the therapist may enhance the therapeutic alliance and help reduce dropout; and the focus on emotions other than anger may allow other skills to be learned (e.g., emotion identification and regulation) to treat skill deficits likely to contribute to aggressive and violent behavior.

References


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**DBT With an Inpatient Forensic Population: The CMHIP Forensic Model**

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**Implementation of Dialectical Behavior Therapy (DBT) in a forensic or criminal justice setting differs dramatically from standard outpatient DBT. Forensic patients are multiproblem patients with violent histories and multiple diagnoses including borderline personality disorder (BPD), antisocial personality disorder (ASPD), and comorbid Axis I psychotic or mood disorders. DBT was selected for this population because of its emphasis on treating life-threatening behaviors of patients and therapy-interfering behaviors of both patients and staff. The forensic inpatient DBT model described here includes modification of agreements, targets, skills training groups, and dialectical dilemmas. An additional skills module, the Crime Review, was developed to supplement standard DBT. Conclusions and recommendations for applying DBT in a forensic setting are presented.**

**FORENSIC INPATIENT SETTINGS**, including criminal justice and forensic hospitals, differ significantly from standard DBT outpatient settings. The patient/inmate population is incarcerated, male, and characterized by antisocial behaviors. In one study, 97% of correctional in-
Invalidation and staff burnout are normative in forensic settings. Therapy that effectively treats staff hopelessness, anger, and fear is needed.

Why Is DBT Appropriate for Forensic Inpatients?

The forensic setting, staff members, and attendant social and legal context are atypical of most outpatient therapy environments. First and most important, forensic staff members treat involuntarily incarcerated inpatients. Second, treatment is provided by a team of individuals (psychiatrist, psychologist, social worker, lead nurse, team leader, occupational therapist, recreational therapist, individual therapist, nursing staff), not primarily by a single individual therapist. Third, the forensic patient has limited choices regarding his particular treatment team. His individual therapist will be a paraprofessional assigned to the individual treatment unit. Treatment team policy may determine clinician-patient assignment and place additional restrictions on interactions beyond those defined by an outpatient setting. Finally, forensic staff members are responsible not only for treatment, but also for security.

Forensic inpatient settings may differ from standard DBT outpatient environments in that staff burnout is common in forensic settings. Burnout is characterized by pessimism with one’s work, frequent apathy or anger directed toward patients, and withdrawal from patient contacts and job duties (Jones, 1981). Correlates of burnout include factors common in inpatient forensic settings, such as high patient-to-staff ratios, frequent direct-care contact, and direct-care contact with difficult-to-treat patients (Maslach & Jackson, 1993). Forensic treatment providers work and live in a crime-and-punishment social context, at best apathetic, and at worst vengeful and unwilling to devote financial resources to patients viewed as criminal, dangerous, and unwanted. The record numbers of mentally ill who now live in prisons or jails, not mental health facilities, are released without treatment or discharge plans (Winerip, 1999). This social context invalidates forensic treatment providers. Thus, treatment that effectively addresses patients’, as well as staff’s, invalidation, hopelessness, anger, and fear is needed in forensic settings.

Five factors argue for the use of DBT in a forensic inpatient setting. The first factor is the incidence of personality disorder diagnoses in this population (Pasewark, Jeffrey, & Bieber, 1987). Strick (1989) found that 20% of forensic inpatients were diagnosed with personality disorders. Empirical validation suggests that DBT is the best practice for patients diagnosed with BPD. The second factor is that DBT is a cognitive-behavioral treatment with a clear behavioral target hierarchy. Wong and Hare (in press), reviewing the correctional treatment literature, concluded that cognitive-behavioral programs are more effective in reducing recidivism than less structured treatments. DBT is such a structured cognitive-behavioral treatment.
Managing aggressive or life-threatening patient behaviors in a forensic unit is a critical need. The DBT approach and systematic treatment of these behaviors is a third factor arguing for the use of DBT in this setting. DBT also addresses staff burnout and behavior that interferes with the conduct of effective treatment.

A final reason to implement DBT in a forensic inpatient setting is that hospital accrediting bodies such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) value systematic and empirically validated behavioral interventions. JCAHO recently recognized the CMHIP forensic DBT model as a competency prototype.

