A RELAPSE PREVENTION APPROACH TO REDUCING AGGRESSIVE BEHAVIOUR

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THE TREATMENT OF VIOLENT BEHAVIOUR PROBLEMS OVER THE LAST TWO decades has increasingly utilised a cognitive-behavioural approach. Relapse Prevention (RP) (Marlatt & Gordon 1985) is a variety of cognitive-behavioural intervention which is gaining increasing currency in the area of violent behaviour, including sexual offending (Pithers 1990) and domestic violence (Jennings 1990). Given the situational and emotionally charged nature of much violent behaviour, a core advantage of RP approaches is that they help the individual avoid situations in which violent behaviour has proved likely to occur, rather than trying to modify the behaviour itself or 'cure' the psychological problems presumed to underly it.

An RP approach is highly suitable for use in a correctional framework. Philosophically, it is consistent with a system which focuses on the offender's criminal behaviour rather than their therapeutic needs, and which elects to retain an emphasis on the offender's continuing responsibility to be actively involved in a search for alternatives to offending behaviour. Strategically, a RP approach does not require high levels of clinically skilled personnel and can hence be 'mainstreamed' in the context of a sentence management approach to correctional programming. It is also able to be flexibly resourced, using a balance of departmental and contracted services.

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1 The views expressed in this paper are those of the author and do not necessarily reflect those of the Western Australian Department of Corrective Services

Issues and Approaches in Reducing Aggressive Behaviour

The cognitive-behavioural approach

The psychological study of aggressive behaviour has a rich history, towards which most major schools of psychological thought have contributed (Geen & Donnerstein 1983). As a result, aggressive behaviour as a clinical problem has been viewed and treated in a variety of ways. From this variety, however, there has arisen a strong tendency to see aggressive behaviour as arising via a social learning process (Bandura 1973) and to approach the clinical treatment of aggression via a cognitive behavioural approach which developed from Novaco's (1978) work and which is probably best currently exemplified in the work of Arnold Goldstein and his colleages (Goldstein & Keller 1987; Goldstein 1988).

In general terms, the cognitive-behavioural approach emphasises that many behavioural problems are maintained by maladaptive cognitions (attitudes, beliefs, interpretations, assumptions, and so on) and thus helping the client develop more appropriate cognitive skills and habits will reduce the problematic behaviour. Of course, new cognitive skills and habits need to then be integrated into adaptive behaviours, often via a process of behavioural skills training.

There are a wide variety of clinical strategies that can assist in this process of cognitive change, but they mainly fall under one of two categories; problem solving training and cognitive restructuring. In relation to modifying aggressive behaviour, cognitive skills training primarily contributes to more effective arousal control (Novaco 1978) although styles of reasoning and cognitive problem solving that provide the client with training in 'moral reasoning' (Kohlberg 1976) can also be included (Goldstein 1988). These cognitive skills are integrated into the behavioural level via behavioural skills training, where clients learn prosocial ways of managing typical situations that have the potential to elicit aggressive behaviour, for example asking for help, making a complaint, accepting a criticism, and so on. This approach to helping clients to modify their aggressive behaviour can be used in an individual or group format and has a substantial research and practice basis to affirm its effectiveness (Goldstein & Keller 1987).

Motivation to change

When these aggression management strategies are applied in a correctional framework it is common to find that the client population has not necessarily come to the conclusion that they require this 'help'. The forces that motivate them to engage in an aggression management program may be complex, and include feelings of frustration or failure in relation to a conviction for a violent offence, feelings of genuine regret and victim empathy, or knowledge that the Parole Board and/or Prisoner Placement Committee will require evidence that they have 'addressed the factors underlying their offence' prior to granting low security placement or conditional release. This problem is not confined to correctional work since many clients approach therapy with mixed feelings but it is an issue that requires early clarification.

Probably the best model currently available to address the issue of the motivation of aggressive offenders to be involved in a treatment program is 'motivational interviewing' (Miller & Rollnick 1990) which builds on Prochaska and Diclemente's (1986) model of the process of therapeutic change. In simple terms, the approach sets non-directive counselling skills in a framework that invites the client to assess the relative costs and benefits of their current problem behaviour and to make a personal assessment of the degree to which that behaviour is a problem for them, and hence the degree to which they are motivated to enter into the change process. Experience so far suggests that this model sits well with aggressive offenders who are characteristically ambivalent about entering an aggression management program.

