The 2018 APT Awards for Excellence in Dialectical Behaviour Therapy

Entry:
Rose Ward, St Andrew's Healthcare, Northampton

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Weighting and Waiting: Integrating DBT into Forensic Neurobehavioural Rehabilitation

Introduction

Rose ward is a 17-bedded medium secure neuro-rehabilitation unit for adult men with a brain injury. Patients' neurological and psychiatric diagnoses include; ABI, TBI, dementia, stroke, epilepsy, Huntington's disease and psychosis. Pre-admission assessment highlights the potential to benefit from neuropsychological rehabilitation in a forensic environment. The unit treatment philosophy combines two approaches – 'the Good Lives Model' and 'Neurobehavioural rehabilitation'. Thus individualised approach goals (Ward & Stewart, 2003) are identified and worked towards within a structured environment supportive of positive behaviours (Woods, 1987).

Individual Adapted DBT within a Forensic Context

One young, male patient (pseudonym Joel), with an acquired brain injury was receiving individual CBT sessions, but presented with increasing levels of maladaptive behaviour, such that the team considered referral to high secure. The behaviours were driven by frustration about his losses, continued incarceration (perceived as outside of his influence) and associated self-derogatory negative thoughts. At this stage a referral was made for Dialectical Behavioural Therapy (DBT) to help him replace his maladaptive behaviours (e.g. aggression and self-harm) with adaptive coping strategies (e.g. ADBT skills). The patient's impaired cognitive ability had precluded enrolment in the standard medium-secure DBT programme. A Trainee Psychologist trained in DBT, was however able to offer weekly 1:1 sessions using materials from the Adapted DBT (ADBT) group skills programme developed within St Andrew's Healthcare. The ADBT modules consisted of Mindfulness, Interpersonal Effectiveness, Coping in a Crisis and Emotional Regulation. Mindfulness was repeated in-between the other modules, to allow repetition of key skills.

Weekly 1:1 sessions, began with the introduction of mindfulness and included homework. He would often neglect to complete this and his memory for the skills was poor. He was still engaging in self injurious behaviours and was spending time in seclusion.

To increase the relevance of the DBT work, weekly supported homework sessions were introduced. In addition, feedback sheets containing that week's DBT skill were created for staff to use during each of his three daily feedback sessions. This aimed to reinforce the skill and encourage learning through repetition. Feedback also encouraged him to consider daily incidents of where other people had interacted with him positively and how his positive behaviour towards had been recognised and/or socially reciprocated. His progress and comprehension were reviewed weekly by his nurse care-co-ordinator to re-inforce his participation in all aspects of this work.

An example of the current weeks DBT skills featured on his feedback sheet:

This week's DBT Skill is 'Right Now', using our 5 senses to do something Right Now to distract from thoughts about the past and future. To be used when I feel angry, anxious or sad.
Exercise: Think of 5 things I can see, 4 things I can hear, 3 things I can touch, 2 things I can taste/smell, 1 deep slow breath and focus on breathing here and now.

Staff were apprehensive about being able to support Joel in using his DBT skills when in crisis, as they had no DBT knowledge. The ward's Assistant Psychologist delivered training, looking at the characteristics of the patient (behavioural/interpersonal/self/cognitive instability), the different components of DBT and how these link together. The aim of the training was not to teach DBT skills, but to help staff to understand how DBT could help Joel and to introduce the new DBT-orientated sheets that they would be using during feedback sessions. Thus staff would learn DBT skills with him week by week.

Results

There was an overall reduction in total aggression following the introduction of ADBT (591 v. 296). Within this, aggression towards others had reduced (42 v. 3), but there had been an increase in self-harm behaviours (139 v. 221). With the ensuing introduction of the weekly homework sessions, the 3 times daily feedback sessions and the noticing of positive interactions there was a clinically significant reduction in overall aggression (296 v. 45), self-harm behaviours (221 v. 40) and aggression towards others (3 v. 0). These reductions have continued and been sustained following the discontinuation of the ADBT.

	27/02/17-25/06/17 **No DBT sessions**	26/06/17-19/11/17 **DBT sessions introduced**	20/11/17-25/03/18 **DBT sessions, homework sessions & 3xDaily Feedback**	26/03/18-25/06/18 **3xDaily Feedback** **DBT sessions ended**
Total Aggression	591 (33 per week)	296 (14 per week)	45 (2.5 per week)	19 (1 per week)
Self Harm behaviours	139 (8 per week)	221 (11 per week)	40 (2 per week)	11 (<1 per week)
Aggression against others	42 (2 per week)	3 (<1 per week)	0	0

During this time he also reported a reduction in the frequency and intensity of intrusive thoughts which tended to trigger episodes of aggression.

Discussion

Joel has engaged well in the ADBT programme and there has been a noticeable difference in his presentation since it started. Aside from reduced levels of aggression, staff have reported that he is thinking things through more often, e.g. if declining medication, he goes to his room, comes out shortly after and requests his medication. It is likely that the supportive components of homework and feedback were vital in him translating the academic aspects of DBT into practical coping strategies, as they helped him to comprehend, remember and see the relevance of what had been introduced in his weekly session. In addition, basic CBT strategies have complemented this approach, addressing his feelings of worthlessness and suspiciousness of other people's thoughts about him.

Recently, during a Low Secure NHS gatekeeping assessment, when asked about the effectiveness of his integrated psychological therapy approach Joel stated that "he had doubted it initially, but that he had noticed how helpful it had been in enabling him to think before acting and weighing up the pros and cons".

He is now waiting for confirmation of funding so he can transfer to a locked rehabilitation ward nearer to home, following his remarkable progress over the last year. He reports feeling happy and looking forward to having future opportunities to be part of the wider community.

There are a number of important factors in his progress, including Joel's motivation to move to lower, not higher secure placements, the ability of the staff team to provide a consistent collaborative intervention and the informed yet flexible application of combined approaches. There is no doubt however that DBT when introduced in a timely manner provided a comprehensive framework and language that could be shared by Joel and the team, in addition to providing him with some basic, independent coping strategies. Beyond this weighting is hard to attribute. But for Joel waiting is no longer his only strategy….

References

Ward, T., & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. *Professional Psychology: Research and Practice*, *34*(4), 353.

Wood, R. L. (1987). *Brain injury rehabilitation: A neurobehavioural approach*. Aspen Publishers.