

**“Staying in the Here-and-Now”:  
A Pilot Study on the Use of  
Dialectical Behavior Therapy Group  
Skills Training  
with Intellectually Disabled  
Offenders**

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# Introduction

- **Dialectic Behavior Therapy (DBT)** is a cognitive behavioral treatment originally designed by Marsha Linehan (1993) as an outpatient treatment for people diagnosed with Borderline Personality Disorder (BPD).
- The DBT approach balances therapeutic **validation** and **acceptance** of the person along with cognitive and behavioral change strategies.
- Controlled outcome trials have shown that DBT has been effective in **reducing self-injurious behaviors** and inpatient psychiatric days in women diagnosed with BPD (Lew et al, 2006). It has also been shown to be helpful in reducing anger and improve social adjustment.

# Introduction

- The use of DBT has recently been expanded to populations with additional diagnoses such as **substance misuse, eating disorders, depression with co-morbid personality disorders**. It has also been used in additional settings such as **forensic services and mental health inpatient units**.
- Current state of treatment of individuals with personality disorders in forensic correctional settings has been largely inadequate.
- It has failed to address both short-term management and adjustment issues and the longer term goals of behavior change, social re-adaptation, and recidivism reduction (Mc Cann et al., 2007).

# Use of DBT in the Forensic Setting

- Recent studies have shown that DBT is highly compatible with **best-practice principles for effective treatment in forensic settings** (Mc Cann et al., 2007).
- A study of male forensic inpatients, most of whom had committed violent crimes, saw a significant decrease in depressed and hostile mood, paranoia, and psychotic disorders with DBT as well as a significant increase in adaptive coping styles (Mc Cann & Ball, 1996).
- Warren et al. (2003) concluded that there is some evidence for the effectiveness of CBT including DBT at lower secure levels.

# Use of DBT in the Forensic Setting

“The **biosocial theory**, which is used in DBT to explain the etiology of BPD, has proved to be relevant in explaining the **genesis of other personality disorders** especially antisocial personality disorders and psychopathy as well as other disorders that are frequently found among correctional populations” (Mc Cann et al., 2007).

# Use of DBT in the Forensic Setting

DBT is compatible with best practice principles for effective forensic treatment for the following reasons:

1. It aims to **decrease the risk of recidivism**. Individuals with relatively poor prognosis are those with concomitant antisocial personality disorder (ASPD) or substance use disorders.
2. DBT supports the best practice forensic principle of **responsivity**. Most meta-analytic studies found that behavioral or cognitive behavioral treatments are the most effective match for offenders with respect to their learning style (Andrews, 1997).

# Use of DBT in the Forensic Setting

3. DBT targets **criminogenic needs** such as substance abuse, poor problem solving, antisocial peers, anger, poor self management, emotional dysregulation, and antisocial beliefs.

It directly **addresses dysfunctional behaviors**, including problems involving emotional regulation, problem solving, self-management, and substance abuse, whilst simultaneously **increasing the behavioral skills and motivation** needed to replace problem behaviors and increase more functional behaviors.

# Use of DBT in the Forensic Setting

4. The biosocial theory asserts that **invalidating environments** play a part not only in etiology but also in the maintenance of the disorder.

The invalidating environments of individuals with ASPD or psychopathy are characterized by “disturbing care; reinforcement of antisocial behavior; and models of antisocial coping and behavior in distressed families.

# Use of DBT in the Forensic Setting

5. Staff burnout is not uncommon particularly with professionals working with people with severe personality disorders.

There is also some evidence that DBT can ameliorate **staff burnout** (McCann, Ball & Ivanoff, 1996).

# **Psychological Treatment with People with Intellectual Disabilities**

- The predominant therapeutic modality used with people with ID involved behavioral approaches.
- **Behavioral interventions** remain the most common intervention particularly in the UK followed by cognitive behavioral interventions, humanistic/person centered and psychodynamic methods (Nagel & Leiper, 1999).

# Psychological Treatment with People with Intellectual Disabilities

- There remains a consensus among clinicians and researchers that **behavioral interventions are more superior to cognitive therapy and CBT** (Sturmey, 2005).
- It is even argued the effectiveness of CBT is more likely due to the behavioral interventions used within the CBT framework.
- In many CBT oriented therapeutic approaches, cognitive therapy procedures are confounded with behavioral procedures which makes it difficult to arrive at conclusions as to which component is responsible for the change.

