

Recidivism and Treatment Behaviour Among High-Risk/High-Need Sexual Offenders with
Psychopathic Traits

by

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Abstract

Treatment of offenders with psychopathic traits has been a widely debated topic for decades. The current study examined the influence of psychopathy and treatment behaviour on recidivism. The sample included 117 high-risk sexual offenders admitted to the Regional Treatment Centre Sex Offender Treatment Program (RTCSOTP) while serving a federal sentence of two years or more. Offenders were grouped based on their scores on the Psychopathy Checklist Revised (PCL-R) and treatment behaviour. With an average follow-up time of 82.62 months, sexual and violent recidivism rates of offenders scoring high and low on the PCL-R could not be distinguished post-treatment. When examining general recidivism and any recidivism, recidivism rates of offenders scoring high on psychopathy and who demonstrated good treatment behaviour were not significantly different than those of offenders scoring low on the PCL-R regardless of treatment behaviour. Implications for treatment are discussed.

Keywords

psychopathy, sexual offender, treatment, recidivism

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Chapter 1

1 Treatment of Sexual Offenders

The term sex offender is a legal term used to describe an individual convicted of a sexual offence under the criminal code (Brown, 2013). Generally, sexual offences are categorized as either contact sexual offences which involve physical interaction with a victim, for example sexual assault (Criminal Code, 1985), or non-contact offences, such as pornography-related offences (Criminal Code, 1985), which involve no physical contact with a victim (Murray et al., 2014). Contact sexual offences in Canada are summarized under the term Sexual Assault which describes criminal acts ranging from unwanted touching of a sexual nature to sexual violence causing serious physical injuries to the victim (Government of Canada, 2018). Crimes considered under the umbrella of Sexual Assault are further divided into three categories (Government of Canada, 2018). Sexual assault level 1 refers to contact sexual offences which do not cause injuries or cause only minor injuries to the victim while sexual assault level 2 involves sexual assault with a weapon, threats, or causes bodily harm to the victim (Government of Canada, 2018). Finally, sexual assault level 3 encompasses sexual offences which cause serious bodily harm or endangers the life of the victim (Government of Canada, 2018). An additional category exists for sexual violations against children that do not fall into these three categories and includes offences such as sexual interference and sexual exploitation (Government of Canada, 2018). In 2018, these four categories accounted for less than 10% of all victims of police-reported violent crime in Canada (Government of Canada, 2019).

While sexual offences account for a relatively small percentage of all offences in Canada, sex offenders remain among the most heavily stigmatized group of offenders both in prison and

in the community (Ricciardelli & Moir, 2013; Tewksbury, 2012). Beyond being stigmatized as criminals, sexual offenders are further vilified as monsters, predators, animals, and generally less than human (Waldram, 2007) often resulting in them becoming victims of verbal and physical harassment in the community and in prison (Ricciardelli & Moir, 2013; Tewksbury, 2012; Waldram, 2007). These attitudes of sexual offenders as dangerous, uncontrollable, and more likely to recidivate than other offenders continues to be widely held despite evidence that these beliefs are largely unfounded (Hanson et al., 2004). In Canada, observed rates of sexual recidivism remain around 13.8% (Hanson et al., 2004) while violent and non-violent recidivism rates are reported at 14% and 30% respectively (Government of Canada, 2003).

Stigmatization of sexual offenders has significantly negative impacts on offenders' self-esteem and psychological well-being (Tewksbury, 2012) as well as their ability to find housing and employment after their release (Levenson & Cotter, 2005). Furthermore, stigmatization of sexual offenders has been found to negatively impact clinical practice among those tasked with their treatment (Lea et al., 1999). As a whole, the consequences of stigmatization and social exclusion has detrimental effects to successful reintegration into society (Ricciardelli & Moir, 2013). Thankfully, resources continue to be improved upon in hopes of promoting successful reintegration. Over time, recidivism rates, politics, public perceptions, and forensic psychology have all contributed to changes in legislation effecting sexual offenders including accessibility to treatment (Brown, 2013).

1.1 Sexual Psychopath Laws

In the 1930s, sexual violence against women and children became a pressing social issue (Brown, 2013; Chenier, 2003; Lave, 2009). Public outcry for legislative changes resulted in the development of laws identifying mentally disordered sexual offenders and referring them to

institutionalized treatment facilities as opposed to prison (Brown, 2013; Wood et al., 2000). Sexual psychopath laws originated in Michigan in 1937 and quickly spread throughout the United States (Brown, 2013; Wood et al., 2000). In 1948, Canada adopted the Sexual Psychopath Act which recognized sexual deviants as unable to control their sexual impulses and required indeterminate commitment to a treatment facility (Chenier, 2003; Glancy et al., 2001). While legislative terms varied greatly, all had the shared goal of providing treatment, though often involuntary, to sexual offenders (Brown, 2013; Wood et al., 2000). The introduction of these laws reflected a lack of public confidence in traditional penal methods as well as significant effort to improve public safety (Glancy et al., 2001).

It is important to note that the term psychopath used in this context did not refer to a clinical definition as we currently define psychopathy. Rather, the term sexual psychopath was used to define individuals posing a significant threat to society and who lacked the ability to control their sexual impulses (Sutherland, 1950b). It was this lack of control which led sexual psychopaths to be considered disordered and therefore requiring treatment rather than punishment; though they were not officially recognized as mentally ill (Chenier, 2003; Sutherland, 1950b). Although treatment recommendations varied greatly, some even including surgical measures, the most common recommendation for treatment involved psychiatric diagnosis and therapeutic interventions (Lave, 2009). These laws represented a joint effort between psychiatrists and the law to address the issue of sexual violence against women and children using a medico-legal approach (Chenier, 2003; Lave, 2009; Sutherland, 1950a, 1950b).

The objective of sexual psychopath legislation was to institutionalize dangerous offenders until their level of risk to the community was reduced (Brown, 2013; Chenier, 2003; Lave, 2009; Sutherland, 1950a). Treatment for sexual offenders during this time did not follow a unified

program and it is at times unclear what interventions were applied (Brown, 2013; Wood et al., 2000). Early treatment interventions following a humanistic or psychodynamic approach were not considered effective with this population (Harris et al., 1998; Wood et al., 2000) and interventions were quickly adapting to the growing popularity of behavioural therapies (Laws & Marshall, 2003; Wood et al., 2000). These approaches often included forms of classical and operant conditioning as well as aversion therapies aimed to reduce deviant sexual responses in order to develop arousal to appropriate sexual stimuli (Laws & Marshall, 2003). Marshall (1973) described a treatment method in which audio recordings of deviant fantasies were paired with electric shock. The second component of their procedure involved instructing participants to visualize prosocial fantasies during progressive stages in a masturbatory sequence in order to reduce deviant fantasies (Marshall, 1973). Treatments such as these aimed to alter deviant sexual arousal or sexual preference of offenders in some way (Barlow et al., 1972; Marshall, 1973; Quinsey, 1977). Many studies at the time used penile plethysmography to measure the success of reducing arousal to deviant stimuli (Barlow et al., 1972; Callahan & Leitenberg, 1973; Laws & Marshall, 2003). Other treatment methods described included group therapy, social skills training, and desensitization in order to improve the offenders ability to function normally in society (Quinsey, 1977).

In the 1970s and 1980s, many of these laws were repealed, ignored, or replaced by newer legislation (Brown, 2013; Horwitz, 1995; Lave, 2009; Wood et al., 2000). While many factors contributed to the demise of sexual psychopath laws, two common factors had arguably the greatest influence in this movement: disagreement in definitions of sexual psychopaths and efficacy of treatment (Horwitz, 1995; Lave, 2009). The term sexual psychopath was used to describe individuals who were considered neither normal nor mentally ill, which led to

significant disagreement in regards to which sexual offenders were considered sexual psychopaths and which were not (Horwitz, 1995; Lave, 2009; Pratt, 1998). The term itself was heavily criticized as lacking diagnostic foundations in psychiatry making it meaningless and seemingly arbitrary (Horwitz, 1995). This led to inconsistencies in applying the legislation and often resulted in individuals being involuntarily committed who were considered ‘deviant’ but who posed no threat to the community (Lave, 2009), such as homosexual men (Barlow, 1973; Laws & Marshall, 2003; Pratt, 1998).

Additional difficulties arose from public disillusionment in the treatability of offenders stemming from outcome studies (Wood et al., 2000) and the rise of retributive sentencing (Horwitz, 1995), leading to the gradual abandonment of these treatment-driven laws. Early reports indicated that many offenders were released early if a new offender required a spot in the program with negligible assessment of risk reduction (Brown, 2013; Wood et al., 2000). A number of studies involving correctional programs reported poor treatment outcomes at this time (Bailey, 1966; Logan, 1972; Robison & Smith, 1971), however, the most commonly cited was that of Robert Martinson in 1974 which has been popularly quoted as saying ‘nothing works’ (Brown, 2013; Hollin, 1999; Martinson, 1974). While many factors contributed to changing sex offender legislation, the volume of ‘nothing works’ literature present at the time contributed significantly to clinical pessimism and legislative changes moving away from treatment directed rehabilitation (Hollin, 1999).