Dimensions of aggressive behaviour

A major challenge in developing programs for reducing aggressive behaviour is the enormous variety of forms that such behaviour can take. The majority of referrals to such programs tend to be in response to what has been called reactive (or 'angry') aggression (Zillman 1979). This is the type of aggression which results from a process of escalating anger and perceived loss of control (the 'short fuse' syndrome). In contrast, aggression which is used to achieve some objective (for example, in armed robbery) is referred to as instrumental aggression. Where reactive aggression is the problem, anger management programs are generally seen as the most appropriate cognitive behavioural interventions (Howells 1989) although Goldstein's broader program also targets people who are reactively aggressive.

In the case of instrumental aggression it is usually assumed that the intervention must focus on helping the client develop other ways of securing rewards (usually money) from the environment and/or moderating their requirements (for example, by overcoming their drug problem). Since the clinical strategies required to assist reactively and instrumentally aggressive individuals are likely to be quite different, this presents problems in program development.

Another significant clinical dimension arising from research with violent offenders is that some of these offenders seem to resort very readily to aggressive behaviour. These individuals are referred to as being 'undercontrolled' and characteristically have offence records including several if not many assaultive offences. At the other end of the spectrum are the individuals who are often perceived by others as somewhat passive and 'laid back' but who in reality bottle up their angry feelings to such an extent that they may eventually explode into a sometimes murderous assault. These individuals often do not see themselves as being aggressive and will therefore resist involvement in an aggression management program.

The distinction between sexual and non-sexual violence is legally clear but many sexual assaults seem to have more to do with motives like power, control and anger than with sexuality as such. Programs for 'sex offenders' nevertheless bring together such diverse offenders as violent rapists and incest offenders, whilst drawing a line between less obviously different offences such as a violent rape and a violent non-sexual assault on a woman by a man.

This heterogeneity within the broad category of violent offences and behaviours requires that a program for aggressive offenders be able to cope, at least at an intake level, with a range of referred behaviours. Having emphasised the variety of aggressive behaviours it is also necessary to acknowledge, paradoxically, that programs for offenders as disparate as rapists and incest offenders contain significantly common elements, so to design a separate program for each subtype of aggression would be redundant and needlessly expensive. A major advantage of the relapse prevention approach, to be outlined below, is that it has some capacity to address this difficulty.

The Relapse Prevention Approach

Relapse Prevention (RP) is a variety of cognitive behavioural approach originated by Dr. G Alan Marlatt and his colleagues from the Addictive Behaviours Research Centre at the University of Washington (Marlatt & Gordon 1985). It now has a substantial research and practice base and in addition to the area of addictive behaviours, in which the approach was developed, it has been applied to other problems of impulse control such as overeating and gambling as well as a variety of sexually aggressive behaviours such as rape and child molestation (Nelson et al. 1989) and sexual aggression generally (Pithers 1990). Jennings (1990) has suggested that the RP approach is applicable to domestic violence. The RP model has clear applicability to aggressive behaviour generally and is outlined in that context as follows.

Underlying assumptions

Probably the key concept in RP is that rather than attempting to address the psychological issues presumed to underly the client's aggressive behaviour, RP helps the client to recognise the sequence of behaviours that typically lead to aggression, identify the situations in this sequence that represent a particularly high risk of aggressive behaviour and develop better ways to cope with these situations so that aggression is avoided or circumvented.

In this sense RP is a behavioural self-management program which helps the client achieve and maintain a reduction in their aggressive behaviour rather than 'curing' some underlying psychological problem. This approach engages the aggressive client as a co-therapist, giving them the primary responsibility for making changes. Reduction of aggressive behaviour is seen as a learning task that involves acquiring new skills.

RP is based on three key assumptions about behaviour change (Daley 1989) which, in the context of aggressive behaviour may be expressed as follows:

- The initial causes of aggressive behaviour (that is, what made the person develop a tendency to frequently resort to aggressive behaviour) and the process of behaviour change are governed by different principles. This means that it is not necessary to know exactly how aggressive behaviour developed in the first place in order to change it now.

