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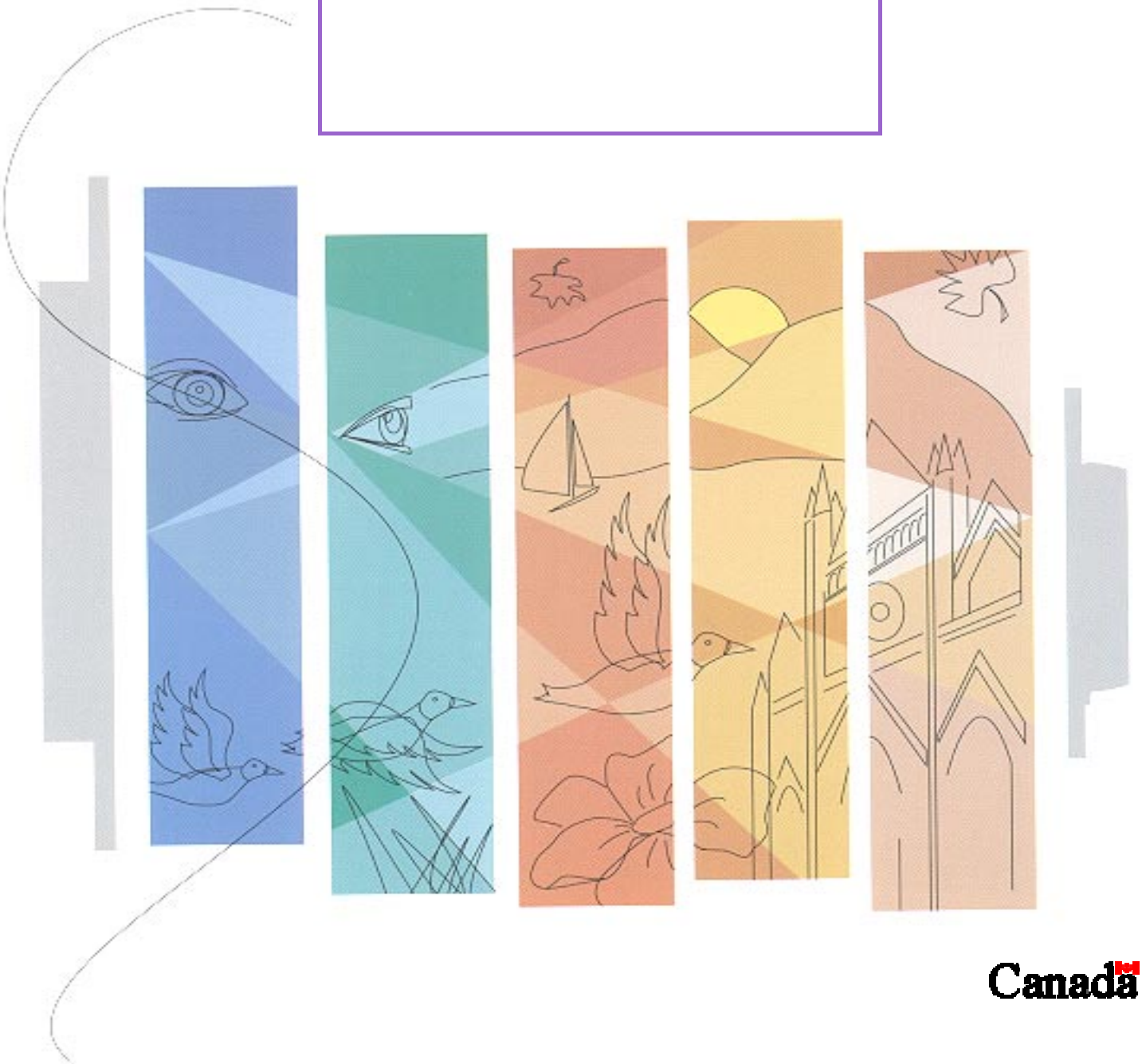
Treating Violent Offenders: A Review of Current Practices



Canada

Treating Violent Offenders: A Review of Current Practices

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Research Report No. R-38

Table of Contents

Executive Summary

Advances in the assessment of violent and high risk offenders have yet to significantly impact on intervention strategies. In addition, despite increased concern regarding violent criminals, the published literature on their treatment is very small. Recent studies which show some improved methodology support the finding that offenders who participate in cognitively based treatment programs with skills practice components show post-treatment gains. However, these gains have yet to be demonstrated to significantly effect recidivism rates. Further, the literature is hindered by lack of a cohesive theoretical model, problems in defining violent offenders, and over-reliance on self-report indeces of treatment gain. Current programs appear sufficiently contemporary to meet the needs of many violent offenders, although improved methodology and empirical validation are required. These existing programs, however, fail to address, specifically, the needs of persistently violent offenders.

Progress in the areas of treatment of sexual offenders and substance abuse has direct application to the treatment of violent offenders. This literature illustrates the importance of matching offenders to the appropriate level of intervention and providing a continuum of intervention from intake to community follow-up and supervision. Additionally, research on persistently aggressive individuals indicates that their cognitive style or aggressive beliefs are important antecedents to violent behaviour and a critical treatment target. Innovation in strategies for the assessment of such deficits and offenders' response to intervention appear to be important in the development of a treatment program for persistently violent offenders. The next requirement is to develop such a program, heeding the aforementioned conclusions.