# Psychological Treatment with People with Intellectual Disabilities

- The literature on cognitive therapy is replete with behavioral techniques which are often mislabeled as cognitive procedures such as **self-management and self-control procedures** (e.g. relaxation training, social skills training, problem solving, role playing and skill rehearsal).
- Overall, **there is no strong evidence for the effectiveness of cognitive therapy for people with IDs** (Sturmey, 2004).

# Use of DBT in people with ID

- There is paucity of research in the use of the DBT with individuals with ID.
- The only published research to date which made use of DBT with women with ID.
- Lew and his colleagues (2006) who conducted this study asserted that DBT is useful with people with ID as it is a skills-based model that is consistent with **psycho-educational and habilitative practice.**

# Use of DBT in people with ID

- In addition, the DBT model is **non-pejorative** in its language and **positive** in its aspirations as it does not focus on blaming the victim.
- Furthermore, it has a strong emphasis on teaching individuals to advocate for themselves within the system of providers which is decidedly consistent with values of **assertiveness and empowerment**.

# Challenges of providing DBT to a Forensic ID population

- Majority of these individuals have co-morbid personality disorders particularly ASPD or substance use disorders.
- Treatment provided should **target risks factors associated with recidivism** such as substance abuse, poor problem solving, anger problems, poor self management, emotional dysregulation, and antisocial beliefs.
- The DBT program should be adapted to cater to individuals with **limited literacy skills** and **significant cognitive deficits**

# **Adapted DBT group skills training program for ID**

## **Offenders**

- **The DBT Coping Skills Training program which was adapted for forensic clients with intellectual disabilities was developed by the ID Offender Liaison Service (IDOLS).**
- **It was adapted from Marsha Linehan's DBT Skills Training Manual (1993 and 2005) and the coping skills programme for people with ID which was developed by Marleen Verhoeven (2007).**
- **The group program runs for a total of 13 weeks. It consisted of 1 ½ hour sessions each week.**

# Adapted DBT group skills training program for ID

## Offenders

- The main focus of the programme is on **quality of life and therapy interfering behaviours** rather than self-harm behaviours.
- It aimed to address issues around **emotional and behavioural dysregulation** which result to offending and challenging behaviours.
- It mainly targeted issues around impulsivity, anger problems, poor problem solving, limited coping skills, emotional dysregulation and poor social skills.

# Adapted DBT group skills training program for ID

## Offenders

- **Structuring environment** to support treatment and the DBT group supervision were also implemented.
- The facilitators provided ongoing **training and education** to vocational and residential staff around the use of DBT with their clients.
- Additional support on completing the DBT home works was provided by the vocational service staff to the participants.
- **DBT peer group supervision** occurred 1 hour/week to discuss client progress, issues that came out of group session, discussion around the next session, and ongoing peer group supervision amongst the facilitators.

# **Programme Structure**

- **The DBT coping skills training modules sequence are as follows:**
  - (1) Orientation and Group Rules;**
  - (2) Mindfulness;**
  - (3) Distress Tolerance;**
  - (4) Emotional Regulation;**
  - (5) Interpersonal Effectiveness; and**
  - (6) Celebration**

# Participants

- **Initially, there were a total of 8 participants in the group.**
- **There were 6 males and 2 female clients who have prior charges and/or convictions for violent crimes. All of them were formally diagnosed with intellectual disability.**
- **Six participants were residing in a 24 hour ID supported accommodation whilst two participants were residing in a Forensic ID medium secure facility.**
- **There were five participants who completed the DBT programme and that three dropped out for various reasons.**
- **The participants were required to attend at least nine sessions (at least 80% attendance) to be considered to have completed the programme**

# Outcome Measures

- **Short Term Assessment of Risk and Treatability (START) (Webster, Martin, Brink, Nicholls & Middleton, 2004)**
- **Vineland Adaptive Behaviour Scales – Second Edition (VABS-II) Coping Skills Subdomain (Sparrow, Balla, & Cicchetti, 2005)**
- **Health of the Nation Outcome Scales for People with Learning Disabilities (HONOS-LD) (Wing, Curtis, & Beevor, 1996)**

# Assessment Process

- The IDOLS team organized a meeting with the participants' key workers at the vocational service to complete the outcome measures.
- The pre-assessment was carried out a few weeks prior to the commencement of the programme.
- The key workers who were involved with completing the pre-assessments were invited to complete the post-assessment a few weeks after the participants have completed the programme.