- Changing aggressive behaviour involves three distinct stages:

  Stage 1—Making a commitment and becoming motivated to change: In its original form, RP applied to clients who have made a 'voluntary' choice or decision to change. It is only more recently that it has been applied to people who have been forced into treatment or abstinence (for example, by court or employer referrals). No change is likely, however, unless the client wants it. As was noted previously, techniques of 'motivational interviewing' (Miller & Rollnick 1990) are useful to help involuntary clients come to a clear decision about whether or not they are committed to reducing their aggressive behaviour.

  Stage 2—Implementing the change: RP uses the widest possible range of intervention strategies at this stage, including the variety of cognitive behavioural strategies outlined previously, and set out in more detail below. A clear distinction is made between this 'treatment' phase (when new coping skills are learned) and the 'maintenance' phase (when the new skills must be consistently applied in order to maintain control over the aggressive behaviour).

  Stage 3—Long-term maintenance of change: Achieving a long term reduction in aggressive behaviour is an ongoing challenge. Changes of job, family problems and other life events will all bring stresses and the accompanying temptation to use aggressive behaviour as a coping strategy. Aggression management is very much a lifelong process and many workers emphasise that adopting a balanced lifestyle is an essential supportive and coping strategy.

- The biggest problem in achieving long term success lies in the maintenance phase. In other words, it is easier to learn new coping skills than to maintain and apply them over a long period. Research demonstrates that the largest amount of variance in treatment success is attributable to this maintenance phase (Marlatt & Gordon 1985).

Lapses and relapses

Given that the aim of aggression management programs is to achieve a long-term reduction in aggressive behaviour, if a client of such a program resorts to aggression on a particular occasion this would be termed a 'lapse'. RP emphasises that a lapse is not a 'relapse', which refers to an ongoing reversion to previous levels of aggressive behaviour. A lapse must be construed as a warning that current coping skills are deficient in particular ways and as an invitation to review them and improve their adequacy.

The client's reaction to a lapse into aggressive behaviour will be a crucial determinant of whether a full-blown relapse will occur. The client who lapses must be seen as a person at a 'fork in the road', one path leading to the former problem levels of aggression, the other path leading toward positive change. According to this model, a lapse represents an opportunity for growth, a useful learning experience.

The relapse process

When an aggressive client decides to enter a program they declare their intent not to behave aggressively. As their day-to-day life progresses they face many situations and to the extent that they deal with them non-aggressively they maintain a strong sense of control. Some situations, however, present them with a sequence of events and responses that brings them closer and closer to a 'high risk situation' in which aggressive behaviour will be very hard to resist. If the person does not realise where this sequence of events is leading, or does not have adequate coping skills to deal with the high risk situation when it arises they may lapse, that is, behave aggressively.

