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## **CHAPTER 2**

### **THE EFFECTIVENESS OF PSYCHOLOGICAL TREATMENTS OF OFFENDERS**

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#### **INTRODUCTION**

The aim of this paper is to summarize the effectiveness of psychological interventions in the treatment of offenders with reference to up-to-date authoritative reviews.

#### **REDUCING OFFENDING BEHAVIOUR USING PSYCHOLOGICAL INTERVENTIONS**

McGuire and Priestly (1995) in an extensive review of meta-analytic studies which aggregate data on thousands of offenders in hundreds of studies conclude the on average psychological intervention with prisoners reduces recidivism by 10-12%. They also note that there is wide variation in the effectiveness of psychological intervention programmes and this is influenced by the nature of the intervention programme; the nature of the offence; and the demographic and psychosocial profile of the treated offender. The more effective programmes reduce recidivism rates by up to 25% (Lipsey, 1995; Lösel, 1995). Effective programmes have the following characteristics (McGuire and Priestly, 1995):

- Cases are assessed in terms of risk and high risk cases receive more intensive intervention than low risk cases.

- There is a direct focus on reducing offending behaviour (e.g. violence, theft, and sexual abuse) as well as improving psychological adjustment, but not an exclusive focus on general psychological adjustment only.
- Active participatory intervention methods are used in preference to didactic teaching or unstructured experiential learning.
- Interventions teach offenders new skills and are based largely but not exclusively on cognitive behavioural methods.
- The integrity of programmes is maintained by manualization of intervention procedures, monitoring of programme integrity, evaluation of programme effectiveness and regular supervision of those delivering the programme.

### **PSYCHOLOGICAL INTERVENTION FOR SPECIFIC PROBLEMS WITH OFFENDERS**

Effective psychological intervention programmes for offenders have been developed in the following domains:

- For offenders who lead disorganized impulsive lives, cognitive skills training (Knott, 1995).
- For violent offenders, anger and conflict management training (Bush, 1995; Browne & Howells, 1996).
- For sexually abusive offenders, multicomponent sexual abuse programmes (Prentky, 1995; Maletzky, 1998; Hanson & Brussiere, 1996; Walsh, 1998).
- For individuals with drug problems, drug abuse specific programmes (Finney & Moos, 1998; Milan, Chin, & Nguyem, 1999; McMurrin, 1996).
- For individuals with anxiety and mood problems, cognitive behaviour therapy (Barlow, Lawton Esler & Vitali, 1998; Franklin & Foa, 1998; Keane, 1998; Craighead, Wilcoxon et al, 1998).

- For young offenders, multimodal, skills training programmes specifically for adolescents and young adults (Lipsey, 1995; Hollin, 1996).

Details on each of these types of intervention programmes are set out in the remaining sections of this document.

### **COGNITIVE SKILLS TRAINING FOR IMPULSIVE DISORGANIZED OFFENDERS**

Cognitive skills training programmes have been shown in Canada and the UK to reduce re-incarceration rates from 30% to 0% over a 9-12 month follow-up period (Knott, 1995). Cognitive skills training programmes have been shown in Canada to reduce reoffending rates from 70% to 18% over a 9 month period and in the UK they have reduced reoffending rates from 44% to 39% over a 12 month follow-up period (Knott, 1995). Cognitive skills training programmes typically involve over 70 hours of treatment and include modules on the following components: problem solving skills, social skills, self-control skills, creative thinking and critical reasoning.

### **ANGER AND CONFLICT MANAGEMENT TRAINING FOR VIOLENT OFFENDERS**

For violent offenders, anger and conflict management training has been shown in a number of studies to reduce violent behaviour (Bush, 1995; Browne & Howells, 1996). Bush (1995) in the US found that after 3 years none of the

offenders who completed more than 7 months of an intensive anger management programme had a conviction for a violent crime compared with 18% of untreated cases in the control group. Anger and conflict management training includes training in recognition of trigger situations, training in reducing physiological arousal, self-instructional training to alter anger maintaining thinking styles, training in social problem solving skills and training in moral reasoning.

### **MULTICOMPONENT PROGRAMMES FOR SEXUALLY ABUSIVE OFFENDERS**

Multicomponent cognitive behavioural treatment programmes have been shown to reduce recidivism rates among sexual offenders from an overall rate of about 40% for untreated offenders down to 19% for rapists and 13% for paedophiles (Maletzky, 1998; Hanson & Brussiere, 1996; Walsh, 1998; Murphy, 1998; Prentky, 1995). Effective multimodal cognitive-behavioural programmes for sex offenders have specific characteristics.

