Behavioural and Cognitive Psychotherapy, 2011, 39, 243–247
First published online 30 November 2010 doi:10.1017/S1352465810000573

Dealing with Feelings: The Effectiveness of Cognitive Behavioural Group Treatment for Women in Secure Settings

Clive G. Long

St Andrew's Healthcare, and King's College London, St Andrew's Academic Centre, Northampton, UK

Barbara Fulton and Olga Dolley

St Andrew's Healthcare, Northampton, UK

Clive R. Hollin

University of Leicester, UK

Background: Women in secure psychiatric settings have gender specific treatment needs. The current study examined the feasibility of a Dealing with Feelings Skills Group training for dual diagnosis women admitted to a medium secure setting. **Method:** A pre-test – post-test design was used to evaluate a group programme adapted from dialectical behaviour therapy skills training. **Results:** Most patients had a primary diagnosis of personality disorder. Treatment completers ($n = 29$) were compared with non-completers ($n = 15$). Clinically significant changes in treatment completers were apparent on coping response measures of positive reappraisal, problem solving and alternative rewards; on measures of anxiety and suicidality; on self-reported ability to engage in activities to reduce negative mood and to recognize mood changes. Self-harming and aggressive behaviours also reduced in the 3 months following group treatment. **Conclusion:** An adapted coping skills component of DBT benefit many dual diagnosis patients: issues related to treatment drop-out and failure to benefit are discussed.

Keywords: Cognitive behavioural group treatment, women in secure psychiatric care, dual diagnosis.

Introduction

Women in secure psychiatric settings represent a distinct population that have differing treatment needs to men: they are more likely to receive a primary diagnosis of borderline personality disorder (BPD), to have fewer previous psychiatric admissions, and to be more likely than men to be convicted of arson (Long, Fulton and Hollin, 2008). Findings such as

Reprint requests to Clive G. Long, St Andrew's Healthcare, Billing Road, Northampton NN1 5DG, UK. E-mail: clong@standrew.co.uk An extended version is also available online in the table of contents for this issue: http://journals.cambridge.org/jid_BCP

these indicate the need for gender specific treatment planning that address the relationship between trauma histories, clinical presentation and antisocial behaviour.

Long et al. (2008) describe the development of "Best Practice Service for Women in Medium Secure Settings" using manualized gender specific CBT group treatment programmes for a population with both personality disorder and mental illness. Core group treatments include those that address areas central to the psychopathology of BPD, including relationship problems and emotional dysregulation (Linehan, 1993). Dialectical behaviour therapy (DBT), which has group coping skills training and individual treatment components, was developed for chronically suicidal people with BPD (Linehan, 1993).

This pilot study aims to evaluate the feasibility of cognitive behavioural group treatment adapted from DBT skills training for women with either a primary or secondary diagnosis of personality disorder (dual diagnosis) admitted to a medium secure setting. The evaluation will examine the characteristics of participants, difference between treatment completers and non-completers, resources utilized, and clinical benefits of this intervention in an everyday inpatient setting.

Method

Patient group

Forty-four women, with stable psychiatric symptoms participated: their mean age was 31.7 years, (*SD* 8.5) and their mean IQ was 84.41 (*SD* 15.32). Their primary diagnosis was Personality Disorder (emotionally unstable or with mixed features) ($n = 31$ [70.4%]) Schizophrenia and Schizoaffective disorder ($n = 10$ [22.7%] and Bipolar and Depressive disorder ($n = 3$; 6.8%). Personality Disorder was the secondary diagnosis for 10 patients (22.7%). All of the women were detained under Sections of the Mental Health Act 1983 and had a history of disturbed behaviour, self-harm, and emotional dysregulation. Index offences included major violence ($n = 17$; 38.7%), arson ($n = 12$; 27.3%), and grievous and actual bodily harm and assault ($n = 10$; 22.6%).

The setting

The study took place within two medium secure wards within the women's service of an independent, registered charitable trust hospital (St Andrews Healthcare, Northampton, UK).

Measures

All patients completed the Barratt Impulsiveness Scale (BIS 11; Patton, Stanford and Barratt, 1995). Pre- and post-group measures were chosen to assess emotional regulation coping skills, symptomatology, self-efficacy, and behavioural disturbance.

Dealing with Feelings Questionnaire (DWFQ) is a 4-item ad hoc self-report measure that covers the ability to a) tolerate emotional distress, b) engage in activities to reduce negative mood, c) engage in pleasant activities on a daily basis, and d) to recognise changes in mood.