The Institute for Forensic Psychiatry at CMHIP

The Institute for Forensic Psychiatry is a 300-bed forensic inpatient division, composing half of a 600-bed state hospital. Ninety percent of the forensic patients are male and 67% have been adjudicated not guilty by reason of insanity (NGRI; Colorado Department of Human Services, 1999). Approximately 75% of patients have been assaultive or have been charged with a violent crime. For example, on the two DBT wards, 30% of our patients committed murder, and another 30% committed aggravated assault or attempted murder. Regarding patient ethnicity, the modal ethnicity of patients was Caucasian, followed by Hispanic, and then black. On average, patients are middle-aged (average age = 44 years). About two-thirds of patients have primary Axis I diagnoses, while the remaining one-third have been diagnosed with character disorders (Colorado Department of Human Services). Common Axis I diagnoses include schizophrenia, bipolar disorder, or major depression, and concomitant Axis II diagnoses include BPD and ASPD. Most of the patients on the DBT wards carried concomitant Axis I disorders, primarily schizophrenia, bipolar disorder, or schizoaffective disorder. Symptoms associated with Axis II disorders are the primary focus of treatment on the DBT wards, as patients' Axis I disorders are largely in remission due to medications. The fact that some patients continue to demonstrate high levels of emotional and behavioral dysregulation despite remission of their Axis I disorders can trigger an assessment for a Axis II diagnosis. Extensive periods of stability of Axis I conditions allow a detailed review of pre-Axis I interpersonal history and facilitates identification of an Axis II diagnosis. Concomitant substance use diagnoses are more common than not; in 1998, 62% of inpatient forensic psychiatric admissions carried substance use diagnoses (Colorado Department of Human Services).

Due to stringent release criteria defined by state statutes, NGRI patients' average length of stay is 8 years. Patient progression through the security levels is significantly determined by bed space; for example, a patient may meet behavioral criteria for a less secure setting but may wait months for an available bed. Conversely, a patient may not meet behavioral criteria for a less secure setting, but may nonetheless be progressed due to overcrowding. Thus, reinforcement for patient improvement, as defined by progression through the security system, can be arbitrary and noncontingent.

Given the significant differences between forensic and standard DBT settings, we modified DBT to address the following issues:

- the preponderance of male patients exhibit behavior described as antisocial
- treatment is involuntary and constrained by institutional and legal demands
- invalidation and staff burnout are normative in forensic settings

DBT Modifications: The CMHIP Forensic Model

In the next section, we review the forensic modification of biosocial theory, including a description of the DBT ASPD staff and patient study group, the method by which these changes were made, modifications of treatment modes; further, an additional skills module, the Crime Review, will be introduced. We address agreements, commitment, and Stage I targets, followed by a discussion of forensic dialectical dilemmas.

Modification of Biosocial Theory

The high frequency of men with antisocial behavioral repertoires in forensic populations required adaptation of DBT. Consistent with biosocial theory, ASPD, like BPD, appears to have a biological underpinning. Evidence from twin and adoption studies suggests that antisocial traits such as aggression are moderately heritable (McGuffin & Thapar, 1998). Again consistent with BPD patients, the environments of patients with ASPD are notable for invalidation. Harsh and inconsistent discipline, little positive parental involvement, and inadequate supervision characterize families of antisocial patients.

However, individuals with ASPD appear emotionally insensitive, unlike individuals with BPD, who are exquisitely emotionally sensitive. There is neurophysiological support for this point of view for at least a subset of the anti-
social population (Hare, 1998). Linehan’s (1993a) biosocial theory was modified for the emotional insensitivity observed in ASPD patients. In other words, the antisocial patient’s threshold for observing emotions is high. Thus, a biosocial theory of ASPD is described as the transaction between biological emotional insensitivity and an environment characterized by two factors:

- Disturbed caring: Patients with ASPD describe histories notable for insufficient modeling of caring and acts of caring by caregivers, family, and peers. Caring acts were not validated or were even punished.
- Models of positive reinforcement for antisocial behavior: Family members may directly train the antisocial individual to emit antisocial behaviors. For example, parents may reinforce the antisocial individual for using aversive behaviors to terminate aversive interactions (Patterson et al., 1989).

**DBT ASPD Staff and Patient Study Group**

Some of the initial staff and patient concerns regarding DBT, a treatment empirically validated only with BPD female outpatients, were instructive. Other concerns reflected fear and mistrust. For example, some of the DBT treatment assumptions, such as the “Observing-Limits Agreement” (i.e., within professional and institutional limits therapists observe their own boundaries), concerned staff, who feared that such flexibility would spin out of control, resulting in egregious boundary violations.