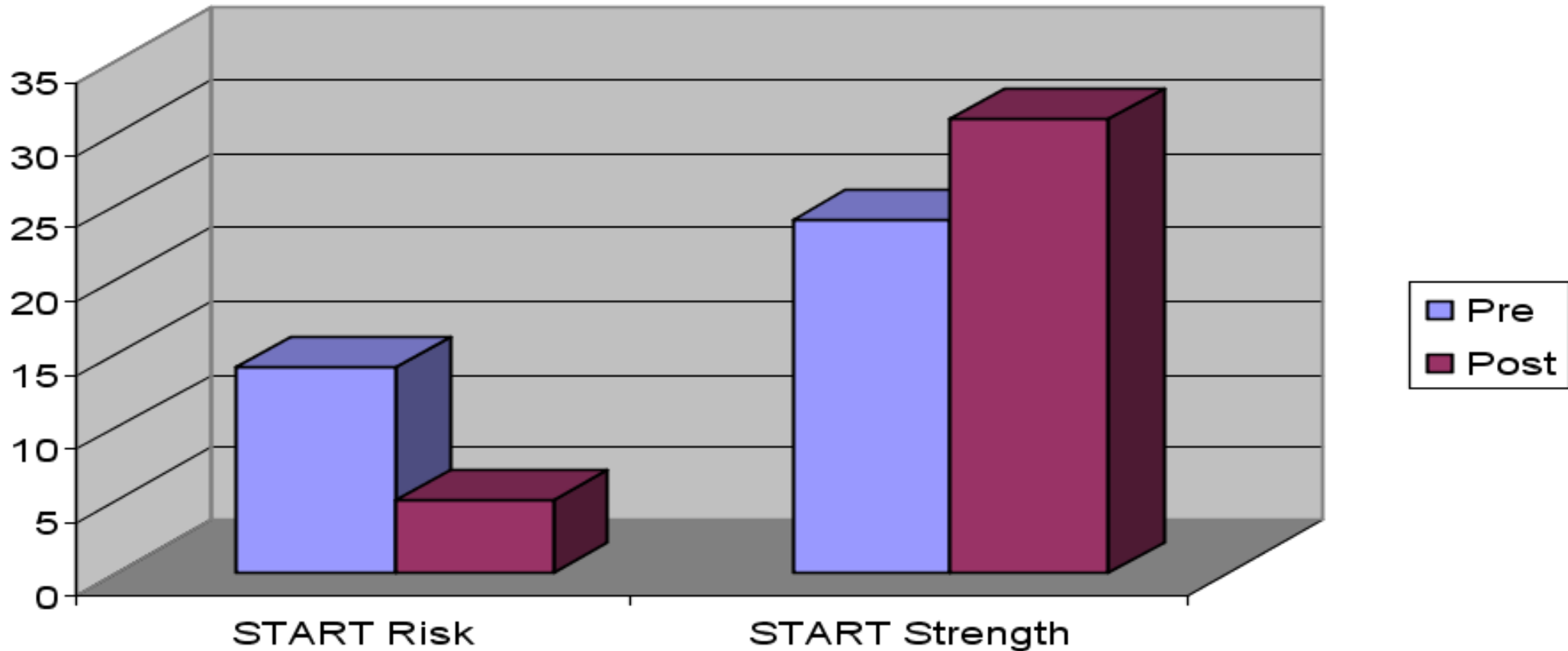
# Results

- The participants' mean age ranged from 23 to 29 ( $M=26$ ;  $SD = 2.9$ ).
- The mean IQ ( $M=57.17$ ;  $SD=8.56$ ) was in the mild to moderate range of intellectual disability.
- There were four males and one female who completed the group.
- Four of the participants were of NZ European descent while the two other participants were of Maori/Pacific Islander descent.

