Trauma Informed CBT And DBT Integrated Programme for Violent Offenders with Intellectual Disability

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Abstract

Purpose: Unresolved trauma, emotional dysregulation, and maladaptive thinking patterns are closely related to violent offending by people with intellectual disability. Current interventions usually use either Cognitive Behavior Therapy (CBT) or Dialectical Behavior Therapy (DBT) alone, with little attention to trauma-informed modifications. The study determined the efficacy of a trauma-informed integrated CBT-DBT programme in violent behavior reduction and the enhancement of emotional regulation in violent offenders with intellectual disability. Methods: The quasi-experimental pre- and post-intervention design was used. The participants of the study were 48 male violent offenders whose intelligence levels ranged from mild to moderate in a secure forensic rehabilitation environment. The participants were provided with a 24-week systematic trauma-informed CBT-DBT programme. Violence risk (HCR-20), emotional regulation (DERS), trauma symptoms (TSQ), and behavioral incidents were outcome measures. Paired t-tests and effect size (Cohen's d) were used to analyze data, and significance was set at p =0.05. Findings: Post-intervention comparison of results indicated that the risk score of violence significantly decreased (mean = 28.6, t(47) = 6.12, p < 0.001, d=0.88). The scores of emotional dysregulations were reduced by 31.4 (p<0.001), and the severity of trauma symptoms was lowered by 26.9 (p=0.002). Violent incidents recorded dropped in an average of 3.4 to 1.2 violent incidents per participant per month, which is a reduction of 64.7%. The evidence endorses the application of trauma-informed, combined CBT-DBT interventions to forensic service provision to individuals with intellectual disability, as a means of providing clinicians with a framework to facilitate a flexible and evidence-based way of rehabilitating individuals. Conclusion: The study is among the first empirical reviews of a trauma-informed CBT-DBT integrated model specifically designed to work with violent offenders who have intellectual disability to fill a major gap in forensic psychological rehabilitation.

Keywords *Trauma-Informed Care; Cognitive Behavioral Therapy; Dialectical Behavior Therapy; Intellectual Disability; Violent Offending; Forensic Rehabilitation.*

Introduction

The presence of challenging and violent behaviors among intellectually disabled individuals means that they are disproportionately represented in the forensic and secure care settings. It has been shown that the patient group is highly susceptible to offending behavior owing to the influence of impaired cognitive processing, emotional dysregulation, social disadvantage, and poor access to early mental health, among others. Violent offenders with intellectual disability are usually complex, clinically needy in forensic settings with a background of co-occurring trauma and impulsivity coupled with an inability to comprehend the implications, thus rendering rehabilitation especially difficult [1][2].

Although there are increasing calls to acknowledge trauma as a major root cause of violent behavior, the forensic interventions that are in place to address the population with intellectual disability are, at best, behavioral and risk-oriented [5][7]. Most programmes focus on the offence-driven patterns of thinking or compliance with behavior without paying much attention to the exposure to trauma and emotional management. The traditional Cognitive Behavioral Therapy (CBT) that is widely used in the rehabilitation of offenders may need to be modified to accommodate people with intellectual disability or may not be adequate as the trauma and emotional instability is not directly tackled [3][4][16]. Equally, Dialectical Behavior Therapy (DBT) has proven to be effective in emotional regulation and impulsivity, but it is hardly ever applied in an integrated trauma-based approach to forensic intellectual disability services [6][8].

The lack of psychotherapeutic models of trauma-informed treatment designed specifically to address violent offenders with intellectual disability is a significant gap in the existing rehabilitation practice [9][11]. Very few empirical studies are available regarding the integrated therapeutic methods, which can be used to treat trauma and cognition, emotional regulation, and behavioral control among this population. The implication of this gap is not only on the outcomes of treatment, but also on the risk management of long term, reintegration of the community, and safety of the community.

The combination of trauma-informed CBT and DBT is a theoretically based, but clinically relevant intervention. CBT adds in the structured cognitive restructuring and adjacency insight, whereas DBT adds to the emotional regulation, distress tolerance, and interpersonal effectiveness. A trauma-informed model makes sure that interventions are provided in a way that acknowledges past trauma, does not re-traumatize, and fosters psychological safety, which are major ideals for people with intellectual disability in safe environments [10].