A DBT ASPD study group comprised equally of patients and staff was implemented to address patient and staff concerns. This voluntary group, composed of both staff and the most antisocial, yet helpful patients, reviewed the *Skills Training Manual for Treating Borderline Personality Disorder* (Linehan, 1993b) and made changes to address behaviors and problems specific to antisocial individuals in an inpatient forensic milieu. The group met for 1.5 hours weekly for approximately a year. The group was unusual in that the patients, not the staff, served as the experts in ASPD phenomenology. In addition, over time, the patients remained the most committed to this group. The first two authors functioned primarily as scribes and interpreters, shaping patients to describe their experience in nonjudgmental behavioral language. Perhaps reflecting years of iatrogenic treatment effects, patients described themselves with global pejorative language; significant energy was expended eliciting behavioral descriptors.

**Modes of Treatment**

Standard outpatient DBT treatment modes include weekly individual therapy, weekly group skills training, weekly case consultation, and as-needed consultation to the patient (by telephone). DBT in inpatient settings has been described elsewhere (Swenson, Sanderson, & Linehan, 1995). The methods and context used to deliver treatment modes and the context of skills training differ from standard DBT and are further modified by the forensic setting.

**Individual Therapy**

The function of the individual DBT therapist at CMHIP is to use the treatment target hierarchy to carry out behavioral and solution analyses of life-threatening, unit-destuctive behavior linked to life-threatening and therapy-interfering behaviors, and to encourage, reinforce, and elicit skills from the patient. The individual DBT therapist simultaneously validates the patient’s experience and his difficulty changing. The focal point of standard outpatient DBT is the individual patient and individual therapist. In contrast, on a forensic inpatient unit, this individual therapy is costly and one of many therapies. Where the outpatient DBT therapist hears stories about the patient’s life, the forensic, inpatient therapist spends 40 hours per week living with the patient and experiencing these stories. Traditionally, outpatient DBT therapists are highly trained. In forensic institutions, those assigned to do individual therapy may have as little as 1 to 2 years post–high school training, with mostly on-the-job training. Highly trained psychologists, psychiatrists, and social workers provide group therapy and act as consultants to these individual therapists.

Consistent with standard DBT, the diary card structures the individual therapy session. What perhaps differs in a forensic setting is the manner in which targets are chosen, and how and when this diary card is reviewed. As in standard DBT, nearly all patients monitor alcohol and drug urges and self-harm and harm-to-others urges and actions. Because 80% to 90% of the CMHIP forensic patients carry concomitant Axis I mental disorders, nearly all patients use their diary cards to monitor relapse signs and symptoms. The Stage 1 targets, as outlined in Table 2, determine additional targets. Initially, the targets are negotiated between the patient and the psychiatrist, with the psychiatrist receiving input from other team members. The decision to target and monitor particular behaviors is made in a team treatment-planning meeting, with input from all team members. Between treatment planning sessions, the individual therapist and patient may add additional targets, but they do not delete previ-
ous targets. Specific change procedures and validation strategies are reviewed and documented in the team treatment-planning meeting. The individual therapist, generally a nursing staff member, implements and documents these strategies. In general, forensic staff members gravitate toward irreverent communication strategies and need encouragement to effectively increase their validation and reciprocal communication strategies.

Early in treatment, targets focus primarily on immi-

ently life-threatening or unit-destructive behaviors. Shaping is needed to promote honest recording of these behaviors on the diary card. For example, a patient may target a potentially therapy-interfering behavior, the use of the word “bitch” on his diary card. Initially, even if this patient said “bitch” 10 times daily, it would not be uncommon for him to report zero on this target. His report can be shaped by nonjudgmental staff and patient observations that he did say “bitch” (e.g., “you said 'bitch' in community therapy twice yesterday”) and, very importantly, positive, not negative, consequences for honest reporting.

