One size does not fit all

The need for treatment tailoring in youth and family services

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Publications and Contributions of Authors

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Chapter 2 is under review as: Bijlsma, A. M. E., Assink, M., Stams, G. J. J. M., & van der Put, C. E. (2022). A critical evaluation of the Risk, Need, and Responsivity Principles in family interventions for delinquent youth: A meta-analysis.

AB, CvdP, and MA designed the study. AB conducted literature searches, AB, MA, and CvdP coded the studies, and AB and MA conducted the statistical analyses. AB wrote the first draft of the manuscript, and all authors contributed to and have approved the final manuscript.

Chapter 3 is under review as: Bijlsma, A. M. E., Assink, M., & van der Put, C. E. (2022). Personalizing child protection: The clinical value and usability of a needs assessment instrument.

AB, CvdP, and MA designed the study. AB conducted and coded the interviews, and performed the statistical analyses. AB wrote the first draft of the manuscript, and all authors contributed to and have approved the final manuscript.

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AB, CvdP, and MA designed the study. AB and CvdP performed the statistical analyses. AB wrote the first draft of the manuscript, and all authors contributed to and have approved the final manuscript.

Appendices

Appendices Chapter 2

Appendix A

Coding Sheet

Coding sheet RNR Meta-analysis

Variable	Coding	Source/Page
GENERAL ARTICLE INFORMATION		
1. Study ID number (1, 2, 3….)		
2. Bibliographic reference: Write a complete citation in APA form		
3. Coder name		
4. Date of coding		
5. Year of publication		
6. Study design	(1) Randomized Controlled Trial (2) Quasi-Experimental	

Subject	Coding	Source/Page
SAMPLE DESCRIPTORS		
7. Overall mean age of sample (at start of the study)		
8. Percentage of cultural minority		
9. Gender of sample	(1) Females (2) Males (3) Both	
10. Percentage of boys		

Subject	Coding	Source/Page
TREATMENT DESCRIPTORS		
11. Which intervention (program) was provided to the treatment group?		
12. Which type of care was provided to the control group?	(0) Waiting list (1) Care/treatment as usual (2) Other intervention program_____	
13. (average) Duration of treatment (in weeks)		
14. (average) Intensity of treatment (in hours per week)		
15. (average) Total contact hours (mentioned in text or treatdur * treatintens)		
16. (average) Frequency of treatment (number of sessions per week)		

Subject	Coding	Source/Page
RISK, NEED, & RESPONSIVITY PRINCIPLES		
17. On which risk factors was the sample selection based (inclusion criteria)?		
18. On how many (above) risk factors was the sample selection based?		
19. Has the sample selection been based on the results of an assessment scale/ instrument?	(0) No (1) Yes	
20. What was the general risk level of the sample?	(0) Low (1) High (the majority of participants had formally penetrated the judicial system at the time of the study and had a prior criminal record or by author's judgments severe antisocial/violent behavior.)	
21. How many previous offenses were convicted on average?		
22. Has the risk principle been adhered to terms of matching the intervention intensity to the general recidivism risk level of the sample? (*aggregate sample approach, by authors' judgements*)	(0) No (1) Not mentioned (2) Yes: mentioned in the manual/ factsheet (3) Yes	
23. Has the risk principle been adhered to terms of matching intervention intensity to recidivism risk of individuals? (*within-sample approach*)	(0) No (1) Yes, based on clinical judgment (2) Yes, based on an instrument	
24. Has the need principle been adhered to terms of a criminogenic need assessment?	(0) No (1) Yes, based on clinical judgment (2) Yes, based on an instrument	
25-32. Which criminogenic need factors were targeted? (*see examples of treatment elements, Bonta & Andrews, 2017)*		
25. Criminal involvement *(build up noncriminal alternative behavior in risky situations)*	(0) No (1) Yes	
26. Antisocial Personality Pattern *(build problem-solving skills, self-management skills, anger management, and coping skills)*	(0) No (1) Yes	
27. Procriminal attitudes *(reduce procriminal cognitions, recognize risky thinking and feeling, build up alternative prosocial thinking and feeling, adopt a prosocial identity)*	(0) No (1) Yes	

