

# Development of the Observation Scale for Aggressive Behavior (OSAB) for Dutch forensic psychiatric inpatients with an antisocial personality disorder

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## Abstract

The Observation Scale for Aggressive Behavior (OSAB) has been developed to evaluate inpatient treatment programs designed to reduce aggressive behavior in Dutch forensic psychiatric patients with an antisocial personality disorder, who are “placed at the disposal of the government”. The scale should have the sensitivity to measure changes in the possible determinants of aggressive behavior, such as limited control of displayed negative emotions (irritation, anger or rage) and a general deficiency of social skills. In developing the OSAB 40 items were selected from a pool of 82 and distributed among the following a priori scales: Irritation/anger, Anxiety/gloominess, Aggressive behavior, Antecedent (to aggressive behavior), Sanction (for aggressive behavior) and Social behavior. The internal consistency of these subscales was good, the inter-rater reliability was moderate to good, and the test–retest reliability over a two to three week period was moderate to good. The correlation between the subscales Irritation/anger, Anxiety/gloominess, Aggressive behavior, Antecedent, Sanction was substantial and significant, but the anticipated negative correlation between these subscales and the Social behavior subscale could not be shown. Relationships between the corresponding subscales of the OSAB and the FIOS, used to calculate concurrent validity, yielded relatively high correlations. The validity of the various OSAB subscales could be further supported by significant correlations with the PCL-R and by significant but weak correlations with corresponding subscales of the self-report questionnaires. The Observation Scale for Aggressive Behavior (OSAB) seems to measure aggressive behavior in Dutch forensic psychiatric inpatients with an antisocial personality disorder reliably and validly. Contrary to expectations, a negative relationship was not found between aggressive and social behavior in either the OSAB or FIOS, which were used for calculating concurrent validity.

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## 1. Introduction

Forensic psychiatric inpatients in The Netherlands who are “placed at the disposal of the government” have committed a crime carrying a prison sentence of at least four years. These are offenders for whom a relationship has

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been established between “deficient mental development or mental disorders” and the crime committed on the basis of examination by a psychiatrist and/or psychologist. In about 75% of the cases the main diagnosis of those inpatients is an antisocial personality disorder on axis II of the DSM-IV and in about 25% of the cases a psychotic disorder on axis I, combined with an antisocial personality disorder on axis II (Van Emmerik, 2001).

Cognitive-behavioral therapeutic methods have been increasingly developed and implemented in forensic psychiatric hospitals in The Netherlands in recent years, including Aggression Control Therapy (ACT) for patients with an antisocial personality disorder (Hornsveld, 2004). To evaluate these therapies, there was a need for specifically designed measurement instruments, the psychometric properties of which were understood with the Dutch forensic psychiatric population. Thus, researchers such as Timmerman, Vastenburg, and Emmelkamp (2001) and Brand and Van Emmerik (2001) have published observation scales for inpatients, the Forensic Inpatient Observation Scale (FIOS) and the FP40 respectively.

It is advisable to use both self-report questionnaires and observation scales to measure aggressive and social behavior in forensic psychiatric populations (Bech, 1994; Polaschek & Reynolds, 2001). Forensic psychiatric patients frequently have insufficient insight into their behavior to give accurate reports, although this is tempered by a tendency to provide socially acceptable answers to questions. Observation scales are not affected by these limitations, however they do require expertise and independence on the part of evaluators in the wards (Bech & Mak, 1995). Since the FIOS and FP40 were not available when development of the Aggression Control Therapy began in 2000 (Hornsveld, 2004), a decision was made to construct an observation scale for aggressive behavior in inpatients with an antisocial personality disorder. This scale would have to have the sensitivity to measure changes in “criminogenic” problem behaviors (Andrews & Bonta, 2003), such as limited control of displayed negative emotions (irritation, anger or rage) and a general deficiency of social skills, as they arise in Aggression Control Therapy (Appendix 1). A literature search showed that most observation scales for aggressive behavior have been developed for (chronic) psychotic patients in closed wards of general psychiatric hospitals. One type of scale, such as the Overt Aggression Scale (OAS: Yudofsky, Silver, Jackson, Endicott, & Williams, 1986; MOAS: Kay, Wolkenfeld, & Murrill, 1988), categorizes acts of aggression according to type, i.e. verbal aggression, physical aggression towards objects, physical aggression towards oneself, and physical aggression towards others. Another approach is to view aggressive behavior as part of a behavioral chain, as seen with the Calgary General Hospital Aggression Scale (CGH Aggression Scale: Arboleda-Florez, Crisanti, Rose, & Holley, 1994; SOAS-R: Nijman, 1999), which includes five aspects of aggressive behavior, i.e. provocation, means used by patients, target of aggression, consequences for victims, and measures to stop aggression. Other scales measure both aggressive behavior and social competence (NOSIE: Hafkenscheid, 1991) or mood (MIBS: Evenson & Dong, 1987; SDAS: Wistedt et al., 1990).

To evaluate the effect of ACT (Hornsveld, 2004), an observation scale was required that could record the following behaviors: (1) emotions or moods displayed that play a possible mediating role in aggressive behavior (e.g. irritation, anger, anxiety or gloominess); (2) aggressive behavior towards fellow patients (e.g. threats), staff (e.g. abusive language) or oneself (e.g. self-inflicted lacerations); (3) antecedents of aggressive behavior (e.g. restrictive measures); (4) sanctions for the patient as consequences of aggressive behavior (e.g. sent to his room); and (5) prosocial behavior towards fellow patients or staff (e.g. giving constructive criticism or adequately making contact). Further, it had to be possible for group supervisors on the ward to fill out such a scale in a short time without the need for extensive instructions.

This article describes the development of the OSAB. In this context, the terms “irritation,” “anger,” and “rage” are understood to mean emotions exhibited in response to a (perceived) provocation, as manifested in behaviors such as staring, talking too loudly, and standing too close to another person. “Anxiety” and “gloominess” are used to refer to moods that last a longer period of time, as can be inferred from behaviors such as restlessness, complaining, and lack of initiative. The term “aggressive behavior” is seen as any form of behavior that is intended to injure someone, physically or psychologically (Berkowitz, 1993); the term violence is used to refer to aggressive behavior where above all physical means are used (Browne & Howells, 1996). Where personality traits are referred to, this is in the context of the “big five” (Hoekstra, Ormel, & de Fruyt, 1996); specifically, antisocial personality disorder refers to the medical-psychiatric classification on axis II of DSM-IV (American Psychiatric Association, 1994).

## 2. Design of the scale: Pilot stage

The following criteria were used to select items for the OSAB: (a) the observation scales for recording aggressive incidents in the extant literature; (b) items drawn from a structured interview on the determinants of aggressive ward

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