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Introduction to the special issue – Working with aggression and violence: Assessment, prevention and treatment

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Introduction

This special edition of *Psychology, Crime & Law* is the outcome of the 2nd International Center for Aggression Replacement Training (ICART) Conference, which was held from 22 to 24 September 2004 in Amsterdam. The point of departure for the conference was Arnold P. Goldstein's Aggression Replacement Training, but the European Violence in Psychiatry Research Group (EVIPRG) and Connecting (partnership for consultancy & training) also took care of presentations.

What works with aggressive behaviour?

In the past, behavioural scientists have been quite pessimistic about the possible role of behavioural interventions in crime reduction. The seminal article by Martinson (1974) was quite influential in this regard. Based on a review of the extant literature, he concluded that "nothing works" in reducing criminal recidivism. It was not until the late 1980s that this trend was countered by a number of meta-analyses that appeared in the literature. These meta-analytic studies demonstrated that there were in fact treatment method that were effective in reducing recidivism (e.g. Andrews et al., 1990; Antonowicz & Ross, 1994; Lipsey, 1992). At the same time, research also showed that mere detention without treatment had no effect on reduction of recidivism (Cooke & Philip, 2000).

Andrews and colleagues (Andrews, 1989; Andrews et al., 1990) were the first to examine which factors in treatments were essential in reducing recidivism. They deduced that effective treatments adhered to three principles: the risk principle, the need principle and the responsivity principle. Later on, the treatment integrity principle was added as a fourth principle. Treatments that followed these principles should have effect sizes of 0.30 and higher (Andrews et al., 1990).

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Risk principle

Criminal behaviour is associated with a set of risk factors. The risk principle argues that the intensity of treatment should be attuned to the level of risk: low-risk offenders should receive no treatment or treatment of low intensity, whereas high-risk offenders should receive high intensity treatment. The risk level should be determined before treatment based on structured and well-validated risk assessment tools. Research has shown that structured risk assessments provide significantly better prediction of future offending than global clinical judgement (De Vogel, De Ruiter, Hildebrand, Bos, & Van de Ven, 2004; Douglas, Cox, & Webster, 1999).

Need principle

This principle determines what should be the treatment targets when reduction of recidivism is the ultimate objective. Recidivism risk is determined by a set of factors, which are static and stable (e.g. gender and age), and changeable and dynamic (e.g. substance abuse). The goal of treatment is the reduction of those dynamic risk factors which show a direct link with the criminal behaviour at hand. Andrews (1996) described the "Big Four" dynamic risk factors. First, he mentions the presence of antisocial cognitions as an important factor, including antisocial and procriminal attitudes, values, rationalizations, and cognitive-affective states (such as rage, despair, negativism). Secondly, he mentions an antisocial network as a risk factor for recidivism. Third, he points to a history of antisocial behaviour. Fourth, he refers to an antisocial personality complex, including aggressive, egocentric, impulsive and/or insensitive temperament; psychopathy, weak problem solving and self-control skills. Substance abuse, too, is an important risk factor (Gendreau, Little, & Goggin, 1995). These general risk factors are relevant to all offender groups, including those with mental disorders and sexual offenders (Bonta, Hanson & Law, 1998; Hanson & Harris, 2000; Hanson & Bussière, 1998; Müller-Isberner & Hodgins, 2000).

Based on these general risk factors, Andrews et al. (1990) selected a number of general treatment targets: (a) *reduction* of antisocial attitudes, antisocial cognitions, antisocial friends and acquaintances, and substance abuse; (b) *increase* of affection for and communication with family members, supervision and support by family members, identification with prosocial role models, self-control, self-management and problem-solving skills; (c) *replacement* of lying, stealing and aggressive behaviour with more prosocial alternatives; and (d) *change* in costs and benefits of criminal versus non-criminal behaviour so that non-criminal behaviour is preferred. Furthermore, Andrews (1995) points at the essential treatment component of relapse prevention by teaching the offender to become aware of high-risk situations and to develop a plan to practice non-offending solutions.