Treating Violent Offenders: A Review of Current Practices

As assessment strategies for the identification of violent and high risk offenders gain prominence and sophistication (Harris, Rice, & Quinsey, 1993- Steadman, Monahan, Robbins, Appelbaum, Grisso, Klassen, Mulvey, & Roth, 1993), consensus regarding effective intervention remains obscured by problems in definition and methodology (Blackburn, 1993). While this situation should be disconcerting, it is not unique (Quinsey, Rice, Harris, & Lalumiere, 1993), nor should it be interpreted to mean that treatment programs for violent offenders are ineffective. The

purpose of this review is to highlight important research which has led to our current level of understanding and to delineate issues that might facilitate progress in this area.

It should be noted that several key reviews must be cited as they provide a detailed understanding of treatment issues for offenders. Rice, Harris, Quinsey, & Cyr (1990) provide an exhaustive review of relevant treatment targets for mentally disordered offenders and their work bears directly on the issue of treating violent offenders. Further, their emphasis on problem identification (Rice & Harris, 1993; Rice, Harris, Quinsey, Harris, & Lang, in press) rather than diagnosis is particularly germane to the treatment of violent offenders given that violent behaviour is observed in many diagnostic groups (Reid & Balis, 1987). Blackburn (1993) also provides a detailed review of the assessment and treatment of violent offenders that extends themes presented by Howells and Hollin (1989) and Roth (1987).

In order to help frame questions for future investigations and to collate the literature, this paper will consider the following issues: heterogeneity of offenders; developmental programs; comorbidity concerns; management of offenders- self-regulation strategies; cognitive style; assessment of treatment gain and outcome measures; setting characteristics; staff training and therapist characteristics. The summary will then attempt to distill from the literature what can be concluded regarding the treatment of violent offenders and future directions.

Heterogeneity of Violent Offenders

What immediately becomes apparent in completing a review of the literature on the treatment of violent offenders is the heterogeneity of this group (Blackburn, 1993- Rice, Harris, Quinsey, & Cyr, 1990). While efforts have been made to provide a typology based on offenses (Dietz, 1987) and detailed clinical reviews (Toch, 1969), recent conceptualizations suggest cognitive style may be more helpful in differentiating among violent offenders (Novaco & Welsh, 1989). Even after excluding sexual offenders and perpetrators of spousal abuse, considered to be relatively distinct groups, in an effort to achieve improved homogeneity, the remaining violent offenders vary according to skills deficits, motivational cues for violence, arousal level, emotional regulation, and impulsivity (this is not to suggest these deficits are absent in sexual offenders or abusive

males). These distinctions need to be considered theoretically in the development of intervention strategies and operationally in the application of admission criteria for treatment programs. In addition, much of the literature reflects work with adolescents and mentally disordered patients. While these findings are clearly relevant, incarcerated populations may have additional treatment concerns (Andrews Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990) or require intervention specific to correctional issues, e.g., the matching of risk and need to ensure programs are provided consistent with what is known about responsivity factors (Andrews & Bonta, 1993). That is, low risk offenders require less intensive intervention than high risk offenders (Andrews, Bonta, & Hoge, 1990).

Related to the problem of offender heterogeneity is how violence is defined. For this review, violent behaviour is considered the intentional and malevolent physical injury of another without adequate social justification (Blackburn 1993). It should be noted that this definition excludes self-injurious behaviour which is prevalent among offenders (Farrell & Mainprize, 1990), however, intervention for this group is beyond the scope of this paper. While threats and psychological injury are not included in this definition, this is not intended to mitigate their harmful effects on the victim. Within this definition there is provision for perpetrators to be anger-motivated or goal-oriented (Buss, 1961 - Ziliman, 1979). Anger is therefore not a prerequisite to offender violence (Novaco & Welsh, 1989), but is a common antecedent.

Summarizing problem-frequency surveys (Rice et all, 1990) indicate that mentally disordered offenders report anger to be a frequent concern, both within the institution (47%) and the community (75%). Further, retrospective reviews of offender's precursors to re-offense suggest anger is experienced often (52%) (Zamble & Quinsey, 1991). Pithers (1988) has provided similar data for rapists. While these findings are at best suggestive that anger is an important antecedent to criminality, it is clear that offenders frequently report anger to be an area of concern.

Hostility, however, is considered negative or distrustful beliefs about others and may also be antecedent to violent behaviour, but is not synonymous with violence. Megargee (1976) has proposed offenders differ in the extent to which

they are over-controlled or under-controlled in their use of aggression, explaining why some violent offenders are typically unaggressive. Violence or aggression is considered to be stable over time (Olweus, 1979), and there is increasing evidence supporting early onset as an important prognostic (Moffit, 1993). Further, mediator variables have also been proposed: substance abuse (Goldstein, 1989; Pihll & Peterson, 1993); mental disorder (Monahan, 1992, 1993; Steadman et al. 1993); psychopathy, (Hart, Hare, & Forth, 1994)- and intellectual abilities (Heilbrun, 1982), implying the need for multifaceted interventions Kazdin, 1987).

These definitional concerns are also reflected in differences among researchers in considering outcome. For instance, many studies consider robbery a violent offense and therefore reflect robbery post-treatment to be a measure of treatment failure in follow-up studies. If the treatment program only addressed anger-motivated aggression, then such a view may not be completely accurate. That is, the robbery may have been motivated by financial pressures, not interpersonal conflict. Confusing aggression with apparently different antecedents may obscure individual treatment gains.

While there has been increased understanding regarding ways in which violent offenders differ (Henderson, 1986-Prisgrove, 1993), it is not clear these have been incorporated into individualized assessments or differentiated treatment (Biaggio, 1987; Blackburn, 1993). Although an empirical question, it would seem plausible that violent offenders who differ with respect to motivation, frequency and intensity of violence, certain dispositional characteristics such as amenability towards treatment and attributions of malevolent intent, intellectual abilities, and substance abuse, might require intervention that varies with respect to treatment targets, intensity of intervention, and mode of delivery. Fortunately, some groundwork in the general area of treatment of offenders (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990; Rice et al, 1990) and antisocial adolescents (Kazdin, 1987) provide some guidelines.