As the patient learns and uses new skills, life-threaten-

ing and unit-destructive behaviors become less frequent, and the focus shifts to behavior linked to life-threatening behaviors and treatment-interfering behaviors. As in standard DBT, the patient monitors targeted behaviors daily, and these are reviewed weekly with the therapist in individual sessions. To increase daily completion of diary cards, some patients have their diary card initiated daily by a ward staff member. Just as in standard DBT, the individ-

ual therapist uses the diary card to collect information regarding targeted behaviors that have occurred since the last session and to assure such behaviors are discussed. Ideally, because the targets are on the patient’s plan of care, additional staff members who interact with the patient on a daily basis also note occurrence of these behaviors, reinforcing the patient’s awareness of the behaviors and the importance of using the diary cards.

When progressing from inpatient to outpatient status, patients must understand the rationale for continuing diary cards. When they discontinue their diary cards as outpatients, they inevitably experience problems that may have been avoided if they had reviewed relapse signs and symptoms and other targeted behavior with their outpatient therapist. Non-DBT trained outpatient therapists have been unexpectedly willing and able to make use of the diary cards, when properly oriented by either the patient or DBT staff.

When a patient engages in a targeted problem behavior, a staff member (ideally, the one who observed the behavior) assigns a written behavioral chain analysis. For example, a staff member observes two patients screaming obscenities at each other in the day hall and then assigns chain analyses to both patients. Patients complete their chain analyses separately, without conferring with each other. Using detailed instructions, patients independently describe the actual problem behaviors, analyze the precipitating events, vulnerability factors, consequences, alternative solutions, prevention plan, and repairs. As patients consider chain analyses aver-

sive, it is important to manage contingencies around completion of the chain analysis. For example, privileges may be withheld until the chain analysis is completed.

Over time, with written feedback, this process helps pa-

tients better understand and change their behaviors. An unexpected and useful side effect of these independently com-

pleted chain analyses is increased honesty on the part of participants, as they are fully aware that the treatment team will compare renditions of the event.

Skills Training Group

The function of weekly group skills training is acquisi-

tion and strengthening of the following skills: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. At CMHIP, skills acquisition is assessed with written and role-play quizzes and exams.

Some patients felt insulted by the exclusive female pronouns in the DBT skills manual. In addition, some of the skills recommendations were poor matches to our male patients. For example, activities such as arranging flowers, sewing, ballet, and lighting a candle were generally not considered “pleasant events” for CMHIP male forensic patients. The ASPD patients recommended no significant deletions to the skills training content, but did suggest significant additions, particularly to the emotion-regulation module.

To address the emotional insensitivity of patients diag-

osed as antisocial, the emotion-regulation module was rewritten (McCann & Ball, 1996b). The primary changes included (a) addition of a fourth goal—increasing emotional attachment; (b) increasing mindfulness of empathy and consequences to others; and (c) the addition of a skill, “random acts of kindness.” Almost all the emotion-regulation handouts were revised to accomplish these changes. For example, emotion regulation homework assignments were significantly changed in order to increase patient mindfulness of the effects of their behavior on others.

The ASPD patients agreed that antisocial persons ei-
ther avoid or cut off attachment to others, thus facilitating other-harm behaviors. Thus, important steps in increasing emotional attachment include the following:

- increase awareness of commonality of experience;
- increase behaviors that cause others to feel cared about;
- understand the reinforcers of attachment and detachment;
- discover and create a social support system (McCann & Ball, 1996b).

Myths or cognitive distortions about emotions are impediments to increasing emotions—caring, compassion, vulnerability, and empathy—that attach us to others. ASPD patients identified several myths about emotion such as “Real men never cry,” “Feelings justify behavior,” “Being afraid is shameful” (McCann & Ball, 1996b).

Another impediment to feeling attached to others is feeling bored, apathetic, or detached. Interventions developed to reduce apathy include “Changing Emotions by Acting Opposite to Apathy or Detachment” and “Random Acts of Kindness.” Steps for changing emotions by acting opposite to apathy or detachment are described in Table 1 (McCann & Ball, 1996b).

A list of random acts of kindness was developed to increase frequency of caring behaviors, linked to feelings of attachment (McCann & Ball, 1996b). Random acts of kindness are kind acts completed in a willing and mindful manner, without expectation of return.

