Chapter 8
General discussion and concluding remarks
In the present thesis several topics of an integrated cognitive behavioural approach of violence were the focus of attention. In the first part of this thesis, the relationship between early environmental variables, namely parental rearing styles and traumatic experiences, and the development of deviant and violent behaviour was examined. Additionally, the relationship between specific attachment styles and criminal and deviant behaviour was studied. Attachment styles and traumatic experiences are not only considered important contributors to the development of problematic behaviour later on in life, but also to the results of treatment with respect to problematic behaviour, including violent behaviour.

In the second part of this thesis the focus of attention was on the treatment of mentally disturbed offenders with primarily personality disorders. The patients were assessed thoroughly on Axis I and Axis II pathology. In order to be able to observe the behaviours that were considered objectives in the treatment of violent offenders, an observation scale, the Forensic Inpatient Observation Scale (FIOS), was developed, which was able to measure behavioural changes during treatment. An intramural cognitive behavioural treatment program with a strong emphasis on milieu-therapy was evaluated. The effects of treatment were assessed by means of behavioural and personality measures that are considered universal problems to all patients.

In the present chapter an overview of the main findings and conclusions is given. Subsequently, the implications of the findings are addressed and directions for future research are given.

8.1 Overview of main findings and conclusions
In the first part of this thesis, attention was directed toward the influence of environmental variables on criminal, deviant behaviour.

In Chapter 2, the relationship between parental rearing styles on the one hand and criminal behaviour and personality pathology on the other hand was examined in forensic psychiatric inpatients, prisoners and controls from the general population. Other studies found that a bad socializing environment (behaviour of the parents) tend to lead to the development of deviance, like criminality and alcoholism, in a child (e.g. McCord, 1999). In the present study the subjects were asked how they perceived their parents during their first 16 years of life. The results of the regression analyses, in which the influence of personality pathology was controlled for, showed that forensic inpatients reported less care from their mother and significantly more overprotection from both parents, when compared to prisoners and controls. Prisoners and controls could be less clearly distinguished with respect to parental rearing styles. The only difference was found on perceived care from the mother. Contrary to the expectations, the prisoners perceived their mothers as significantly more caring than the controls. One explanation for this counterintuitive finding is that much care from the mother may be pathological under certain circumstances, especially when it indicates that deviant behaviour of the child is not disapproved of.
The major finding of the analyses on the relationship between parental rearing styles and personality pathology was that, whether or not relationships were found to be significant strongly depended on the way personality pathology was measured: categorically or dimensionally.

In Chapter 3, the attachment styles of forensic inpatients, prisoners and controls were assessed using the Relationship Questionnaire (RQ) of Bartholomew and Horowitz (1991) in which four attachment styles are distinguished. In line with the theory of Bowlby (1977, 1984) it was hypothesized that the dismissing attachment style would be highly prevalent among the forensic, criminal groups. The fact that this hypothesis was not supported by findings of other studies in which the Adult Attachment Interview (AAI) was used, led to the hypothesis that the dismissing attachment style may be assessed more accurately with the RQ than with the AAI. The results of the study showed that prisoners and forensic inpatients were more insecurely attached than controls from the general population. The only specific insecure attachment style that was more common among the patients and prisoners, however, was the fearful attachment style and not the dismissing attachment style. After controlling for the influence of personality pathology, the relationships between criminal (and patient) status and attachment styles were less clear. When controlling for the categorical personality pathology, the relationships did not differ. However, after controlling for the dimensional personality pathology, the relationships between the overall (in)secure attachment style and the fearful attachment style with criminal status were no longer significant, but now, a significant association between patient status and a fearful attachment style was found.

In Chapter 4, the relationship between traumatic experiences, dissociation and borderline personality pathology was examined in forensic inpatients and prisoners. Sexual and emotional abuse were significantly more common among forensic inpatients than among prisoners. Additionally, the patients reported significantly more different types of traumatic experiences. The results of this study lend support to the hypothesis that sexual abuse is not related to dissociative symptoms, but merely to borderline personality pathology. In addition, dissociative symptoms were found to be related to borderline personality pathology. These results are in line with the findings of Zweig-Frank et al (1994). This study also lends support to the finding of psychiatric and psychological clinical practice in offender samples, namely that dissociative disorders are rare, despite the fact that traumatic experiences are very common.