Contributions from Developmental Literature

Conceptual considerations and treatment programs relating to conduct disordered youths also has some direct

applications to the design of programs for violent offenders. First, this literature reflects a high level of sophistication and provides a good model. Second, many persistently violent offenders would have likely received a diagnosis of conduct disorder as a child, although this information is not available in either retrospective or prospective studies of offenders. It is nonetheless implied from clinical experience and follow-up studies of juveniles (Robins, 1978). Third, the developmental literature prescribes a multifaceted approach, emphasizing skills acquisition (Kazdin, 1993), but cognizant of cognitive processing or neuropsychological deficits (Moffit, 1993- Quay, 1993). Treatment programs address proximal or process issues, but it is recognized that gains dissipate over time suggesting a maintenance perspective and not a treatment cure (Dodge, 1993; Kazdin, 1993).

Kazdin (1993) makes specific recommendations regarding the development of treatment programs. Relevant to the correctional setting, these include: developing offender subtypes to identify points for treatment- developing manuals with specific and concrete guidelines to better assess program integrity and facilitate replication; considering small scale (individual) and group designs to generate promising techniques; considering multiple measures of treatment outcome; and considering such issues as duration of treatment and the relative and combined efficacy of treatment combinations.

Diagnosis and Co-Morbidity

While there has been an extensive debate regarding the relationship between mental disorders in offender populations and potential for violence (Monahan, 1992), there is agreement that various socio-political decisions have led to significant numbers of mental disordered patients being diverted from mental health settings to prisons (Roesch & Golding, 1985; Steadman, McCarty, & Morrissey, 1989; Steadman & Cocozza, 1993). Surveys using the Diagnostic Interview Schedule, a structured psychodiagnostic interview for use in large-scale epidemiological studies, suggest that 50%-90% of Canadian offenders meet the criteria for substance use disorders or antisocial personality disorder (Hodgins & Cote, 1990- Motiuk & Porporino, 1991; Wormith & Borzecki, 1985). From 10%-30% meet the criteria for serious mental disorder such as a depressive, bipolar, schizophrenic, or organic disorder. As well, it is common for offenders to meet more

than one diagnosis, i.e., co-morbidity, yet it is less clear to what extent this effects treatment outcome. Intuitively, co-morbidity raises questions regarding the priorization of treatment needs.

The diagnosis of mental disorder in an offender, however, should not be confused with criminogenic need (Quinsey, 1988; Shapiro, 1991). Clearly, for some offenders, the presence of mental illness is ancillary to factors more germane to their motivation to commit crimes. Distinguishing these issues is vital to appropriate intervention. That is, ameliorating the symptoms of mental disorder may be insufficient to reduce the likelihood of future criminal behaviour. Addressing mental illness, however, is a required mental health concern for correctional staff and failure to respond to their distress would be viewed as unethical (Ogloff, Roesch, & Hart, in press) given their potential for victimization (Cooley, 1992). Several authors have raised concerns regarding the disadvantages faced by mentally disordered offenders in terms of access to programs and release opportunities (Freeman & Roesch, 1989; Porporino & Motiuk, in press).

Notwithstanding resistance to consider mental illness a risk factor for future violence (Monahan & Steadman, 1983; Teplin, Abram & McClelland, 1994), there is increasing evidence that some forms of mental illness are related to violence (cf Monahan, 1993). The magnitude of risk associated with the combination of male gender, young age, and lower socio-economic status, however, exceeds that presented by mental disorder. As well, alcoholism and other drug use is a more robust risk factor than major mental disorders such as schizophrenia and affective disorder. The prevalence rates of antisocial personality disorder and substance abuse in offender populations (Motiuk & Porporino, 1991) is particularly relevant since these factors are related to risk of violent offending. It is important to note that *current* psychotic symptoms are a defining risk factor, not previous admissions for psychotic symptoms (Link, Andrews, & Cullen, 1992). This distinction may not have been incorporated into actuarial risk scales for mentally disordered offenders which report schizophrenia to be a protective factor, suggesting lower risk (Harris, Rice, & Quinsey, 1993). Compliance with medication is also an issue that may relate to level of risk (Steadman et al, 1993).

The issue of mental illness also raises the question of management of an offender's behaviour. At a minimum, pharmocotherapy may be an adjunct to psychological interventions where there is evidence of acute or serious mental illness. Multidisciplinary treatment teams may therefore be more efficacious in cases where mental illness is present.

Managing Violent Behaviour

This section deals with the management of aggressive behaviour through pharmocotherapy. The literature distinguishes between short and long term management of violent behaviour in mentally disordered patients, and refers to inpatient and outpatient programs. Several reviews are available which present the issues relating to the use of medication to reduce aggressive behaviour (Bond, 1993; Conacher, 1988; Eichelman, 1988- Rice, Harris, Varney, & Quinsey, 1989; Tupin, 1987). These, however, will only be summarized as the main focus of the paper is on psychological interventions.

Short term use of psychopharmaocologic agents is most often applied in situations where the offender is acting in a seriously threatening manner towards self or others. The issue is one of control and the medication must have a rapid onset of action. Offenders in crisis are unlikely to co-operate with oral medication independent of the onset issue and there may be other medical contraindications (Tupin, 1987). Intramuscular injection appears to be the preferred intervention. Choice of medication includes antipsychotic, antianxiety and sedative medications, although each has specific strengths and weaknesses. Monitoring by staff or effects on respiration, blood pressure, pulse rate, and level of consciousness are imperative. Side effects may need to be controlled and toxicological screens should be obtained.

