



**California Department of Corrections  
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**DIALECTICAL BEHAVIOR THERAPY:  
EVIDENCE FOR IMPLEMENTATION IN  
JUVENILE CORRECTIONAL SETTINGS**

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California Department of Corrections and Rehabilitation

# **DIALECTICAL BEHAVIOR THERAPY: EVIDENCE FOR IMPLEMENTATION IN CORRECTIONAL SETTINGS**

## **Background**

Dialectical Behavior Therapy (DBT) is an approach to mental health treatment that combines the techniques of standard cognitive behavioral therapy (CBT) with elements from the behavioral sciences, dialectical philosophy, and Zen and Western contemplative practice. It was developed by Marsha M. Linehan in the late 1970s to treat women with the symptoms of borderline personality disorder (BPD) and is the first and only therapeutic approach whose effectiveness in treating BPD has been strongly supported when subjected to an experimentally designed study. Repeated studies over a twenty-year period have established its effectiveness in treating women and men with emotional instability, cognitive disturbances, self-harming behavior, chronic feelings of emptiness, interpersonal problems, poor impulse control and anger management (Bohus, et. al, 2004; Linehan, et.al., 2006; Linehan, et. al, 1993; Linehan, et. al, 2001; Robins, & Chapman 2004). More recent research also strongly supports the utilization of DBT in effectively treating individuals with the varied symptoms and behaviors associated with spectrum mood disorders, self-injury, sexual abuse, and substance abuse (Brody, 2008, Decker and Naugle, 2008, Linehan, et. al, 2006). Research on DBT applications in correctional settings, although limited in terms of number and scope, has produced promising results. For example, a recent and carefully designed study of a DBT program (modified for a correctional population) produced positive institutional behavior outcomes for aggressive and impulsive men and women offenders in Connecticut (Shelton, et.al, 2009). DBT has also been found to be associated with reductions in recidivism for juvenile justice

involved youth with mental health issues in the state of Washington (Drake & Barnoski, 2005; Trupin, et al., 2002).

DBT bases its approach on the philosophical idea of “dialectic.” Dialectic is a type of reasoning that recognizes there can be more than one reality (polarities) and that the synthesis of these realities leads to continuous change. In employing DBT, the therapist teaches a type of reasoned thinking intended to replace the rigid “black and white” thinking patterns that contribute to intra- and interpersonal conflicts. Such “black and white” (or dichotomous) thought patterns lead to beliefs that prevent an individual from responding creatively in conflict situations. Dialectical thinking, therefore, can enable an individual to use problem-solving skills in a conflict situation by considering alternatives to rigidly held beliefs (Linehan, 1993).

DBT therapy involves five basic functions: 1) enhancing capabilities, 2) improving motivation, 3) ensuring generalization of skills, 4) structuring the environment, and 5) enhancing provider skills and motivation. There are four core treatment modes: 1) individual therapy, 2) skills training, 3) consultation group and 4) milieu in residential settings (or telephone consultation in outpatient treatment). DBT thus utilizes both one-on-one therapy and skills training, usually conducted in groups. In one-on-one therapy the therapist’s primary aim is to increase the youth’s motivation to change. Secondly the therapist’s aim is to encourage the individual to examine his or her behavior and, through coaching, increase skill development, improve thinking patterns, and develop better approaches to problem management. The goal is to increase adaptive thinking and behavior and reduce dysfunctional thinking and behavior. In skills training, for example, the facilitator guides the group in the use of specific skills in the following four major areas: 1) core mindfulness, which emphasizes focusing on the present moment, self control and self-awareness; 2) interpersonal effectiveness, which focuses on assertiveness and interpersonal skills in dealing with conflict in a manner that respects self and others; 3) emotion regulation, which focuses on identifying and describing emotions and how to reduce vulnerability to negative emotions and how to increase positive ones; and 4) distress tolerance, which focuses on distraction, self-calming techniques, and

strategies to help the individual accept traumatic events (Linehan, 1993).

## Implementation of DBT in Correctional Settings

Compared to other therapeutic approaches, DBT is relatively new. In regard to its application in correctional settings, much less in juvenile correctional settings, DBT is in its infancy and is only beginning to be thought of as a correctional treatment possibility. Nevertheless, it has been implemented in some adult and juvenile correctional facilities and has strong advocates. (Berzins & Trestman, 2004; Drake & Barnoski, 2006; McCann, Ivanoff, Schmidt and Beach, 2007).

Unfortunately, as with the implementation of any new treatment modality, DBT has frequently been only partially implemented or modified for specific purposes. DBT skills training segments, for example, are sometimes utilized with a variety of other treatment approaches. However, the goals for the implementation of the full DBT modality in correctional settings generally focus on: 1) a reduction of suicidal incidents, assaultive incidents, and other disruptive behavior; 2) a reduction in other problematic behaviors that can interrupt or delay treatment services to an individual or the unit; 3) an increase in staff morale and a corresponding reduction in burnout; and, 4) relapse prevention (i.e., recidivism reduction).

