INTRODUCTION

Women in secure settings have multiple and complex needs. The call for gender specific and gender sensitive treatment has been repeatedly made for this group (Dept of Health, 2002). In forensic settings cognitive behaviour therapy (CBT) has typically been regarded as the preferred method of treatment (Day and Doyle, 2010). Despite an absence of controlled research in secure settings for women (Galletta, 2010) reasons for adopting such a CBT approach include its consistency with the main principles of feminism (Alden, 2006) and the emphasis on a collaborative therapeutic relationship (Williams, 2006). The development of a ‘best practice’ service for women in secure settings has been described which advocates the use of Manualised group CBT treatment programmes based on gender specific needs and a symbiotic relationship between management and clinicians (Long et al, in press). Such approaches seek to harmonise forensic and clinical models of practice and to include developments that represent the ‘third wave’ of cognitive behaviour therapy (Howells, 2010).

OBSTACLES TO CBT TREATMENT

The failure to complete psychological treatment is a long standing concern (Wierzbicki & Pekatit, 1963) that is particularly acute in offending populations (Wormith & Oliver, 2002), particularly those with personality disorder (McMurrant et al, 2010).

The findings that ‘those who do not complete treatment are actually made worse’ (McMurrant & Theodoli, 2007) increases the importance of maximising the potential for engaging patients in secure settings.

The Patient Group

Women admitted to psychiatric facilities often have difficulty in forming a therapeutic alliance, cognitive deficits and poor motivation to engage.

The Therapeutic Environment

Features of secure settings that are potentially counter therapeutic include a perceived lack of safety, poor facilities, security threats and abuse by other women (Mezey et al, 2005). Thus far there have been few attempts to measure aspects of the physical environment and its impact in patient behaviour and satisfaction. Recently however, Long et al (in press) have used an architectural checklist to compare the homeliness of two medium secure psychiatric facilities and to relate this to user satisfaction, ward atmosphere, symptomaticity and behavioural disturbance.

NEED FACTORS

Need Specific Treatment Groups

A thorough analysis of the presenting needs of service users is vital prerequisite of effective CBT group treatment development. Important principles include the development of a core series of group treatment deemed applicable to all, (e.g. emotional regulation; social problem solving) and non-core treatments, deemed applicable to most (e.g. substance misuse; self care and body image). An example of this mis given in Long et al, 2011).

The Group Process in CBT

In secure environments where maximising group process mechanisms is paramount. The CBT group can provide a corrective social learning experience for maladaptive interpersonal problems that have developed through early experiences (Yalom, 1995).

The attempt to understand and capitalise on the group process in CBT groups is a comparatively recent phenomena (Biegel et al, 2006). Group process factors in CBT are recognised by patients as important (Glass & Ankoff, 2000) and are predictive of patient improvement (Castonguay et al, 1998). Psycho education is the cornerstone of group therapy for women in secure settings (Long et al, 2008) as is experimental problem based learning. The accurate assessment of readiness to engage (Day et al, 2010) is key to the timing and intensiveness of CBT group treatment.

ENVIRONMENTAL FACTORS

Setting, content, delivery and common factors.

An emerging body of research has conceptualised aggressive and violent behaviour as a function of the social context in which it takes place (Day et al, 2008). In addition common factors across different treatment models appear to contribute significantly to effective treatment results (Kozar, 2010). These considerations have led some to consider the potential benefits of therapeutic communities (both democratic and concept based) to enhance the therapeutic impact of CBT interventions (Day & Doyle, 2010). However in settings for women where the need for relational security dominates (Allen, 2010) there is a potential clash between the Socratic style of CBT groups and confrontational style of therapeutic community group work (Miller, 2007).

Establishing an Environment Supportive of Therapeutic Activity

Central to the establishment of an effective therapeutic milieu are:

- Achieving a common understanding of therapeutic purpose
- Turning staff-patient interactions into therapeutic encounters
- Generalising treatment effects (Long et al, in press)

Achieving a common understanding of therapeutic purpose involves ensuring a consensus and understanding of treatment goals among members of the multi disciplinary team; that patients ‘own’ their care plan, understanding its content and see the connections between overarching treatment goals and specific care plan interventions. It is arguably the case that group CBT is best delivered in the context of a treatment milieu that is underpinned by social learning theory and by a treatment philosophy that also embraces positive psychology and the development of the therapeutic relationship. The RAID (Reinforce, Appropriate, Implode, Disruptive) approach to the management of extreme behaviour (Davies, 2001) has the careful use of contingency management as its cornerstone and is consistent with a focus on women’s strengths and resources (Alden, 2006). The RAID approach provides a vehicle for transforming staff-patient interactions into therapeutic encounters. The need to programme generalisation rather than to passively expect it as an outcome of training procedures (Stokes & Baer, 1977) is crucial.

Monitoring and Addressing Social Climate Issues

Work on the social climate or ward atmosphere of treatment settings has recently been adapted for forensic settings. The use of EssenCES (Shalans et al, 2008) has been advocated as an indicator of the need for service improvement in the key areas of perceived safety, therapeutic hold and patient cohesion and support.

Maximising the Therapeutic Potential of the Built Environment

The influence of the physical environment on treatment in forensic settings has been noticeably neglected (Howells & Day, 2007). Thus far there have been few attempts to measure aspects of the physical environment and its impact in patient behaviour and satisfaction. Recently however, Long et al (in press) have used an architectural checklist to compare the homeliness of two medium secure psychiatric facilities and to relate this to user satisfaction, ward atmosphere, symptomaticity and behavioural disturbance.

CONCLUSION

Whilst a compelling argument can be made for the use of a cognitive behavioural approach to the treatment of women in secure settings, such interventions need to overcome formidable obstacles related to characteristics of the patient group, issues of treatment non compliance and a therapeutic environment which accepts the ‘privity of security over treatment’ (Wexler, 1997). It is imperative that those factors that are amenable to therapeutic intervention (need and environment) are addressed to maximise the effectiveness of CBT gender specific group interventions for women. This involves:

1) The development of interventions that are treatment preparatory which are motivational and focused on the therapeutic alliance (Kuzar, 2010).
2) More accurate assessment of treatment readiness (Day et al, 2010) to avoid mistimed interventions which are counter-productive.
3) Abandonment of a ‘one size fits all’ treatment approach to disparate patient populations. This would allow for more ‘customised’ treatment approaches, more appropriate ‘pacing’ of treatment and the use of ‘adaptive’ strategies that readjust interventions during the course of treatment (Day et al, 2010).
4) The more effective deployment of milieu therapeutic approaches (e.g. RAID; Davies, 2001) to produce behavioural stabilisation at an earlier stage of secure care.

The importance of the wider social context of treatment is paramount in secure settings necessitating the clinician to concurrently work at the level of the therapeutic milieu to develop an optimal recovery oriented environment for women.