Long term use of drugs to manage aggressive behaviour should incorporate a detailed history and diagnosis (Tupin, 1987). Prior treatment experience, substance abuse, and diagnostic precision should inform physicians regarding the appropriate medication. Unlike short term management, then, the aim is more than symptom reduction. Long term drug use also has implications for monitoring of harmful side effects and titration to a therapeutic dosage.

It is clear that many offenders with mental disorders will be considered candidates for drug treatment, yet their compliance is not guaranteed. Neuroleptics have been demonstrated to reduce symptoms of schizophrenia such as agitation, hallucinations and delusions and lithium has been effective in the management of bipolar disorders (Bond, 1993). It is less clear that medication is effective in the management of violence with personality disordered

offenders (Conacher & Fleming, in press), although staff might resort to such a strategy for crisis management (Rice et al, 1989).

Rice and Harris (I 993), however caution that medication is not a panacea for the
management of violent behaviour. Further, this may be a litigious issue for advocacy groups. Not all offenders comply with physicians' prescriptions, and they have the right to refuse treatment. Harris (1989) has noted that neuroleptic drugs are not effective for all psychotic symptoms, nor for all patients. Partial or complete nonresponders appear relatively insensitive to medication or dosage changes. Side effects of these drugs result in noncompliance, as do patients' perceptions of staff motivation regarding prescriptive practices. Compliance may be improved by behavioral intervention (Michenbaum & Turk, 1987), yet drugs may not prove to be the treatment of choice for all offenders who exhibit violent behaviour. It may be that for offenders without a medical etiology to their aggressive behaviour that medication might facilitate cognitive-behavioral intervention, perhaps by reducing arousal level so that they might attend to program content, with a view towards eventually discontinuing the medication if possible.

Treatment Programs

Under the rubric of treatment programs for violent offenders the most common category is that of anger management or anger control. Although there is a relatively large literature on the assessment of violence in offender populations, surprisingly there is a dearth of published studies on the treatment of violent offenders.

While the specific treatment components vary somewhat across programs and settings, it is common to see components to address arousal levels and some review or rehearsal of alternative thinking. Stress inoculation is advocated by Novaco (1975) and more cognitively based programs often refer to Ellis (1977) irrational thoughts. More recently it appears that both components are incorporated into programs, although it is uncertain which contributes greatest to treatment gain, or the manner in which they may interact.

The components of a stress inoculation program typically consider: awareness of hierarchy of individual anger cues;

relation between self-statements and anger level; model of anger and measurement of parameters (intensity, duration, frequency, behavioral outcome); reappraisal of anger situations; self-instructional coping aids- relaxation training to reduce arousal level and facilitate self-control; and skills practice. Increasingly, communication and assertion skills are incorporated into this approach described by Novaco (1978), although the core elements are cognitive preparation, skill acquisition, and application practice.

Elise (1977) approach more specifically emphasizes the role of cognitions, notably irrational beliefs, in the provocation and maintenance of anger levels. Offenders are taught to recognize that what they believe results in increased arousal, labeled as anger, which precipitates aggressive behaviour. This ABC model considers irrational thoughts, e.g., the other person is deliberately putting me down, to produce strong feelings, e.g., anger or frustration. Intervention targets the thought to feeling link, challenging offenders to refute irrational beliefs, decreasing the likelihood of aggressive responses.

Implicit in the proliferation of anger control programs is that violent offenders are angry and that their level of anger exceeds that of nonviolent offenders (Hunter, 1993). Accordingly, reduced levels of anger are anticipated to result in less frequent and optimally less violent behaviour. This is a curious notion in that violence is relative infrequent, unreliably measured, and that many offenders' violence appears to be motivated for reasons other than anger (Henderson, 1984). Perhaps for this last reason recent programs have included skills practice in the areas of social skills, empathy, assertion, and problem solving. Clearly, from what is known about offenders generally regarding their treatment needs, these appear to be viable treatment targets (Ross & Fabiano, 1985). Unfortunately what is missing is a cohesive theoretical model by which to guide assessment and intervention (Steadman et al, 1993). Organizing intervention in sections which relate to self-regulation issues and cognitive deficiencies may be instructive in moving forward in developing working models for subsequent investigation.

Self-Regulation Strategies

Within the various treatment targets described in programs for violent offenders, they appear to reflect arousal reduction

techniques (Levey and Howells, 1990), interpersonal skill acquisition, e.g. social skills, assertion, problem-solving (Guerra & Slaby, 1990; Henderson, 1989), and cognitive distortions (Elise, 1977; Rokach, 1987). Some authors have incorporated several of these components into a more comprehensive package (Goldstein & Keller, 1987). Also, it has been suggested that treatment programs vary according to their emphasis on cognitive or behavioral deficiencies (Kennedy, 1990) and this may relate to approaches used to measure treatment gain. Again, many studies are multifaceted in their assessment of treatment gain (Kennedy, 1990; Kolko, Loar, & Sturnick, 1990).

When provided, a review of the descriptions of treatment programs for violent offenders lends one to conclude that different clinicians label similar interventions differently. For instance, some programs are described as social skills training, yet targeted several different components, e.g., assertion, self-control (arousal reduction) and social anxiety (Henderson, 1989). Other social skill programs, however, targeted specific areas, e.g., social withdrawal (Quinsey & Varney, 1977), conversational skills (Rice, 1983), and assertion (Marshall, Keltner, & Marshall, 1981). Within these studies there assumptions theoretically relating patients' poor social skills to violent behaviour. While it is likely that these treatment targets all fall within a cluster of interaction skill deficiencies, it is not clear that all violent offenders are equally deficient in these areas Henderson (1989).

