

Correctional adaptation of Dialectical Behaviour Therapy (DBT) for federally sentenced women

Donna McDonagh¹

Health Services, Correctional Service of Canada

Kelly Taylor, and Kelley Blanchette²

Research Branch, Correctional Service of Canada

Dialectical Behaviour Therapy (DBT), is an empirically supported, systematic and comprehensive psychotherapeutic approach for treating individuals struggling with severe emotion and behavioural dysregulation (including chronic suicidality, intentional self-harm, as well as extreme and problematic impulsive behaviour.³ DBT, employing cognitive and behavioural principles united by strategies to achieve balance and underlying assumptions, is increasingly being used to treat individuals presenting with these difficulties. In community-based settings, DBT was more effective than community based treatment-as-usual in reducing incidence and severity of parasuicidal acts (including suicide attempts), therapy drop-outs, inpatient psychiatric days, and self-reported anger, and in increasing interpersonal and global adjustment.⁴ This article describes DBT and outlines the Correctional Service of Canada's (CSC) adaptation of the therapy. In particular, the article highlights CSC's Comprehensive DBT Model and the evaluation framework developed to assess its effectiveness with women offenders.

Dialectical Behaviour Therapy: Foundations

DBT was developed from a joint motivational and capability deficit model of problematic behaviour. In brief, in such a model, personal difficulties stem from:

- 1) deficits in important interpersonal, self-regulation (including emotion regulation) and distress tolerance skills, and
- 2) personal and environmental factors that reinforce maladaptive behaviours and inhibit the use of existing behavioural skills and the development of new skills and capacities.

DBT is framed by an overarching perspective that emphasizes the interrelatedness and wholeness of reality and the synthesis of opposites. The dialectical viewpoint is the foundation upon which the entire structure of the treatment rests. Dialectics is a process of achieving balance. In DBT, synthesis, or balance, is sought on several levels: the key dialectic

being *acceptance* on the one hand and *change* on the other. Thus, DBT includes specific strategies to promote acceptance and validation of the individual's current capabilities and behavioural functioning (e.g., mindfulness; recognizing aspects of problematic behaviour as having an adaptive function). These are balanced by strategies for promoting change (e.g., behavioural analysis, problem solving, contingency procedures, skills training) which teach the individual more adaptive ways of dealing with difficulties and assist in the acquisition of skills to accomplish this. Dialectical strategies inform all aspects of DBT treatment.

DBT targets skill development to address dysregulation in the sphere of emotions, relationships, cognition's and behaviours while increasing adaptive behaviours. The goal of DBT is for individuals to increase dialectical thinking, emotional and behavioural patterns — to learn and refine skills to identify and change rigid, dichotomous patterns associated with significant problems in living.

Standard DBT — DBT as originally developed by Dr. Linehan — involves four treatment components: individual psychotherapy, skills training, telephone consultation (to provide additional support and assistance to clients, especially during crisis) and therapist consultation. The purpose of DBT is to: 1) improve behavioural capabilities; 2) improve motivation to change; 3) promote the generalization of new capabilities to other environments (e.g., everyday life settings); 4) structure the environment to support the individual and inter-disciplinary treatment team members' capabilities; and 5) enhance inter-disciplinary treatment team members' capabilities and motivation to treat individuals effectively.⁵ DBT treatment is a process that involves the collaborative efforts of the clinicians/service providers and the individual in order to devise the most effective intervention. This process encourages individuals to acquire and generalize skills to

more appropriately and effectively address their mental health and other needs at a pace consistent with their needs and learning styles.

CSC correctional/forensic adaptation

DBT has been applied in correctional/ forensic settings and appears promising for assisting offenders manifesting the problems associated with severe emotional and behavioural dysregulation.⁶

These initiatives have integrated recent theoretical and clinical thinking suggesting that Borderline Personality Disorder (the population DBT was originally developed to treat) and Antisocial Personality Disorder (highly prevalent in forensic/ correctional settings) share several common characteristics, lending support to efforts aimed at such treatment adaptations.

CSC first introduced DBT for use with women offenders in 1997, in an effort to respond to the needs of those women presenting serious emotional and behavioural difficulties. The consideration of DBT as a treatment option was supported by the fact that its theoretical base is compatible with the *Mental Health Strategy for Women Offenders*⁷, and its approach to treatment is non-pathologizing, client-centred and empowering. Between 1997 and 2000, various CSC facilities for women offenders offered some aspects of DBT. A great deal was learned from these early initiatives and for the past several years, CSC National Mental Health Services has been concentrating its efforts on an extensive adaptation of DBT to address the needs of its correctional populations. In 2001, the Service began exploring options for extending the availability of DBT to its male population. Three CSC DBT Models have been developed: Comprehensive DBT (for use with offenders residing in mental health units), General DBT (for offenders in general population) and Secure DBT (for maximum-security women offenders).

While integrating key targets and treatment components of the original model, CSC's adaptations have needed to also address: an expanded target offender population (including correctional-specific targets), a different treatment context or environment (prison as compared to community out-patient), and then within the carceral environment, the needs associated with different settings (general population inmates, inmates housed in treatment facilities, and maximum-security inmates). Moreover, broader organizational factors, such as consistency with, and

incorporation of, correctional philosophy, principles and practices, as well as planning for multi-site implementation were addressed.

