IS MINDFULNESS GOOD FOR PSYCHOPATHS ?

ADAPTING DIALECTICAL BEHAVIOR THERAPY FOR PSYCHOPATHIC OFFENDERS

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Overview

- Background
- Introduction to DBT
  - Rationale and theoretical overview
  - Elements of treatment
- Adaptation to offender treatment
  - Challenges in adapting DBT
- A case vignettes or three
- Summary/Future directions

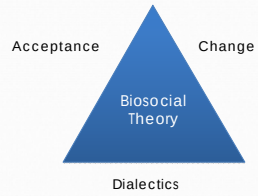
What Should Offender Treatment Look Like?

- Core issues include:
  - RNR principles
  - Addressing motivation to change
  - Acceptance and non-confrontational approach
  - Development of pro-social skills
  - Measurable outcomes

What is DBT?

- Integrative treatment incorporating cognitive, behavioral techniques with mindfulness-based strategies
  - Originally developed by Linehan (1993) for treatment of self-injury in Borderline PD
  - Subsequently applied to wide range of problem behaviors (substance abuse, eating disorders, juvenile offenders)

Theoretical Background & Treatment Frame



Underlying Biosocial Theory

Biological Dysfunction in the Emotion Regulation System

Invalidating Environment

Pervasive Emotion Dysregulation (BPD)

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Invalidating Environment

Pervasive Emotion Dysregulation (BPD)
Under-experience of Emotion (Psychopathy)

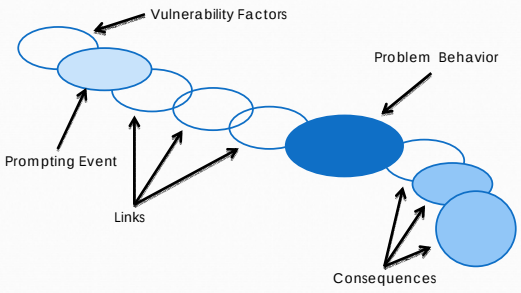
The General Approach

- Principle, not protocol driven
  - Allows for considerable flexibility but creates challenges for therapists
- Treatment engagement is CRUCIAL first step
  - Validation is integral to developing engagement
- Focus is development of skills, not insight
- Functional assessment of individual behavior key
- Individual and group elements support each other

What Is Validation?

- Validation is:
  - Treating the client as worthy of attention and respect
  - Finding kernels of truth or wisdom in client's behavior
  - Seeing the the client's point of view – and saying so
- What validation can do is:
  - De-escalate a dysregulated individual
  - Reduce isolation, stress and opposition
  - Strengthen ability to find own wisdom, confidence
  - Strengthen the relationship
  - Increase desire to solve problems, change behavior

Behavioral Chain Analysis



Elements of DBT

- Four "modes" of treatment
  - *Group skills training* – 4 modules: mindfulness, emotion regulation, distress tolerance, interpersonal effectiveness
  - *Individual therapy sessions* – focuses heavily on behavioral analysis, reviewing problem behaviors, applying skills
  - *Coaching* – enables application of skills to everyday problems and situations
  - *Consultation team* – provides support and feedback for therapists
- *Ancillary treatments* often recommended – e.g., substance abuse, psychopharmacology

Adapting the Approach

- Emphasizing commitment
  - Explicit validation of mandated tx/power differential
  - Problem Orientation: MUST find shared genuine goal
- Treatment targets
  - Instant offense is starting point, but often minimized
  - Other illegal behaviors
- Treatment interfering behaviors
  - Lying, threats, being unavailable for tx (rearrest)
- Structuring the environment (SAFETY)
  - Observing limits around self-disclosure
  - Multiple staff available at all times
  - Regular violence risk assessments

Commitment Strategies

- Issue of mandated treatment prominent
  - Explicit validation of experience of mandated treatment
  - Explicit validation of bias, racism, injustice in their lives and the criminal justice system, as appropriate
  - Freedom to choose with absence of alternatives
- Agreement on goals is essential
  - Is life worth living?
  - What changes would YOU like to see?

Treatment Target Hierarchy

1. Life-threatening behaviors
   - Violent behaviors, thoughts, and urges
   - Suicidal behaviors, thoughts and urges
   - Serious criminal behaviors and urges
2. Therapy-interfering behaviors
   - Absenteeism, lying, no homework
3. Quality-of-life interfering behaviors
   - "Minor" or non-violent criminal behaviors
   - Interpersonal, employment, housing, school-related
   - Mental health/substance abuse needs

Adapting the Skills

- Most skills were originally developed for women
- Adaptations for antisocial males include:
  - Finding balance between demands of probation, work, other obligations, AND impulse to refuse treatment
  - Weighing pros/cons of impulsive actions in response to frustrating situations (e.g., impulse to fight, no-show)
  - Using mindfulness exercises to address reactivity
  - Teaching validation and dialectical thinking
  - Challenging cognitions that support antisocial behaviors w/ dialectical strategies, not confrontation
  - Teaching problem-solving skills

Summary of DBT Approach

- DBT principles appear to have excellent utility
- Need to focus on all emotions, not just distress
- Concept of dialectics avoids power struggles
- Treatment engagement and extensive validation allows treatment to occur
- Behavioral contingencies frequently create problems in real world … crime and aggression pay!