### Table 1
<table>
<thead>
<tr>
<th>Steps for Changing Emotions by Acting Opposite to Apathy or Detachment</th>
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<tbody>
<tr>
<td>Make a list of prior wise-mind commitments. Do them.</td>
</tr>
<tr>
<td>Commit RANDOM ACTS OF KINDNESS. Again and again.</td>
</tr>
<tr>
<td>Listen MINDFULLY to another person.</td>
</tr>
<tr>
<td>Participate in a GROUP ACTIVITY, even though you don’t feel like it.</td>
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</table>

Antisocial individuals tend to be less concerned about rejection and are more interested in using others. ASPD patients suggested that it was necessary to challenge interpersonal myths such as “The weak deserve to be exploited,” “I’m all that matters,” “I deserve to get what I want or need no matter what,” “Stupid people deserve to be manipulated” (McCann & Ball, 1996b). These myths can maintain antisocial patients’ relative disinterest in getting or keeping good interpersonal relationships. CMHIP patients needed frequent prompting to use skills for maintaining or improving relationships. The content of the Interpersonal Effectiveness Skills was not otherwise significantly changed. In contrast to their reluctant use of skills for improving relationships, CMHIP forensic patients quickly, without much prompting, used skills geared toward obtaining their wishes or rights and those skills geared toward improving their self-respect.

### Consultation Team

Case consultation meets weekly. The function of case consultation is to keep the therapist on therapeutic task. In other words, therapists must conceptualize treatment problems behaviorally, maintain hierarchical treatment targets, and teach skills. The spirit of the case consultation team is “dialectical.” This means the treatment team attempts to achieve a balance between seemingly discordant beliefs, tensions, and goals. For example, a common dialectical dilemma that occurs in a forensic treatment team is a “split” between more treatment-mindful versus more security-mindful team members. A dialectical philosophy encourages the team to find the “truth” in both positions.

### Consultation to the Patient

The function of consultation to the patient is to generalize skills from therapy to everyday life. In standard DBT, the individual therapist consults by telephone. In our setting, consultation occurs with visual cues (posters), in-vivo coaching (or Therapy on the Hoof), and modeling. Posters summarizing DBT skills are posted throughout the unit, particularly in areas of high interpersonal exchange, such as in the dining hall, kitchen, nursing station, and therapy rooms. In-vivo coaching or “Therapy on the Hoof” occurs when a staff member prompts a patient to use a skill. For example, when a patient is requesting linen, a staff member may prompt him to use his interpersonal objectives effectiveness skills (DEAR MAN). Staff may ask permission to “coach” a patient, particularly when the patient is engaged in therapy-interfering behaviors. For example, in the case of a patient engaging in hostile and judgmental comments, a staff member may coach use of mindfulness skills.

Both patients and staff model DBT skills. Patients serve as models for each other, not only by using DBT skills in the ward milieu, but also by independently form-
ing study groups to prepare for their DBT exams. One example of staff modeling occurred when a staff member, quite uncharacteristically, forgot to attend her therapy group, eliciting concern from patients and staff. She dutifully wrote a chain analysis of her own behavior, acknowledging the consequences to group members, and copying her chain analysis for all group members to read. Patients were moved by her sincerity and by her open acknowledgement and functional commitment to the DBT Therapist Consultation Agreement that all therapists are fallible.

**Advanced DBT: Crime Review**

Following completion of two cycles of basic DBT skills training and satisfactory completion of an in-house comprehensive exam covering these skills, patients are referred to DBT Graduates' Crime Group. The function of the Crime Review is to increase victim empathy and prevent violent relapse. More specifically, patients learn what led up to their crime(s), practice standing in their victim's shoes, and develop a prevention plan that includes specific DBT skills. The group meets for 1.5 hours per week. Each patient is expected to complete a thorough written chain analysis of the crime, using copies of his or her police report. Each patient presents his or her crime to the group in five separate sections. The purpose of each section is as follows:

- **Section 1:** Patients nonjudgmentally and specifically describe their crime, precipitating events, vulnerability factors, and outline the chain of events that led to the crime.
- **Section 2:** In order to promote empathy, patients outline the consequences of the instant offense for all potential victims.
- **Section 3:** Again, in order to enhance empathy, patients re-present the crime, precipitating events, vulnerability factors, and chain of events entirely from the direct victim's point of view.
- **Section 4:** Patients develop a relapse plan by summarizing the causes of the crime, addressing skills deficits, interfering emotions, reinforcers of ineffective behavior, and punishers of effective behavior. Patients generate multiple solutions, with special focus on DBT skills they could have used. Patients identify the specific skills needed to prevent a recurrence of dangerous behavior.
- **Section 5:** Patients address repair—what can they do to correct and overcorrect for the consequences of their crime?