This section will address strategies related to arousal reduction and skills acquisition. The strategies reflect activities that the offender engages in, through instruction, which enhance the regulation of his behaviour. Cognitive style will be considered separately in that there is a large literature regarding cognitions and aggressive behaviour (Novaco & Welsh, 1989). Where possible studies with offender populations will be described.

Cutting across various prison settings and populations, evidence exists to support the application of relaxation training or stress inoculation to anger control issues ; Hughes, 1993; Hunter, 1993; Kennedy, 1990- Rokach, 1987; Schlichter & Horan, 1981- Stermac, 1987). These studies replicate findings with non-offender samples (Deffenbacher, Story, Stark, Hogg, and Brandon; 1987-

Deffenbacher, 1992) which consider heightened arousal to be a component of anger so that improved relaxation facilitates of anger control. It is not clear, however, that arousal reduction strategies are necessarily superior to simple skills acquisition, whether in the area of social interactions or problem solving (Kennedy, 1990; Moon & Eisler, 1983) or cognitive coping skills (Deffenbacher, Story, Brandon, Hogg, & Hazaleus, 1988). Further research is required before conclusions can be made regarding the differential treatment effects of components of typical anger control programs. Such research will need to ensure that offenders with pre-treatment deficits are matched to the relevant area and that attentional controls are available (Guerra & Slaby, 1990- Henderson, 1989- Kolko et al, 1990).

Some programs target impulsivity, yet these appear to reflect a problem-solving strategy with a delay or pause feature comparable to self-instructional training (Camp, Blom, Herbert, & VanDoominck, 1977). The notion of a cost/benefit analysis has also been suggested (Doren, 1987). One novel application has been Rokach's (1987) use of a forced delay feature as part of a process reviewing simulated social situations. This is consistent with research highlighting the central role latency (impulsivity) plays in the expression of cognitive schema (Dodge & Newman, 1985). That is, pausing may inhibit expression of negative thoughts and facilitate generation of alternative responses.

Cognitive Processing Strategies

Novaco and Welsh (1989) describe the importance of appraisals and expectations in viewing potentially provocative events and promoting an aggressive response. They describe how automatic processing of information is facilitated by prior beliefs or schema, which is but one form of cognitive processing. Research in the area of developmental aggressive behaviour has highlighted the critical role information processing deficits play in determining and maintaining aggressive behaviour in adolescents (Crick & Dodge, 1994- Dodge and Frame, 1982; Dodge, Price, Bachorowski, & Newman, 1990; Slaby & Guerra, 1988). This work has prompted investigations into the efficacy of interventions developed to improve the information processing skills of subjects (Lochman & Lenhart, 1993). An ambitious effort with juvenile offenders

described the utility of a problem-solving strategy which targeted biased thinking skills (Guerra & Slaby, 1990), although examples are found elsewhere in the developmental literature for aggressive and delinquent youth (Feindler, Marriot, & Iwata, 1984; Hains, 1989; Kolko et al, 1990). Similarly, research with adult offenders has demonstrated irrational beliefs (Ford, 1991) and attributional biases (Serin, 1991) in violent offenders.

In an early study, Kirchner, Kennedy, and Draguns (1979) proposed that assertion training would be an important treatment target in aggressive offenders given their deficits relative to nonaggressive offenders. However, treatment or follow-up data are unavailable from this study. Several recent studies with offenders extend this work. Hunter's (1993) study appears the "best" with adult offenders in that it utilized a control group (not randomly assigned), specifically targeted aggressive beliefs, assessed pre and post-treatment with self-report and behavioral measures (institutional infractions), and considered social desirability. No follow-up data are yet available, however, and the total sample is only 55 offenders. She concludes treated offenders showed significant gains relative to nontreated offenders across self-report and behavioral ratings. Another study worthy of note is by Hughes (1993) because it considers behavioral ratings of role plays pre and post-treatment, staff ratings (post-treatment only) and recidivism for completers (n=52) and a waiting list control (n=27, not randomly assigned). Treated offenders reported post-treatment gains regarding anger scores, irrational beliefs, and in role plays. There was no difference in recidivism rates between the treated and nontreated groups. Lastly, Kennedy (1990) compared the relative efficacy of stress inoculation treatment to a behavioral skills treatment (Goldstein & Keller, 1987) with a sample of 37 offenders. Order of presentation of treatment had no effect, with the greatest treatment gain occurring in the initial phase of treatment regardless of treatment, using interim assessment. Treatment gain was measured by self-report, behavioral ratings in structured scenarios (role plays), and incident reports.

The cognitive processing approach emphasizes the role of beliefs or schema in motivating and regulating social behaviors (Bandura, 1986). Applying this approach to aggressive behaviour in adolescent offenders (Gueffa &

Slaby, 1990; Slaby and Guerra, 1988) and aggressive children more generally (Lochman & Lenhart,1993) has yielded specific intervention targets that should apply equally to adult offenders. Aggressive juvenile offenders were found to be deficient in social problem-solving skills and beliefs supporting aggression. Specifically they tended to define problems in hostile ways, adopted hostile goals, sought less confirmatory information, generated fewer alternative solutions, anticipated fewer consequences for aggressive solutions, and were less effective at choosing "better" solutions. For those familiar with the psychology of criminal conduct (Andrews & Bonta, 1993) they will note this is a specific application of investigating those thoughts which maintain violent criminal behaviour.