1.2 From Pessimism to Optimism in Treatment of Sexual Offenders

Over time the prevalence of ‘nothing works’ literature began to decline, with researchers noting significant flaws in many of these popular studies. One major criticism of these studies is

that it is difficult to comment directly on the influence of treatment as most studies focused on the reduction of deviant fantasies and arousal as successful outcome of behavioural therapy rather than recidivism (Laws & Marshall, 2003). Other methodological issues such as inconsistencies and a lack of information regarding treatments used or how risk was assessed led some to suggest that treatment programs may be effective in other ways which could have been overlooked (Laws & Marshall, 2003; Wood et al., 2000). In a critique of Martinsons' popular review, Palmer (1975) remarks that Martinson notes in many studies he reviewed that the treatments did have some positive outcomes, suggesting a gross overgeneralization of the remark that 'nothing works'.

Following the change in legislation, which in many cases resulted in offenders being returning to the community after serving their sentence, some researchers continued their mission to identify effective correctional interventions (Gendreau & Ross, 1979, 1983; Palmer, 1975). Noting that many who argued that 'nothing works' based their conclusion on studies published before 1967, Gendreau and Ross (1979) compiled a review of research more current to the time. Studies included in this review were examined based on the therapy employed which included: family and community intervention, contingency management, counseling, diversion, biomedical assistance, and other miscellaneous treatments (Gendreau & Ross, 1979). The miscellaneous category reviewed studies which included education, skills training, work furlough, or combinations of therapies such as group, individual, and educational (Gendreau & Ross, 1979). Other programs discussed in the review included drug and alcohol treatments which were said to be addressing criminality indirectly (Gendreau & Ross, 1979) a conviction which has held true to this day (Best & Savic, 2015). Overall, this review found many positive outcomes for treatment of offenders, including sexual offenders, particularly in treatment

approaches which employed more than one intervention strategy, such as family and community interventions which addressed various components of an offenders' daily life that contributed to their antisocial behaviours (Gendreau & Ross, 1979). Conversely, treatment programs which employed a single method, such as diversion or behavioural contracts, had less positive results which led researchers to conclude that an integration of treatment modalities may be most effective in treating offenders and reducing recidivism (Gendreau & Ross, 1979).

As noted in the study by Gendreau and Ross (1979), treatment for offenders began to employ combinations of intervention strategies in the 1970s and 1980s. One major development in interventions for sexual offenders came from the integration of cognitive and behavioural models. Initially, this involved incorporating aspects of the cognitive model into behavioural therapy such as social skills training (Hollin & Palmer, 2006; Quinsey, 1977; Ross et al., 1988), education (Antonowicz & Ross, 1994; Gendreau & Ross, 1983; Ross et al., 1988), problem-solving (Gendreau & Ross, 1983; Hollin & Palmer, 2006), and pro-social modelling (Antonowicz & Ross, 1994; Gendreau & Ross, 1983). In the early 1980s, Martlatt (1982) developed the relapse prevention model for treatment of addictive behaviours. This method was promptly adapted for the treatment of sexual offenders (Pithers et al., 1983). The basis of this treatment model is to identify what factors predispose an individual to commit a sexual offence, and what factors need to be addressed to discourage further offences upon release into the community (Pithers & Gray, 1996). The relapse prevention model grew rapidly in popularity following its incorporation to treatment programs within the Vermont Department of Corrections (Marshall & Laws, 2003; Pithers & Gray, 1996) and the California Department of Mental Health (Marques, 1988) the latter of which has produced a number of outcome studies over the last three decades illustrating the utility of the relapse prevention model (Marques, 1988; Marques et al.,

1994, 2005). The relapse prevention model quickly became incorporated into correctional treatment programs in the U.S. (Marques, 1988; Pithers & Gray, 1996), the U.K. (Hollin & Palmer, 2006), and Canada (Wormith & Hanson, 1992) and continues to be used today in updated forms (Marshall & Laws, 2003; Ward & Hudson, 1998).

As researchers continued to report positive treatment outcomes clinical perceptions shifted from ‘nothing works’ to ‘what works’ (Brown, 2013; Hollin & Palmer, 2006). Research interest in this population was renewed and the 1990s saw a large number of new publications and uniquely informed treatment programs for sexual offenders (Marshall & Laws, 2003). Meta-analyses of cognitive-behavioural based programs at this time frequently agreed that recidivism rates were reduced by treatment programs (Marshall & Pithers, 1994; Wormith & Hanson, 1992). Nonetheless, it remained clear that treatment is not effective for all offenders (Marshall et al., 1991), leading researchers to examine what factors most effectively predicted recidivism. The focus of much literature was on static and dynamic factors contributing to sexual recidivism (Marshall & Laws, 2003). Static factors refer to factors that cannot be changed such as offender age and criminal history while dynamic factors refer to factors that can be changed over time such as attitudes and cooperation with supervision (Hanson & Thornton, 1999; Harris et al., 2015). Some factors identified as being related to recidivism included psychiatric history, psychopathy rating, age and marital status of the offender, criminal history, and victim demographics such as gender and age (Harris et al., 1993; Quinsey et al., 1995; Rice et al., 1991; Rice et al., 1990). Improvements in our ability to identify factors related to sexual recidivism contributed significantly to the development of evidence-based risk assessments (Bonta & Andrews, 2007) which aimed to allow clinicians to more accurately assess risk of recidivism post-treatment (Marshall & Laws, 2003). This new generation of evidence-based and dynamic

risk assessment tools (Bonta & Andrews, 2007) led to such developments as the Violence Risk Appraisal Guide (Harris et al., 1993) which was later modified to assess risk of sexual recidivism in the form of the Sex Offender Risk Appraisal Guide (SORAG) (Quinsey et al., 1995).

In developing a tool to predict risk of sexual recidivism, Quinsey et al. (1995) utilized factors identified as being associated with recidivism among certain groups of sexual offenders (Quinsey et al., 1995; Rice et al., 1991; Rice et al., 1990). These included psychiatric history, criminal history, sexual preference, psychopathy rating, sexual misbehaviours up to and including index offence, and demographic variables (Quinsey et al., 1995). The authors found sexual recidivism to be best predicted by criminal history, psychopathy rating, and sexual preference as assessed by phallometric data (Quinsey et al., 1995). These items were then combined to develop the final version of the SORAG which consisted of 14-items and was used by clinicians to assess risk of violent (i.e. contact) sexual recidivism (Quinsey, 2008). The items include such variables as sexual and non-sexual criminal history, age of victims, substance abuse, offender age, marital status, employment difficulties, history of personality disorders or schizophrenia, phallometric test results, and score on the Psychopathy Checklist Revised (Quinsey, 2008).

Other important developments in sex offender risk assessment at this time included the Rapid Risk Assessment for Sex Offenders (RRASOR) (Hanson, 1997), Structured Anchored Clinical Judgement (SACJ) and the Static-99 (Hanson & Thornton, 1999). The RRASOR was designed as a brief risk scale for the prediction of sexual recidivism (Hanson, 1997). Preliminary research using the tool indicated that it was possible to distinguish between low risk (less than 15% chance of recidivism over 10 years) and high risk (greater than 50% chances of long-term recidivism) sexual offenders (Hanson, 1997). This scale included factors such as victim gender,

relationship to victim, prior sexual and non-sexual offences, marital status, and age in the prediction of sexual recidivism (Hanson, 1997). The SACJ was developed using factors such as current and prior sexual and/or violent offences, victim and offender demographics, treatment, and the presence of any stranger victims (Grubin, 1998). The benefit of the SACJ was the use of a step model, the first of which considered the offenders official convictions, the second considered aggravating factors such as relationship to the victim, and the final step giving consideration to treatment factors such as treatment dropout (Grubin, 1998; Hanson & Thornton, 1999). Finally, the Static-99 was developed using only static factors such as offence history and offender age, by combining items of the RRASOR and SACJ (Hanson & Thornton, 1999). This assessment tool was designed to assess long-term risk potential of sexual offenders; however it is limited by a lack of dynamic factors which does not allow for development of treatment targets or evaluation of treatment efficacy (Hanson & Thornton, 1999). Nonetheless, the Static-99 proved to be a useful tool in assessing the overall risk of offenders and continues to be used in its revised versions (Babchishin et al., 2012; Hanson & Thornton, 2003; Helmus et al., 2009).

Improvements in the field of risk assessment also contributed to progress in treatment development for sexual offenders. One of the most influential treatment models for offenders is the Risk-Need-Responsivity (RNR) model, first established in 1990 (Bonta & Andrews, 2007). The core principles of this model focus on the offenders risk level, criminogenic needs, and responsivity issues in order for treatment to be effective (Andrews & Dowden, 2007; Bonta & Andrews, 2007). The risk principle incorporates risk assessment as a major contributor to treatment, stating that the treatment plan provided must match the offender's risk to reoffend (Andrews & Dowden, 2007; Bonta & Andrews, 2007). For example, offenders at a greater risk of reoffending would require treatment of longer duration (Abracen & Looman, 2016). The

second core principle, needs, requires that treatment focus on the offenders criminogenic needs (Andrews & Dowden, 2007; Bonta & Andrews, 2007). Criminogenic needs are defined as dynamic risk factors that are associated with criminal offending such as substance abuse, procriminal attitudes, and antisocial personality patterns (Andrews & Bonta, 2010; Bonta & Andrews, 2007). Assessment of criminogenic needs informs the clinician on what must be addressed by the treatment program with a focus on factors strongly related to recidivism, as opposed to minor or non-criminogenic needs, for example physical health (Andrews & Bonta, 2010; Bonta & Andrews, 2007). Finally, the responsivity principle is founded on cognitive social learning interventions which are most effective in modifying behaviour (Bonta & Andrews, 2007). The responsivity principle is summarized in two parts: a respectful and collaborative relationship between the clinician and the client and treatment structured to encourage prosocial changes by including methods such as reinforcement, modelling, and problem-solving exercises (Andrews & Dowden, 2007; Bonta & Andrews, 2007). The RNR model has shown to be effective in the treatment of offenders and, more specifically, has been successful in reducing recidivism rates among sexual offenders (Hanson et al., 2009).