# Results

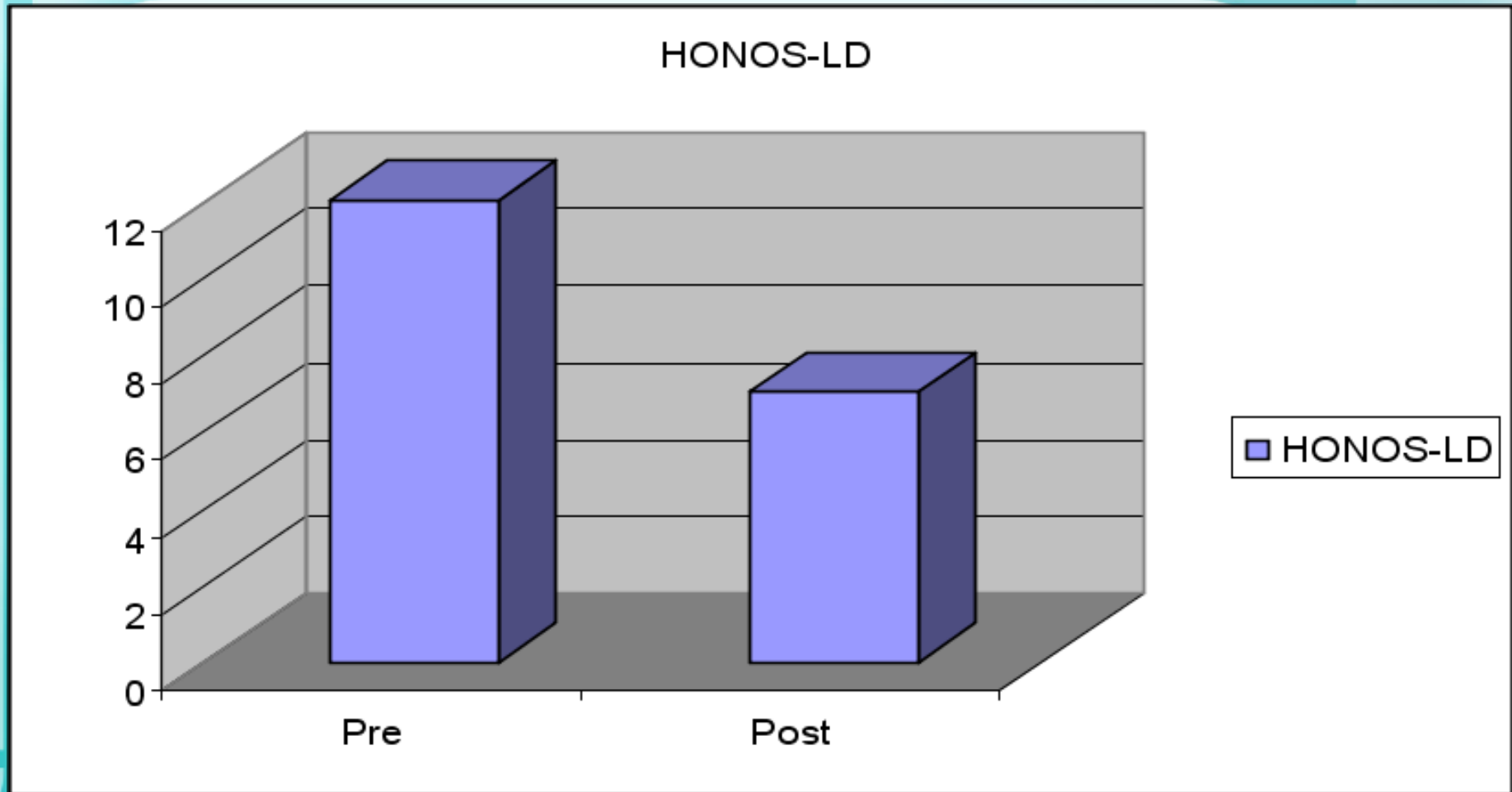
- Two of the participants were under a supervised care order which is a legal status in New Zealand for ID offenders who are under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
- All the participants had previous charges or convictions for **violent behaviours** (e.g. physical and verbal assault, property destruction).
- One of the participants had an extensive **history of challenging behaviours and inappropriate sexual behaviours**.