The intervention consisted of 120 aggressive adolescents, equally divided by gender, randomly assigned to a 12 week cognitive mediation training, attention control, or no-treatment control. The former intervention specifically targeted the deficits noted previously by Slaby and Guerra (I 988). Pre and post-treatment assessment incorporated measures of social cognition (beliefs about aggression), behavior ratings, self-report, and recidivism (24 months). Post-treatment gains for the treatment group were noted in terms of increased skills in solving social problems, reduced support of aggressive beliefs, and reduced aggressive behaviours (based on blind raters). The inference is that these socio-cognitive factors regulate aggressive behaviour, yet recidivism rates for the treated subjects were reduced but not significantly lower than the control groups. It would appear that follow-up issues are important in the maintenance of treatment gains if release rates are to be markedly effected, but this is not a new concept to correctional and forensic staff (Motiuk & Porporino, 1989; Quinsey & Walker, 1992). Rather, it emphasizes the limitations of even rigorous and theoretically-derived intervention which is institution-based only, an issue currently being addressed in the areas of programming for sexual offenders and offenders with substance abuse problems (Pithers, 1990- Lightfoot & Boland, 1994).

Treatment of Psychopaths

While this is a potentially contentious area, it must be considered so that interventions for specific groups of offenders might be reviewed. Early work in this area

suffered the same concerns referred to previously, i.e., disagreement regarding definitions, lack of control groups, and theoretically obscure intervention. The review of 295 studies by Levine and Bornstein (1972) yielded on a handful (IO) of studies which approached methodological requirements (homogeneous samples, untreated controls, follow-up, and specific outcome criteria). Reasonable conclusions regarding treatment are not possible given the heterogeneity of samples. Suedfeld and Landon's (I978) review of studies until 1975 echo the problems of inadequate definitions of psychoapthy. Their conclusions regarding the need for firm rules, non-gullible supportiveness, the use of therapeutic communities, and judicious pharmocotherapy may therefore be somewhat flawed.

More recently Wong and Elek (1990) have proposed specific criteria for reviewing the efficacy of treatment studies of psychopaths. They suggest the following: a definition of psychopathy based on Cleckley (1976)- an assessment of diagnostic reliability; a detailed description of the treatment program- the use of objective and reliable measures of treatment outcome- and the use of an appropriate control group. These criteria appear reasonable and two more contemporary studies have been published which reflect this second generation of treatment of psychopaths. Both studies provide important clues regarding specific treatment targets and operational issues. The first, by Ogloff, Wong, and Greenwood (1990) describes a therapeutic community (Jones, 1982) treatment program with 80 offenders. Emphasis was on offenders increasing personal responsibility, socialization and assertion. Attrition rate, clinical improvement, motivation, and institutional behaviour were investigated. Psychopaths, as measured by the Psychopathy Checklist-Revised (PCL-R, Hare, 1990), showed less clinical improvement, were less motivated, and had a higher attrition rate. On average, psychopaths were in treatment 43% shorter time than nonpsychopaths. One goal of future treatment programs would clearly be to develop strategies to improve compliance to better enable intervention to be successful (cf Miller & Rollnick, 1990).

The second study, by Rice, Harris, and Cornier (1992) was a retrospective investigation of a therapeutic community and incorporated a 10 year follow-up and a matched control group in a sample of 176 mentally disordered forensic

patients. That psychopaths did poorer post-treatment than matched controls is disconcerting, Recently these authors (Harris, Rice, & Cornier, in press) note that the unstructured therapeutic community while innovative at the time was incompatible with contemporary views regarding best practices in offender treatment (Andrews, Zinger, Hoge, Bonta, Gendreau, & Cullen, 1990). Whether this study's findings generalize to offender populations is not the issue. Rather, treatment programs for psychopaths should recognize a central tenet must be that intervention must meet criteria for good correctional programs. Specific applications to match the cognitive style of psychopaths may be helpful, but this work is only beginning to evolve.

Assessing Treatment Gain and Outcome

One major shortcoming of this literature on the treatment of violent offenders is the over-reliance on self-report measures of treatment gain. Concerns regarding the veracity of uncorroborated self-report in offender samples have been expressed elsewhere (Rogers, 1988; Shapiro, 1991), and efforts to control for social desirability and/or intelligence appear warranted. Self-report information is important as it reflects offenders' self-perceptions (Blackbum, 1993), yet it may be an insufficient measure of treatment gain given the demand characteristics, the reality that intervention is often accepted under duress, and where less than favorable post-treatment reports have significant negative consequences. Related to the concern about self-report instruments is that most have been developed for non-offender populations (Novaco, 1994), lack validity scales, and have such transparent items that interpreting post-treatment improvement without corroborating indices of gain may be at best speculative (Bellemare & McKay, 1992; Hughes, 1993). A related concern is that violent offenders inconsistently report higher scores, and therefore greater problems, on self-report measures of anger, aggressiveness, and hostility (Novaco, 1993; Selby, 1984; Serin & Kuriychuk, in press). Baseline measures or within subjects comparisons also appear warranted so that individual offender's improvement may be considered.

Performance measures such as role-play are common in the social skills programs (Henderson & Hollin, 1986) and they reflect a model for programs concerned more broadly with violent offenders. Independent behavioral ratings are also recommended to validate self-report indices and as a

strategy to demonstrate convergence of treatment gains. Both performance measures and behavioral ratings require careful training of staff and efforts to ensure inter-rater reliability. Apart from specialized treatment centres or research projects it would appear such measures are absent in correctional practice. The treatment literature suggests, however, they are important for demonstrating transfer of treatment gains from knowledge to performance, i.e., behaviour (Goldstein & Keller, 1987).

