Strosahl, *Central Washington Family Medicine*

Institutes

Thursday, October 27, 2016 – Full Day – 8:30 AM – 5:00 PM

The Mindful Way Through Anxiety: Helping Clients to Worry Less and Live More

Susan M. Orsillo, *Suffolk University*

Lizabeth Roemer, *University of Massachusetts at Boston*

Thursday, October 27, 2016 – Full Day – 8:30 AM – 5:00 PM

Neuroscience-Informed Behavioral Interventions: From Cognitive Behavioral Therapy to Cognitive Training

Sheila Rauch, *Emory University*

Martin Paulus, *Laureate Institute for Brain Research*

Kevin Pelphrey, *Yale Child Study Center*

Denis Sukhodolsky, *Yale University*

Rebecca B. Price, *Western Psychiatric Institute and Clinic*

Greg J. Siegle, *Western Psychiatric Institute and Clinic*

Rudi de Raedt, *Ghent University*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Treatment of Complex Obsessive-Compulsive Symptoms

Dean McKay, *Fordham University*

Fugen Neziroglu, *Bio-Behavioral Institute*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Emotion Regulation Therapy

Douglas S. Mennin, *Hunter College, Graduate Center City University of New York*

David M. Fresco, *Kent State University*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Adapted Parent-Child Interaction Therapy for Early Childhood Anxiety

Anthony C. Puliafico, *Columbia University Medical Center*

Jonathan S. Comer, *Florida International University*

Jami M. Furr, *Florida International University*

Donna B. Pincus, *Boston University*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

A Manualized Cognitive-Behavioral Therapy Group for Treating Diverse Addictive Behaviors

Bruce S. Liese, *University of Kansas*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Special Considerations: Implementing and Adapting Treatment Protocols for PTSD With Active-Duty Military Service Members

Brooke A. Fina, *University of Texas Health Science Center at San Antonio*

Katherine A. Dondanville, *University of Texas Health Science Center at San Antonio*

Lindsay M. Bira, *University of Texas Health Science Center at San Antonio*

Alan L. Peterson, *University of Texas Health Science Center at San Antonio*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Treating Executive Functioning and Motivation Deficits in Teens With ADHD

Margaret H. Sibley, *Florida International University*

Thursday, October 27, 2016 – Half Day – 1:00 PM – 6:00 PM

Cognitive Therapy for Suicide Prevention

Gregory K. Brown, *Perelman School of Medicine of the University of Pennsylvania*

Kelly L. Green, *Perelman School of Medicine of the University of Pennsylvania*

ABCT invites

Fellows Applicants

for the Class of 2017

ABCT members who have been Full members for 10 or more years prior to the date of the Fellows application may apply for Fellow status in the Association for Behavioral and Cognitive Therapies (ABCT); the period of 10 years as of Full membership does not have to be continuous. This prestigious membership status is awarded based on an evaluation of a Full member's application by the Fellows Committee, which makes a recommendation to the Board of Directors for final approval. Applicants must show evidence of outstanding and sustained contributions to ABCT and have earned their terminal a degree a minimum of 15 years. Upon successful completion of the process, new Fellows may indicate ABCT Fellow status on their CV and as a part of their signature line.

The 2017 Fellows application form and accompanying materials must be sent to the ABCT Central Office, fellows@abct.org, by July 5, 2016. Applicants will be notified of the Board's decision by October 1, 2016. New Fellows will be recognized as a class at the ABCT Awards Ceremony at the Annual Convention in New York City on October 28, 2016, and will receive a Fellows ribbon each year. The Association website will list all Fellows and will be updated annually with each new Fellows class. Fellows will be removed from the website listing if their ABCT dues are not renewed by January 31 of each year.

A full description of the application requirements can be found at:

<http://www.abct.org/Members/?m=mMembers&fa=Fellow>

Submission Deadline:

Tuesday, July 5, 2016

call for

))) Golden Moments

In celebration of ABCT's 50th Anniversary, we are seeking "Golden Moments" from the ABCT membership. Please send your memories. This can entail:

- your own personal golden moment
- a colleague or friend's golden moment
- a BT/CBT-related golden moment
- an ABCT-specific golden moment

The Golden Moments will be featured in the Oct. issue of *tBT*, on our website, and live at the 50th Annual Convention in NYC (Oct. 27-30).

Please send to ABCT in the form of text, image (jpeg, 300 dpi), or both to:
GoldenMoments@ABCT.org

**Deadline:
August 25**

Examples:

"Being in awe every moment of my first ABCT meeting in 1985..." (Michelle Craske)

"Watching Art Freeman and Art Nezu compare ribbons..." (David Teisler)

"In 1979, ABCT, then AABT, offers first award, President's New Researcher, and Dianne Chambless is first recipient!" (M. J. Eimer)



Join us in celebrating our 50 years!

ABCT: Get ready for, and be a part of, the October *tBT*, a commemorative issue marking ABCT's 50 trailblazing years.

This is your chance to publicly thank someone (or thing) in your cognitive, behavioral, research, academic, professional life.

Place a Gratitude Ad.*



*Gratitude Ad

OCT. ISSUE ONLY!

Thank a mentor, training program, publisher, faculty, book, concept, friend

Send text/art to **sschwartz@abct.org**

Payment: credit card or check to ABCT:

305 Seventh Ave., 16th floor, New York, NY 10001

RESERVE by AUGUST 15

Camera-ready deadline: August 25

DIMENSIONS: 2 3/16 x 1" (or approximately 145 characters)
PRICE: **\$50**

the Behavior Therapist

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ABCT Membership+Convention: *What you need to know*

2016
membership
year ends:
Oct. 26

2017
membership year
BEGINS: Oct. 27, 2016
ENDS: Oct. 31, 2017

*Renew 2017
membership
to enjoy 2016
convention rates*

ABCT's 50th Anniversary Annual Convention will be held in New York City from October 27–30, 2016, at the New York Marriott Marquis. This year's convention will be held a little earlier than our usual November convention. Because this is the case, ABCT will be ending the 2016 membership year 5 days early (on October 26), and beginning the 2017 membership year the day after (on October 27). The 2017 membership year dates will be October 27, 2016–October 31, 2017. You will not be losing any of your 2016 ABCT benefits with this change. You will still receive 8 issues of *the Behavior Therapist*, have access to the journals, be on our list serve, be listed in the online clinical directory and membership directory, and have access to our products and services.

As always, you'll need to renew your 2017 membership to get the member rates for the New York City Annual Convention.