1.3 Modern Approaches to Sex Offender Treatment

The RNR model remains the most reliable treatment model for sexual offenders to this day (Abracen & Looman, 2016; Polaschek, 2012). Over time, this model has continued to receive strong empirical support demonstrating its adaptability to a variety of individual circumstances (Melton et al., 2014; Polaschek, 2012; Rettinger & Andrews, 2010). This model, based in Cognitive-Behavioural Therapy (CBT) and social learning theory provides essential guidelines for effective treatment of offenders while being amenable to the individual needs of the client (Abracen & Looman, 2016; Andrews & Bonta, 2010). Over time, this model has been

updated allowing it to remain current with best practices without deviating from the original core principles (Andrews & Bonta, 2010). For example, in the early 2000s, distinctions between general and specific responsivity targets were introduced (Bonta & Andrews, 2007). General responsivity refers to delivering treatment in a way that is suitable to the learning style of the individual offender, or offenders in the case of group interventions, and employs cognitive-behavioural and skill building methods appropriate to their level of understanding (Andrews & Bonta, 2010). Specific responsivity involves more specialized and individual characteristics of the offender to be taken into consideration in treatment delivery such as their individual strengths and motivating factors (Andrews & Bonta, 2010). Furthermore, Andrews and Bonta (2010) outlined the “Big 8” criminogenic needs to be assessed and appropriately addressed in treatment; originally summarized as the central 8 (Bonta & Andrews, 2007). The Big 8 criminogenic needs are: criminal history, criminal associates, criminal attitudes, criminal personality, problematic circumstances in family and marital relationships, problematic circumstances at school or work, few if any prosocial activities, and substance abuse (Abracen & Looman, 2016; Andrews & Bonta, 2010).

Other models have also been developed to address areas which were considered to be lacking for the treatment of sexual offenders in the RNR model (Abracen & Looman, 2016; Ward & Stewart, 2003). The Good Lives Model (GLM) was developed by Ward and Stewart (2003) as a strength-based treatment approach. This model differs from the RNR model by reducing focus on negative qualities and directing attention to establishing the necessary internal and external abilities to secure primary human goods in a way that is prosocial and focuses on personal identity as an essential component of change (Ward & Stewart, 2003). Primary human goods, in this context, refers to factors essential to leading a fulfilling life and include

relationships, autonomy, social roles, community involvement, and physical health and functioning (Ward et al., 2002).

Eleven primary human goods have been identified by the Good Lives Model: life (including healthy living and functioning), knowledge, excellence in play, excellence in work (including experience of mastery), excellence in agency (i.e. autonomy), inner peace (i.e. freedom from emotional turmoil), relatedness (family and friend relationships), community, spirituality (finding meaning in life), happiness, and creativity (Willis et al., 2013). Each of these primary goods are then associated with secondary goods which provide the means of acquiring primary goods (Abracen & Looman, 2016; Willis et al., 2013). It is through these secondary goods that criminogenic and non-criminogenic needs are theorized to be exerting influence on the individual, leading to antisocial choices in order to facilitate obtaining primary goods (Willis et al., 2013). Therefore, GLM aims to assist the offender in making prosocial decisions and facilitating problem solving in a way that allows them to obtain goals in a way that is positive and personally fulfilling (Ward & Stewart, 2003; Willis et al., 2013).

The primary factors of GLM and RNR have been studied and employed in developing additional models for the treatment of high-risk high-need sexual offenders. The Integrated Risk-Need-Responsivity (RNR-I) model proposed by Looman and Abracen (2013) integrates aspects of the GLM within the RNR model in order to address a larger variety of risk factors facing high-risk groups of sexual offenders. This model includes classes of factors such as developmental factors, static risk factors, stable dynamic risk factors, complex trauma-related antecedents, external pressures, and internal pressures (Abracen & Looman, 2016). The RNR-I model is designed to address the ways in which high-risk behaviours interact and influence one another as well as the barriers that these interactions may cause to achieving the desired treatment outcomes

(Looman & Abracen, 2013). A number of studies by those involved in the development of this treatment model have demonstrated its efficacy in reducing the risk of recidivism among high-risk sexual offenders (Abracen et al., 2008, 2011; Looman & Abracen, 2013).

In sum, decades of research and clinical persistence has contributed to the establishment of reliably successful treatment programs for sexual offenders. While it is now well established that recidivism rates can be reduced through appropriate intervention methods (Abracen & Looman, 2016; Andrews & Bonta, 2010) research continues to pursue progressive models which could be applied to even higher risk groups of offenders (Abracen & Looman, 2016; Looman & Abracen, 2013). One notable group of high risk offenders continues to be those classified as psychopathic (Abracen & Looman, 2016; Salekin, 2002). Psychopathic offenders remain one of the most challenging groups of high risk offenders to treat, resulting in a high prevalence of clinical pessimism to this day (Abracen & Looman, 2016; Salekin, 2002). However, both concentrated studies (Langton et al., 2006; Looman, Abracen, et al., 2005; Olver et al., 2013; Olver & Wong, 2009) and literary reviews (Abracen et al., 2008; Olver & Wong, 2013; Salekin, 2002; Salekin et al., 2010) have shown optimistic results in regard to treatment benefits for psychopathic offenders. One may argue that treatment for psychopathic offenders is following a similar progression from ‘nothing works’ to ‘what works’ as was seen over the past several decades with sexual offenders.

Chapter 2

2 Psychopathy

The concept of psychopathy was first described by Hervey Cleckley in his 1941 book, *The Mask of Sanity*. Cleckley's description of the psychopathic personality consists of 16 distinct characteristics: superficial charm, absence of delusions, absence of nervousness, unreliability, untruthfulness and insincerity, lack of remorse or shame, inadequately motivated antisocial behaviour, poor judgement and failure to learn by experience, pathologic egocentricity and incapacity for love, poverty in affective responses, and lack of insight (Cleckley, 2014; Cleckley, 1964). Cleckley's definition of psychopathy was initially included in the DSM-II although, over time, his definition came to be replaced by the behavioural definitions of antisocial personality disorder (ASPD), conduct disorder (CD), and oppositional defiant disorder (ODD) as behavioural characteristics could more easily and reliably be assessed (Salekin, 2002).

The definition of psychopathy was later revised by Robert Hare who devised a method of assessing the psychopathic personality (Hare, 1980). The Psychopathy Checklist (PCL) (Hare, 1980) and subsequent Psychopathy Checklist Revised (PCL-R) (Hare, 1991; 2003) consist of structured interviews to assess psychopathy. These instruments rely on a two-factor model of psychopathy. Factor 1 describes affective and interpersonal traits including the following: glibness/superficial charm, grandiose sense of self-worth, pathological lying, conning and/or manipulative, lack of remorse or guilt, shallow affect, callousness and/or lack of empathy, and failure to accept responsibility (Hare, 2003). Factor 2 consists of the following lifestyle and antisocial factors: need for stimulation, parasitic lifestyle, lack of realistic long-term goals impulsivity, irresponsibility, poor behavioural control, early behavioural problems, juvenile

delinquency, revocation of conditional release, and criminal versatility (Hare 2003). In contrast to Cleckley's original model, Hare's model of psychopathy deviates from strictly personality characteristics to include patterns of problematic behaviours (Salekin, 2002). The Psychopathy Checklist has also been adapted to assess youth offenders who may display similar characteristics (Forth et al., 2003).

The PCL-R, though initially developed to assess psychopathy, has proven to be a consistent and reliable predictor of both general and violent recidivism (Gacono, 2015; Hare et al., 2000; Hemphill et al., 1998). In 1999, Valliant and colleagues found violent and general offenders to have higher scores on the PCL-R on average than a non-offender comparison group, although PCL-R scores did not reach clinical significance. These findings suggest that elevated or moderately elevated scores on the PCL-R may be associated with offending behaviours in general (Valliant et al., 1999). Given its versatility, proven validity, and accessibility of assessment instruments, modern research and clinicians have relied heavily on the Hare model when defining psychopathy (Gacono, 2015; Hare et al., 2000). It is also important to note that although a score of 30 marks the PCL-R cut-off score for psychopathy, a score of 25 or above has shown to be a reliable predictor of future recidivism (Quinsey et al., 1998) which is commonly employed within psychopathy literature (e.g. Abracen et al., 2008; Looman et al., 2005; Salekin, 2002).