- Effective programmes involve explicit contracting and treatment engagement procedures and individualised assessment often involving penile plethysmographic assessment of offenders sexual arousal patterns to a range of sexual stimuli.
- Effective programmes create a context within which offenders take full responsibility for their offence and give up the process of denial and cognitive distortions that go with this process.
- Effective programmes promote the development of victim empathy, sometimes through the use of victim impact statements.
- Effective programmes help offenders develop an understanding of the cycle of sexual offending and the offence decision chain.
- A variety of behavioural techniques may be used to alter deviant patterns of arousal including aversion therapy and covert sensitization.

- Social skills training where offenders learn skills necessary for developing appropriate heterosexual relationships are included in many effective programmes.
- Most effective programmes include a relapse prevention component.
- Effective programmes are intensive and involve weekly sessions over a minimum period of a year and are followed by long-term supervision to monitor relapse and recidivism risk.

Hormonal treatments to lower testosterone levels and sexual drive are only effective in the short-term while medication is being taken and relapses occurs once offenders stop taking medication (Maletzky, 1998; Hanson & Brussiere, 1996).

### **DRUG AND ALCOHOL TREATMENT PROGRAMMES**

A number of psychological intervention programmes for drug and alcohol abuse have been shown to be significantly more effective than no treatment but the bulk of such research has been conducted outside of prison settings (Finney & Moos, 1998; Milan, Chin, & Nguyem, 1999; McMurrin, 1996). Effective drug and alcohol abuse programmes suitable for prison based offenders include motivational interviewing; behavioural self-control and skills training; and 12 step programmes modelled on the Alcoholics Anonymous treatment approach. With motivational interviewing a non-confrontational approach is adopted and the offender is invited to explore the consequences of continued drinking on the one hand and ceasing alcohol abuse on the other. Effective cognitive behavioural programmes include social skills training, stress management training, self-control training, cue-exposure treatment, cognitive therapy and covert sensitization based aversion therapy. 12-step programmes provide long term

group based support and a structured rationale for abstinence and the development of an alcohol free lifestyle.

### **COGNITIVE BEHAVIOUR THERAPY FOR ANXIETY AND MOOD PROBLEMS**

Offenders, particularly, those facing long sentences may develop anxiety and mood problems in response to incarceration. For individuals with anxiety and mood problems, cognitive behaviour therapy has been shown to be significantly more effective than no treatment and positive outcomes occur in about two thirds of treated cases but the bulk of such research has been conducted outside of prison settings (Barlow, Lawton, Esler & Vitali, 1998; Franklin & Foa, 1998; Keane, 1998; Craighead, Wilcoxon et al, 1998).

Broadly speaking, effective therapies for anxiety disorders are brief (10-20 session) involve psychoeducation about anxiety; exposure to intrapsychic and environmental anxiety eliciting stimuli until habituation occurs; and the provision of training in using coping strategies or support to help the client cope with the process of exposure and habituation.

Psychoactive medications - specifically certain tricyclic antidepressants and serotonin reuptake inhibitors - have been shown to have clinically significant positive short-term effects on some anxiety disorders (Roy-Byrne & Cowley, 1998; Rauch & Jenike, 1998; Yehuda, Marshall & Giller, 1998). In some instances it may be appropriate for these medications to be combined with psychological interventions for anxiety disorders. Psychologists typically work in multidisciplinary teams with physicians who prescribe and monitor medication in cases of anxiety where medication is appropriate. High relapse rates in people with depression of up to 50% within one year associated with the exclusive use of pharmacological treatments for depression - specifically certain tricyclic antidepressants and serotonin reuptake inhibitors - may be significantly reduced

by concurrent brief (20 sessions) psychological treatment with cognitive behavioural therapy (Craighead, Wilcoxon et al, 1998; Nemeroff & Schatzberg, 1998). Psychologists typically work in multidisciplinary teams with physicians who prescribe and monitor medication in cases of depression where medication is appropriate.

Cognitive therapy focuses on challenging pessimistic or self-deprecating attributions, beliefs, assumptions and expectations and training in behavioural routines to manage negative mood states.

### **MULTIMODAL PROGRAMMES FOR YOUNG OFFENDERS**

Lipsey (1995) in a meta-analysis of 397 intervention studies for young offenders found that intensive carefully monitored multimodal skills based behavioural programmes of 100 hours duration over a 6 month period were the most effective and reduced the net recidivism by about 25% over a 6 month follow-up period. Recidivism in control groups who received routine management was 50% and in treated groups was 36.5%. This 12.5% difference represents a net reduction of 25%. Multimodal skills based behavioural programmes cover such themes as understanding offending behaviour patterns; developing alternatives to offending behaviour patterns; social skills training; anger management training; moral reasoning training; substance abuse treatment; literacy and work skills training; and family involvement in treatment (Hollin, 1996).

### **CONCLUSION**

There is a wealth of empirical data to show that clinical psychology services for young offenders and adult offenders can reduce re-offending rates. In view of

this, clinical psychology services for offenders should be expanded and developed.

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