Objectives

The overall goal of the research will be to determine the efficacy of a trauma-informed integrated CBT -DBT programme in violent offenders with intellectual disability working in a forensic context. The study seeks to:

- Determine the changes in violence risk and offending behavior.
- Evaluate emotional regulation and trauma symptoms.
- Investigate the clinical and rehabilitative implication of the combination of trauma-informed CBT and DBT in forensic intellectual disability services.

The rest of this paper is structured in the following way. Section 2 gives a literature review on the area of intellectual disability and offending behavior, trauma informed practice, use of Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT) in a forensic context. Section 3 outlines the study design, the characteristics of the participants, ethical issues, the trauma-informed CBT-DBT integrated intervention, and data collection and statistical analytic methods. Section 4 presents the intervention results that dwell on the shift in the risk of violence, emotional regulation, symptoms of trauma, and behavioral outcomes. Section 5 reviews the findings concerning the existing research, clinical practice, and forensic rehabilitation frameworks. Lastly, Section 6 summarizes the study limitations, clinical and policy implications and the general findings of the research.

Literature Review

Trauma-informed care is a service model which acknowledges the elevated illness of trauma exposure and the influence of trauma on the control of emotions, thinking, interpersonal functioning, and conduct. Instead of posing the question What is wrong with you, trauma-informed practice poses the question What has happened to you and tries to minimize re-traumatization through the focus on psychological safety, trust, choice, collaboration, and

empowerment. In the case of people with intellectual disability, the problem of trauma under-recognition might exist due to the barriers in communication, overshadowing of diagnosis, and inaccessibility of services targeted at the treatment of trauma [12][14]. Hyperarousal, threat sensitivity, dissociation and reactive aggression may be considered as contributing factors of trauma histories in a forensic setting, thus causing more violent behavior and making it harder to rehabilitate. Trauma informed modalities will thus have clinical significance in safe care where restrictive practice, coercion, and institutional practices can create traumatic responses unintentionally.

The existing interventions of violent offenders with intellectual disability are often based on the risk management, behavioral control and cognition related to offence [13][15]. Although these strategies can minimize a portion of behavioral events, they might not cope with the trauma-based processes perpetuating aggression, including shame, fear-based responses, emotional flooding, and interpersonal mistrust. Current CBT-only programmes can potentially enhance the thinking patterns and coping behaviors but are less effective in the cases of the emotional dysregulation that are severe. DBT-only models can be useful in the area of emotional regulation and distress tolerance, yet neither appear to adequately address offence-related beliefs, criminogenic thinking, and victim empathy, which are focal in violence reduction practice. In both methods, weaknesses identified in the evidence base have been small sample sizes, disparate outcome measures, absence of randomized trials, insufficient reporting on culture and service context, along with insufficient long-term follow-up on recidivism and community outcomes.

The integrated trauma-informed CBT-DBT programme can provide a more holistic approach to the treatment of violent offenders with intellectual disability since the therapy model takes into account both the cognitive and emotion regulation routes to aggression [17]. CBT provides systematic thinking restructuring, offence-chain, problem-solving, and relapse prevention planning. DBT reinforces mindfulness skills, distress tolerance skills, emotional regulation skills and interpersonal effectiveness, all of which are directly related to impulse control and anger management. Integrating them into a trauma-informed approach would see to it that the overall intervention delivery is sensitive to issues of trauma triggers, minimizes re-traumatization, and promotes engagement in a safe, supportive, and collaborative way. In principle, the integration is rationale since most of the violent activities in this group are not only connected to criminogenic beliefs, but also related to trauma-related arousal and emotional dysregulation. Thus, the integration of CBT and DBT with the principles of trauma-informed care is likely to enhance responsiveness to treatment, decrease violent behavior, and improve the outcomes of rehabilitation of secure forensic services.