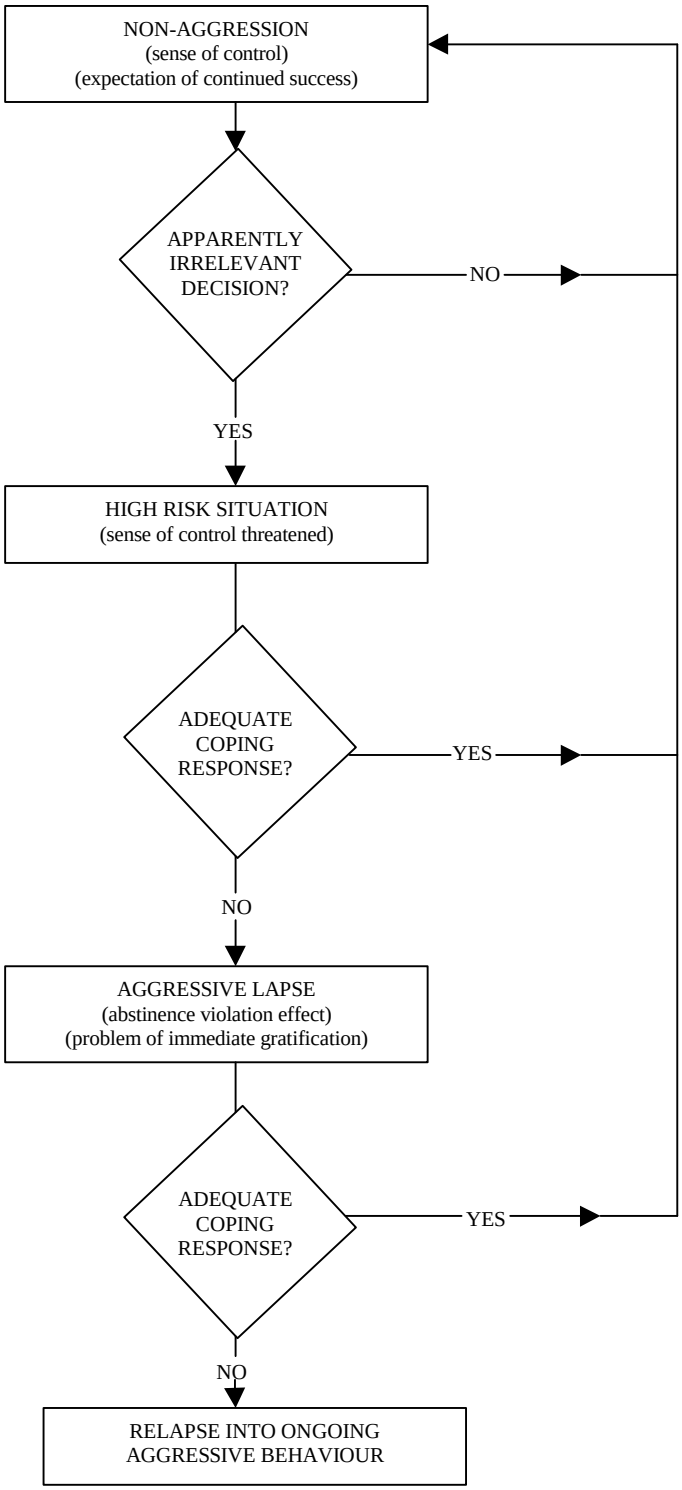
This lapse is likely to result in the person experiencing a complex mixture of thoughts and feelings. They may think that they have failed themselves and that they are 'no good'. They may feel disappointed, confused, anxious, frustrated or angry, and begin to think that trying to maintain control is just a waste of time, or that the lapse proves that they are just an aggressive person and there is nothing that they can do about it. This reaction has been called the *Abstinence Violation Effect* (AVE) (Nelson et al. 1989) and represents a conflict between the person's previous self-image as someone who can cope without aggression and their current experience of acting aggressively. Clearly, if they do not have the coping skills to deal with these thoughts and feelings they may well go on to a complete relapse, where seriously aggressive behaviour may reoccur.

Another problem that can arise from a lapse is that the power and relief that they experienced in being aggressive may leave them with a short-term 'high'. This is referred to as the *Problem of Immediate Gratification* (PIG) (Pithers 1990). This effect can be powerful and require significant coping skills to prevent it (combined with the confusion involved in the abstinence violation effect) leading the person to abandon their attempts at self-control.

This relapse process is shown in a diagram taken from Nelson et al. (1989) in Figure 1. An additional factor included in the diagram is the *Apparently Irrelevant Decision* (AID). This occurs when the person makes a small decision in the course of their day-to-day life which, though minor and seemingly inconsequential in itself, has the effect of leading the person into a high risk situation. For example, when driving to visit a relative the person takes a route that takes them past a hotel where they will be tempted to pick up some alcohol. In the past, drinking at this relative's house has often lead to arguments and fighting. Their decision to take that particular route is seemingly innocuous but it leads them towards a high risk situation: it is apparently irrelevant, but in reality is highly relevant to their ability to maintain control.