The use of recidivism rates as a measure of treatment gain has been debated (cf BIackburn, 1993), yet for offender populations the expectation of increased community safety and reduced violent recidivism is often their raison d'être. This distinction between treatment gain (intermediate within-program targets) and generalization (longer-term effects) has been noted by Andrews (1983). Multiple outcome measures are also strongly recommended to detect partial successes which may be obscured by dichotomous success/fail definitions. As the concept of relapse prevention is applied to violent offenders (Prisgrove, 1993), this provides another avenue for investigation, that of the identification of risk situations, their relation to outcome, and continuity of care in the community.

Setting Characteristics

While the therapeutic community (TC) has been proposed to facilitate treatment of violent offenders (Suedfeld & Landon, 1978), recent research is disappointing (Harris, Rice, & Cornier, in press). Reflecting on earlier views regarding the application of the therapeutic community to correctional settings is illustrative (Toch, 1982). Jones (1982) described essential principles if a TC is to be successful in a prison setting. The more difficult to attain include: clients and staff must be motivated and volunteer to work together; confidentiality must be respected- traditional prison rules must be modified; prison authorities must delegate responsibility and authority to the TC; and, the concept of "treatment" is an existential one in which the individual and the group seek a feeling of purpose in relation to society. Interestingly, correction administrators at the time conceded this type of program might be just the thing for some offenders, but is not a panacea (Levinson, 1982). More recently, Cooke (1989) and Agee (1990) have incorporated aspects of TC as a *milieu* to facilitate treatment, but it is not the treatment per se.

Clearly, only a specialized facility or dedication of a specific range could meet the environmental milieu recommended to in a TC. In addition, there is some evidence that staff respond somewhat poorly towards offenders with improved assertion skills (Rice et al, 1989) in that it may be easier for staff to interact with offenders in an authoritarian and capricious manner. Token economy is another setting characteristic which has been recommended as an adjunct to institutional programs to produce and maintain behaviour change (Paul and Lentz, 1977). Rice Harris, Quinsey, and Cyr (I 990) strongly advocate token economies for a range of self-help behaviours, compliance issues, interpersonal behaviour. Laws (1974), however, cautions against having correctional staff operate a token economy because of the likelihood of disruption of appropriate contingencies.

Staff Training Issues

A major impact on the frequency of aggression in institutions relates to the manner in which staff interact with their wards (Rice et al, 1989; Thackrey, 1987). Staff training in the recognition of potential conflict situations and appropriate verbal and physical intervention increases staff confidence and reduces the frequency of assaults against staff and patients (Rice et al, 1989).

Staff most likely to be effective with offenders are those who use authority to enforce rules, but in a nonconfrontational manner, i.e., firm but fair. They model prosocial and anticriminal attitudes, are able to be empathetic, and are interpersonally skilled (Andrews, Bonta, & Hoge, 1990). This is consistent with the approach advocated by Miller and Rollnick (1991) in what they refer to as "motivational interviewing".)Well developed specifically for addictions, it would appear that their principles apply to other highly resistant populations such as offenders.

Psychologists in corrections " have seen their role shift over the past decade from one of intervention to that of assessment (Watkins, 1990). Provision of training to deal with potential role conflicts would therefore seem important to improve intervention, as would direction regarding priorization of assessment and treatment demands. It may be that a restructuring of psychological resources will be required before specialized programs will be able to be developed and provided to persistently violent offenders,

Also, increasingly, treatment is considered in the context of packaged programs, but some offenders may require longer and more intensive intervention (Kazdin, 1987).

Therapist Characteristics

Madden (1987) describes the challenge facing clinicians who provide treatment services to violent offenders. In addition to concerns regarding ethical dilemmas and litigation, the issue of staff burnout is very real. The skills and characteristics alluded to previously, e.g., empathetic and fair but firm, are difficult to sustain with somewhat noncompliant patients (Roth, 1987), but more problematic for those dealing with offenders for a sustained duration. Blackbum (1993) among others has noted that treatment is often a long-term commitment and efforts need to be taken to ensure opportunity for collegial support, perspective-taking, humor, and blowing off steam.

Miller and Rollnick (1990) review the literature on therapist effects related to treatment efficacy and conclude that individual therapists can have significant impact on patients motivation for treatment, including compliance and continuance issues. Further, they note that the therapeutic alliance requires a challenging, but not confrontational therapeutic orientation. Such an approach is not always easy with violent offenders (Novaco, 1983).

CSC Initiatives

In reviewing the literature on treatment of violent offenders it is noticeable that nonsexual and nondomestic violence receives relatively little attention. This is the case in CSC, where proportionately greater resources have been committed to the treatment of sexual offenders and those who abuse partners.

While few CSC studies have been published, this is not to imply that specific initiatives for "generic" violent offenders are not proceeding. Gordon (1993) and Serin (1993) completed informal surveys and concluded that many psychology departments provide some form of anger management programming, typically with a cognitive-behavioral orientation, and utilizing pre and post-treatment assessment to consider treatment gain. Unfortunately, these programs vary with respect to the resources available, they lack standardized admission criteria or assessment protocols, and vary regarding treatment goals. At times these programs are part of a broader intervention such as with substance abuse or sexual offenders.

Each region and each institution within each region have established multidisciplinary committees to review violence in the institutions. These have led to improved communication between staff, increased understanding about the impact of environmental and physical cues, and the impact of drugs on the stability of institutions. These have been major endeavors, however, treatment for violence remains an important prerequisite for reviews for conditional release.

Last year NHQ Programs developed an Anger and Emotions Control Program to complement Cognitive Skills Training. The material is consistent with the literature described earlier regarding anger control programs. Courses are facilitated by a trainer, similar to other Correctional Programs initiatives. This program has just begun pilot testing in several regions, yet the current methodology will limit the extent to which conclusions can be drawn regarding the efficacy of different components. In addition, it was never intended this program be suitable for all violent offenders. Finally, specialized programs have been developed at RPC Prairies and Pacific specifically to meet the needs of serious violent offenders (Presse, 1993; Smiley, 1993), however, to date only preliminary or anecdotal evaluative information is available.