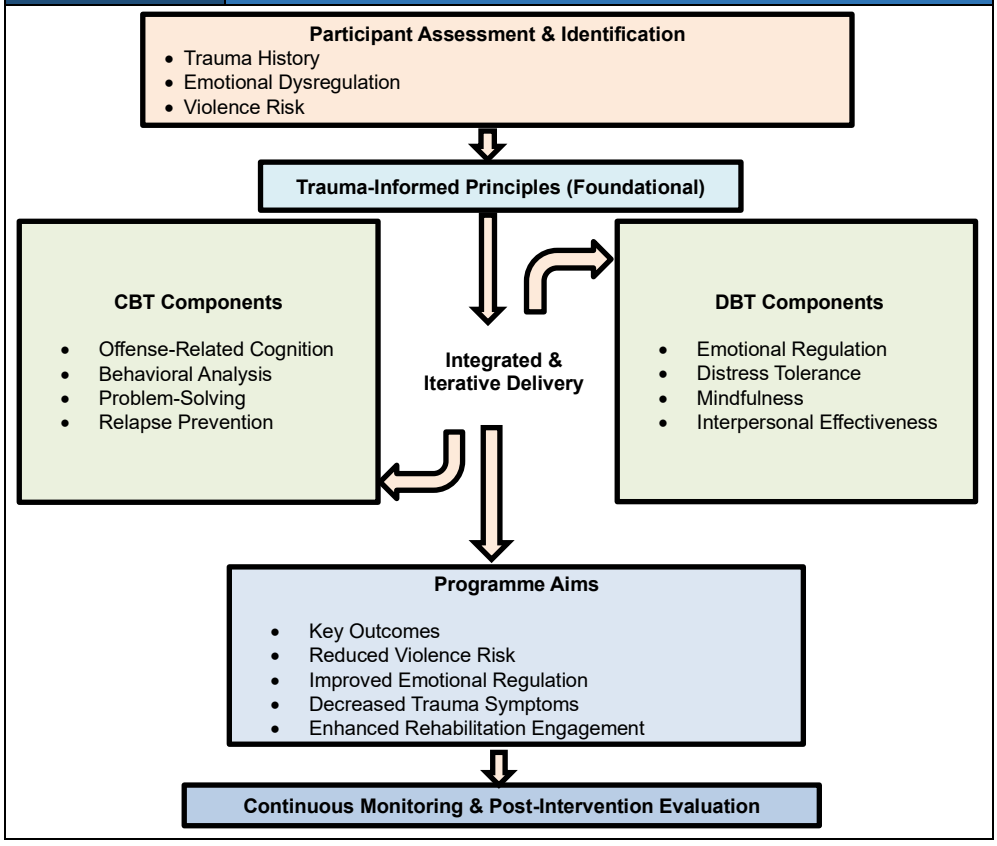
Inference

It is reported in literature that CBT and DBT have the potential to decrease aggression and enhance emotional regulation in offenders, although their application alone and their adoptions as not well-informed trauma therapies diminish their efficacy with intellectually disabled people. Trauma-informed care has become a necessity that is not used extensively in forensic treatments of this population group. This niche justifies the presence of a multilateral trauma-informed CBT-DBT strategy that directly dictates the objectives and structure of the current study.

Methodology

This Figure 1, shows the design and flow of the trauma-informed integrated Cognitive Behavior Therapy (CBT) and Dialectical Behavior Therapy (DBT) programme in forensic institutions to assist violent offenders with intellectual disability. The framework starts with the assessment and identification of the factors in the participants, which include the history of trauma, emotional dysregulation, and violence risk. The model is based on trauma-informed principles, and all the steps of intervention delivery follow these principles. CBT elements are centered on offence-related cognition, behavioral analysis, problem-solving, and relapse prevention whereas the elements of DBT are centered on emotional regulation, distress tolerance, mindfulness, and interpersonal effectiveness. The deliveries of these therapeutic aspects are done interactively and iteratively to treat both the cognitive and emotional streams leading to violent behavior. The programme will generate the following important outcomes, such as the minimization of the risk of violence, the enhancement of emotion regulation, the minimization of the symptoms of trauma, and the maximization of engagement in rehabilitation. Fidelity and evaluation of the results of the treatment are guaranteed by the constant monitoring and post-intervention evaluation.

Figure **1** Trauma-Informed CBT–DBT Integrated Intervention Framework



This research used the quasi-experimental pre -post intervention format to determine the usefulness of a programme based on trauma-informed integrated CBT-DBT to violent offenders with intellectual disability. The sample was comprised of 48 male patients who had a clinical diagnosis of mild to moderate intellectual disability, and had a history of violent offending recorded in a secure forensic rehabilitation environment. Participants had to possess adequate cognitive and communicative functioning to participate in structured psychological intervention, and those who were severely intellectually disabled, or who were actively psychotic or experiencing acute behavioral instability were not included in the study.

