PROVOCATION

Revisiting the effectiveness of CBT in the CJS - Is it still working?

Cognitive behavioural therapy, or 'CBT', dominates much of the offender behaviour programming in the UK and elsewhere. Over the past 20 years, CBT has come under significant scrutiny from a range of quarters. This document offers an overview of some of these broader discussions distilling them into what we refer to as a 'typology of criticisms' (see table 1). This provided the framework for developing four provocations set out below which provide the foundation for the first stage in a broader project that aims to revisit the effectiveness of CBT in the criminal justice system.

These provocations do not articulate our conclusions, but instead our starting point. They provide a succinct challenge to the prevailing discourse with an aim of stimulating discussion and 'provoking' a response. We therefore invite you to read what follows with a critical eye and look forward to collaboratively interrogating these ideas with you.

	Title	Key problem	Application to CJS (?)
1	Philosophical underpinnings	What theoretical assumption have been made? Contains much broader problems e.g. epistemology/definitions of suffering etc.	Do the assumptions underpinning CBT fit with the perspective of the person taken with the CJS?
2	Psychological underpinnings	Do the principles of CBT align with current psychological understanding on development, behaviour and thinking?	Does it fit with current understanding of rehabilitation need and growth?
3	Evidential critiques	Is the evidence really as supportive as first thought?	Are there similar concerns with the evidence in the CJS?
4	The application problem	Has CBT been over/mis-applied?	Are we asking CBT to do too much in the process of rehabilitation?
5	Politics of CBT	Politicisation of treatment e.g. how political models influence service delivery	Cheap and quantifiable so appealing
6	Other	The 'other' category stemming from linguistics, evolutionary sciences.	Unsure

Table 1: A typology of criticisms

Provocation 1 (Philosophical underpinnings): CBT is not a guide for life, it's a set of skills

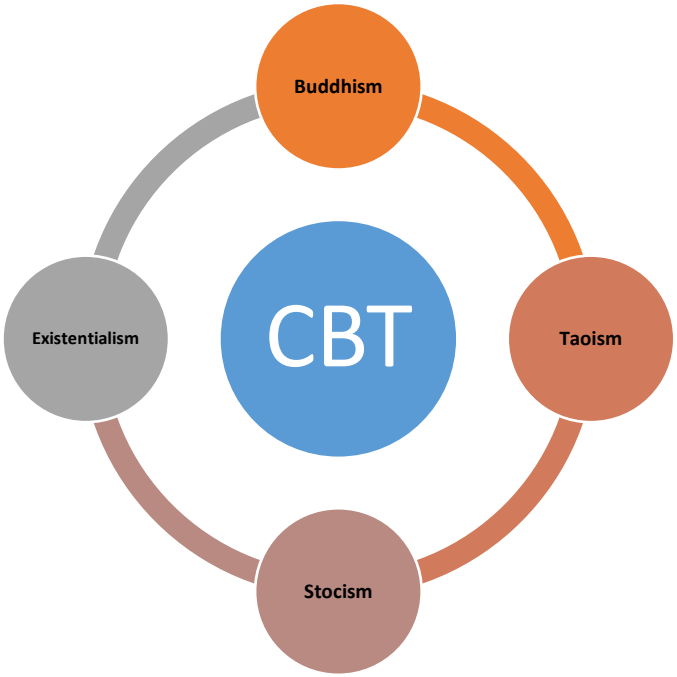

Fig.1 Schools of CBT thought

CBT draws on broad 'philosophies for life' (originally Stoicism, more recently Buddhism), extracting a set of practices which these philosophies encourage, packaging them into a set of skills for people to learn. CBT practice departs from ancient philosophies in that it "…lacks a clear account of the ideal toward which it aims" (Robertson 2010, p.124). Stoics refer to notions of the 'ideal' stage whilst Buddhists refer to 'enlightenment' – both concepts go beyond action and instead refer to character, virtues, or moral frameworks. In contrast, CBT's outcomes of interest are observable, measurable behaviours or self-report measures.

Embracing the easily learnt mental techniques CBT provides, criminal justice has co-opted CBT as a means of rehabilitation. As in mental health, CBT focuses on basic practices saying little about broader contextual factors and personal needs. CBT loses the essence of the original philosophies, stripping out values and reducing the practices to a set of skills to learn. Stoicism, Buddhism, Taoism, and Existentialism go far beyond the basic practices they teach for inner discipline. Extracting a set of practices for managing cognitions from more far-reaching philosophies or schemas will not help people achieve wellbeing, but is simply a 'sticking plaster'.

<u>Discussion</u>

Can CBT help achieve eudemonia? Can it encourage human flourishing? Or, is something further required beyond emotions management? What about *relational* aspects of being and managing emotions? The intention here is to ask what it is CBT (and the skills and practices it encourages) actually *does* or *can* do for the individual?

Provocation 2 (Psychological underpinnings): CBT's assumptions are logically inconsistent

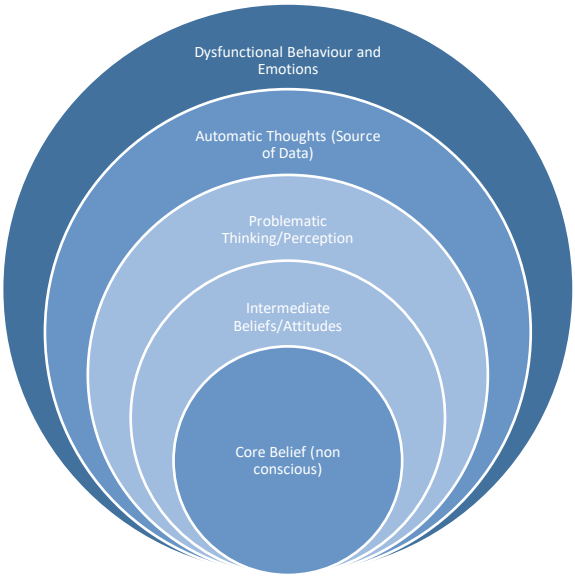

Fig. 2 CBT's Hypothesized Mental Structure of Belief

Fundamentally, CBT rests on the claim that managing cognitions (and therefore emotions) can lead to a change in behaviours. Within this statement lies several assumptions.