Figure 1

Cognitive Behavioural Model of Aggressive Reoffence



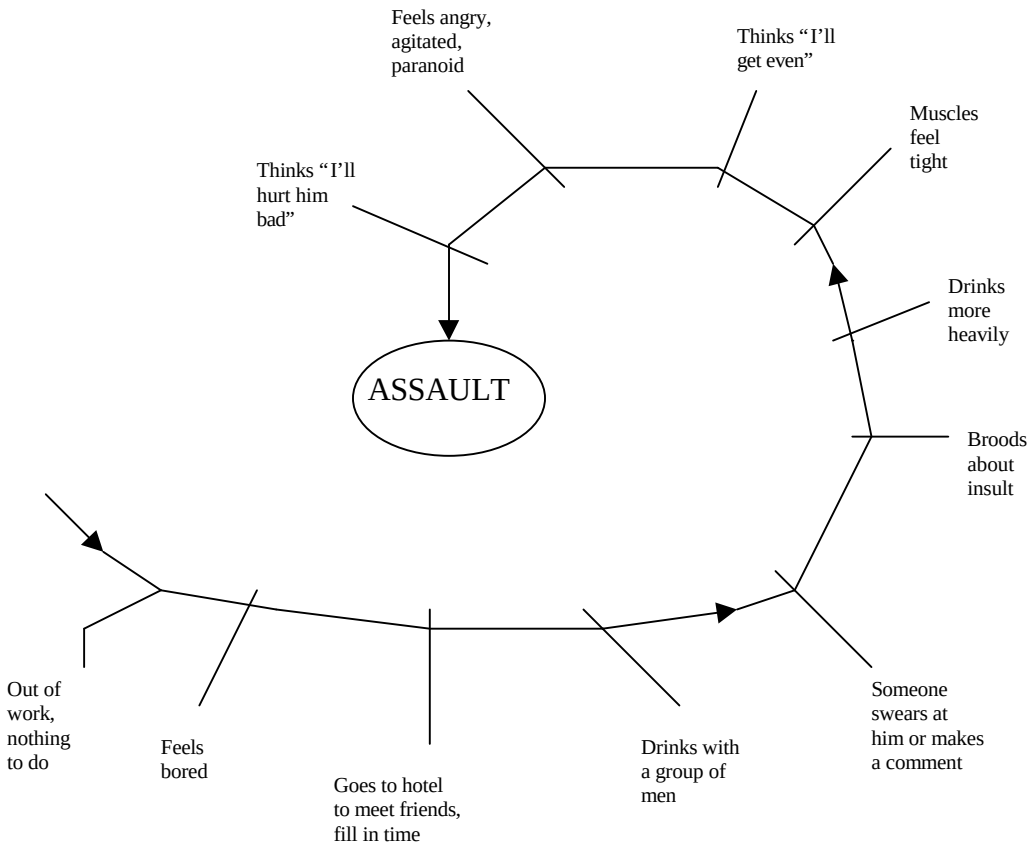
Relapse prevention strategies

The key to relapse prevention is identifying the sequence of events and behaviours that result in a high risk situation. Although high risk situations will vary to some degree there are usually common factors which, for a particular individual, will lead to aggressive behaviour. For example, for a particular person, being criticised or 'put down' in a social situation when they have been drinking may almost inevitably lead to their becoming violent.

In order for the person to avoid situations that are high risk for them, it is essential to identify the sequence of events that lead from life situations in which they are in effective control to situations that pose a high risk of lapse. In relation to aggressive offending, this offence sequence or 'cycle' (since the sequence of events tends to be repeated) will be different for different people, but Figure 2 gives an example of an offence cycle for a young man who has had several convictions for assault. As can be seen from the diagram the long-term antecedents of the assault behaviour include being unemployed, bored and seeking company in hotel peer groups. The short-term antecedents relate to being oversensitive to criticism, brooding, drinking to excess, vengeful thinking and feelings of paranoid anger and revenge.