As in the standard delivery of DBT, once individuals in a correctional treatment setting achieve behavioral control (i.e. cease disruptive or self-injurious behavior), treatment targets shift to targeting the development of specific skills, skills generalization, and motivation, as described earlier (McCann, Ivanoff, Schmidt and Beach, 2007).

## Research on DBT in Correctional Settings

As mentioned above, DBT is a relatively new therapeutic approach and has not, therefore, been implemented in correctional settings long enough to produce much research literature. Berzins and Trestman (2004) reviewed DBT programs in ten correctional settings in the United States and Canada that were implemented to assist in the management of inmates with the most severe behavioral problems or personality disorders. The programs were strongly supported by their institutions, but no scientific study was conducted to establish their effectiveness. Program monitoring data was often available, such as reports of incidents, segregation, and restraint, but anything more was not recorded in a form useful for evaluation.

As also mentioned above, DBT has been only partially implemented or has been implemented with modifications in many cases. Additionally staff has typically received little or no formal DBT training. Ivanoff, Schmidt, & Finnegan (2006) report that among the reasons cited for the partial or modified implementation of DBT programs are DBT's alleged incompatibility with correctional programs, the unwillingness of staff to participate, its complexity and cost to fully implement, and a sentiment that not all its components are necessary in a given setting.

Research on partially implemented or modified DBT correctional programs, even if available, cannot be considered valid tests of DBT's effectiveness because omitting or modifying various components has unknown effects on outcome. To date, the research literature on correctional DBT programs does not include any long-term experimentally controlled studies (i.e., with randomly assigned treatment and control groups). McCann, Ivanoff, Schmidt, and Beach (2007), however, argue that evidence from two major studies (summarized below) and other smaller examples of DBT strongly suggest that DBT be used in correctional settings.

### ***DBT Implementation at the Colorado Mental Health Institute in Pueblo Colorado***

The Colorado Mental Health Institute in Pueblo (CMHIP) implemented DBT in a 300 bed adult inpatient division housed within a 600 bed state hospital in 1995. Of the 300 residents in the division implementing DBT, 180 had been committed to CMHIP for adjudications of “not guilty by reason of insanity” (NGRI) for mostly violent crimes. Of these, 160 were male. Most of the residents had Axis I diagnoses and one-third had a concomitant Axis II diagnosis. Most also had substance use disorders. The mean length of stay was 6 years.

The DBT program implemented by CMHIP was comprehensive and was operative on two units within the inpatient division mentioned above. One was a medium-security unit and the other a minimum-security unit. Data were collected for 19 months. Outcomes for residents who received DBT were compared to a “treatment-as-usual group” but the two groups were not randomly assigned nor otherwise controlled for differences. Those who received DBT demonstrated increased effective coping skills, decreased ineffective coping skills and decreased hostility and depression (McCann, Ivanoff, Schmidt & Beach, 2007; McCann, Ball, & Ivanoff, 2000).

### ***DBT Implementation by the Washington State Juvenile Rehabilitation Administration***

The Washington State Juvenile Rehabilitation Administration implemented a pilot DBT program in 1998 in order to determine whether DBT reduces recidivism. It was designed for residential juvenile offenders with mental health problems. The evaluation was conducted by the Washington State Institute for Public Policy.

Although the study showed reductions in recidivism for the DBT participants compared to the comparisons, the differences between the two groups were not statistically significant. Additionally, the experimental and comparison groups were not randomly assigned or adjusted for demographic and other characteristics that could possibly affect outcome. However, youth in the DBT group were

found to have slightly higher scores on measures of criminal history, were younger, had higher Initial Security Classification Assessment risk scores, and had shorter stays in the Washington State Juvenile Rehabilitation Administration facilities. These characteristics of the experimental (DBT) group's characteristics put them at higher risk of recidivism than those in the comparison group.

Study findings showed that by 36 months following release, the DBT group had 19 percent fewer post-release convictions overall. The DBT group also had lower recidivism rates for all types of offenses, including 15 percent fewer felony convictions and 9 percent fewer convictions for violent offenses than the comparison group. The Washington researchers argue that the higher risk characteristics of the experimental (DBT) group provide additional support for the argument that DBT is effective in reducing recidivism. Nevertheless, the outcome differences between the groups were not considered statistically significant due to their small size. (Drake & Barnoski, 2006).

## **Discussion: Issues in implementing DBT in Correctional Settings**

Dialectical Behavior Therapy has been implemented thus far in a small number of correctional settings and only within recent years. This is even truer with regard to juvenile corrections. Correspondingly, little research has been completed, with existing work limited in scope and scientific rigor. Several replications of carefully conducted, long-term scientific studies (with random assignment to DBT or an alternative) must be conducted before any definitive statements regarding its unique effectiveness or efficacy in correctional settings can be made. It should be noted here, however, that DBT is a type of cognitive-behavior treatment (CBT) and CBT is evidence-based. CBT has been successfully demonstrated to be effective in a variety of correctional settings for many years (Morgan & Flora, 2002).