The adaptations have included modifying published DBT materials (particularly the Skills Training Manual)⁸ and the development of CSC-specific materials to support training and implementation of DBT with CSC offender populations. For example, materials required extensive modification and development so that they were sensitive and relevant to a carceral offender population and environment; inclusive of criminogenic considerations; integrated crime cycle and relapse prevention information; had straightforward and understandable language; and had clear directions accompanying *any* and *every* treatment tool, procedure or homework assignment. Additional treatment tools were developed to support treatment team consultations (particularly to enhance communication between staff involved in the various treatment components and shift-work schedules), behavioural analyses and the implementation of contingency procedures. Further, materials were developed to standardize, as much as possible, the administering of DBT treatment components across multi-sites, so that information regarding best practices and further adaptation of treatment materials could be efficiently distributed and data on treatment process and outcome aggregated nationally.

Finally, to support the implementation of its DBT Models, CSC developed a national training curriculum for DBT with specialized training specific to each of the Models and designed for delivery to an inter-disciplinary team comprised of both correctional and clinical staff. As such, training begins from the point of assuming that some participants will have no prior knowledge of cognitive-behavioural theory and principles. In addition, ongoing training and consultation is provided nationally.

CSC's comprehensive DBT Model

In 2001, CSC opened *Structured Living Environment (SLE)* units in each of its four regional institutions for women offenders. These SLE units each accommodate eight medium- and minimum-security women whose significant mental health needs are addressed by an interdisciplinary team providing 24 hour support and supervision. The two primary treatment models being implemented in each of the SLE units are DBT and Psychosocial Rehabilitation (PSR).⁹

The Model of DBT implemented in these units is the Comprehensive Model — the most intensive of the CSC DBT Models. Within the context of an effective therapeutic environment, the Comprehensive Model incorporates the following treatment components: Individual Psychotherapy (minimum 1 hour/week); DBT Skills Training Sessions (once or twice/week); Support/Coaching (available 24 hours/day); DBT Team Consultations (various formal and informal consultations with DBT treatment team members); and DBT National Consultations (including weekly conference calls with the psychologists and site visits).

The DBT Treatment Team staff, in consultation with each of the participants identifies individual treatment targets. Consistent with the Linehan model, these treatment targets are arranged in a hierarchy with imminently life-threatening and unit destructive behaviours and are rated first priority. When significant treatment gains have been achieved, the treatment focus is shifted to quality-of-life interfering behaviours. Adaptive behaviours the participant already has in her repertoire are also identified, so that these may also be targeted for increase. Targeted behaviours (behaviours to increase and behaviours to decrease) are also conceptualized in terms of corresponding skill development areas. Assistance in the acquisition of new skills occurs in the DBT Skills Training Sessions as well as in the therapeutic environment. Targeted behaviours and skills practiced are monitored daily by each participant on a *DBT Diary Card*.

Aside from the *DBT Diary Card* providing a means for analyzing behaviour daily and weekly (particularly when these are reviewed by the psychologist in the individual sessions), the use of behavioural analyses figures prominently in the therapeutic environment. When a participant is struggling with making a decision, or has engaged in a slightly problematic response to a situation, staff assign a *Decision Balance Sheet* — a treatment tool designed to quickly assess the ‘pros and cons’ of choosing, or having chosen, a particular behaviour. When more egregious problem behaviours have occurred, staff assigns a *Behaviour Chain Analysis*, that assesses, in intricate detail, the entire problematic event. The focus is placed more heavily on what led up to the event (internal and external vulnerability factors, precipitating factors and the prompting event) and the consequences that occurred following it, as well as an analysis of possible

alternative solutions, rather than the display of the problem behaviour itself. This is done so that treatment team staff and the participant can examine the behaviour in its entirety — the accompanying thoughts, emotions, body sensations, actions and the reactions of others. Given that participants generally consider the *BCA* aversive, a *BCA Protocol* has been established to assist in managing the contingencies around its completion, including a 24-hour rule for the completion of a first draft.

Comprehensive DBT is an intensive and thorough psychological treatment. The process of change is a slow and difficult one — taxing both the participant and the treatment team. It is anticipated that participants stay in the treatment for at least a year — continually understanding, analyzing and changing behaviour, cycling through the Skills Training Sessions, abandoning maladaptive behaviours, and acquiring, practicing and integrating new skills to improve their quality of life.

Evaluation

A complete program evaluation framework has been integrated into the SLE Comprehensive DBT Model. The evaluation will use a multi-method, multi-wave approach in its overall assessment, and both qualitative and quantitative research methods will be employed in a longitudinal study design. Interviews and surveys will be administered to staff and program participants throughout the implementation of the program and quantitative assessment scales will be administered to participants and staff pre-, interim- and post-program. This approach will mitigate methodological biases resulting from use of only one method in addition to tracking program effectiveness as the program advances.