Figure 2

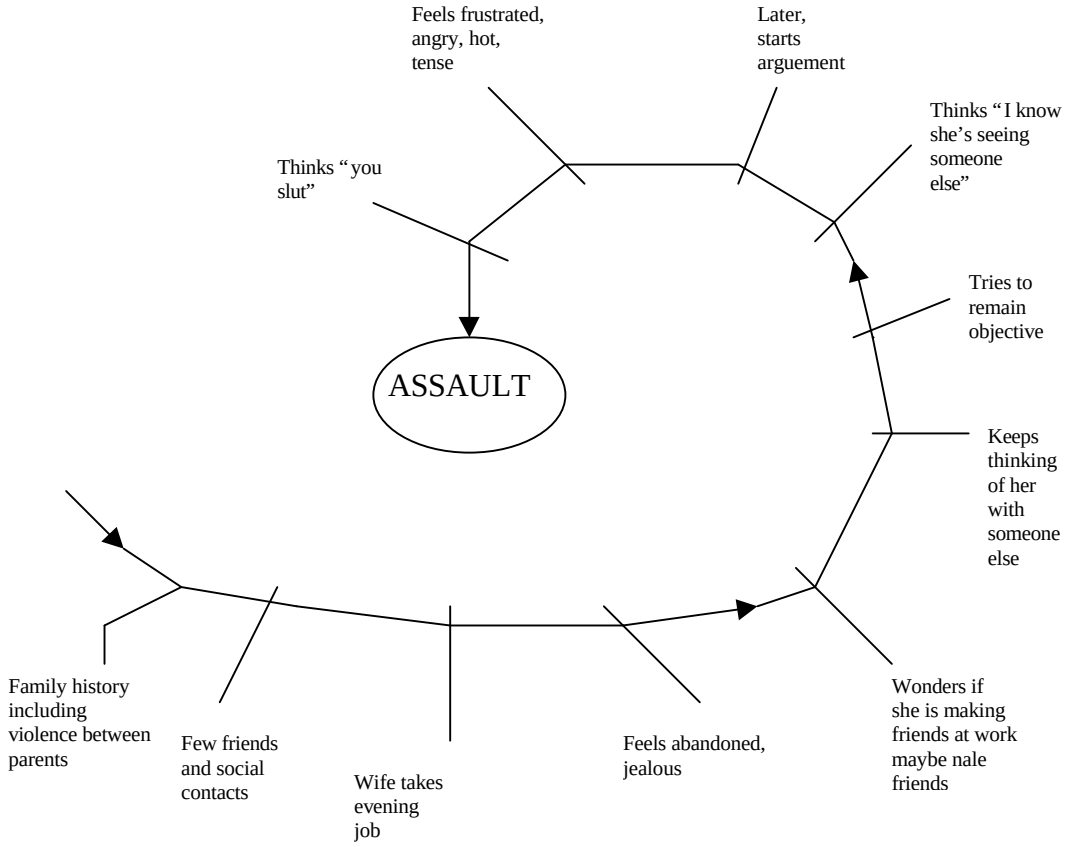
Example Offence Cycle



Another example of an assault cycle is shown in Figure 3. In this case the sequence comes from a man in his late twenties and results in him assaulting his wife. Such assaults have happened twice previously, once resulting in a conviction for aggravated assault. His current charge is unlawful wounding. The cycle shows long term antecedents of growing up in a family where violence between parents was common, a minimal number of friends and a job that involves few contacts with others. The more immediate long-term antecedents involved his wife getting work that involved her being out at night. This led to him feeling abandoned and jealous. He tried to remain objective about the situation but was obsessed by the idea that she was seeing other men. This led to arguments and an increasing frustration on his part. His anger and tension resulted in an outburst in which she was assaulted and injured.

Figure 3

Example Offence Cycle



Effective relapse prevention strategies will be based on three steps. The first of these comprises a detailed *identification of each person's unique offending*

sequence and associated high-risk factors. A detailed reconstruction of their assault cycle may involve self-monitoring records, self-efficacy ratings (self-efficacy is a concept that refers to the degree to which the person feels confident that they can avoid relapse), autobiographical statements, and a review of past aggressive incidents (relapses).

The next step will involve *assessing the coping skills* that will help the person deal adequately with the high risk situations identified in the assault cycle. This can be done via naturalistic observation of the person in an actual problem situation. Self-report, simulations and role playing can also be used effectively as assessment tools.

Once the person's coping skill deficits have been identified an *action plan* should be constructed so as to facilitate the person gaining the skills and information required. These skill and information needs may not all be equally important and they may need to be developed in different situations or gained from different sources. The action plan should be time lined and take these realities into account, with the key needs being prioritised.

When developing an action plan for a particular individual, a range of levels of intervention should be considered, from the specific to the general and covering both the cognitive and behavioural arenas. Some groups of strategies might include:

- Skill training strategies which help people learn to cope with high-risk situations through behavioural and cognitive responses. Dry runs, covert modelling, and lapse rehearsal are examples of useful skill training methods.