On account of the high incidence of criminal offences among psychopathic individuals and overlapping personality traits, psychopathy is often mistaken as synonymous with Antisocial Personality Disorder (ASPD) (Berg et al., 2013; Hare, 1996; Levy, 2011). Psychopathy and ASPD can be distinguished in at least two key aspects: behavioural and affective features (Levy, 2011). As described above psychopathy is characterized by both behavioural and affective

criteria while ASPD refers only to a persistent pattern of antisocial behaviours (Levy, 2011). The Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5) defines ASPD as: “a pervasive pattern of disregard for and violation of the rights of others” (American Psychiatric Association, 2013). While some behavioural patterns of ASPD described by the DSM-5 resemble those in Factor 2 of the PCL-R, such as impulsivity and irresponsibility, ASPD lacks the affective component found in Factor 1 that is essential to the criteria of psychopathy (American Psychiatric Association, 2013; Hare, 2003; Levy, 2011). The affective component is a critical aspect of psychopathy (Hare, 2003), however, it is not a necessary or essential component of ASPD (Levy, 2011). Although a lack of remorse is indicated as a possible feature of ASPD, it is possible to diagnose ASPD without meeting the criteria for a lack of remorse (American Psychological Association, 2013). In addition, the behavioural patterns of ASPD focus specifically on a disregard for or violation of the rights of others, while psychopathy refers to broader behavioural concerns affecting both oneself and others (Hare, 2003; Levy, 2011).

Furthermore, it is often mistakenly believed that early abuse or trauma may cause psychopathy although this effect is limited to antisocial behaviours common to ASPD and psychopathy and does not extend to the affective component of psychopathy (Berg et al., 2013). While early exposure to abuse or trauma may worsen the behavioural features of psychopathy, the affective components of the condition relate specifically to underlying neurological differences and therefore cannot be caused by environmental factors alone (Berg et al., 2013; Bezdjian et al., 2011). Research has shown activation in the insula, limbic system, Orbitofrontal Cortex (OFC), and Anterior Cingulate Cortex (ACC) to be associated with the experience of empathy (Kiehl et al., 2001; Shirtcliff et al., 2009). Individuals scoring high on psychopathy have demonstrated reduced activation of the amygdala, insula, and ACC, which has been

associated with callousness and lack of empathy (Kiehl et al., 2001; Shirlcliff et al., 2009; Stratton et al., 2015). Furthermore, OFC dysfunctions in psychopaths have been thought to result over time as their hypoactive amygdala fails to trigger a large enough response to emotional stimuli to enforce emotional learning or internalization required for the normal development of empathy (Shirlcliff et al., 2009). Reduced activity in the amygdala and OFC has also been associated with the shallow emotional responses, inability to establish long-term goals, and impulsivity observed in psychopathic individuals (Penney, 2012; Shirlcliff et al., 2009).

It is especially important to understand the unique factors distinguishing psychopathy and ASPD when working in a forensic setting as it is estimated that up to 90% of offenders meet diagnostic criteria for ASPD while 15 to 25% meet the criteria for psychopathy (Levy, 2011). This would suggest that while 90% of inmates repeatedly engage in antisocial behaviour, as many as 75% do not show evidence of the psychological markers of psychopathy that can affect treatment methods (Levy, 2011; Berg et al., 2013). That is not to say that psychopathic individuals are not significantly represented among prison populations. Given the persistent antisocial behaviors and unfavorable interpersonal characteristics that make up the psychopathic personality, it is not surprising to find that psychopaths represent between 15 to 25% of the incarcerated population while the prevalence in the general population is estimated to be between 0.3 and 2% (Boduszek et al., 2017). One common misconception is that all psychopaths are violent, however, psychopathy is only a moderate predictor of violence and psychopathic offenders can be identified across offence types including white collar and non-violent offences (Berg et al., 2013; Boduszek et al., 2017). Other common misconceptions of psychopathy pertain to gender, intelligence, and responsiveness to treatment (Berg et al., 2013). While psychopathy is most commonly identified among men, prevalence rates of psychopathy among female inmates

range from 9 to 13% (Berg et al., 2013). In regard to intelligence, it is often believed that psychopaths have significantly higher IQ than the average person although studies comparing intelligence scores and the PCL-R have identified no significant relationship between psychopathy and intelligence (Johansson & Kerr, 2005). With a clear understanding of the factors influencing individuals with psychopathic traits, it is easy to see why treatment suitable to sexual offenders in general may not translate as effectively to sexual offenders with psychopathic traits.

2.1 Offenders with Psychopathic Traits vs. Sexual Offenders: Special Considerations

A number of components of the psychopathic personality described above pose serious obstacles to treatment. Therefore, special considerations must be given when treating sexual offenders with psychopathic traits as compared to sexual offenders in general. Treatment approaches present in the current literature will be described in detail in following sections; this section will focus on factors which distinguish treatment needs of psychopathic sexual offenders from sexual offenders in general.

First, given the pattern of antisocial behaviours inherent in psychopathy, they are considered to be higher risk to reoffend by nature (Hemphill et al., 1998). Therefore, treatments designed to be effective with psychopathic offenders must account for their elevated risk to reoffend (Abracen & Looman, 2016; Hemphill et al., 1998; Looman & Abracen, 2013). Second, the callousness, lack of empathy and remorse, and unemotional responses have been shown to create barriers in developing a meaningful therapeutic alliance (Olver & Wong, 2011). This factor, in addition to other affective components of the psychopathic personality, constitutes a significant responsivity issue in treatment (Olver & Wong, 2011). Additionally, lacking empathy

and fear of punishment has been suggested as a barrier to ‘moral internalization’, which refers to integrating moral values into our sense of self (Eysenck, 1979; Fine & Kennett, 2004; Hardy et al., 2008). While psychopaths can distinguish between right and wrong, this knowledge is limited to a cognitive, rather than affective, or emotionally meaningful, knowledge (Berg et al., 2013; Levy, 2011; Fine & Kennett, 2004; Hare, 2003). Attempts to instill empathy and appropriate affective responses are unlikely to be effective (Olver & Wong, 2011) given the significant neurological foundation of these deficits (Kiehl et al., 2001; Stratton et al., 2015). Therefore, treatments for offenders which rely on appealing to empathy or emotional responses would not be effective in the treatment of offenders with psychopathic traits.

Although these treatment considerations are well documented now, this was not always the case. Decades of research has examined whether or not psychopaths can benefit from treatment, most of which found very poor outcomes (Hare et al., 2000; Harris & Rice, 2006; Ogloff et al., 1990; Marnie E. Rice et al., 1992; Seto & Barbaree, 1999; Valliant et al., 1998). Much like treatment for sexual offenders, treatment of psychopathic offenders has had a long journey originating from significant scepticism and pessimism.

2.2 Evolution of Treatment of Offenders with Psychopathic Traits: Clinical Pessimism

Within Robert Hares’ research surrounding psychopathy included their potential for treatment (Hare, 1970). His initial belief, following the psychopathic personality described by his research, was that therapeutic communities would provide the most promising environment to alter problematic personality characteristics associated with psychopathy (Hare, 1970; Harris & Rice, 2006). While some initial reports provided promising outcomes (e.g. Barker & Mason, 1968; J. B. Copas & Whiteley, 1976; John B. Copas et al., 1984); a study by Rice and colleagues

(1992) found that not only were therapeutic communities not effective in treating psychopathic offenders, but could be making them worse. This study evaluated 146 offenders who spent a minimum of 2 years in a maximum security therapeutic community program and matched them to 146 untreated offenders for comparison with an average follow up time of 10.5 years (Rice et al., 1992). In assessing psychopathic offenders in the community, a comparison of problematic behaviours in their first and final years of the program indicated that they had poorer adjustment to the therapeutic community environment compared to non-psychopathic offenders (Rice et al., 1992). Furthermore, while the treated non-psychopathic group showed lower rates of recidivism than the matched untreated non-psychopathic group, the treated psychopathic offenders showed higher rates of recidivism than their matched non-treated psychopathic controls (Rice et al., 1992). This study became popularly cited as evidence that treatment makes psychopathic offenders worse (D'Silva et al., 2004; Harris & Rice, 2006).

A large number of outcome studies from therapeutic communities continued to conclude that treatment was not effective for psychopathic offenders (e.g. Ogloff et al., 1990; Richards et al., 2003). Therapeutic communities were later criticized as inappropriate treatment methods for psychopathic offenders as they relied on peer input and encouraged offenders to act as therapists (Looman et al., 2005). Given the manipulative and disruptive nature of the psychopathic personality it was not surprising to some that this method was not successful (Looman et al., 2005). In 1985, Brown and Gutsch found that cognitive behaviour modification techniques may be effective in delaying gratification among psychopathic individuals. These results would suggest that cognitive behavioural therapies may be effective in psychopathic behaviour modification (Brown & Gutsch, 1985). Nonetheless, additional studies employing behavioural (Valliant et al., 1998) and cognitive behavioural (Hare et al., 2000; Seto & Barbaree, 1999)

approaches found treatments to have no effect (Seto & Barbaree, 1999; Valliant et al., 1998), or to have worsening effects (Hare et al., 2000) similar to those found by Rice and colleagues (1992).

As was discussed above, the RNR model was growing in popularity as a model of correctional intervention in the 1990s and quickly became best practice in the field (Andrews & Bonta, 2010). It was therefore recommended that treatment for psychopathic offenders should follow suit and suggesting that intensive treatments targeting criminogenic needs may be most effective (Andrews & Bonta, 1994; Serin & Kuriyчук, 1994; Wong & Hare, 2005). However, in 1999, Seto and Barbaree conducted a study investigating outcomes of such a program and did not report optimistic findings. This study consisted of 283 sexual offenders who had undergone treatment in a medium-security federal penitentiary (Seto & Barbaree, 1999). The average follow up time for this study was 32 months (approximately 2.7 years) (Seto & Barbaree, 1999). Although an assessment of treatment behaviours indicated that offenders scoring high on psychopathy had shown the greatest improvements in treatment, recidivism data suggested that they remained a greater risk to reoffend than their non-psychopathic counterparts (Seto & Barbaree, 1999).