# START



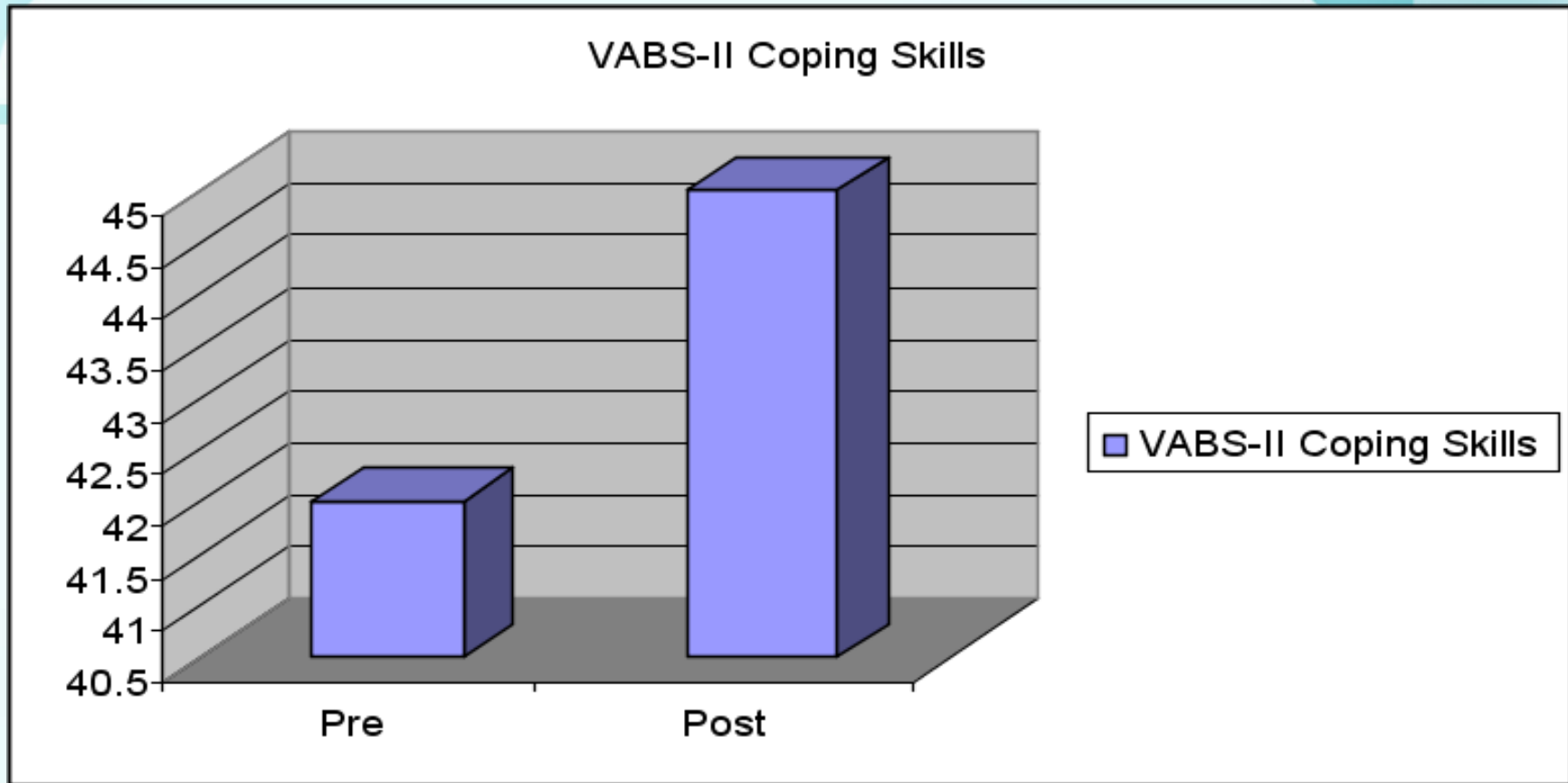
- Significant decrease in the level of risk which was accompanied by a significant increase in the level of strength (significant .05 and 0.1).
- Improvement in the level of strength is much more significant than the improvement in the level of risks.