28. Procriminal associates *(reduce association with criminal others, enhance association with prosocial others)*	(0) No (1) Yes
29. School/Work *(enhance involvement, rewards, and satisfactions)*	(0) No (1) Yes
30. Leisure/Recreation *(enhance involvement, rewards, and satisfactions)*	(0) No (1) Yes
31. Substance abuse *(reduce substance abuse, reduce the personal and interpersonal supports for substance-oriented behavior, enhance alternatives to substance abuse)*	(0) No (1) Yes
32. How many criminogenic need factors were targeted?	
33. Did the family program target improving the parent-child relationship (*affection/communication*)?	(0) No (1) Yes
34. Did the family program target increasing monitoring/supervision?	(0) No (1) Yes
35. Has the need principle been adhered to terms of consideration of the Central Eight criminogenic need factors (25-32)?	(0) No, treatment was not targeted at the (assessed) criminogenic needs of individual offenders (1) Yes, treatment was targeted at criminogenic needs of individual offenders *(at least one of the above)*
36. Has the need principle been adhered to terms of consideration of either or both of the "appropriate forms" of family intervention (37/38)?	(0) No (1) Yes, improving parent-child relationship (2) Yes, increasing monitoring/ supervision (3) Yes, both (1) and (2)
37. Has the *general* responsivity principle been adhered to? (*social-learning or cognitive-behavioral programs that used modelling, role-play, reinforcement, and graduated practice*)	(0) No (1) Yes
38-45. Has the intervention been tailored to clients based on the following factors?	
38. Intelligence/Cognitive skill level (*e.g. verbal intelligence, interpersonal maturity, empathy)*	(0) No (1) Yes
39. Social support (*e.g. modeling, neutralize procriminal associates)*	(0) No (1) Yes
40. Gender (*e.g. abuse, trauma)*	(0) No (1) Yes
41. Age (*e.g. developmentally appropriate services)*	(0) No (1) Yes
42. Culture/Race/Ethnicity (*e.g. responsiveness)*	(0) No (1) Yes

43. Psychopathological problems *(e.g. counseling, aftercare, medication, institutionalization)*	(0) No (1) Yes
44. Treatment motivation (*e.g. stages of change, motivational interviewing techniques, collaborative goal setting)*	(0) No (1) Yes
45. Other:	
46. Has the *specific* responsivity principle been adhered to terms of intervention tailoring to client motivation, personal, or situational factors (at least one of the above)?	(0) No (1) Yes
47. Adherence to the risk/need/ responsivity principles	(0) No adherence to any of the three principles (1) Adherence to only the risk principle (2) Adherence to only the need principle (3) Adherence to only the responsivity principle (4) Adherence to the risk and need principles (5) Adherence to the risk and responsivity principles (6) Adherence to the need and responsivity principles (7) Adherence to all three principles
48. Adherence to number of RNR principles	(0) 0 principles (1) 1 principle (2) 2 principles (3) 3 principles

Subject	**Coding**	**Source/Page**
EFFECT SIZE CODING		
49. Effect size ID number		
50. Effect size type	(1) Pre-test comparison (baseline; prior to start of the intervention) (2) Post-test comparison (first measurement point; post intervention) (3) Follow-up comparison (all subsequent measurement points; post intervention)	
51. If the effect size type is a follow-up comparison, what is the length of the follow-up in months?		

52. Delinquency dimension (what is measured in delinquent behavior?)	(1) Participation (yes/no) (2) Frequency (3) Seriousness (4) Versatility (number of crime types)
53. Measurement type of delinquency dimension	(1) Official record (2) Self report (3) Parent report (4) Other_____
54. Total sample size after randomisation on which ES is based	
55. Treatment group sample size for this effect size	
56. Control group sample size for this effect size	
57. Calculated effect size (Cohen's *d*)	
58. When there is a difference between groups, which group shows less delinquency?	(0) Treatment/Experimental group (1) Control group