Chapter 5 is the first chapter of the second part of this thesis, in which assessment and treatment of mentally disturbed violent offenders was the focus of attention. In Chapter 5, the assessment of the prevalence and co-occurrence of lifetime Axis I and Axis II pathology using (semi-) structured interviews was assessed in male forensic inpatients who participated in a treatment outcome study. The results showed that substance abuse (75.7%) and mood (51.3%) and anxiety (40.3%) disorders were the most common Axis I lifetime disorders. Nearly 87% of
the subjects received a diagnosis for a specific personality disorder or a personality disorder ‘Not Otherwise Specified’, most frequently from the dramatic B cluster. The present findings emphasize the importance of assessing a broad range of disorders and using (semi-) structured interviews, since comorbid disorders may be of influence of the seriousness of the problems and the course of treatment. This, however, is not only relevant for offender populations. Studies among non-forensic in- and outpatients also demonstrated high comorbidity rates of Axis I and Axis II pathologies (Oldham, Skodol, Kellman, Hyler, Doidge, Rosnick, Gallaher, 1995). And patients dependent on cocaine who also had an additional diagnosis for post traumatic stress disorder, not only had a higher rate of co-occurring Axis I and Axis II disorders. They were also found to be more resistant to therapy compared to those without an additional diagnosis of PTSD (Najavits, Gastfriend, Barber, Reif, Muenz, Blaine, Frank, Crits-Cristoph, Thase and Weiss, 1998). The presence of a comorbid Axis I disorder may also be a positive prognostic indicator for patients with personality disorders (e.g., Shea, Widiger and Klein, 1992).

In the present thesis it was further argued that the sadistic personality disorder, which was a proposed disorder in DSM-III-R, may have been a clinically useful personality dimension in addition to the antisocial personality disorder, to examine more precisely the severity and nature of the pathology of criminally behaving individuals. It is therefore considered regretful that the sadistic personality disorder is left out of the DSM-IV classification.

In Chapter 6 the development of an observation scale, the Forensic Inpatient Observation Scale (FIOS) is described. Due to a lack of reliable and valid observation instruments that are relevant for forensic psychiatric inpatients, the FIOS was developed. The FIOS has six scales that are believed to represent important areas in the treatment and functioning of forensic inpatients: (1) self-care, (2) social behaviour, (3) oppositional behaviour, (4) insight into offence/problems, (5) verbal skills and (6) distress. The psychometric qualities of the FIOS are satisfying.

Finally, in Chapter 7, the effects of an intramural cognitive-behavioural treatment program for mentally disturbed offenders was evaluated. The main focus of treatment was on the milieu of the wards. By means of operant conditioning techniques, inadequate behaviour of the patient was negatively reinforced and adequate behaviour positively reinforced. Shaping, modelling, positive reinforcement, time-out, punishment and challenging irrational thoughts were the techniques applied by the staff. Treatment goals were aimed at: (1) enhancing adequate coping skills, (2) enhancing adequate interpersonal behaviours, (3) reducing reactions of anger and fear, (4) improving social awareness, (5) improving self-worth, (6) reducing oppositional behaviour and 6) reducing distress. After 2.5 years of treatment, patients as a group showed fewer depressive and dissociative symptoms, they were less distrusting, less egoistic, and reported lower levels of anxiety and anger disposition. Patients also showed less avoiding coping strategies and they sought more social support. No increase in social
(assertive) behaviours was found, neither on self-report nor on observational measures. A significant decrease of oppositional behaviour was observed by the staff. Although at group level the behavioural changes are quite well, at individual level only a minority of the patients showed clinical improvement over time. Results suggested that patients with more psychopathic traits may show more clinical improvement. Since no data on recidivism were available yet, it was not possible to determine if, despite these intramural clinical improvements, these psychopathic patients would re-offended more after discharge from the clinic, as was found in other studies (Steels et al, 1998).

8.2 Limitations of the present studies
Specific limitations of the individual tests and methodologies were discussed in each of the chapters. These are therefore not repeated in detail here. In this section only problems regarding generalisation of the findings are discussed.