Project SHARP

- 6-month program comparing DBT, anger mgmt
  - Participants referred from NYC Dept of Probation, court (direct), lawyers (most mandated to tx)
- Initial intake assessment focused on diagnosis, understanding offense, violence risk assessment
  - Collateral info available varied from none to extensive
- Formal assessment before participation included
  - Structured clinical interview (SCID I & II, PCL-SV)
  - Battery of self-report questionnaires
- Exclusion criteria: acute or unmanaged psychosis, high risk of violence, adults, English speaking

Preliminary Observations

- Began expanding treatment population from stalking to DV to general offender sample
  - Incorporated CAPP to permit more comprehensive assessment of psychopathy, assessing change
- Varying levels of success
  - No apparent connection to psychopathy severity
- Trainee therapists seemed to disarm offenders
  - Helps minimize power struggles

Case Vignette: RH

- 31 y.o. BM referred after domestic violence arrest
  - Multiple prior arrests for domestic violence
  - Also had hx of gun possession & distribution charges (first arrested at age 15, multiple felony charges)
  - Raised by mo, in/out of group homes as child; extensive hx of physical abuse – family and in group homes
  - PCL-SV=19; dx'd w/ APD, cannabis abuse
  - Initially manipulative and superficial; some attendance probs (late, occasional missed sessions)
  - By month 4, had become more engaged; actively participating in group, calling between sessions
  - At 2-year f/u had no re-arrests

Case Vignette: VL

- 23 y.o. mixed race M, arrested for grand larceny but w/ extensive psych hx, multiple past violent offenses
  - Raised in foster care 2° mo's substance abuse; ran away frequently, involved in ETOH/SA since 10 y.o.
  - > 20 prior arrests;
  - Multiple prior hosps, suicide attempts/gestures
  - High level of psychopathy (PCL-SV=21); met dx criteria for APD, BPD, Paranoid and Depressive PD's
  - Easily engaged but VERY needy; attendance probs due to childcare responsibilities (gf's child)
  - Completed tx, w/ no evidence of reoffense @ 2 yr f/u

Case Vignette: LR

- 29 y.o. HM referred for stalking and DV; had multiple open cases against two different women
  - Attributed charges to anger when both women discovered he was cheating on them
  - Lived in multiple homes as child; on own since 14 y.o.
  - Had moderate level of psychopathy (PCL-SV=16) and significant ETOH/SA hx, but no prior psych tx
  - Attended 3 sessions, but rearrested on new charge
  - Resumed tx 3 mos later, but rearrested after another 3 sessions; never able to engage in tx

Case Vignette: AW

- 27 y.o. WM self-referred at gf's suggestion
  - Acknowledged long hx of criminal behavior, infidelity in relationships, but no prior arrests
  - Upper middle class background (both parents MDs), college grad, but minimal work hx, aimless lifestyle
  - Hx of psych tx, dx'd w/ APD, bipolar (Rx: Depakote)
  - Motivation seemed questionable; presented as very manipulative, but more engaged as tx progressed
  - Therapist left mid-tx; requested continued tx outside of study (offered $, meet at Starbucks); became angry when request not met and refused new therapist

Lessons Learned (The Hard Way)

- Psychopaths are heterogeneous
  - Stereotypical presentation is not the norm
- And assessing psychopathology is challenging
  - Data collected at baseline may under-estimate actual psychopathy AND psychopathology
  - Need to integrate clinician observations without blurring treatment effects and instilling biases
- Assessing outcomes is even harder !!
  - Frequent distortion on self-report questionnaires
  - Adopting a "relapse" model is challenging

Assessing Treatment Success

- Self-report measures are problematic
  - Baseline data is of questionable validity AND measures of response bias cannot "control" for distortions
- Re-offense is also a crude indicator
  - Obscures "hidden" differences in case outcomes
  - Model "accepts" some re-offenses during tx; offenses AFTER completion are more problematic
  - Differences also exist within TYPE of reoffense
- Pilot study focusing on psychophysiological and behavioral indicators of change

Ethical Challenges

- Setting up randomized trials is hard …
  - But not impossible
- Ethical issues for court-ordered treatment
  - Research is voluntary but treatment may not be
  - Offering untested treatments are also a concern
- Confidentiality also presents complications
  - Need to report potential violence, serious concerns
  - Has potential to create problems with tx alliance
- Maintaining therapist and staff safety
  - And other group members !

Next Steps

- Focusing on more specific questions
  - Are some commitment strategies more effective w/ psychopaths than others?
  - Are different techniques more effective with different types of psychopathic offenders?
  - How do we *systematically* adapt treatment to fit RNR?
  - Can behavioral and/or psychophysiological measures guide treatment outcome?

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