Responsivity principle

This principle emphasizes that the way treatment is delivered is essential for its effectiveness. Treatment needs to be offered in a modality that matches the learning style of the offender. The meta-analyses demonstrate that interventions based on cognitive and behaviour therapy are the most effective in changing criminogenic needs (Andrews et al., 1990; Antonowicz & Ross, 1994; Lösel, 1995). Treatment should be highly structured and directed at measurable goals (Lipsey, 1992). Therapy methods that allow participants to play an active role, by using role play and therapists as role models, are especially effective. Emphasis should be placed on specific skills, such as social skills and participants should

train these skills in their day-to-day life. Community-based treatment is always preferable to residential treatment, if risk levels allow it (Andrews et al., 1990). Multimodal treatment matched to the individual offender requires the design of an individual treatment plan with explicit mention of how specific criminogenic needs will be targeted and how change will be monitored. To avoid relapse in the future, a relapse prevention and aftercare plan should be made (Lösel, 1996). Voluntary treatment is not a necessary condition for success. However, motivational techniques can help increase the treatment's effectiveness (Stewart & Picheca, 2001).

Treatment integrity

After having determined "what works", it is important to identify the factors that ensure that treatment is delivered in the way it is meant to, the so-called treatment integrity. Meta-analyses have shown that the way treatment is delivered is crucial to its effectiveness—the reason why treatment integrity can be considered the fourth principle (Cooke & Philip, 2000; Lipsey, 1995). This principle becomes relevant only after all the other principles have been fulfilled (Cooke & Philip, 2000). Hollin (1995) summarizes factors that form a threat to treatment integrity. First of all, programme drift, by which he means the process through which targets and basic principles over a programme change in an unsystematic way over time. Secondly, Hollin describes programme reversal, which takes place when treatment goals are threatened, for instance by staff members who demonstrate aggressive behaviour while the treatment goal for the offender was to learn to control their anger. Finally, Hollin points at the risk of treatment non-compliance, which occurs when the content of a treatment programme or the goals of a session are changed or deleted without consideration of the theoretical principles that formed the basis of the programme.

To avert these threats to treatment integrity, several avenues are open. First, the treatment should be theoretically based (Harris & Rice, 1997), and a cognitive behavioural approach has been shown to be most effective (Antonowicz & Ross, 1994). Subsequently, treatment should be described in detail in a manual or protocol (Hollin, 1995). The organization where the treatment is offered should be dedicated to its success. Priority should be given to the treatment versus security issues (Gendreau & Goggin, 1996; Harris & Rice, 1997). Basic facilities for the treatment such as adequate rooms and equipment should be in order (Cooke & Philip, 2000).

The person of the therapist plays a crucial role in treatment success. Knowledge, motivation, expertise and attitudes towards the particular treatment play a role. Patients in forensic psychiatric institutions suffer from a great diversity of mental disorders, so staff need to be well trained in psychopathology. Staff support and supervision are of prime importance to prevent burnout and decreasing motivation. Supervision also safeguards that the treatment programme is implemented correctly (Hollin, 1995; Lösel, 1996). Staff members who are not delivering the treatment, e.g. prison wardens, need to be well informed of the treatment's methods and goals (Cooke & Philip, 2000).

Many authors point out the relevance of continuous monitoring and evaluation of the treatment (Harris & Rice, 1997; Hollin, 1995). In this way, treatment integrity is guarded and improvements can be made. Monitoring and evaluation should be based on different sources of information, such as staff members, independent expert reviews and the offenders themselves.

The contributions to this special issue should be placed in the tradition of the What Works principles. Each contribution, in its own way, makes an effort to apply these principles to arrive at more effective ways of reducing aggressive and violent behaviour.

Theory, therapy and prevention of aggressive behaviour

This special issue opens with the obituary of Arnold P. Goldstein, as published in a 2002 edition of the *American Psychologist*. *Jane Close Conoley* describes the merits of Goldstein for helping to create a safer society. He knew with his zest and personality how to inspire professionals all over the world in developing new interventions for the abatement of aggression and violence.