- Cognitive reframing strategies teach clients techniques such as alternative cognition, coping imagery, and reframing reactions to initial lapses into aggression.

- Lifestyle interventions, such as exercise or relaxation, are designed to strengthen total coping ability and reduce anxiety and stress. Any input that helps the person manage stress more effectively is useful in this context as is a review of their health status. An action plan could encourage the person to review their exercise habits, relaxation practices, use of drugs or medications, social and interpersonal activities, and religious beliefs. Based on their review of these areas, the client can be helped to include broad lifestyle changes in their action plan.

- Other broadly based interventions include helping the person find and keep a job, develop constructive recreational outlets and activities to promote their health and fitness, and so on. One of the concepts often used in RP programs when considering these broader interventions is the ratio of 'shoulds' to 'wants' in the person's life. The 'shoulds' in this context are the external demands placed upon the person, and the 'wants' are the activities and involvements the person engages in for pleasure and fulfilment.

Servicing the action plan

As was alluded to previously, many action plans will have elements in common, and some of these elements will be able to be provided through community resources (for example, employment and recreational facilities), existing departmental programs (for example substance abuse programs) and existing self-education resources (educational courses and self-development books, audio-visuals, and so on). Although it may be necessary to provide some purpose built programs, perhaps including anger management, the RP model outlined above is potentially extremely cost-effective since it uses the majority of its resources in performing only those functions that are essential to develop an action plan and to service the elements of that plan that are not already available elsewhere. It should be noted that not all RP approaches are structured in this way, and in particular those operating within prisons, without access to broad community resources, often have to provide all major action plan components 'in house'. In addition, some community based programs choose to be self-contained in this way. In programs such as this the RP model becomes the unifying theory around which a series of treatment modules are linked. Such modules would typically deal with interpersonal skills training, anger management, rational thinking and related cognitive skills, avoidance strategies, relapse rehearsal, relaxation training, and positive lifestyle analysis. Some programs go well beyond the cognitive behavioural realm in terms of the modules included, whilst maintaining a RP model as the core of the program.

Applying a Relapse Prevention Model in a Correctional System

RP approaches are particularly viable within a correctional framework. The reasons for this span the areas of correctional philosophy, policy and practice. From a philosophical point of view, there is a growing community impatience with an approach that puts expensive correctional resources into servicing the psychotherapeutic needs of violent offenders at the expense, as it is perceived, of services to the victims. The focus of RP methods on the reduction of violent behaviour rather than on broader psychotherapeutic goals is therefore attractive. In addition, some broader psychotherapeutic approaches tend to see offenders as being themselves the victims of their developmental histories, and thereby imply a lessened capacity for self-determination and culpability. The RP approach maintains a clear focus on the offender as fully responsible for their behaviour and for maintaining their efforts to improve it.

The rehabilitation ideal has taken a battering over the last two decades and in its current form asserts that nothing works for everybody, but that some interventions are effective for particular offender groups (Gendreau & Ross 1987). The RP emphasis on identifying each offender's idiosyncratic offence pattern(s) and identifying what will achieve change for them is consistent with this 'some things work for some people' approach.

It has been suggested that some forms of programs for offenders tend to be built around a somewhat middle class view of the world and therapeutic style. Because an RP approach requires each offender to be fully involved in

identifying the patterns of events and behaviour that does in fact lead to particular offences, and then identify the ways in which these sequences could be coped with in a non-offending manner, there is less room for workers to impose such an imperialistic framework on offending clients.

Since RP methods are so straightforward they can be implemented in a program framework by a blend of staff with varying levels of groupwork and casework qualifications and experience. In addition, the majority of these services can be acquired on a contract basis, with full-time program staff adopting a largely coordinating and training role. This means that the program can be more responsive to changing demands and resourcing levels than could a program using a more traditional team of full time clinical professionals. A significant demand that can be met in this way is the demand for services to offenders in outlying areas, where it has often been difficult to provide more traditional clinical services. Linked to this, custodial and supervisory staff can be trained to use RP methods both as an outreach of the major program and in their own sentence management work in prisons and community based offices. This 'mainstreaming' of the RP model throughout the organisation amplifies its value as more and more staff use the concepts in their day-to-day work.

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