In order to promote increased empathy for victims, patients engage in videotaped role-plays. The roles include Victim Voices, who act as the perpetrator's victims; Victim Empathy Advocates, who push for the presenter to feel from the victim's shoes; Hospital Disposition Committee members, who assess whether the patient is eligible for release; an Emotions Observer, who watches for and asks for expression of observed but unexpressed emotion; and a DBT coach who quietly coaches the presenter.

**Modification of Agreements**

Because many forensic hospitals are public, state-supported, and state-mandated facilities, such settings must comply with Mental Health Commitment laws and regulations and work within the expectations of numerous outside agencies and statutes, such as JCAHO. In addition, such settings must also respond to governmental expectations, rules, and political pressures.

DBT always begins with a pretreatment stage of commitment, including a number of agreements. Patient agreements include (a) a 1-year therapy commitment, (b) a formal termination rule (patients who miss 4 weeks of therapy in a row are out of therapy), (c) attendance (patients will attend all individual and therapy sessions), (d) an agreement to reduce life-threatening behaviors (patient will use means other than self-harm to solve problems), and (e) a commitment to work on any therapy-interfering behaviors. Individual therapist, skills trainers, and case consultation agreements have been discussed elsewhere (Linehan, 1993). These agreements provide clarity and structure regarding the goals and methods of therapy.

Given institutional and legal constraints, forensic treatment agreements may require multiple revisions from standard DBT pretreatment and commitment strategies. First, to increase clarity and structure, a Patient Agreement is implemented. This provides all parties with a written document to review when disagreements arise. To avoid potential legal entanglements, it is emphasized that the DBT Patient Agreement is an agreement between patients and treatment providers, not a legally binding contract.

In designing the forensic Patient Agreement, it is helpful to address the dialectic between patient involuntary status and the freedom to make decisions within the parameters of involuntary status. Several DBT commit-
ment strategies are of use, particularly "Highlighting Freedom to Choose and Absence of Alternatives," "Evaluating the Pros and Cons," "Shaping," and "Cheerleading." Salient in a forensic setting is "Highlighting Freedom to Choose and Absence of Alternatives," whereby patients must be prepared to accept the natural consequences of their choices. For example, should a patient continue to engage in life-threatening behavior, such as assault, a natural consequence is regression to a higher security ward. "Evaluating the Pros and Cons" is helpful with patients who refuse DBT. In our setting, the pros of such refusal include non-DBT treatment on medium-security status. The cons of such refusal include ineligibility for certain privileges and freedoms granted to those committed to DBT. "Cheerleading" is a useful commitment strategy not only with hopeless patients, but with patients who fear they are not "smart enough" to learn DBT, complete DBT homework, and pass skills tests. Many of our patients experienced less than successful school careers. Thus, teaching and teachers have been classically conditioned with fear, hopelessness, shame, and humiliation. "Cheerleading" (encouraging hope) and "shaping" (reinforcing the tiniest glimmer of progress) are essential in eliciting and maintaining commitment.

No significant changes were made to the Therapist or the Therapist Case Consultation agreements. Interestingly, staff members experienced particular difficulty following agreements to coach versus rescue patients and to search for nonpejorative empathetic interpretations of patient behavior. Difficulty refraining from rescue may reflect institutionalization or learning that has shaped staff to act as caretakers and patients to act helpless. Pejorative interpretations are positively reinforced in forensic settings with increased staff affiliation, cohesiveness, and camaraderie associated with an us-against-them attitude. Negative reinforcers include relief from anxiety and work. Why take risks or work hard with a bad and hopeless person? The signed agreements, while no guarantee, provide an avenue for refocusing a team or individual staff member's behavior when treatment slides into a nontherapeutic stance.

**Stages of Treatment and Forensic Modification of Stage 1 Targets**

After obtaining patient commitment to change, the goal of the first stage of treatment is to gain control of severely dysregulated behavior. Stage 1 will likely be the primary, if not the only, focus in many forensic settings. The modified Stage 1 targets appear in Table 2. The primary four targets are modified in the CMHIP Forensic DBT model. The final Stage 1 targets, quality-of-life interfering behaviors and increasing behavioral skills, remain the same.