Matching Offenders to Programs (Differential Treatment)

While there is some agreement regarding the requisite treatment components, it is not clear which components relate to treatment gain for which offenders (Blackbum 1993). Further, the issue of program intensity (Kazdin, 1987) has been absent in discussions of programs for violent offenders. Neither is it clear the optimal length of a treatment program, since relative success has been reported with programs that are brief and intermediate in length (Stermac, 1986; Lochman, 1985). One lesson learned from the addictions area is that not all offenders require the same level or intensity of intervention (Fabiano, 1993).

Reconciling difficulties in definition and classification of violent offenders should facilitate matching offenders to the appropriate level of intervention. This strategy will require some standardization in assessment procedures, however. Programs will need to be compatible conceptually and lower risk, infrequently violent offenders' treatment needs may be

met with a program such as the Anger and Emotions Control. Persistently violent offenders will require more intensive intervention which recognizes the stability of their aggressive response to a broader range of situations. This group of offenders will more likely reflect the cognitive distortions described previously (Serin & Kuriychuk, in press; Slaby and Guerra, 1988).

Another area relevant to matching offenders needs to treatment targets relates to the notion of treatability. It is clear that this concept is difficult to operationalize (Heilbrun, Bennett, Evans, Offult, Reiff, & White, 1988) and that clinicians have low agreement regarding who is treatable (Quinsey & Maguire, 1984). It is equally clear that determining the degree of resistance towards treatment has implications at various stages of the criminal justice system (Quinsey, 1988; Rogers & Webster, 1989). Further, ameliorating resistance appears to be an important initial treatment goal (Miller & Rollnick, 199 1), which is prognostic of outcome (Ogloff et al, 1990). This would appear to be an important area to develop as a component of a treatment program for persistently violent offenders.

A final comment relates to relapse prevention. Increasingly it is being presented as an integrative framework for managing offenders. The success in the substance abuse and sexual offender treatment literature (Browned, Marlatt, Lichenstein, & Wilson, 1986- Pithers, 1990) has resulted in its application to violent offenders (Prisgrove, 1993). This may lead to the identification of more individualized treatment targets, but it is premature to conclude that the identification of high risk situations will effect outcome. Supervision and monitoring, however, would be facilitated by such information, and this might impact outcome. These remain empirical questions to be investigated.

Summary

What Do We Know?

Notwithstanding the concern about violent offenders, there exists a surprisingly small body of literature describing treatment efforts and their efficacy. Recent studies have shown improved methodology, however, we are far from determining what intervention works best for which violent offenders. Although there is evidence to support treatment gain, this has not generalized to improved recidivism rates,

but this is an understudied issue. Despite this relatively gloomy outlook, there is relative consensus among clinicians and researchers regarding the types of intervention to consider with violent offenders.

Research on the treatment of violent offenders identifies arousal reduction, problem solving and challenging aggressive beliefs to be promising treatment targets. Measurement of treatment efficacy in offender populations has been confounded by the over-reliance on self-report questionnaires, the absence of control groups, and problems in the definition of violent offenders. There is little evidence, however, that such programs reduce violent recidivism.

Theoretical models which integrate arousal level, impulsiveness, and cognitive style in the stability of violence across situations for persistently violent offenders may provide some direction for the development of assessment strategies and treatment targets (Serin & Kuriychuk, in press-, cf Zillman, 1988). The extent to which self-regulation deficits, developmental history, and motivation may also impact the leaning style of such offenders warrants consideration (Newman, 1990). Since self-reported perceptions of treatment benefits is a limiting feature, multi-method assessments need to be considered such that convergent validity becomes possible, Anger is considered an important treatment target, however, many offender's violent behaviour may have other antecedents not previously considered in treatment programs (Henderson, 1989).

What To Do? (Future Directions)

It is recommended that NHQ Research co-ordinate the development of a multi-site treatment program for persistently violent offenders. Such co-ordination will facilitate the following key principles: standardized admission criteria- the identification of several control groups, preferably matched according to severity of criminal history or current offense; random assignment to treatment and control groups; development of multi-method assessment strategies; and assessment of process and outcome measures of treatment gain.

What is required is-. the development of a working conceptual model; the development of a research methodology to address questions regarding treatment effectiveness; the identification of treatment targets and multiple methods for assessing need and treatment gain (behavioral ratings, self-report, and performance tasks)- determining admission criteria relative to existing programs to ensure a hierarchical approach- developing a treatment manual; developing guidelines for assisting in maintenance of treatment gains; and follow-up, with emphasis of reasons for success *and* failure. It is important to note that desistance is not the same as treatment success.

Additional issues need to be considered. Attempting to provide such a program at several sites across the country means that the number of offenders treated will be high, permitting easier analysis of the findings. Some sites, such as an RPC will already have trained staff, but regular institutional staff will require training to complete some of the more promising behavioral rating scales (Agee, 1990). As well, some institutions may need additional resources to provide an additional program of the integrity intended. Some settings win be more "therapeutic" than others, perhaps as a function of security level. Some may choose to allocate a particular treatment range, however, these matters warrant further consideration.

It is clear, however, that the knowledge and expertise exists to provide a theoretically relevant and methodologically sophisticated treatment program for violent offenders comparable to those currently in place for sexual offenders

(Marquis, 1993), however its efficacy in terms of reduced violent recidivism will not be known for several years.

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