The Theory part opens with a contribution from *Emma Palmer* about the relation between moral development and aggressive behaviour. In her article, she gives special attention to the influences of family members and peers on the development of cognitions in children. Finally, she makes, on the basis of her analysis, recommendations for interventions such as Aggression Replacement Training.

Coralijn Nas, Bram Orobio de Castro, and Willem Koops report on a study of "Social Information Processing" by comparing adolescent delinquents with low-educated and high-educated peers. They conclude that delinquent adolescents express more aggression, but their attributions are not more hostile. However, significant differences in attributions are expected when a larger group of adolescent delinquents is studied.

According to *Richard Whittington and Dirk Richter*, aggressive behaviour on locked wards not only has to do with the psychopathology of the patients, but also with the interaction between patients and staff. Misunderstanding, anger and a need for security are the processes in staff members which can lead to escalation. Therefore, staff members are advised to receive training in how to deal with such processes.

Dan Olweus starts the Therapy part with a contribution about his Bullying Prevention Program. Positive results of a few important projects are reported, e.g. the "Bergen Project against Bullying" and the "New National Initiative Project against Bullying". The author ends with a description of a "train-the-trainer model" necessary for realizing the national implementation of the Bullying Prevention Program.

The application of an ART-based treatment intervention for violent forensic psychiatric patients (boys and men) is the focus of the contribution of *Ruud Hornsveld*. An evaluation of Aggression Control Therapy resulted in a decrease of aggressive behaviour. There are indications that the training of social skills in this population should be conducted with caution.

Moynahan and Strømgren report on a study of the effect of ART in a group of children and adolescents with different psychiatric diagnoses, including autism spectrum disorders. They demonstrate positive results, but mention that results can differ greatly among diagnoses. ART appears to be beneficial to children with autism spectrum disorders.

Coralijn Nas, Daniel Brugman, and Willem Koops describe a study on the effects of EQUIP for a group of adolescent delinquents. Because of the limited changes in cognitions and overt behaviour, they advise to intensify the programme and to repeat the study with a larger group of adolescent delinquents.

Gundersen and Svartdal studied the effect of a postgraduate education programme for implementation of ART. This programme contains theory, but also training of skills for conducting ART and skills for the implementation in organizations in which ART is not yet applied.

In the article by *Ellie Leenaars*, the differences between violent women and men are discussed. In view of experiences with a first version of Emotion Control Therapy with violent women and a preliminary study of the specific characteristics of violent female forensic psychiatric outpatients, the author makes recommendations for the further development of this therapy.

Machiel Polak and Henk Nijman address pharmacological treatment of forensic psychiatric patients who committed severe sexual offences. After a discussion of international literature findings about the effectiveness of libido-reducing medication, preliminary treatment results of four Dutch sexual offenders are described.

That the development of an effective treatment programme for sexually violent forensic psychiatric inpatients requires much effort comes forward in the contribution of *Chijs Van Nieuwenhuizen*. She describes the first modules of this programme, addresses some first results and makes some recommendations for the further development of this programme.

In the article by *Ruud Hornsveld and Cindy De Kruyk*, a study of personality characteristics and problem behaviours of sexually violent forensic psychiatric outpatients is reported. They describe which components of ART seem to be suitable for this patient group.

In the last part of this special edition, Prevention, *Joost Stolker, Gerard Hugenholtz, Eibert Heerdink, Henk Nijman, Hubert Leufkens, and Willem Nolen* discuss the associations between the use of antipsychotic medication and the seclusion frequency of psychiatric inpatients.

Although several studies presented at the ICART conference "Working with Aggression and Violence" concern preliminary findings, we hope that the readers of *Psychology, Crime & Law* will find the results and discussions collected in this special issue about assessment, prevention, and treatment of aggressive, violent and criminal behaviour interesting and stimulating. We thank Clive Hollin for providing the presenters of the ICART conference with the opportunity to publish in this journal.

References

Andrews, D. (1989). Recidivism is predictable and can be influenced: Using risk assessments to reduce recidivism. *Forum on Corrections Research*, *1*, 11–18.