Appendix B

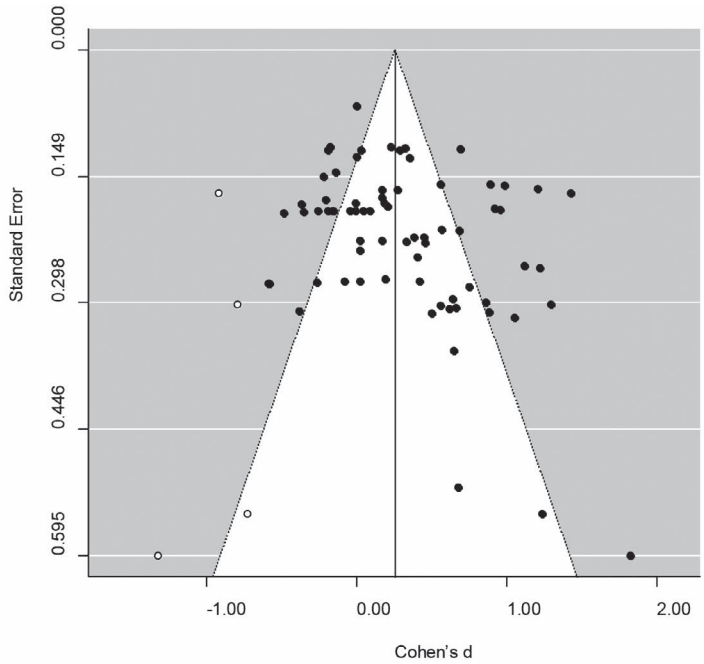
Characteristics and References of Included Studies

Reference	Year	Sample size (*N*)	% Minority	% Male	Age (*M*)	Treatment duration (weeks)	Program	Quality Control (Scale 0-15)
Asscher et al.	2014	256	45	73.44	16.02	-	Multisystemic Therapy	11
Bank et al.	1991	55	-	100	13.67	52	Oregon Social Learning Center – program in family management	6
Barton et al.	1985	74	35	-	-	-	Functional Family Therapy	6
Borduin et al.	2009	46	29.2	95.8	14	30.8	Multisystemic Therapy	8
Borduin et al.	1995	176	30	67.5	14.8	-	Multisystemic Therapy	9
Borduin et al.	1990	16	37.5	100	14	-	Multisystemic Therapy	9
Byles & Maurice	1979	305	37	87	11.5	-	Juvenile Services Project	10
Celinska et al.	2018	155	30.8	59.8	15.4	74.4	Functional Family Therapy	8
Dakof et al.	2015	112	94	88	16.1	20	Multidimensional Family Therapy	11
Davidson et al.	1987	84	26	83	14.2	18	Action Family Focus	9
Dembo et al.	2000	303	66	55	14.6	10	Family Empowerment Intervention	11
Elrod & Minor	1992	43	62.79	76.74	14.8	12	Project Explore	7
Gilman et al.	2020	1593	29.9	65.5	16.1	21	Step Up	10
Gordon et al.	1995	45	0	70.37	15.4	22	Functional Family Therapy	7
Gordon et al.	1988	54	0	55.56	15.4	22	Functional Family Therapy	4
Greenwood & Turner	1993	148	40	100	16.6	46.71	Paint Greek Youth Center	9
Henggeler et al.	2002	70	53	79	15.7	19	Multisystemic Therapy	8

Reference	Year	Sample size (*N*)	% Minority	% Male	Age (*M*)	Treatment duration (weeks)	Program	Quality Control (Scale 0-15)
Henggeler et al.	1999	118	53	79	15.7	19	Multisystemic Therapy	11
Henggeler et al.	1992	84	58	77	15.2	13.4	Multisystemic Therapy	9
Howitt & Moore	1991	206	20	89	-	48	Early Offender Program	8
Karam et al.	2015	310	70	74	15.4	24	Parenting with Love and Limits	9
Klein et al.	1977	56	-	44.19	-	-	Short-term behavioral intervention with delinquent families	4
Lab et al.	1993	155	32	100	14.2	-	Sexual Offender Treatment program	8
Letourneau et al.	2009	127	85	97.6	14.6	28.4	Multisystemic Therapy	9
Letourneau et al.	2013	124	85	100	14.7	28.4	Multisystemic Therapy	8
McPherson et al.	1983	75	-	-	15	14	Intensive Family Counseling	6
Quinn et al.	2004	455	50	58	13.91	10	Multiple Family Group Intervention - Family Solutions Program	10
Sawyer & Borduin	2011	148	23.9	69.3	14.5	-	Multisystemic Therapy	10
Schaeffer & Borduin	2005	165	23.9	69.3	14.5	-	Multisystemic Therapy	11
Sexton & Turner	2010	917	22	79	15.02	-	Functional Family Therapy	11
Timmons-Mitchell et al.	2006	93	22.5	78	15.1	20.69	Multisystemic Therapy	10