Despite a scarcity of research publications, with most existing studies pointing to negative outcomes, clinical pessimism spread rapidly (Salekin, 2002). Rather than accepting the conclusion that nothing works, researchers used their knowledge of what did not work to identify what does work. A popular review by Salekin (2002), 42 studies addressing the treatment of psychopathy were evaluated. While many studies reported poor treatment outcomes, a number of these studies were criticized as using small sample sizes or outdated treatment methods (Salekin, 2002). Furthermore, a small number of studies were identified in which treatment was effective

in reducing recidivism (Salekin, 2002). The results of this review suggested that CBT and psychoanalytic therapies were among the most effective interventions, and that a combination of CBT and insight training may be effective in the treatment of individuals with psychopathic traits (Salekin, 2002). While the methodology of this review has been questioned (Harris & Rice, 2006), it marked an important starting point for more positive literature regarding treatment of offenders with psychopathic traits.

2.3 Evolution of Treatment of Offenders with Psychopathic Traits: Modern Approaches

While the previous research studies initially inspired clinical pessimism, modern research studies have interpreted these results to indicate that inappropriate treatment methods can have harmful outcomes for psychopathic offenders (Rice et al., 1992) and result in greater rates of treatment dropout (Ogloff et al., 1990) but that these individuals can benefit from treatment, given the appropriate interventions (Olver et al., 2013). Abracen & Looman (2016) noted that, although psychopaths are not a low-risk post-treatment, there is a growing body of evidence to suggest that psychopathic offenders can benefit from appropriate contemporary treatment methods. Commonalities among treatments which have demonstrated a reduction in risk to reoffend for psychopathic offenders have been collected in hopes of identifying the key therapeutic elements for this population. Important themes in the literature to date include skills-based and educational treatment addressing specific criminogenic factors, appropriate length (generally 6 – 12 months), and cognitive-behavioural approaches incorporating the Risk-Needs Responsivity Model (RNR) (Abracen & Looman, 2016).

These factors are common across contemporary sex offender treatment programs offered by the Correctional Service of Canada (CSC) which have shown some effectiveness in

moderating risk levels in psychopathic offenders (Abracen & Looman, 2016). The Regional Treatment Centre High Intensity Sex Offender Treatment Program (RTCSOTP) is one such treatment program offered by the CSC in the Ontario Region (Abracen & Looman, 2016). This high-intensity, in-patient based program is provided to sexual offenders serving a federal sentence of 2 years or more who have been deemed a high-risk and/or have high treatment needs (Looman et al., 2005; Abracen & Looman, 2016). This program serves as a basis for strong treatment research based on its long-standing establishment allowing for long follow-up times, high base rate of recidivism typically observed as a result of the high-risk nature of clients admitted, and close collaborative relationships with other facilities in the CSC (Abracen & Looman, 2004).

A number of studies have well established the efficacy of the RTCSOTP in mediating recidivism of high-risk/high-need sexual offenders (Looman et al., 2000; Abracen & Looman, 2004; Looman et al., 2005; Abracen et al., 2008; Abracen et al., 2011; Olver & Wong, 2013; Abracen & Looman, 2016). Recent studies have also examined its influence on psychopathic offenders. Abracen et al. (2011) conducted an outcome study which matched treated offenders from the RTCSOTP to non-treated sexual offenders based on age at index offence, PCL-R score, and type of sexual offence. It is important to note that the untreated comparison groups members also received treatment geared toward criminogenic targets although not sexual offence specific (Abracen et al., 2011). These groups were compared on projected risk of recidivism as measured by the Rapid Risk Assessment of Sexual Offence Recidivism (RRASOR) and found both groups evidenced low rates of sexual recidivism over a follow up period extending beyond 9 years (Abracen et al., 2011). Furthermore, offenders rated high on PCL-R (25 or above) evidenced low recidivism rates in both treated and untreated groups suggesting a potential for psychopathic

offenders to benefit from treatment geared toward criminogenic targets, or at least to moderate recidivism upon release (Abracen et al., 2011).

Outcome studies from Canadian Correctional facilities have also assisted in the development of treatment programs specific to offenders with psychopathic traits (Wilson & Tamatea, 2013). The High-Risk Personality Program was developed in New Zealand and is a prison-based treatment program designed to reduce recidivism among offenders with psychopathic traits (Wilson & Tamatea, 2013). This intensive program is based in cognitive-behavioural methods and progressed in three parts over approximately 9 months (Wilson & Tamatea, 2013). Part one addressed past treatment failure and psychoeducation regarding therapy and barriers to effective outcomes (Wilson & Tamatea, 2013). Part two addressed appropriate outlets for aggressive impulses and part three focused on preparation for reintegration to society (Wilson & Tamatea, 2013). Overall, offenders illustrated a reduced risk of recidivism as assessed by the Violence Risk Scale (VRS), although no conclusions could definitively be made regarding recidivism because of a small sample size ($n=11$) and only some offenders were release into the community at the time of follow-up (Wilson & Tamatea, 2013).

In addition to inspiring the development of new treatment programs, many research studies from RTCSOTP employing modern approaches, such as the RNR-I noted above, have shown to be effective in reducing recidivism rates among sexual offenders with psychopathic traits (Abracen et al., 2011; Abracen & Looman, 2016; Looman, Abracen, et al., 2005; Looman & Abracen, 2013). Some studies suggest the possibility of a subgroup of offenders with psychopathic traits who are more responsive to treatment (Langton et al., 2006; Looman, Abracen, et al., 2005; Olver & Wong, 2013). A study by Looman and colleagues in 2005 focused specifically on treatment behaviours and recidivism in sexual offenders with psychopathic traits

who had completed RTCSOTP requirements (Looman et al., 2005). PCL-R scores and treatment behaviours were used to establish four groups whose recidivism rates were compared over a 7-year follow up period: High PCL-R/good progress, High PCL-R/poor progress, Low PCL-R/good progress, Low PCL-R/poor progress (Looman et al., 2005). Although the finding did not reach statistical significance, pairwise comparisons demonstrated that recidivism rates of individuals rated high on the PCL-R and who were rated as having a reduction in risk post treatment did not differ from either of the low PCL-R groups (Looman et al., 2005).

A similar study by Langton and colleagues (2006) also supported the notion that a subgroup of psychopathic offenders may be responsive to treatment, although these results differed from the results of Looman et al. (2005). This study instead found that offenders scoring above 25 on the PCL-R and who were rated poor on response to treatment recidivated faster and at a higher rate than those rated low on the PCL-R (Langton et al., 2006). Furthermore, it was found that psychopathic offenders who received positive ratings in regard to treatment behaviour recidivated at a lower rate (Langton et al., 2006). It has been suggested that the studies by Looman et al., (2005) and Langton et al, (2006) found opposing subgroups of psychopathic offenders responding best to treatment because of their differing operational definitions of treatment behaviour (Abracen & Looman, 2016). The study conducted by Langton et al. (2006) used an 8-factor model in measuring treatment behaviour while Looman et al. (2005) considered only 3 facets of treatment behaviour.

Chapter 3

3 Current Study, Methods, & Analysis

The current study intends to expand on the growing body of research regarding treatment outcomes of offenders with psychopathic traits. In particular, this study will explore the relationship between treatment behaviour and recidivism among psychopathic sexual offenders using a more comprehensive measure of treatment behaviour in hopes of expanding our understanding of treatment behaviours among this subgroup of offenders which may act as indicators of future success upon release. The hypotheses of this study are as follows: 1) high PCL-R scores will be related to increased recidivism compared to individuals rated low on the PCL-R; 2) individuals rated poor on treatment behavior will recidivate at higher rates than those rated good on treatment behaviour; 3) individuals in the high PCL-R/good treatment behaviour group will recidivate at a lower rate than those in the high PCL-R / poor on treatment behaviour group; 4) individuals in the high PCL-R/poor treatment behaviour group will have the highest rates of recidivism overall.

3.1 Methods

Ethical approval was granted for the current study by the Laurentian University Research Ethics Board (see Appendix A). The treatment data for this study was originally collected as part of a treatment assessment study conducted by Dr. Jan Looman and Dr. Jeffrey Abracen at the RTCSOTP. Updated outcome data was collected as part of a larger outcome study currently underway. No identifying information was retained as part of this data set. A copy of the consent form used in the original study to obtain informed consent from all participants can be found in Appendix B.

3.1.1 Participants

Participants were recruited for the original study from the RTCSOTP. As previously introduced, the RTCSOTP is a high-intensity treatment program offered by the Correctional Services of Canada Treatment. This is a high-intensity 7-month program designed to reduced recidivism among sexual offenders (Abracen & Looman, 2016; Looman, Abracen, et al., 2005). This program incorporates RNR and relapse prevention models described above (Abracen & Looman, 2016; Looman, Abracen, et al., 2005). Content covered in this program includes self-management, cognitive distortions, and emotion management (Abracen & Looman, 2016). Treatment data was collected from 155 consecutive admissions to the program. When updating the dataset with follow-up data, every effort was made to retain participants, however, a total of 38 cases were dropped resulting in a final N of 117 for this study. Cases were eliminated for individuals who were serving life in prison (n=13), died while incarcerated (n=9), or who otherwise provided insufficient follow-up time (e.g. charges added while incarcerated extending sentence or released shortly before follow-up data was collected) (n=9). Additional cases were lost to invalid identification numbers preventing follow-up data from being collected (n=7).