# Global Functioning



- **There was a significant improvement in the overall functioning ( $t = 2.60$ ,  $p < .05$ , two tailed) after the clients completed the programme as measured by the HONOS-LD**

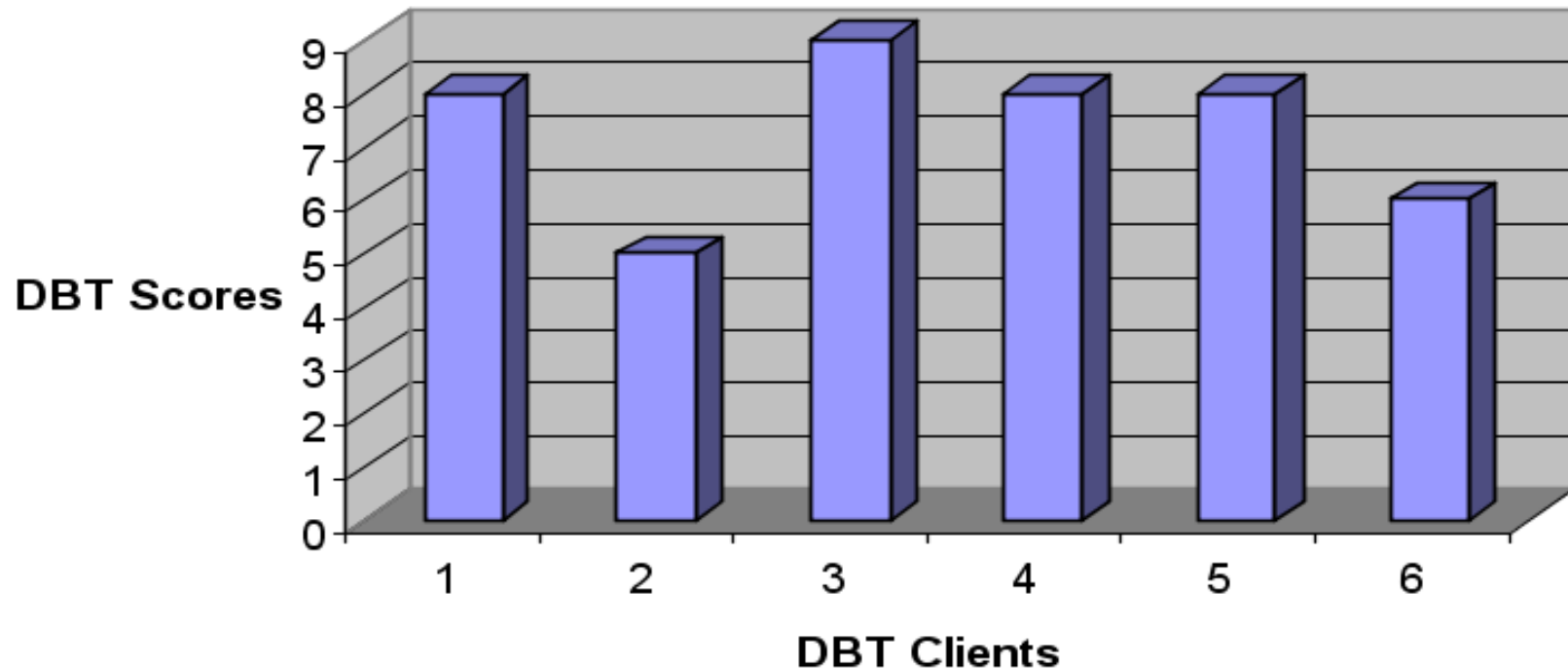
# Coping Skills



- There was a noted improvement with the participants' coping skills after they completed the programme. However, it was found to be non-significant.

# DBT Assessments

Individual DBT Assessment



- Overall the participants' achievement on the DBT assessment was high.
- One participant scored 9/9 & three other participants scored 8/9. The other two participants scored 5/9 & 6/9 respectively.
- The participant who scored the lowest (5/9) had demonstrated a higher level of understanding of DBT coping skills during the course.

# **Feedback from Participants**

- **All six participants indicated that they enjoyed the course and that they learnt a lot from the programme.**
- **The participants recommended more assistance with completion of homework and the need to provide more visual aids and to further simplify the information provided in the handouts.**
- **Two of the participants joined the next group.**

# Summary and Conclusions

- Overall, the results were promising as evidenced by the noted improvement across all outcome measures which assess **levels of risk and strengths, coping skills and global functioning.**
- This pilot study has shown that the DBT groups skills training programme format has the potential to be used as a **stand-alone intervention.**
- Presently, there is a paucity of research on the effectiveness of the DBT group skills training programme particularly with ID offenders without the provision of the full DBT package which include individual coaching and coaching in crisis.