The proper institutional ethics committee granted ethical approval of the study and all procedures were carried out in ethical guidelines of research involving vulnerable population. Informed consent was achieved by taking availed information formats, and the ability of the participants to give an informed consent was determined according to applicable legal and clinical protocols. The intervention was provided in the secure forensic environment by the trained clinicians who have experience in working with offenders with intellectual disability.

The intervention involved 24 weeks of trauma-informed CBT-DBT integrated intervention, which was conducted in the form of a weekly structured session. Components of CBT emphasized the offence-chain analysis, cognitive restructuring, problem-solving, and relapse prevention, whereas DBT elements were set on mindfulness, emotional regulation, distress tolerance, and interpersonal effectiveness. All the sessions were based on trauma-informed principles, which focused on psychological safety, collaboration, choice, and the prevention of re-traumatization. Season manuals, structured checklists, and routine clinical supervision were used to support the use of treatment fidelity. Outcome measures were validated violence risk assessment tools, emotional regulation assessment tool, and trauma-related symptoms assessment tool, and the rate of behavioral incidents. The evaluations were performed at the baseline and right after the completion of the programme. The paired t-tests were used to test the differences between the pre- and post-intervention scores of the quantitative data with the effect sizes calculated as Cohen d. The statistical significance was postulated at $p < 0.05$, and the characteristics of the participants and the outcomes of their behavior were summarized using descriptive statistics.

Experimental Setup

The research design was to use an experimental design that included a trauma-informed interdisciplinary CBT-DBT intervention in a secure forensic rehabilitation unit in those with intellectual disability. 48 male subjects with mild to moderate intellectual disability who had a history of violent offending were recruited. After the baseline test, the subjects were provided with a 24-week structured programme based on the weekly sessions with a therapist. Validated measures of the risk of violence, emotional regulation, trauma symptoms, and behavioral incidents were used to gather pre- and post-intervention data. Trained clinicians conducted all the sessions using a standardized manual to behave consistently and fidelity to treatment was assessed using supervision and session checklists. The post-intervention assessment was promptly followed by the assessment of changes at the end of the study, and the analysis of the results was performed with the help of the statistical methods to determine the changes that can be attributed to the intervention.

Evaluation Metrics

Quantitative outcome measurement at pre- and post-intervention levels was used to measure the effectiveness of the trauma-informed CBT-DBT integrated programme in equation (1). The risk %age change in structured risk assessment scores was calculated as violence risk reduction:

$$\text{Risk Reduction (\%)} = \frac{R_{\text{pre}} - R_{\text{post}}}{R_{\text{pre}}} \times 100 \qquad (1)$$

The process of emotional regulation improvement was measured by the standardized scale scores and put in the form of equation (2) as the mean change:

$$\Delta ER = \dot{X}_{\text{post}} - \dot{X}_{\text{pre}} \qquad (2)$$

Trauma symptom reduction was calculated in equation (3) similarly using trauma severity scores. Behavioral incident reduction was measured using recorded incident frequencies:

$$\text{Incident Reduction (\%)} = \frac{I_{\text{pre}} - I_{\text{post}}}{I_{\text{pre}}} \times 100 \qquad (3)$$

Statistical significance of pre–post differences was evaluated in equation (4) and (5), using a paired t-test:

$$t = \frac{\dot{d}}{s_d/\sqrt{n}} \qquad (4)$$

$$d = \frac{\dot{X}_{\text{post}} - \dot{X}_{\text{pre}}}{s_p} \qquad (5)$$

where $s_p$is the pooled standard deviation.

All these measures reflected clinical performance, behavioral change and statistical strength of intervention results.