By definition, all participants in this study were high-risk offenders incarcerated in a Canadian federal penitentiary serving a sentence of 2 years or more. Means and standard deviations of criminal history for this sample are summarized in Table 1. Criminal history data was collected from criminal records using the Canadian Police Information Centre (CPIC) as part of the original study. Criminal history reported accounts for both provincial convictions (sentence less than 2 years) and federal convictions (sentence 2 years or more). As seen in Table 1, this sample consisted of multiple recidivists with relatively lengthy criminal histories. The average age at the time of release from the index offence (offence for which they were attending

RTCSOTP) was 39.4 ($SD = 10.8$; $n = 101$). This sample represents a group of offenders at a high risk to reoffend.

Table 1

Means and Standard Deviations of Sample Criminal History (n=106)

	Mean	Standard Deviation
<i>Number of Sex Convictions Prior to Index</i>	3.75	3.60
<i>Number of Non-Sexual Violent Convictions Prior to Index</i>	5.94	4.41
<i>Number of Non-Violent Convictions Prior to Index</i>	15.78	15.60

3.1.2 Measures

Recidivism. Recidivism data for this study was collected as part of a larger outcome study underway at CSC using the Offender Management System (OMS). This study used an inclusive measure of recidivism which encompassed sexual, violent, and general recidivism as indicators of post-treatment recidivism. This has been argued to be a more effective outcome measure as it accounts for low rates of sexual recidivism in general and the number of sexual offences that are plea bargained to assault convictions (Abracen & Looman, 2004; Looman, Abracen, et al., 2005). Offences committed since the time of release for the index offence was coded as either sexual, non-sexual violent, or other non-violent offences. A comprehensive list of coding decisions based on these three categories can be found in Appendix C. Follow-up times ranged from 1 to 241 months with an average follow-up time of 82.62 months ($SD = 76.99$, $Mdn = 45$; $n = 117$). In total 62.4% (73/117) of offenders recidivated within this time, 24.8% (29/117) recidivated with a new non-sexual violent offence, 54.7% (64/117) recidivated with a new non-violent offence, and 24.8% (29/117) recidivated with a new sexual offence.

3.1.3 Procedure

Psychopathy. Psychopathy was assessed by the PCL-R prior to admission to the treatment program and was collected as part of the original study. The average PCL-R score for this sample was 23.2 ($SD = 7.50$) with a median score of 25. The median score for this sample is consistent with the findings of Quinsey and colleagues (1998) which recommends a cut-off score of 25. Using a median split, individuals scoring 24 or below were classified as low on psychopathy and individuals scoring 25 or above were classified as high on psychopathy. PCL-R data was available for 70 of the 117 cases included in the analyses.

Treatment Behaviour. This study aimed to use a more inclusive measure of treatment behaviour in order to demystify previously conflicting findings regarding the relationship between treatment behaviour and recidivism among sexual offenders with psychopathic traits. Components of treatment behaviour were coded from treatment files by psychologists employed at RTCSOTP at the time of the original study. Treatment behaviour was then coded into a single variable by combining five dimensions of treatment: victim awareness, offence cycle, relapse prevention plan, treatment progress, and prosocial supports. These variables were selected as they represented primary treatment targets of sex offender treatment programs and reflect dimensions of treatment founded in sound theoretical models previously described. Victim awareness, offence cycle, and relapse prevention plan were coded as part of the original study on a 4-point scale ranging from 0 to 3 with 0 representing no awareness of impact in these items and 3 representing good awareness of impact. Treatment progress as evaluated by treatment reports in the original study was coded on a 3-point scale ranging from 0 to 2. Coding of this item was described as follows: 0 – no reduction in risk, 1 – some reduction in risk, 2 – risk reduced. Finally, prosocial supports were rated as present (1) or not present (0). These items were

combined for a total treatment behaviour score resulting in a 13-point scale ranging from 0 to 12 with 0 being the worst and 12 being the best possible ratings on treatment behaviour for the current study.

Following coding of treatment behaviour, a median split was used to separate offenders into two groups: good treatment behaviour and poor treatment behaviour groups. The average treatment behaviour rating for this sample was 5.98 ($SD = 2.42$) with a median of 6. Individuals with a score of 6 or lower were classified as poor in treatment behaviour and those with a score of 7 or above were classified as having good treatment behaviour. In total, 50.4% of participants (59/117) completed the treatment program, 6% (7/117) withdrew from the program, 12.8 % (15/117) were discharged, and 30.8 (36/117) completed only the assessment. Complete treatment data was available for 72 of the 117 cases included in the analyses.

Additional treatment factors were available within the data set but did not qualify as measures of treatment behaviour. These variables were instead grouped into the following categories to be evaluated independent from the main analyses of this study: change in treatment motivation, change in denial, and behaviour on unit.

Change in Treatment Motivation. Treatment motivation was calculated using three dimensions of motivation: treatment motivation, agreement on necessity for behaviour change, and agreement on treatment goals. These measures were all assessed pre and post to evaluate changes over the course of treatment. Each of these dimensions were rated on a 3-point scale from 0 to 2. For treatment motivation 0 indicated no motivation, 1 indicated some motivation for treatment, and 2 indicating high levels of treatment motivation. For agreement on treatment goals and necessity of behaviour change, a score of 0 indicated no agreement, 1 indicated some agreement,

and 2 indicated agreement on these measures. The pre and post measures of each of these dimensions were compared and recoded resulting in three new variables: change in treatment motivation, change in agreement on treatment goals, and change in agreement on necessity of behaviour change. Each of these variables was rated on a 3-point scale as follows: 0 – reduction in motivation, 1 – no change, 2 – improvement in motivation. These measures were combined for a final treatment motivation score resulting in a 7-point scale ranging from 0, indicating reduction in treatment motivation, to 6, indicating improved treatment motivation.

Change in Denial. Denial and minimization of offending is an important factor related to sexual offending and can interfere with treatment outcomes (Abracen & Looman, 2004). Pre and post data was available for 7 dimensions of denial: denial of facts, denial of awareness, denial of impact, denial of responsibility, denial of grooming, denial of sexual intent, and denial of being in denial. Measures were rated on a 3-point scale defined as follows: 0 – full denial, 1 – partial denial, 2 – no denial. Pre and post measures were compared and combined resulting in 7 denial variables corresponding to changes in denial over the course of treatment. These variables were coded using the following scale: 0 – increased denial, 1 – no change in denial, 2 – reduction in denial. Finally, these variables were combined to form a total assessment of change in denial throughout treatment rated on a 15-point scale ranging from 0, increased denial, to 14, reduction in denial.

Behaviour on Unit. Although not classified as a treatment behaviour, data was available regarding behaviour on unit outside of treatment hours. These variables included: manipulative behaviours, infractions, supportive behaviours, and respectful behaviour and were rated as being either present or not present. For positive behaviours (respectful and supportive), a score of 1 indicated the presence of these behaviours while a score of 0 indicated these behaviours were not

present. Negative behaviours (infractions and manipulation) were reverse coded, therefore a score of 1 indicated these behaviours were not present while a score of 0 indicated these behaviours were present. These ratings were then combined to establish an overall score of behaviour on unit on a 5-point scale ranging from 0, poor behaviour, to 4, good behaviour.

3.1.4 Data Analysis

Statistical analyses were conducted using the Statistics Package for Social Sciences (SPSS) version 26. Cox regression analyses, which allows for the analysis of both categorical and continuous variables as well as controlling for variable follow up time, were used to evaluate the relationship between PCL-R, treatment behaviour, and recidivism. Hazard ratios ($\text{Exp}[B]$) reported for all outcomes refers to the degree to which recidivism increases or decreases based on its relationship to the variable with which it is compared (i.e. PCL-R, treatment behaviour, or PCL-R x treatment behaviour). For all forms of recidivism, three models of comparison were conducted as summarized by Table 2. For each model, change in denial, change in treatment motivation, and behaviour on unit were entered simultaneously on the second block to evaluate the extent to which these ancillary treatment variables mediated the relationship of the predictor variable and recidivism. Similar to analyses by Looman et al., 2005, offenders were classified into 4 groups based on treatment behaviour and PCL-R scores using the median splits for these groups described above. The resulting groups were as follows: Low PCL-R/Poor Treatment Behaviour, Low PCL-R/Good Treatment Behaviour, High PCL-R/Poor Treatment Behaviour, and High PCL-R/Good Treatment Behaviour. These groups were used in Cox Regression analyses to assess the influence of an interaction of PCL-R score and treatment behaviour on recidivism. Furthermore, Kaplan-Meier survival analysis was used to evaluate the influence of PCL-R and treatment behaviour variables on recidivism rates for this sample.