Appendix C

Funnel Plot



Note. A contour enhanced funnel plot with Cohen's *d* on the X axis and standard error on the Y axis. The black dots denote the observed effect sizes and the white dots the filled effect sizes. The solid vertical line represents the summary effect. From inside to outside, the dashed lines limit the 90%, 95%, and 99% pseudo confidence interval regions. The imputation of 4 white dots to the left of the summary effect indicates that publication bias may have been present in our results.

Appendix Chapter 3

Appendix A

Vignette (fictitious CPS case)

The family comprises father, mother, and their three sons K. (9), I. (7), and U. (3). Parents got divorced after twelve years of marriage marked by a long period of arguments and fights. Father mentioned that mother cheated on him, although mother claims that her contact with other men took place after they broke-up. For a long time, father kept hoping they would get back together. This 'on-again, off-again' situation has been very confusing for the children.

Mother has no own place to live, so she and the youngest sun are currently staying in a house that is rented by her parents. The middle son stays with her every now and then, but is mostly staying with father who lives at his parents' house together with the oldest son.

Mother is unemployed and has debts. Father has a fulltime job at a bakery, and is getting assistance from social services to pay off his debts. Mother feels very dependent on father, and she frequently asks him to help her out with parenting and financial issues. Father tries to meet her needs as best he can.

The children struggle with their parent's divorce. The oldest son (K.) blames mother for the break-up, and he prefers not to visit her. When he does visit mother, he shows rebellious and defiant behavior causing mother to call father to come and pick him up. K. is having angry outbursts, in which he sometimes kicks and hits mother. Father says that he does not recognize the problematic behavior of K.

The middle son (I.) blames father for hitting mother and finds it difficult to decide where he should live. Parents are not making consistent decisions for him on suitable parental access arrangements. I. witnessed father hitting mother after which the police arrived at their house. He has spoken about this bad experience openly at school with his classmates.

The youngest son (U.) cries a lot and clings to mother when she leaves. He also sleeps in mother's bed when he is scared at night. U. has speech problems and struggles with expressing himself.

From the first few conversations with parents, it became clear that no progress has yet been made. Parents would like to solve their problems, but they keep on arguing a lot. There are serious doubts on whether or not the children should be placed out of home. Mother experiences stress and difficulties in raising her children, but is willing to cooperate with child protection services. However, father shows less treatment motivation. He is ashamed of his living situation, because his parents smoke in the house, and he is afraid that the children will be placed out of his home.

Nederlandse Samenvatting (Dutch Summary)

Het Belang van Behandeling op Maat in de Jeugdbescherming

Kindermishandeling is een omvangrijk probleem dat wereldwijd de levens van miljoenen kinderen beïnvloedt. Het is gerelateerd aan ernstige korte- en lange termijn gevolgen voor slachtoffers, zoals depressie, middelenmisbruik, agressie en posttraumatische stresssymptomen. Een effectieve aanpak gericht op het voorkomen van kindermishandeling is dan ook essentieel. Helaas zijn interventies in de jeugdzorg gericht op het voorkomen van kindermishandeling nog slechts in beperkte mate effectief. Een mogelijke oorzaak van deze matige effectiviteit is dat interventies niet of onvoldoende zijn toegespitst op zorgbehoeften en kenmerken die per risicogezin kunnen verschillen. Dit terwijl het personaliseren van behandeling de effectiviteit van interventies kan vergroten, zoals ook beschreven wordt door middel van het Risk-Need-Responsivity (RNR) model. Dit model is ontwikkeld voor de inrichting van strafrechtelijke zorg en schrijft in een aantal principes voor hoe interventies vormgegeven moeten worden om de effectiviteit te vergroten. Hoewel het RNR-model is ontwikkeld ter voorkoming van criminele recidive, is het model ook veelbelovend voor de preventie van kindermishandeling. Zo kunnen zowel delinquent gedrag als kindermishandeling worden verklaard door een disbalans tussen risicofactoren (denk aan armoede, stress en psychopathologie) en beschermende factoren (zoals sociale steun) in verschillende sociale systemen rondom een cliënt of risicogezin, zoals de familie, een school, en de buurt waarin een cliënt of gezin woont.