The primary life-threatening behavior target for borderline female outpatients is suicide/parasuicidal behavior. In contrast, the primary life-threatening behavior target for ASPD forensic patients is other-harm behavior (see Table 3). These targets remain the focus of treatment until the patient has gained behavioral control.

The second target in the CMHIP Forensic DBT model is unit-destructive behaviors, including behaviors that destroy the unit's milieu or social environment to the degree that treatment cannot proceed and behaviors such as "stings," substance use, and criminal activities that result in unit "lockdowns," which prevent patients from attending their therapy groups. See Table 4 for additional examples of unit-destructive behavior.

The third most important target in the CMHIP Forensic DBT model is behavior linked to life-threatening behaviors. These include individualized precursors, triggers or cues, suggesting risk for life-threatening behaviors. After repeated behavioral chain analyses, patients become mindful of these behaviors. Examples of behavior linked

<table>
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<th>Table 2</th>
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<tr>
<td><strong>Primary Targets in Stage 1 Forensic/Criminal Justice Settings</strong></td>
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<tr>
<td>Decrease</td>
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<tr>
<td>Life-threatening behaviors</td>
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<tr>
<td>Unit-destructive behaviors</td>
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<tr>
<td>Behaviors linked to life-threatening behaviors</td>
</tr>
<tr>
<td>Therapy-interfering behaviors</td>
</tr>
<tr>
<td>Quality-of-life interfering behaviors</td>
</tr>
<tr>
<td>Increase</td>
</tr>
<tr>
<td>Mindfulness</td>
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<tr>
<td>Interpersonal effectiveness</td>
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<td>Emotion regulation</td>
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<td>Distress tolerance</td>
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<td>Self-management</td>
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<th>Table 3</th>
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<tr>
<td><strong>Imminently Life-Threatening Behaviors</strong></td>
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<tr>
<td>Actions resulting in irreversible physical harm</td>
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<tr>
<td>Killing, maiming</td>
</tr>
<tr>
<td>Actions resulting in serious but reversible harm or high risk of irreversible physical harm</td>
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<tr>
<td>Assault with deadly weapon or extreme physical force, sexual assault with deadly weapon or extreme physical force</td>
</tr>
<tr>
<td>Unprotected sex with multiple partners</td>
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<tr>
<td>Actions resulting in serious, potentially irreversible emotional harm</td>
</tr>
<tr>
<td>Sexual assault, prostitution</td>
</tr>
<tr>
<td>Kidnapping, pushing drugs</td>
</tr>
<tr>
<td>Behaviors suggesting imminent risk of physical harm</td>
</tr>
<tr>
<td>Obtaining or hiding or making weapons</td>
</tr>
<tr>
<td>Physical attack stance</td>
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<tr>
<td>Intense or frequent thoughts of killing or physically hurting others</td>
</tr>
<tr>
<td>Intense or frequent thoughts devaluing others</td>
</tr>
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Table 4
Examples of Unit-Destructive Behaviors

Using substances
Sexual relations with members of same unit
Behaviors that violate rights or endanger safety
   stealing, planting evidence
   lying resulting in charges, regression, or solitary, for others
Keeping secrets
Stings: group of patients acting together in criminal activity
Interfering with willingness of others to engage in treatment
   lying, conning, harassment, bulldogging: use status or physical prowess to make others obey
   paybacks, dropping lugs: use sensitive or embarrassing information about another person in order to hurt that person.
   Shaming: statement made to look good at others’ expense
Violation of major unit rules

To imminently life-threatening behaviors include devaluing statements or thoughts ("Others don’t matter," "Women are just bitches and hoes") and blaming statements or thoughts ("I’m the real victim," “Why me?” “You are picking on me,” etc.).

Consistent with standard DBT, the next most important target is therapy-interfering behavior by patients, therapists, or staff, including behavior that interferes with effective therapy (Linehan, 1993a). Because both patients and staff commit therapy-interfering behaviors, both have the freedom to provide nonjudgmental feedback about such behaviors. For example, not all staff and patients experience swearing as interfering with therapy. However, a conservative older white female staff member might experience a young black male patient’s angry utterance, “You are fucking me over,” as sexually aggressive, and not only therapy interfering, but as a personal violation, and also unit-destructive. Endless staff discussions about whether or not the comments were or were not “sexually aggressive” may be avoided by the simple acknowledgment that the behavior is offensive to the individual staff member, and therefore therapy-interfering for her. Arguments with the patient regarding whether his words reflect acculturation (he is good, we are bad) or sexual aggression (he is bad, we are good) can be avoided by stressing that his behavior is therapy interfering and, hence, ineffective. In general, denigrating comments to group members and staff interfere with other patients and create staff burnout. The idea that patients need to act likeable if they want help was clarifying for both patients and staff.