# Summary and Conclusions

- Of particular relevance in this study is the noted decrease in the level of risks and improvement in strengths after completing the group programme. These are the most pertinent areas that should be targeted with this population given that they possess serious risk of re-offending.
- It is also noteworthy that this study supports the assumption that DBT is a skill and strength-based model that is consistent with psycho-educational and rehabilitative practice.

# Limitations and Future Directions

- Small sample size
- Improve and lengthen the programme in order to further reinforce the DBT concepts and behavioural skills
- There is a need to employ **multiple repetitions** that are persistent and **embedded in a milieu or culture** in which central themes of DBT are constantly resonated.
- Participants in the programme who have mild to moderate intellectual disability had difficulties with comprehending some abstract concepts even if they were explained in simple terms.
- Further improve the DBT coping skills training manual and lengthen the programme to at least 24 weeks and implement a more comprehensive DBT package that include individual therapy and counseling in crisis to maximize learning and support for the participants.

# **Case Study Presentation**

**I am Matthew**

**I attended the DBT coping skills group and I am going to tell you about my experience**

# Matthew

- I am nearly 30 years old
- I come from Auckland
- I currently live at Te Roopu Taurima Trust
- I am good at maths and adding up
- I like swimming, basketball, soccer, fishing and going to the movies

# Matthew

- I attend Framework Trust 5 days a week to help me learn new skills
- These skills include:
  - Going to the gym
  - Woodwork
  - Arts and crafts
  - Mahi Ora
  - Literacy programme
  - DBT coping skills group once a week

# Matthew's Feedback

- *Did you like the DBT coping skills group?*

*“Yes”*

- *What did you like the best?*

*“teaching me the right ways to handle anger”*

- *What have you learnt?*

*“how to cope with my anger”*

# Matthew's Feedback

- *What could we do in the next group to make it better?*

**“Put on a light morning tea”** 😊

- *What did you think of how the facilitators presented the group?*

**“They’re doing remarkably well”** 😊

- *Do you use your wise mind skills?*

**“Yes I walk away”**

# Behaviours I want to **STOP**:



- Hitting others



- Swearing



- Picking up furniture



- Running away



# Matthew's Chain Analysis

## Weaknesses

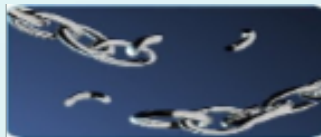
Not getting enough sleep



Being woken up



Worrying about Mum



Feeling sick



## WISE MIND

Matthew will get enough sleep



Matthew will tell people he doesn't like to be woken up

Matthew will visit Mum regularly



Matthew will stay home if sick



# Matthew's Chain Analysis

## Triggers

## WISE MIND

When things don't go right



Matthew will ask someone to explain things to him

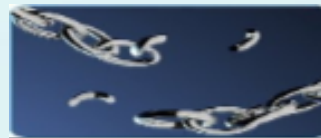


Other people talking without thinking



Matthew will talk to the person about what he is thinking and feeling

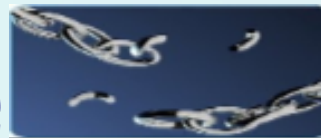
People talking when I need space



Matthew will go to his room for time out and listen to music



Feeling unsafe



Talk to someone (staff)



# Matthew's Chain Analysis

What happened afterwards

WISE MIND



I get angry/cross



Matthew will talk to staff



Feel sorry for what I did



Say " Sorry"

**SORRY!**

# Matthew's Chain Analysis

What harm do I cause others

WISE MIND

They get sad, upset or angry



Say " Sorry"

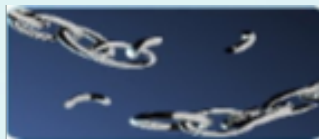
**SORRY!**

Person may need to see a Doctor



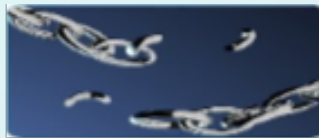
Take responsibility and not blame others

May tell the Police



Take responsibility and not blame others

I hurt others feelings



Say " Sorry"

**SORRY!**

# Matthew's Feedback

- Matthew is currently attending the 2<sup>nd</sup> DBT coping skills group.

- *Which group do you think is better?*

**“The second one”**

***Why?***

**“Because I get more help from Vicki with homework its clearer”**

# Acknowledgements

- Intensive Support Services (Framework Trust)



- Matthew would like to thank Actions for Survival for funding his attendance at the NZASID conference