Het implementeren van het RNR model in de jeugdbescherming om kindermishandeling in risicogezinnen te voorkomen omvat het personaliseren van interventies aan de hand van drie kernprincipes: (1) het *risicoprincipe* betreft het aanpassen van de intensiteit van een interventie aan het risico op toekomstige kindermishandeling binnen een gezin (een hoger risico vraagt om een intensievere aanpak), (2) het *behoefteprincipe* houdt in dat interventies gericht moeten zijn op veranderbare (dynamische) risicofactoren die samenhangen met (het risico op) kindermishandeling en (3) het *responsiviteitsprincipe* betreft de aanpassing van interventies aan specifieke mogelijkheden en kenmerken van gezinnen. Om het RNR model te kunnen toepassen in jeugdbescherming zijn instrumenten nodig om risico's, behoeften en responsiviteitsfactoren in kaart te brengen. Er is tot op heden echter nog geen onderzoek beschikbaar over de implementatie van de behoefte- en responsiviteitsprincipes in de jeugdbescherming. Daarom staat in dit proefschrift de

toepassing van een complete RNR-aanpak in de jeugdbescherming centraal, onder andere door middel van onderzoek naar de toegevoegde waarde van het toepassen van de behoefte- en responsiviteitsprincipes in de jeugdbescherming.

Studies in dit Proefschrift

Hoewel er nog geen onderzoek beschikbaar is naar de effectiviteit van het toepassen van de RNR principes in de jeugdbescherming, is er al wel veel wetenschappelijke ondersteuning beschikbaar van de effectiviteit van de RNR principes in forensische zorg. Dit bewijs kan echter in twijfel worden gebracht, aangezien er inconsistenties zijn tussen studies in de toetsing van de effectiviteit van de RNR principes. Daarnaast zijn sommige van deze studies enkele decennia oud en ontbreekt recent onderzoek naar implementatie van het RNR model. Daarom betreft **hoofdstuk 2** een update van een meta-analyse naar de effecten van toepassing van de risico-, behoefte- en responsiviteitsprincipes in gezinsinterventies gericht op het voorkomen van recidive van criminele jongeren. Er is gekozen om de effectiviteit van de RNR principes in specifiek gezinsinterventies kritisch te her-evalueren, omdat deze interventies zich richten op risicofactoren die gelinkt zijn aan zowel delinquent gedrag als kindermishandeling (o.a. een verslechterde communicatie tussen ouder en kind). Uit de meta-analyse van k = 31 studies die 71 effectgrootten rapporteerden, is een klein significant effect gevonden van gezinsinterventies op het verminderen van recidive onder criminele jongeren (d = 0.382, $p < .001$). Hoewel er grotere effecten werden gevonden bij toepassing van de RNR principes, waren deze verschillen niet significant. Deze resultaten impliceren dat wel of geen toepassing van de RNR principes geen invloed heeft op de uitkomsten van gezinsinterventies voor delinquente jongeren. Mogelijk zijn deze resultaten te verklaren door een lage statistische power door een klein aantal studies dat volgens de codering niet voldeed aan de RNR principes. Een andere verklaring is dat deze resultaten waarschijnlijk niet per se duiden op een gebrek aan effectiviteit van de principes, maar eerder op een gebrek aan concrete implementatie van de principes in interventiestudies. We benadrukken daarbij het belang van het gebruik van valide en betrouwbare risico-, behoefte-, en responsiviteitstaxatie instrumenten om interventies op een gestructureerde manier aan te passen aan de diverse kenmerken en behoeften van individuele cliënten.