Although standard DBT addresses patient therapy-interfering behavior, it does not fully cover the therapy-interfering behaviors generated by policies and constraints of inpatient and forensic settings. Examples of forensic therapy-interfering behaviors include lockdowns or mass punishment for wrongs of a few, use of labels such as “sociopath,” or “criminal,” and enforcement of rules inconsistent with societal norms.

Forensic Dialectical Dilemmas

The dialectical worldview is fundamental to DBT. Some of the core dialectical dilemmas patients struggle with include the following: (a) the freedom to participate in treatment versus the experience of treatment as coercion; (b) acknowledging no responsibility for their crimes because they are NGRI versus being guilty, blame-worthy, and required to take responsibility for their crimes in order to obtain a legal release; (c) experiencing staff as jailers versus treatment providers who want to help them; and (d) living by the “con-code,” which is known and predictable, versus taking the risk of trust, vulnerability, growth, and treatment alliance.

Recognizing these dialectical dilemmas is difficult. Consistently considering the truth of both positions, and synthesizing these truths into a useful whole, is even more difficult. Forensic patients who are most effective in this environment are those who radically accept these disparate, and perhaps desperate, realities. They remain skeptical of staff, yet engage in treatment and consider that staff may have something of value to offer. They accept responsibility for ineffective and harmful past behavior, yet find self-forgiveness by recognizing and accepting their own traumatic, deprived, mentally ill past. They remain aware of the con-code, but mindfully extend their hands to others and test who can be trusted and who cannot.

Staff dialectical dilemmas include (a) treatment versus security, (b) acceptance versus change, (c) liking versus disliking, and (d) hope versus burnout. Staff members may experience themselves as both helpers and jailers. In order to help forensic patients, staff members must accept or acknowledge the harm patients have done and could do, and they must nonjudgmentally help patients change. It is not uncommon for staff to very much like a patient who has done something heinous.

Conclusions

The CMHIP Forensic DBT model is the current prototype for DBT in an inpatient forensic setting. Staff members have received annual training for the past 3 years in addition to the self-study group initially led by the first two authors. The committed presence of the primary staff who developed and lead this program, and their creativity in adapting DBT to meet the needs of their foren-
sic population, provide exemplary models. Numerous forensic and criminal justice settings, both residential and outpatient, have been trained and now work to implement DBT within their populations and settings. A number of suggestions emerge from their experiences.

1. Institutions and their staff have unique issues; assess each specifically. Carefully assess existing and potential staff reinforcers. Consider linking training to merit evaluations. Carefully assess administrator reinforcers to ensure program continuity.

2. Validate staff. Related to the above, identify what is validating for staff working in this setting. Simply put, functional validation or validating behavior is often more effective than words.

3. Expect recurring obstacles. If DBT program developers hold expectations not tied to the realities of working in high-visibility, complex forensic agencies, the resulting frustration will prove invalidating and potentially derailing to program proponents, staff, and administrators. One strategy for dealing with these obstacles is to begin by linking systemic and institutional administrative goals to DBT implementation and improved outcomes. Such goals may be tied to hospital or accreditation standards or political agendas.

DBT is currently conducted in approximately 12 forensic institutions and at least 6 to 10 criminal justice settings in the U.S., Canada, U.K., and Australia. Staff members in other countries have also been trained and program implementation is pending. Programs to date are about equally divided between residential and outpatient. The majority of programs in the U.S., Canada, and the U.K. report comprehensive implementation as their goal, including all major functions and modes of DBT. The most common challenges to implementation include training staff with little to no mental health experience and no behavior therapy training, adapting material and the model to meet restrictions of individual settings, adapting the material to meet the needs of the population (e.g., mostly male with antisocial characteristics), and, finally, overcoming staff reluctance. In the U.S. and Canadian sites, almost all programs are also engaged in ongoing empirical evaluation, while sites across the U.K. participate in an organized, developed research effort. A number of sites have received funding or other external support for such evaluation (Ivanoff, 1998).

References