Coping Responses Inventory (CRI: Moos, 1990). This 48-item questionnaire has 8 scales covering the use of cognitive and behavioural approach or avoidance strategies.

https://doi.org/10.1017/S1352465810000573 Published online by Cambridge University Press

The Anxiety, Depression, Suicidality, Hostility, Guilt and Tension subscales of the Expanded Brief Psychiatric Rating Scale (BPRS-E; Lukoff, Nuechterlin and Ventura, 1986). Symptom constructs are rated on a 7-point scale from "not present" to "extremely severe".

Generalized Self-Efficacy Scale (GSES; Jerusalem and Schwarzer, 1992). This 10-item scale assesses the strength of an individual's belief in his or her ability to respond to different situations and to deal with associated obstacles or setbacks.

The women were also monitored for risk behaviours grouped according to the categories of the Overt Aggression Scale (Yudofsky, Silver, Jackson, Endicott and Williams, 1986) in the 3 months before the commencement of the group and in the 3 months afterwards.

Group treatment

An individual orientation and information giving session preceded group work. A manualized cognitive behavioural group programme adapted from Linehan (1993) was developed and delivered by an accredited cognitive behavioural therapist and a trained co-facilitator. Group content and materials were adapted to ensure comprehension by individuals of below average cognitive functioning. Weekly, 90-minute group sessions covered distress tolerance (7 sessions), emotional regulation (8 sessions), and reducing emotional vulnerability (2 sessions). Individual sessions addressed issues relating to skills practise. Post group, participants developed individual relapse prevention plans based on coping skills they had found helpful.

Results

Completers v. non completers

Twenty-nine (65.9%) women who completed 12 or more sessions were classified as treatment completers. Completers were older [mean age 33.4 years (*SD* 8.97) compared to 28.4 years ($SD = 6.97$); $t(42) = 1.87$, $p < .05$]; and less likely to be single [69% v. 100%; $X^2 = (4)$ $p < .05$]; to have a criminal record prior to index offence [86.1% v. 94.3%; $t(42) = 2.77$; $p < .05$]; and to have a primary diagnosis of personality disorder [65.5% v. 80%, $t(42) = 2.19$, $p < .05$]. Non-completers scored significantly higher on both the BPRS Hostility subscale, [$t(21) = 2.90$, $p < .05$], and on the BIS 11; [$t\ (21) = 2.90$, $df = 21$, $p < .05$]. There were no differences between the two groups in terms of diagnosis, IQ or risk behaviours in the 3 months prior to group attendance.

Following treatment, completers had lower scores on the BPRS-E subscales of Anxiety [$t(24) = 1.86$, $p < .01$], Suicidality [$t\ (24) = 2.57$, $p < .0$], Guilt [$t\ (24) = 1.75$, $p < .05$] and Hostility [$t\ (24) = 1.52$, $p < .05$]. The CRI Approach subscales that showed significant change were Positive Reappraisal [$t\ (24) = 2.87$, $p < .01$], and Problem Solving [$t\ (24) = 3.21$, $p < .01$]. The CRI Avoidance subscale Alternative Rewards also changed significantly post treatment [$t\ (24) = 2.88$, $p < .01$] (see Table 1).

A clinically significant change for completers was defined as a combination of more than half of all subjects showing positive change in psychometric scores and a highly significant ($p < .01$) change on that psychometric for the whole group. Clinically significant changes were observed for the CRI Subscales, Positive Reappraisal; Problem Solving and Alternative Rewards; the BPR subscales Anxiety and Suicidality; and DWF items of ability to engage in

https://doi.org/10.1017/S1352465810000573 Published online by Cambridge University Press

Table 1. Pre and post group psychometric assessment ($N = 29$)

	Pre group		Post group	
Measure	Mean	(*SD*)	Mean	(*SD*)
BPRS-E Scale				
Anxiety***	3.92	(1.77)	2.44	(1.87)
Depression	3.14	(1.74)	2.92	(1.82)
Suicidality***	3.18	(1.55)	1.82	(1.71)
Guilt*	3.30	(1.22)	2.50	(1.16)
Hostility*	2.13	(1.45)	1.96	(0.97)
Tension	1.17	(0.65)	1.30	(0.70)
CRI				
Coping Response Inventory Approach Total***	43.85	(11.29)	49.34	(10.45)
Coping Response Inventory Avoidance Total***	56.75	(12.19)	57.56	(9.01)
*GSES**	25.36	(6.34)	29	(4.94)
DWF				
Ability to tolerate emotional distress	3.21	(1.47)	3.94	(1.42)
Ability to engage in activities to reduce negative mood***	3.92	(2.02)	4.82	(1.31)
Engagement in pleasant activities on daily basis	4.77	(1.74)	5.37	(1.26)
Ability to recognize changes in mood***	4.78	(1.65)	5.68	(0.92)

*$p < .05$; ***$p < .01$.