De studie in **hoofdstuk 3** onderzocht de klinische waarde en bruikbaarheid van een behoeftetaxatie instrument (ARIJ-Needs) in het besluitvormingsproces van

professionals over passende zorg voor gezinnen in de jeugdbescherming. ARIJ-Needs is een computerapplicatie waarmee clinici worden ondersteund bij het toepassen van het behoefteprincipe in de jeugdbescherming, door middel van het structureel taxeren van zorgbehoeften van gezinnen en het selecteren van interventies die aansluiten op de getaxeerde behoeften. Voor dit onderzoek werden semigestructureerde interviews gehouden met 15 professionals (n = 12 vrouwen en n = 3 mannen) die werken met gezinnen in de jeugdbescherming (o.a. sociaal maatschappelijk werkers en psychologen). De interviews begonnen met vragen over het huidige besluitvormingsproces van de professionals. Vervolgens werd een fictief vignet voorgelegd waarin een jeugdbeschermingscasus over een multiprobleemgezin werd beschreven. Er werd gevraagd aan de professionals of zij alle zorgbehoeften uit de casus wilden taxeren en welke interventie zij passend vonden bij de casus. Daarna werd ARIJ-Needs geïntroduceerd en gevraagd of de professionals een tweede behoeftetaxatie wilden uitvoeren met ARIJ-Needs. Ten slotte werden gebruikservaringen met ARIJ-Needs uitgevraagd en werden de resultaten van de behoeftetaxatie met de tool geëvalueerd. Uit de resultaten bleek dat professionals significant meer zorgbehoeften taxeerden met behulp van ARIJ-Needs dan met de behoeftetaxatie zonder ARIJ-Needs. Specifiek gezins- (o.a. huiselijk geweld en financiële problemen), ouder- (o.a. crimineel gedrag) en opvoeding-gerelateerde factoren (o.a. een problematische ouder-kind relatie) werden vaker getaxeerd met ARIJ-Needs dan met de ongestructureerde taxatie. Deze factoren zijn sterke voorspellers voor kindermishandeling en daarmee belangrijke aanknopingspunten voor behandeling. De bevindingen van dit onderzoek wijzen erop dat ARIJ-Needs professionals kan ondersteunen in het identificeren van relevante aanknopingspunten voor behandeling in risicogezinnen, die zonder de tool wellicht over het hoofd worden gezien. Daarnaast werd de zorgkeuzemodule van ARIJ-Needs beoordeeld als een 'verbreding van de horizon' in het voortdurend groeiende aanbod van zorg en interventies in de jeugdbeschermingspraktijk.

Hoewel er steeds meer onderzoek beschikbaar is over de voordelen van toepassing van de RNR principes in de jeugdbescherming, is er tot op heden weinig aandacht besteed aan de implementatie van het responsiviteitsprincipe. Om die reden is in **hoofdstuk 4** de klinische waarde van toepassing van het responsiviteitsprincipe in de jeugdbescherming onderzocht. Kortgezegd houdt het responsiviteitsprincipe in dat interventies moeten aansluiten op specifieke kenmerken van cliënten om de effectiviteit ervan te vergroten. Om relevante responsiviteitsfactoren te identificeren, werd een

literatuurreview uitgevoerd naar componenten van (forensische) responsiviteitstaxatie-instrumenten (*N* = 19). Op basis van deze resultaten is een overzicht opgesteld met responsiviteitsfactoren gerelateerd aan kenmerken van gezinnen in de jeugdbescherming. Vervolgens werd dit overzicht tijdens semigestructureerde interviews voorgelegd aan 14 professionals die werkzaam zijn in de jeugdbescherming om de relevantie van elke factor in de jeugdbeschermingspraktijk uit te vragen. Aanvullend werd aan de professionals gevraagd of zij klinische behandelsuggesties konden geven voor het aanpassen van behandeling aan geïdentificeerde responsiviteitsfactoren. De resultaten van de interviews leidden tot een overzicht van zeven responsiviteitsfactoren gerelateerd aan opvoeders van gezinnen in de jeugdbescherming: probleemontkenning, behandelmotivatie, psychische problemen, cognitieve capaciteiten, culturele achtergrond, praktische behandelbarrières (o.a. financiële problemen), sociale steun, en barrières voor groepstherapieën. Dit overzicht kan professionals ondersteunen in het identificeren van belangrijke responsiviteitsfactoren die een positieve uitkomst van behandeling mogelijk belemmeren. Daarnaast biedt dit onderzoek aanknopingspunten voor behandeling op maat om behandelbetrokkenheid van opvoeders in de jeugdbescherming te versterken.