Implementing DBT in correctional settings also has its challenges. Although it addresses explicitly therapy-interfering behavior, common correctional challenges to

therapy such as lockdowns, group consequences for the behavior of a few, and inmate on inmate pressure to conform to behaviors inconsistent with societal norms need to be specifically addressed by DBT providers. Other challenges include the expense of bringing on trained therapists as well as the necessity to provide DBT training for all staff members that interact with those receiving treatment. This is a particular challenge in the face of severe budget restraints and high staff turnover.

A review of the literature, nevertheless, indicates that there are a number of compelling reasons for conducting pilot studies of DBT in correcting settings. McCann, Ivanoff, Schmidt and Beach (2007) group these into four major points, which are roughly paraphrased below:

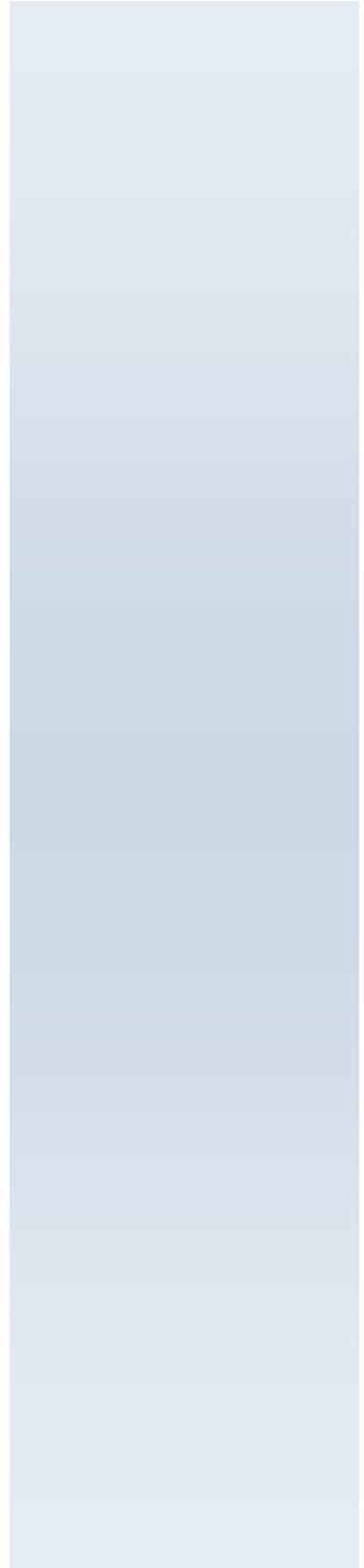
1. The first reason is the high proportion of individuals with personality disorders in the correctional population. DBT, unlike most current rehabilitative approaches, addresses both short-term management and adjustment issues (that are critical in working with individuals with personality disorders) as well as the longer-term rehabilitative goals of behavior change and recidivism. DBT, for example, has been shown to be the only effective treatment for Borderline Personality Disorder.
2. The second reason is that DBT is a highly structured, comprehensive cognitive-behavior treatment (CBT) program. As mentioned above, CBT is an evidence-based treatment program that has been successfully demonstrated as effective in a wide variety of correctional settings for many years. For example, Morgan & Flora (2002) report a number of positive effects of CBT from a meta-analysis of 26 research articles examining the effectiveness of group therapy with adult correctional populations: improvements in 1) interpersonal functioning, 2) self esteem, and 3) anger management; a reduction in reported feelings of anxiety; and fewer disciplinary problems. Allen, Mackenzie and Hickman (2001), reviewed studies of

the implementation of two distinctive types of CBT in correctional settings: CBT with a focus on the improvement of moral reasoning and CBT targeted at criminogenic thoughts and attitudes. Each was found to reduce recidivism. DBT includes both approaches.

3. The third reason is that DBT was designed to, and has been shown to be effective at managing life threatening and aggressive behaviors (against self and others) that are common in correctional populations with high rates of antisocial personality disorder (ASPD), borderline personality disorder (BPD) and psychopathy. In the absence of such a mental health treatment framework, correctional staff may perceive some of these symptoms of mental illness as simply “bad behavior” and respond solely with punitive actions (Cohen, 2003). Stress among both custodial staff and inmates can be alleviated when such disorders are effectively treated (Trupin, et al., 2002; Robbins and Chapman, 2004).
4. The fourth and final reason is that DBT appears to successfully address staff burnout, which is common in correctional settings (McCann, et.al, 2000). The threat of violence is the most frequently identified source of stress among correctional officers and is exacerbated by inmates with severe behavioral problems. (Appelbaum, Hickey & Packer, 2001). DBT addresses this by providing effective treatment and management strategies for inmates as well as including consultation groups for staff. The consultation groups function not only for purposes of case management, but also function as a forum for staff training and support.

The provision of DBT is obviously resource intensive and requires a broad base of support for the idea that people can change. Obtaining such resources and support is naturally more feasible in regard to juveniles than adults. The reason

for this is the assumption, which is not unfounded, that juveniles are generally more amenable and deserving of treatment and a chance to change than are adults.



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