1. CBT proponents use a range of terms such as thoughts, beliefs, cognitions, and emotions. However, these terms are often poorly defined and lack rigorous analysis. How are these concepts different from one another? Which of these constructs can be accessed in therapeutic encounters?

2. CBT makes assumptions regarding *how* we access our core beliefs and what our verbal articulations represent. Introspection is accepted as unaffected and unfiltered by personal experience and that it leads to a verbal articulation of core beliefs. At the heart of CBT practice is the notion that we can 'catch' a thought and then spend time working out the beliefs behind it. When patients are asked to *introspect* and consider what they were thinking 'at the time', CBT accepts a statement of "I was thinking X" as being representative of a core belief. However, such statements could be simply be after-the-fact rationalisations.

<u>Discussion</u>

These logical inconsistencies challenge CBT's claim of being *empirically* grounded. CBT makes a range of assumptions that are accepted as axiomatic when in fact the concepts have been poorly interrogated – what is meant by 'thoughts', 'beliefs', 'emotions', and 'cognitions'? Further, how do we know that CBT practitioners are interpreting verbal statements correctly – are we changing cognitions or simply how we verbalise cognitions?

Bearing in mind the studies that indicated good *outcomes* for CBT, what relevance do these observations have for the question of whether CBT works?

Provocation 3 (Evidential issues): CBT is not any more effective than other therapies

Padesky and Beck (2003) state that CBT as a treatment for mental illnesses (specifically depression) has undergone extensive research to a) strengthen the underlying cognitive-behavioural model and b) test the effectiveness of treatment on specific outcomes. However, each of these claims can be challenged.

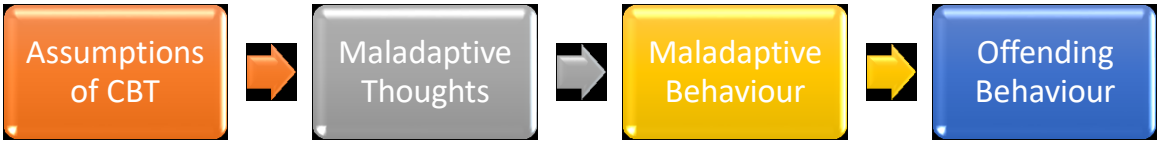

Fig.3 CBT thinking model

1. The underlying treatment model of CBT contains assumptions about causality. Most fundamentally, that maladaptive thinking causes maladaptive behaviour. This claim needs to be interrogated; questions remain about whether faulty cognition are either necessary or sufficient in explaining offending behaviours.

2. Arguably, the salient factor in CBT is the common 'treatment effect' (e.g. therapeutic relationship, a non-judgemental atmosphere). A core feature of any successful intervention outcome is the therapeutic alliance, which is based on the shared sense of empathy, agreement of treatment, trust and collaboration within the therapeutic relationship. Some evidence indicates that CBT is no more effective that other forms of psychotherapy.

Discussion

If maladaptive thinking is neither necessary nor sufficient to cause maladaptive behaviour, where does that leave the claims of causality? What is actually 'working' with regards to CBT interventions? Agency over one's life and the ability to test out and practice behaviours between sessions is key to the CBT approach. How do you test a behaviour/false belief hypothesis in a prison? Given the mandated nature of CBT programming in the CJS, is it possible to coerce someone into cognitive change?

Does the nature of delivery in the CJS (often in groups rather than 1-2-1) affect the therapeutic alliance? The therapeutic alliance (TA) usually rests on a two-way collaborative, consensus reaching process - how do you get in that in a group? Achieving a stable TA in group therapy is more complicated, as you have a series of (at times) conflicting interests which have to be managed by the therapist. A great question to ask here is whether the therapeutic alliance has ever been measured in the CJS context specifically as an experience sense of 'safety' is one of the essential factors to a TA.

Provocation 4 (application/politics): CBT is tied up in politics and over-applied

In the UK (and elsewhere) CBT was part of a much wider paradigm shift towards evidence-based policy and practice, which is sometimes linked to New Public Management, with its emphasis on 'measurement, management and markets'. These evidence-based practices prioritise certain forms of data, interventions and to a lesser extent the value systems themselves. This has political/social policy implications as other forms of treatment are naturally devalued and disregarded unless they follow/incorporate this positivist, evidence-based practice framework.

In Layard's (2006) report from the London school of Economics (just prior to CBT's nationwide adoption), mental illness was framed in economic terms. The Layard report makes the point that poverty isn't the real cause of human misery, it is previous mental illness "What is the biggest single cause of misery in our community? Most people would answer 'poverty'. But they would be wrong. If we try to predict who is unhappy we find that the strongest predictor is a person's prior mental illness" (p.6). Have we done the same in the criminal justice system?

Discussion

Has CBT transcended beyond being an intervention, and is now a management and measurement tool? How have broader policy-making and implementation trends sometimes described as 'New Public Management influenced the development, promotion and assessment of CBT as a treatment modality inside and outside the criminal justice system? Outside of this political framework, how well does the theory of CBT stand up?