Dynamic quantitative assessment measures were selected based on: their link to treatment targets; appropriateness and availability of normative data for women offenders, and Aboriginal people; reading level required (for self-report measures); and time, cost, and expertise required for administration. Quantitative assessments will examine the following areas: inmate functioning in six different domains (including daily living, interpersonal relations, personal involvement/development, institutional behaviour, work conduct and mental health issues); psychiatric symptomatology; psychological symptom patterns; coping strategies; subjective mood states; self-control behaviours; and negative

experiences and pessimism concerning the future. Finally, an estimate of the extent of socially desirable responding (managing the impression one gives by describing themselves in overtly positive terms or exaggerating virtues as a result of self-deception) that exists in the results provided by respondents will be included.

Research to date provides support for the utilization of the above mentioned assessment instruments. More specifically, a comprehensive review of the literature reveals that randomized clinical trials indicate treatment targets such as parasuicide,¹⁰ social adjustment and anger¹¹ are important in the evaluation of a DBT program. Preliminary findings in uncontrolled clinical trials provide further support for treatment targets of depression,¹² and anxiety.¹³ Appropriately, each of these areas is evaluated with the assessment battery previously mentioned.

The evaluation was designed such that the measures have both clinical and empirical utility. More specifically, correctional staff can use the measures to assess each woman's current level of functioning and progress, and research staff can use the measures for an overall assessment of the treatment. Moreover, researcher will provide on-going individual or group feedback regarding the women's scores in

relation to published norms and to earlier assessments. Such an arrangement permits continuous verification of a participant's progress and assists in ensuring high completion rates of the assessment battery.

For ease of administration of the DBT test battery, all pre-, interim- and post-measures have been incorporated into a computer software application. The application has been implemented in each of the SLE units within four of the regional facilities (Edmonton Institution for Women, Grand Valley Institution for Women, Nova Institution for Women and Joliette Institution for Women) providing staff and program participants with an easily accessible and user-friendly reporting medium.

As previously mentioned, qualitative (staff and inmates interviews) information will supplement the quantitative assessment. Semi-structured interviews provide respondents with an opportunity to confidentially express personal views, feelings, and ideas about the program. Such qualitative data provides invaluable information that is overlooked when quantitative assessments are used in isolation.

Preliminary evaluation of the DBT Program is currently underway with the intention of determining any imminent successes, difficulties or concerns the treatment may be presenting. ■

¹ Inquiries regarding CSC's correctional adaptations of DBT should be directed to Donna McDonagh, 340 Laurier Avenue West, Ottawa, Ontario K1A 0P9.

² Inquiries regarding the assessment and evaluation of CSC's SLE Comprehensive DBT Model should be directed to Kelley Blanchette, 340 Laurier Avenue West, Ottawa, Ontario K1A 0P9.

³ DBT was developed by Dr. Marsha Linehan to treat individuals who meet criteria for Borderline Personality Disorder (BPD); the types of difficulties noted here are characteristic of the BPD diagnosis. See: Linehan, M. M. (1993a). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York, NY: Guilford Press. Also see, Linehan, M. M. (1993b). *Skills Training Manual for Treating Borderline Personality Disorder*. New York, NY: Guilford Press.

⁴ Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, A., and Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48, 1060-1064. Also see, Linehan, M. M., Tutek, D. A., Heard, H. L., and Armstrong, H. E. (1994) Interpersonal outcome of cognitive-behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry*, 151, 1771-1776.

⁵ Op. cit., Linehan, 1993a.

⁶ McCann, R. A., Ball, E. M., and Ivanoff, A. (2000). *Forensic modification of Dialectical Behavior Therapy modes, targets, and skills: The CMHIP Forensic Model*. Paper presented at the 8th Symposium on Violence and Aggression, Saskatoon, SK.

⁷ Laishes, J. (1997). *Mental Health Strategy for Women Offenders*. Ottawa, ON: Correctional Service of Canada.

⁸ Op. cit., Linehan, 1993b.

⁹ For more information on the Structured Living Environments (SLE), see: McDonagh, D; Noël, C., and Wichmann, C. Mental health needs of women offenders: Needs analysis for the Development of the Intensive Intervention Strategy. *Forum on Corrections Research* (this issue).

¹⁰ Op. cit., Linehan, Armstrong, Suarez, Allmon, and Heard, 1991. Also see Linehan, M. M., Heard, H. L., and Armstrong, H. E., (1993). Naturalistic follow-up of a behavioral treatment for chronically suicidal borderline patients. *Archives of General Psychiatry*, 50, 971-974.

¹¹ Op. cit., Linehan, Heard, and Armstrong, 1993, p. 971-974. Also see, Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., and Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline /personality disorder and drug-dependence. *American Journal of Addictions*, 8, 279-292.

¹² Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Boehme, R., and Linehan, M. M. (2000). Evaluation of inpatient Dialectical-Behavioral Therapy for borderline personality disorder: A prospective study. *Behaviour Research & Therapy*, 38, 875-887. Also see, Telch, C., Agras, S. W., and Linehan, M. M. (2000). Group dialectical behavior therapy for binge-eating disorder: A preliminary, uncontrolled trial. *Behavior Therapy*, 31, 569-582.

¹³ Ibid, Bohus et al, 2000, p. 875-887.