Andrews, D. (1995). The psychology of criminal conduct and effective treatment. In J. McGuire (Ed.), *What works: Reducing reoffending—Guidelines from research and practice* (pp. 35–62). Chichester, UK: Wiley.

Andrews, D. (1996). Criminal recidivism is predictable and can be influenced: An update. *Forum on Corrections Research*, *8*, 42–44.

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, A., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinical relevant and psychologically informed meta-analysis. *Criminology*, *28*, 369–404.

Antonowicz, D. H., & Ross, R. R. (1994). Essential components of successful rehabilitation programs for offenders. *International Journal of Offender Therapy and Comparative Criminology*, *38*, 97–104.

Bonta, J., Hanson, R. K., & Law, M. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin*, *123*, 123–142.

Cooke, D. J., & Philip, L. (2000). To treat or not to treat? An empirical perspective. In C. R. Hollin (Ed.), *Handbook of offender assessment and treatment* (pp. 17–34). Chichester, UK: Wiley.

De Vogel, V., De Ruiter, C., Hildebrand, M., Bos, B., & Van de Ven, P. (2004). Different ways of discharge and risk of recidivism measured by the HCR-20. *International Journal of Forensic Mental Health*, *3*, 149–165.

Douglas, K. S., Cox, D. N., & Webster, C. D. (1999). Violence risk assessment: Science and practice. *Legal and Criminological Psychology*, *4*, 149–184.

Gendreau, P., & Goggin, C. (1996). Principles of effective correctional programming. *Forum on Corrections Research*, *8*, 38–41.

Gendreau, P., Little, T., & Goggin, C. (1995). *A meta-analyses of the predictors of adult offender recidivism: Assessment guidelines for classification and treatment*. Ottowa, Canada: Ministry Secretariat, Solicitor General of Canada.

Hanson, R. K., & Bussière, M. T. (1998). Predicting relapse: a meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology*, *66*, 348–362.

Hanson, R. K., & Harris, A. J. R. (2000). Where should we intervene? Dynamic predictors of sexual offense recidivism. *Criminal Justice and Behaviour*, *27*, 6–35.

Harris, G. T., & Rice, M. E. (1997). Mentally disordered offenders: What research says about effective service. In C. M. Webster, & M. A. Jackson (Eds.), *Impulsivity: Theory, assessment, and treatment* (pp. 361–393). New York: Guilford.

Hollin, C. R. (1995). The meaning and implications of 'programme integrity'. In J. McGuire (Ed.), *What works: reducing reoffending—Guidelines from research and practice* (pp. 195–208). Chichester, UK: Wiley.

Lipsey, M. W. (1992). Juvenile delinquency treatment: A meta-analytic inquiry into the variability of effects. In T. D. Cooke, H. Cooper, D. S. Cordray, H. Hartman, L. V. Hedges, R. L. Light, et al. (Eds.), *Meta-analysis for explanation: A casebook* (pp. 83–127). Newbury Park, CA: Sage.

Lipsey, M. W. (1995). What do we learn from 400 research studies on effectiveness of treatment with juvenile delinquents? In J. McGuire (Ed.), *What works: reducing reoffending—Guidelines from research and practice* (pp. 195–208). Chichester, UK: Wiley.

Lösel, F. (1995). The efficacy of correctional treatment: A review and synthesis of meta-evaluations. In J. McGuire (Ed.), *What works: reducing reoffending— Guidelines from research and practice* (pp. 79–111). Chichester, UK: Wiley.

Lösel, F. (1996). Effective correctional programming: What empirical research tells us and what it doesn't. *Forum on Corrections Research*, *6*, 33–37.

Martinson, R. (1974). What works? Questions and answers about prison reform. *The Public Interest*, *35*, 22–54.

Müller-Isberner, R., & Hodgins, S. (Eds) (2000). *Violence, crime and mentally disordered offenders*. Chichester, UK: Wiley.

Stewart, L., & Picheca, J. C. (2001). Improving offender motivation for programming. *Forum on Corrections Research*, *13*, 18–20.