A common limitation of all studies in this thesis is the generaliseability of the findings. Only male forensic patients and prisoners were subject of the studies. Further, the offences that were committed by the prisoners and forensic patients are considered severe offences by the courts. Therefore, the findings of the studies may not apply to offenders who only have committed minor offences.

The sample size of the forensic inpatients was rather small. Due to the way the treatment study was conducted, only those patients that entered the clinic and were willing and capable to participate, were entered in the treatment outcome study. With a maximum of 15 new patients a year, including the patients who were not motivated or capable to participate in the study, it takes years to obtain a large sample size. Drastic re-organizations in the clinic had such a tremendous impact on the content and nature of treatment, that it was considered no longer appropriate for our study to recruit any new patients that were admitted to the clinic after these re-organizations took place.

The current findings can also not be generalised to the whole population of TBS patients, since the patients were assigned to a specific TBS clinic, also based on the nature and severity of their problems. Illustrative for this fact are the relatively large differences in baseline scores between the present sample and the sample in the Grieven study (1997). As long as we are aware of these differences and describe them, studies among small and selected samples are very useful. Although from a scientific point of view we may wish to have large samples and randomised controlled studies, from a clinical practical point of view this is not always possible or considered ethical. This should, however, not imply that studies on the effects of treatment should not be done at all. Descriptive studies, using structured and standardized assessment instruments do supply relevant information on the effects of treatment and the behavioural changes patients make.
8.3 Current directions in criminal research: risk assessment

During the past decades the focus of attention in research among violent offenders has become more and more on risk assessment. The major goal is to be able to predict as precisely as possible which offenders are likely to re-offend in the future, with a minimum chance of false negatives and false positives.

The call for more accurate risk assessment comes from (1) society and the government, which are confronted directly and indirectly with the consequences of offending, (2) the criminal justice system, which frequently has to deal with the same criminals and as a consequence needs better information about how to deal with these offenders, (3) clinical decision makers, who have to give their opinion on the risk of re-offending.

Efforts were made to improve the accuracy of forensic clinical predictions of violence by adopting a theoretically based decision-making approach (Pollock, McBain and Webster, 1989). Studies on the predictions of dangerousness, however, initially remained pessimistic, even when actuarial methods were used (Menzies, Webster, McMain, Staley and Scaglione, 1994). More recent studies, however, are more optimistic and found actuarial assessment methods to be more accurate in the prediction of re-offending than clinical decision making (Steadman, Silver, Monahan, Appelbaum, Clark Robbins, Mulvey, Roth and Banks, 2000).

Actuarial assessment instruments are a-theoretical, and consequently, do not examine the causes of the behaviour that the instruments were designed for to predict (e.g. Krauss, Sales, Becker and Figueredo, 2000). Summation of risk-factors does not lead to an explanation of why offenders may re-offend. Nor does it provide information of how to handle criminal behaviour in terms of prevention, treatment or rehabilitation. A pitfall of all this is that offenders may be classified as dangerous or prone to commit a crime in the future, without knowing exactly why. Excluding these offenders from treatment or rehabilitation may be the consequence, but may also be premature, since no theoretically based empirical information is available that supports the hypothesis that the only way to prevent these subjects from re-offending is (lifetime) imprisonment.

Theory based actuarial risk-assessment instruments are lacking at the moment, but are already subject of present and future research (e.g. Monahan and Steadman, 1994). Furthermore, efforts are made to make risk assessment tools more accessible for clinicians, by making the actuarial decision method resemble the clinical assessment process more (Steadman, et al, 2000; Doyle and Dolan, 2002).

In the holistic model that was presented in the general introduction of this thesis, several theories on the development and continuation of deviant offensive behaviour were integrated. This model was proposed as a model in the assessment of the individual offender, since it clearly demonstrates problem areas and the way in which these influence each other. The alleged causal paths that lead to violent
behaviour can be read from the model. And consequently, targets of treatment can be derived from it. The model is also applicable to empirically testing theories with respect to risk assessment. The model can be modified in such a way that specific theoretical models can be tested. For example, to test cognitive theories on the development of violent behaviour, the personality features that are listed can be substituted by core self-beliefs or cognitive schemata.