Hoewel uit onderzoek blijkt dat mannen en vrouwen in gelijke mate betrokken zijn bij huiselijk geweld, is er nog weinig onderzoek beschikbaar naar genderspecifieke risicofactoren gerelateerd aan het plegen van huiselijk geweld. Om die reden was het doel van de studie in **hoofdstuk 5** om mogelijke verschillen in criminogene risicofactoren tussen mannelijke en vrouwelijke huiselijk geweldplegers te onderzoeken. Er is gebruik gemaakt van gegevens uit klinisch gestructureerde risicotaxaties van 366 mannelijke- en 87 vrouwelijke forensische zorgcliënten die een GGZ behandeltraject hebben gevolgd vanwege betrokkenheid bij huiselijk geweld. Verschillen in de prevalentie van criminogene risicofactoren tussen mannelijke en vrouwelijke huiselijk geweldplegers werden onderzocht, en voor mannen en vrouwen is afzonderlijk de relatie tussen deze factoren en behandeluitval onderzocht. Om de onderlinge samenhang tussen de risicofactoren te onderzoeken, zijn door middel van netwerkanalyses statistische netwerken gecreëerd waarmee interacties tussen risicodomeinen (gegroepeerde risicofactoren) werden bepaald. De resultaten lieten genderverschillen zien in zowel de prevalentie van- en onderlinge samenhang tussen risicofactoren, als in de relaties tussen risicofactoren en behandeluitval van mannelijke en vrouwelijke huiselijk geweldplegers. Bij mannelijke huiselijk geweldplegers was de prevalentie van de

risicofactoren 'een crimineel verleden', 'middelenmisbruik' en 'criminele attitudes' hoger dan bij vrouwelijke huiselijk geweldplegers. Bij vrouwen bleek de prevalentie van sociaaleconomische risicofactoren (o.a. werkloosheid en financiële problemen) hoger dan bij mannen. Behandeluitval bij mannen bleek gerelateerd te zijn aan de risicofactoren 'omgang met vrienden in het criminele circuit', 'een crimineel verleden' en 'drugsmisbruik'. Bij vrouwen bleek behandeluitval gerelateerd te zijn aan de risicofactoren 'een problematische relatie met familieleden', 'woninginstabiliteit', 'een gebrek aan sociale steun' en 'werkloosheid'. Uit de netwerkanalyses bleek dat emotionele/persoonlijke risicofactoren (o.a. impulsiviteit en een gebrek aan zelfinzicht) een centrale positie innamen in de onderlinge samenhang met andere risicofactoren voor zowel mannelijke als vrouwelijke huiselijk geweldplegers. Dit betekent dat het behandelen van deze risicofactoren een indirect positief effect kan hebben op de vermindering van andere risicofactoren, zoals de risicofactor 'problematische relaties met familieleden', die sterk samenhing met emotionele/persoonlijke risicofactoren. De resultaten van dit onderzoek bieden inzichten in genderspecifieke verschillen in criminogene risicofactoren voor huiselijk geweld en in de onderlinge samenhang tussen deze factoren. Deze inzichten kunnen aanknopingspunten bieden voor clinici bij het vormgeven van behandeling op maat voor huiselijk geweldplegers.