Table 2

Summary of Cox Regression Models used to Assess Relationship to Recidivism

	Block 1	Block 2
<i>Model 1</i>	PCL-R	Change in denial, Change in treatment motivation, Behaviour on unit
<i>Model 2</i>	Treatment behaviour	Change in denial, Change in treatment motivation, Behaviour on unit
<i>Model 3</i>	PCL-R x Treatment behaviour	Change in denial, Change in treatment motivation, Behaviour on unit

Note. PCL-R and Treatment behaviour variables were dichotomous category variables based on median splits described above. PCL-R x Treatment was categorized into 4 groups described above.

Chapter 4

4 Results

When evaluating the relationship between PCL-R group, treatment behaviour group, PCL-R x treatment behaviour group, and any recidivism a number of cases were censored. Analyses involving PCL-R (i.e. PCL-R and PCL-R x treatment behaviour) include only 70 of the possible 117 cases because 47 cases were missing PCL-R data. Similarly, analyses of treatment behaviour groups included only 72 of the possible 117 cases because of missing treatment data. Cox Regression analyses identified no significant relationships between PCL-R group, treatment behaviour group, or PCL-R x treatment behaviours groups and any recidivism. A summary of these analyses can be found in Table 3.

Table 3

Hazard rate of Predictor Variables, Change in Denial, Change in Treatment Motivation, and Behaviour on Unit with Any Recidivism ($n_{\text{recidivist}}=73/117$)

Predictor Variable	Unadjusted Model	Adjusted Model			
	Predictor Variable	Predictor Variable	Change in Denial	Change in Treatment Motivation	Behaviour on Unit
	Hazard Ratio (95% CI)				
PCL-R	1.40 (0.76 – 2.59)	1.35 (0.72 – 2.55)	0.99 (0.82 – 1.19)	0.97 (0.71 – 1.32)	1.20 (0.75 – 1.94)
Treatment Behaviour	0.56 (0.31 – 1.04)	0.48* (0.25 – 0.93)	0.95 (0.78 – 1.15)	0.90 (0.65 – 1.23)	1.37 (0.85 – 2.22)
PCL-R x Treatment Behaviour	1.02 (0.77 – 1.34)	0.98 (0.73 – 1.30)	0.98 (0.81 – 1.18)	0.99 (0.73 – 1.35)	1.27 (0.78 – 2.07)

Note. The unadjusted model provides the bivariate relationship between predictor variables and any recidivism. The adjusted model provides the relationship that is adjusted for the influence of changes in denial, changes in treatment motivation, and behaviour on unit. * $p < .05$.

Similarly, these variables were not found to be related to sexual recidivism (Table 4), non-sexual violent recidivism (Table 5), or non-violent recidivism (Table 6). Although, when accounting for changes in denial, changes in treatment motivation, and behaviour on unit, treatment behaviour was significantly predictive of any recidivism and non-violent recidivism.

Table 4

Hazard rate of Predictor Variables, Change in Denial, Change in Treatment Motivation, and Behaviour on Unit with Sexual Recidivism ($n_{\text{recidivist}}=29/117$)

Predictor Variable	Unadjusted Model	Adjusted Model			
	Predictor Variable	Predictor Variable	Change in Denial	Change in Treatment Motivation	Behaviour on Unit
	Hazard Ratio (95% CI)				
PCL-R	1.03 (0.38 – 2.77)	0.90 (0.32 – 2.54)	0.90 (0.67 – 1.22)	1.23 (0.74 – 2.04)	1.14 (0.52 – 2.49)
Treatment Behaviour	0.83 (0.32 – 2.15)	0.82 (0.30 – 2.24)	0.86 (0.63 – 1.11)	1.16 (0.71 – 1.90)	1.04 (0.47 – 2.27)
PCL-R x Treatment Behaviour	0.96 (0.61 – 1.49)	0.90 (0.57 – 1.43)	0.90 (0.66 – 1.22)	1.23 (0.74 – 2.02)	1.17 (0.53 – 2.59)

Note. The unadjusted model provides the bivariate relationship between predictor variables and any recidivism. The adjusted model provides the relationship that is adjusted for the influence of changes in denial, changes in treatment motivation, and behaviour on unit. * $p < .05$.

Table 5

Hazard rate of Predictor Variables, Change in Denial, Change in Treatment Motivation, and Behaviour on Unit with Non-Sexual Violent Recidivism ($n_{\text{recidivist}}=29/117$)

Predictor Variable	Unadjusted Model	Adjusted Model			
	Predictor Variable	Predictor Variable	Change in Denial	Change in Treatment Motivation	Behaviour on Unit
		Hazard Ratio (95% CI)			
PCL-R	1.92 (0.68 – 5.42)	1.96 (0.68 – 5.65)	0.96 (0.70 – 1.33)	0.95 (0.58 – 1.55)	0.94 (0.42 – 2.10)
Treatment Behaviour	0.62 (0.23 – 1.66)	0.59 (0.21 – 1.64)	0.89 (0.65 – 1.22)	0.93 (0.56 – 1.53)	0.99 (0.44 – 2.20)
PCL-R x Treatment Behaviour	1.15 (0.73 – 1.81)	1.15 (0.72 – 1.83)	0.96 (0.70 – 1.31)	0.98 (0.60 – 1.63)	0.96 (0.42 – 2.19)

Note. The unadjusted model provides the bivariate relationship between predictor variables and any recidivism. The adjusted model provides the relationship that is adjusted for the influence of changes in denial, changes in treatment motivation, and behaviour on unit. * $p < .05$.

Table 6

Hazard rate of Predictor Variables, Change in Denial, Change in Treatment Motivation, and Behaviour on Unit with Non-Violent Recidivism ($n_{\text{recidivist}}=64/117$)

Predictor Variable	Unadjusted Model	Adjusted Model			
	Predictor Variable	Predictor Variable	Change in Denial	Change in Treatment Motivation	Behaviour on Unit
		Hazard Ratio (95% CI)			
PCL-R	1.71 (0.86 – 3.36)	1.60 (0.79 – 3.22)	0.96 (0.78 – 1.19)	0.90 (0.65 – 1.26)	1.46 (0.88 – 2.40)
Treatment Behaviour	0.51 (0.26 – 1.01)	0.39* (0.19 – 0.81)	0.93 (0.75 – 1.14)	0.82 (0.59 – 1.15)	1.72* (1.05 – 2.81)
PCL-R x Treatment Behaviour	1.06 (0.80 – 1.45)	1.00 (0.73 – 1.37)	0.96 (0.78 – 1.17)	0.93 (0.67 – 1.30)	1.54 (0.93 – 2.58)

Note. The unadjusted model provides the bivariate relationship between predictor variables and any recidivism. The adjusted model provides the relationship that is adjusted for the influence of changes in denial, changes in treatment motivation, and behaviour on unit. * $p < .05$

Results of the Kaplan-Meier survival analyses for any recidivism and non-violent recidivism indicate individuals in the high PCL-R/poor treatment behaviour group recidivated faster and at higher rates than those in both low PCL-R groups, although differences between the two high PCL-R groups did not reach statistical significance. Even so, the high PCL-R/good treatment behaviour group could not be meaningfully distinguished from recidivism rates of either of the low PCL-R groups. A summary of results for any recidivism and non-violent recidivism are provided by Tables 7 and 8 respectively. Survival plots are provided in support of both analyses (Figures 1 and 2). In contrast, when evaluating sexual recidivism (Table 9; Figure 3) and non-sexual violent recidivism (Table 10; Figure 4) no significant differences in recidivism rates were noted between any of the four groups.

Table 7

Estimated Mean Survival Time in Months by Group for Any Recidivism ($n_{\text{recidivist}} = 73/117$)

Group	Mean (95% CI)
Low PCL-R/Poor Treatment Behaviour	130.65 (86.68 – 174.62)
Low PCL-R/Good Treatment Behaviour	135.70 (93.42 – 177.98)
High PCL-R/Poor Treatment Behaviour	54.96 (29.94 – 80.00)
High PCL-R/Good Treatment Behaviour	97.41 (62.23 – 131.49)

Note. Estimated means are limited to the largest survival time if censored.