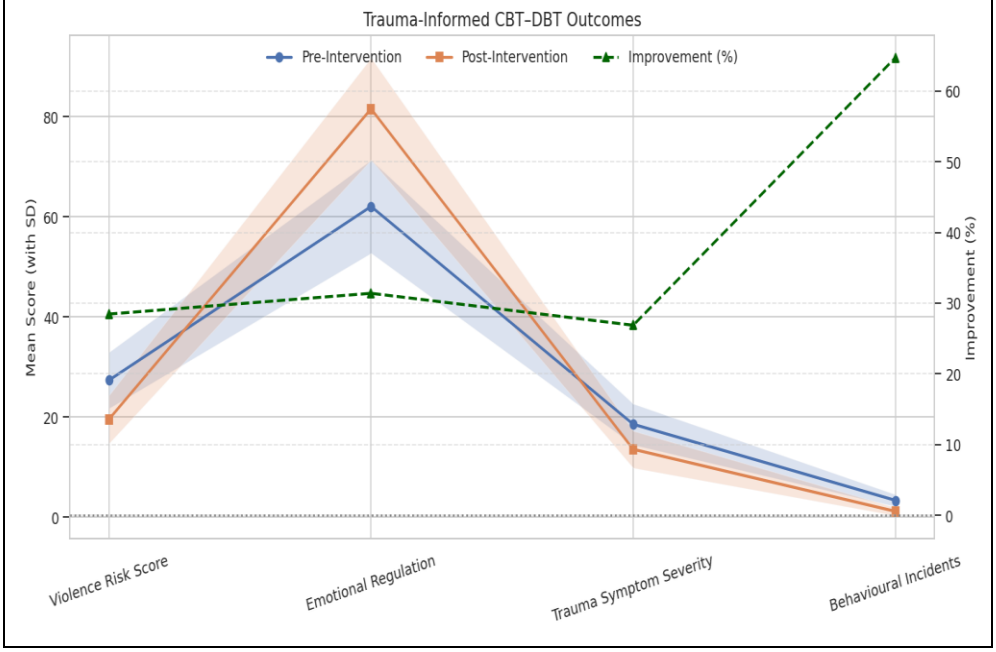
Results

Table 1 Pre- and Post-Intervention Outcomes for the Trauma-Informed CBT–DBT Programme

Outcome Measure	Pre-Intervention Mean (SD)	Post-Intervention Mean (SD)	Mean Change	*t* value	*p* value	Effect Size (Cohen's *d*)
Violence Risk Score	27.4 (5.6)	19.6 (4.8)	−7.8	6.12	< 0.001	0.88
Emotional Regulation Score	62.1 (9.3)	81.6 (10.2)	+19.5	7.04	< 0.001	0.96
Trauma Symptom Severity	18.6 (4.1)	13.6 (3.7)	−5.0	3.45	0.002	0.54
Behavioral Incidents (per month)	3.4 (1.2)	1.2 (0.8)	−2.2	—	—	—

The findings indicate that the trauma-informed integrated CBT DBT programme resulted in statistically significant changes in the violence risk and psychological functioning of participants with intellectual disability. Table 1 indicates the comparison of the pre- and post-intervention scores of all outcome measures whereas Figure 2 represents the extent of change found after completion of a programme.

Figure 2 Trauma Informed CBT-DBT Outcomes



Violence risk scores were analyzed and identified to reduce significantly after the intervention. The mean structured risk assessment scores changed to lower levels than they were at the pre-intervention stage, which shows that the impulse control has improved, and the risk associated with aggression has decreased. The statistically significant ($p < 0.001$) results of paired t-tests indicated that this reduction was statistically significant and a large effect size, which indicated that the programme had a clinically meaningful impact on risk of violence. There was also improvement on emotional regulation. The subjects showed a better capacity to handle anger, distress, and emotions reactivity after the intervention. Mean scores of emotional regulations improved after the intervention and the statistical analysis showed that there was a significant difference between the pre-intervention and post-intervention scores ($p < 0.001$). This enhancement implies the success of the skills training based on DBT in the combined programme.

The level of symptoms associated with trauma significantly but moderately decreased following the completion of the programme ($p < 0.01$). Respondents also expressed less trauma-related emotional reactions, which was in favor of the usefulness of trauma-informed values integrated into the intervention model. These findings were further facilitated by behavioral incident analysis. The records of the institutions showed that violent and difficult behavioral incidents at post-intervention were significantly decreasing than at baseline. The quantitative risk assessment results were supported by descriptive analysis that showed a steady downward trend of the participants.

Generally, the findings suggest that trauma-informed CBT-DBT integrated programme was efficient in the minimization of the risk of violence, emotional regulation, and reduction of the symptoms of the traumatic events in the violent offender with intellectual disability. All these results are indicative of the potential of the programme as an evidence-based and structured rehabilitation technique in the forensic environment.