Hoewel de meeste slachtoffers van kindermishandeling meerdere vormen van kindermishandeling hebben ervaren, zijn er relatief weinig studies naar de comorbiditeit van typen kindermishandeling en de gevolgen van specifieke typen kindermishandeling binnen steekproeven. Daarom is in **hoofdstuk 6** het onderscheidend vermogen van twee dimensies van kindermishandeling onderzocht ('mishandeling versus verwaarlozing' en 'emotionele versus fysieke mishandeling') in het identificeren van ontwikkelingsproblematiek in een klinische steekproef van 146 Nederlandse kinderen uit gezinnen die de interventie 'Multisystemic Therapy – Child Abuse and Neglect (MST-CAN)' kregen aangeboden. Uit de resultaten bleek dat er geen verschillen waren in ontwikkelingsproblematiek (externaliserende en internaliserende problematiek) bij slachtoffers binnen de dimensie 'mishandeling versus verwaarlozing'. Er was echter wel sprake van meer externaliserende problematiek (o.a. agressiviteit) bij slachtoffers van fysieke mishandeling vergeleken met slachtoffers van emotionele mishandeling. Verder werd er meer gedragsproblematiek (o.a. sociale problemen, aandachtsproblemen en traumasymptomen) gesignaleerd bij slachtoffers van meerdere vormen van kindermishandeling vergeleken met slachtoffers van één

type kindermishandeling. De resultaten van dit onderzoek dragen bij aan meer kennis over de impact van meervoudige kindermishandeling, en belichten de waarde van het onderscheiden van fysieke en emotionele kindermishandeling. Deze kennis kan clinici mogelijk ondersteunen in het aanpassen van behandelingen aan individuele behoeften van slachtoffers van kindermishandeling.

Belangrijkste Conclusies

In dit proefschrift wordt het belang van implementatie van valide en betrouwbare RNR taxatie instrumenten benadrukt, zodat behandeling op gestructureerde wijze aangepast kan worden aan risico's, behoeften en omstandigheden van individuele cliënten in de jeugdbescherming. De resultaten uit dit proefschrift lieten zien dat een gestructureerde behoeftetaxatie clinici kan ondersteunen in het identificeren van relevante behoeften van risicogezinnen die samenhangen met toekomstige kindermishandeling, die met een ongestructureerde klinische taxatie wellicht over het hoofd worden gezien. Aanvullend zijn in dit proefschrift zeven responsiviteitsfactoren geïdentificeerd als mogelijke behandelingsbarrières die gesignaleerd en geadresseerd kunnen worden om behandelsucces van gezinnen in de jeugdbescherming te verhogen. Verder bieden de resultaten inzichten in de belangrijkste risicofactoren van vrouwelijke en mannelijke huiselijk geweldplegers en in de onderlinge samenhang tussen deze factoren, hetgeen belangrijke informatie kan opleveren voor behandeling. Ten slotte bieden de resultaten in dit proefschrift inzichten in de impact van meervoudige kindermishandeling en in het belang van differentiatie tussen fysieke en emotionele mishandeling. Deze inzichten vormen mogelijke aanknopingspunten voor professionals bij het personaliseren van interventies voor slachtoffers.

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About the Author

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Anne Bijlsma (1993) was born in Sliedrecht, the Netherlands. She currently lives in Houten with her husband Reinier and their daughter Julia (2021). Anne received a bachelor's degree in Child and Youth Psychology at Utrecht University (2015). After this, she started her master's degree in Clinical Child and Youth Psychology at Utrecht University. During her master, she was an intern at the Department of Children and Youth Medical Psychology at the Diakonessenhuis hospital in Utrecht. After her cum laude graduation in 2016, she worked at Utrecht University as a research assistant for the 'Better Start' project, a trial on the effectiveness of parent training for incarcerated mothers. In addition, she started teaching courses in the bachelor's and masters' program of Clinical Child and Youth Psychology. In 2017, she decided to join the Vrije Universiteit Amsterdam to teach at the Psychology bachelor's program. In 2018, she started her Ph.D. project at the Department of Forensic Child and Youth Care at the University of Amsterdam. The main focus of her research was on strengthening the prevention of child abuse, by examining how treatment can best be personalized to the specific needs and characteristics of at-risk families and children. In 2019, she received the Early Career Researcher Prize Certificate for her poster presentation on tailoring interventions for reducing child maltreatment at the annual European Society for Prevention Research conference. Anne recently started as a postdoctoral researcher at the Department of Preventive Youth Care at the University of Amsterdam. The main focus of her research project is on examining 'what works' in Home-Start, a preventive parenting program that provides volunteer led services supporting families through challenging times.