Table 2. Completers vs non-completers: means and standard deviations of number of risk behaviours according to Overt Aggression Scale

	Completers ($N = 29$)		Non-completers ($N = 15$)	
Risk behaviours	Mean	(*SD*)	Mean	(*SD*)
Physical aggression against self***	2.6	(1.17)	4.9	(2.34)
Physical aggression against people***	1.31	(0.71)	4.5	(1.89)
Verbal aggression	2.5	(1.04)	2.98	(1.12)
Total number of risk behaviours***	6.41	(2.92)	12.38	(5.35)

***$p < .01$.

activities to reduce negative mood, and ability to recognize mood changes. For non-completers only scores on BPRS-E Hostility reduced [t (10) = 2.75, $p < .05$] while BPRS subscale Tension scores increased [t (10) = 1.96, $p < .05$].

Risk behaviour outcomes for completers and non-completers

In the 3-month post-group period the mean number of risk behaviours was 6.41 (*SD* 2.92) for completers versus 12.38 (*SD* 5.35) for non-completers. There was a significant reduction in risk behaviours following treatment for completers. [t (21) = 3.1, $p < .05$] with self-injurious behaviours [t (21) = 2.89, $p < .05$], suicide attempts [t (21) = 2.92, $p < .01$] and physical assaults [t (21) = 3.21, $p < .01$] reducing. There was no change in risk behaviours for non-completers (see Table 2).

https://doi.org/10.1017/S1352465810000573 Published online by Cambridge University Press

Discussion

The uptake and completion of treatment was favourable when compared to previous reports of group CBT with dual diagnosis patients (e.g. Oestrich, Austin and Lykke, 2007). This may reflect the use of a manual-based treatment which considered responsivity in its construction and delivery, and which was neither patronising, too slow nor too demanding (McMurran and McCulloch, 2007).

Clinically significant changes following treatment were evidenced for the majority of treatment completers on measures of suicidality, anxiety, coping skills and the ability to engage in activities to reduce negative mood and to recognize mood changes. Results suggest that an adapted coping skills component of DBT may benefit a proportion dual diagnosis in patients without concurrent individual therapy (Sambrook, Abba and Chadwick, 2007). However, one-third of patients did not complete treatment nor improve. Issues for further investigation include judgements of psychiatric stability, readiness for treatment, and the possible adverse effects of group rather than individual therapy.

The lack of a control group in the current pilot study limits the robustness of the findings and the sample was not a representative cross-section of women in medium-secure settings. Nonetheless, the findings provide a basis for further research into the therapeutic potential of this type of treatment in secure settings for women with a history of behavioural disturbance and complex psychopathology.

References

Jerusalem, M. and Schwarzer, R. (1992). Self-efficacy as a resource factor in stress appraisal process. In R. Schwarzer (Ed.), *Self-efficacy: thought control of action*. Washington, DC: Hemisphere.

Linehan, M. (1993). *The Cognitive Behavioural Treatment of Borderline Personality Disorder*. New York: Guilford Press.

Long, C. G., Fulton, B. and Hollin, C. R. (2008). The development of a "Best Practise" service for women in a medium secure psychiatric setting: treatment components and evaluation. *Clinical Psychology and Psychotherapy*, *15*, 304–319.

Lukoff, D., Nuechterlin, K. and Ventura, J. (1986). Manual for the expanded brief psychiatric rating scale. *Schizophrenia Bulletin*, *13*, 261–276.

McMurran, M. and McCulloch, A. (2007). Why don't offenders complete treatment? Prisoners' reasons for non-completion of a cognitive skills programme. *Psychology, Crime and Law*, *13*, 345–354.

Patton, J. H., Stanford, N. S. and Barratt, E. S. (1995). Factor structure of the Barratt Impulsiveness Scale. *Journal of Clinical Psychology*, *51*, 768–784.

Moos, I. H. (1990). *Coping Responses Inventory Manual*. Palo Alto: CA: Stanford University and Veterans Administration Medical Centres.

Oestrich, I. H., Austin, S. F. and Lykke, J. (2007). The feasibility of a cognitive behavioural intervention for low self-esteem with a dual diagnosis inpatient population. *Behavioural and Cognitive Psychotherapy*, *35*, 403–408.

Sambrook, S., Abba, N. and Chadwick, P. (2007). Evaluation of DBT emotional coping skills groups for people with para suicidal behaviours. *Behavioural and Cognitive Psychotherapy*, *35*, 241–244.

Yudofsky, S. C., Silver, J. M., Jackson, W., Endicott, J. and Williams, D. (1986). The Overt Aggression Scale for the objective rating of verbal and physical aggression. *American Journal of Psychiatry*, *143*, 35–39.