Discussion

The current paper evidences the fact that CBT-DBT interventions that are informed by trauma are important in enhancing the results of people with intellectual disability that are prone to offending [18]. The participants reported significant decreases in aggressive behaviors and severity of trauma symptoms, as well as, the enhancement of emotional

regulation and positive behavioral involvement. These results co-exist with the available literature attesting the efficacy of a combined cognitive-behavioral and dialectical approach to emotional dysregulation and decreased recidivism risk in vulnerable populations. In comparison with earlier research, this study findings present another piece of evidence that planned and combined interventions may yield significant pre-post effects in a variety of psychosocial areas.

In terms of forensic practice, the provided outcomes emphasize the role of integrating trauma-informed practice into assessment and treatment plans. Early detection of risk factors and tailored intervention strategies should be prioritized by the practitioners, and adequate staffing, training, and supervision to ensure treatment fidelity by the service providers. The implications of the policies are as follows: There should be official guidelines about encouraging evidence-based interventions, resources should be provided to facilitate specialized programmes, and there should be some safeguards to ensure the rights and dignity of people with intellectual disability [19][20]. Moreover, the models of service delivery must promote cross-disciplinary cooperation between mental health professionals, social workers, and criminal justice agencies to promote a holistic approach and long-term rehabilitation.

The strengths of the study are the pre- post design, the various outcome measures validated and also the clinical relevance of the domains measured. The drawbacks are described as a small size of the sample, implementation at one site, and absence of a long-term follow-up which can limit the generalizability. Further studies are required to explore longitudinal effects, multi-site studies to explore scalability and involving complementary interventions (e.g., family support, mentoring and training social skills) to further optimize clinical effect. Some of the areas that should be researched are the cost-effectiveness, staff training models, and policy frameworks, which are required to normalize the application of the trauma-informed treatment, in forensic and community environments.

Policy Recommendation

The results demonstrate the necessity of such policy frameworks, which will focus on the incorporation of trauma-informed CBT -DBT interventions into the forensic and community services in respect to people with intellectual disability. Intervention fidelity and participant safety should be mandated by policies that require staff training, adequate allocation of resources and subject to standardized treatment protocols. Strong safeguards should be enhanced in the protection of the rights, dignity and social inclusion of service users. The collaboration of mental health professionals, social workers and criminal justice agencies should be encouraged to improve service provision and rehabilitation success. To scale up these programmes based on evidence, policymakers ought to endorse longitudinal evaluation and multi-site implementation research. In addition, continuous monitoring and outcome reporting mechanisms can be used to direct continuous improvement and hold everyone accountable. Through these policies, the vulnerable group can be served more efficiently, effectively, and safely through the inclusion of these interventions within national and institutional frameworks that will support the vulnerable population.

Conclusion

The given research proves that the trauma-informed CBT-DBT interventions yield a tremendous change among the intellectually disabled who are likely to commit an offense. There were significant changes in violence risk scores (pre: 27.4 ± 5.6; post: 19.6 ± 4.8, $p < 0.001$), trauma symptom severity (pre: 18.6 ± 4.1; post: 13.6 ± 3.7, $p = 0.002$) and behavioral incidents per month (pre: 3.4 ± 1.2; post: 1.2 ± 0.8), and also significant changes in emotional regulation (pre: 62.1 ± 9.3; post: 81.6 ± 10.2, $p < 0.001$). Such results demonstrate that multidisciplinary, systematic interventions can be used effectively to support a combination of psychosocial areas at a time, including support of safer behaviors, greater emotional regulation, and decreased risk of offending. To clinicians, the findings demonstrate the value of integrating trauma-informed care in therapeutic and rehabilitation programmes, the importance of personalized care, adherence to intervention regimes, and continuous result evaluation. The study highlights to policymakers the necessity of evidence-based guidelines, the allocation of resources, staff training, and protective safeguards to guarantee the protection of participants, their rights, and social inclusion. These findings can be applied in rehabilitation programmes to shape the programme design, interdisciplinary cooperation, and long-term planning. The study contributes to the field as it offers solid pre-post data on the usefulness of combined CBT-DBT interventions in a forensic population with intellectual disability, which the literature lacks on the topic of multi-

domain psychosocial outcomes. Though this can be limited by the small sample size and single site operation which can limit the generalization, the results provide the background for future larger multi-site studies and longitudinal research. This study offers a practical research-based framework to improve therapeutic intervention, make better policy decisions and achieve better outcomes by showing change in behavioral, emotional, and risk-related indicators.

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