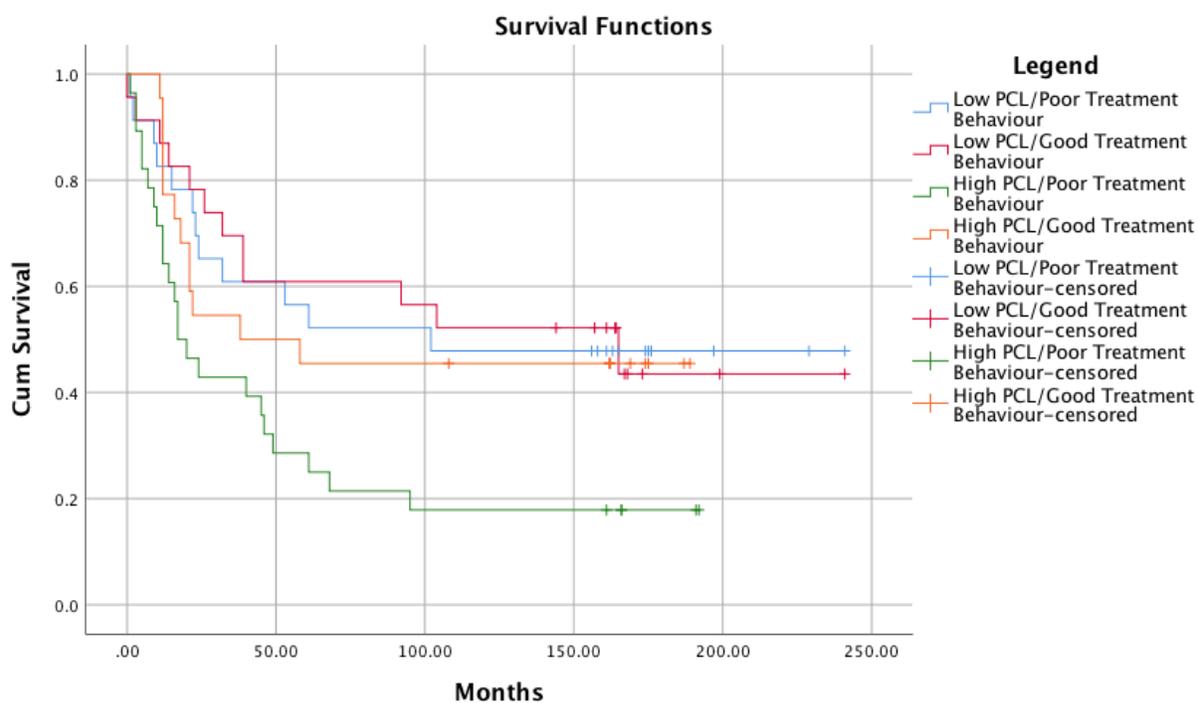


Figure 1: Kaplan-Meier Survival Plot for Any Recidivism by Group

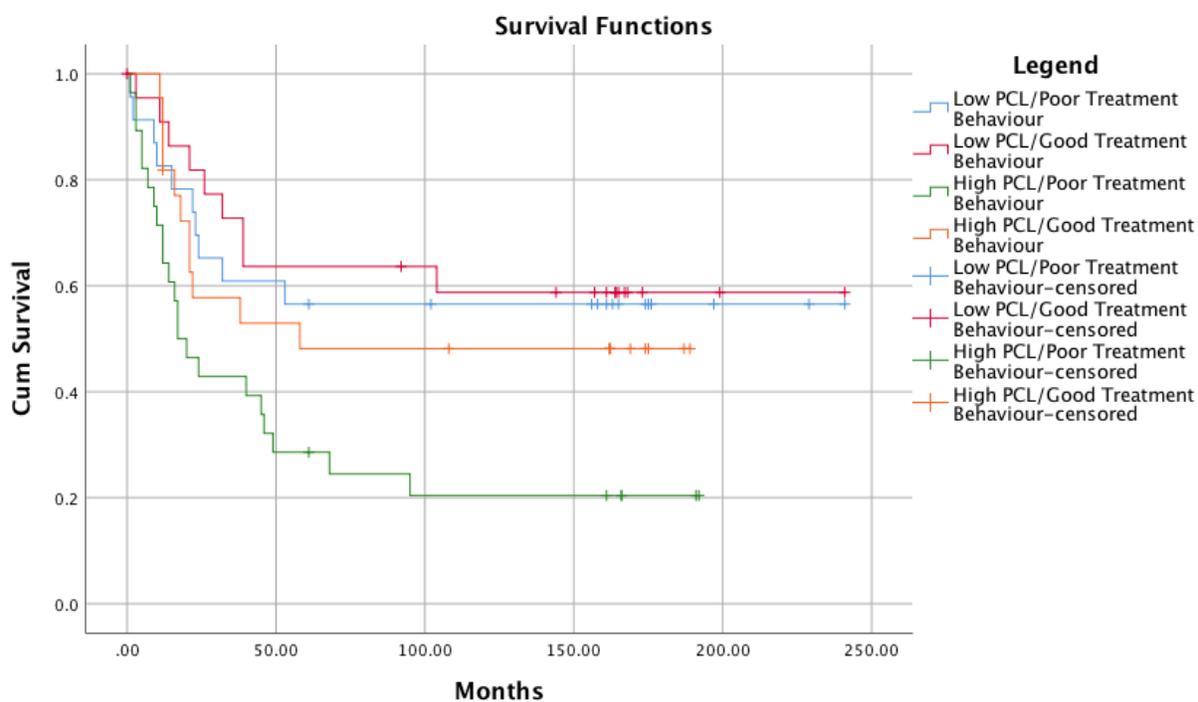
Note. Censored cases in each category (i.e. Cases which did not recidivate but had shorter follow up times) are marked on the survival graph as indicated by the legend.

Table 8

Estimated Mean Survival Time in Months by Group for Non-Violent Recidivism
($n_{\text{recidivist}} = 64/117$)

Group	Mean (95% CI)
Low PCL-R/Poor Treatment Behaviour	144.52 (99.40 – 189.65)
Low PCL-R/Good Treatment Behaviour	155.07 (111.41 – 198.73)
High PCL-R/Poor Treatment Behaviour	58.52 (31.95 – 85.08)
High PCL-R/Good Treatment Behaviour	102.44 (66.60 – 138.28)

Note. Estimated means are limited to the largest survival time if censored.

**Figure 2: Kaplan-Meier Survival Plot for Non-Violent Recidivism by Group**

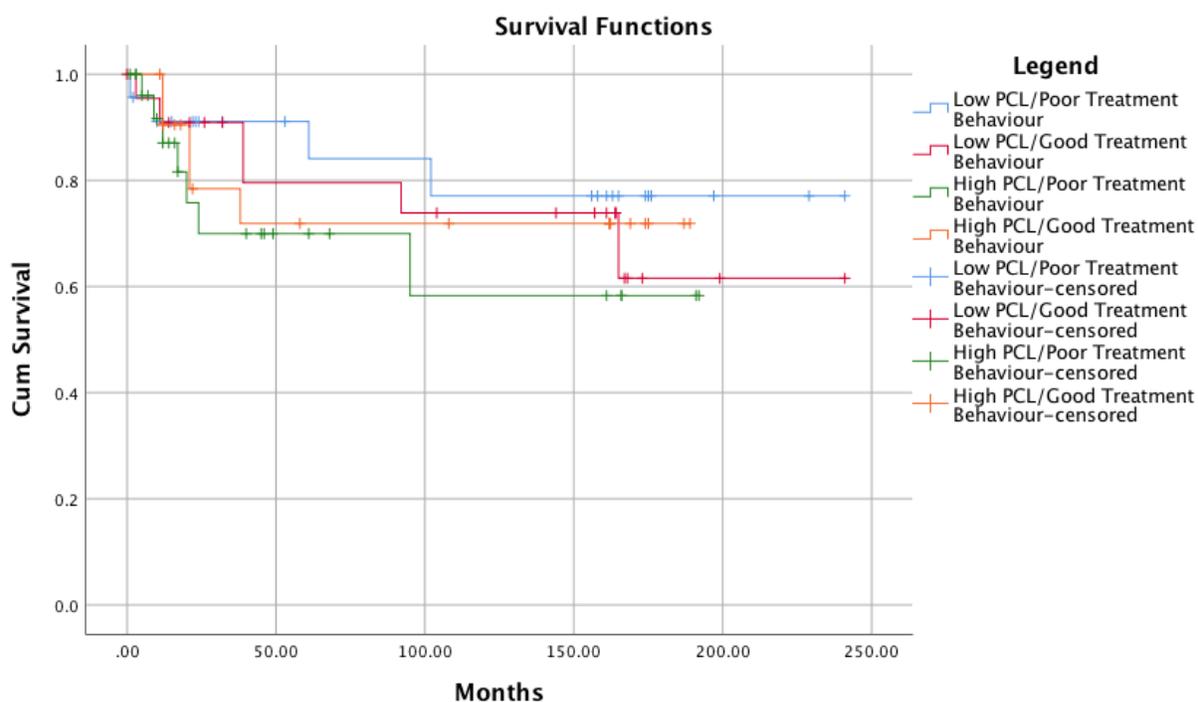
Note. Censored cases in each category (i.e. Cases which did not recidivate but had shorter follow up times) are marked on the survival graph as indicated by the legend.

Table 9

Estimated Mean Survival Time in Months by Group for Sexual Recidivism ($n_{\text{recidivist}} = 29/117$)

Group	Mean (95% CI)
Low PCL-R/Poor Treatment Behaviour	197.64 (159.59 – 235.70)
Low PCL-R/Good Treatment Behaviour	178.95 (137.59 – 220.31)
High PCL-R/Poor Treatment Behaviour	127.64 (89.05 – 166.22)
High PCL-R/Good Treatment Behaviour	142.01 (106.61 – 177.41)

Note. Estimated means are limited to the largest survival time if censored.

**Figure 3: Kaplan-Meier Survival Plot for Sexual Recidivism by Group**

Note. Censored cases in each category (i.e. Cases which did not recidivate but had shorter follow up times) are marked on the survival graph as indicated by the legend.

Table 10

Estimated Mean Survival Time in Months by Group for Non-Sexual Violent Recidivism
($n_{\text{recidivist}} = 29/117$)

Group	Mean (95% CI)
Low PCL-R/Poor Treatment Behaviour	194.97 (154.51 – 235.43)
Low PCL-R/Good Treatment Behaviour	180.33 (138.70 – 221.97)
High PCL-R/Poor Treatment Behaviour	100.34 (63.76 – 136.91)
High PCL-R/Good Treatment Behaviour	161.30 (132.43 – 190.17)

Note. Estimated means are limited to the largest survival time if censored.

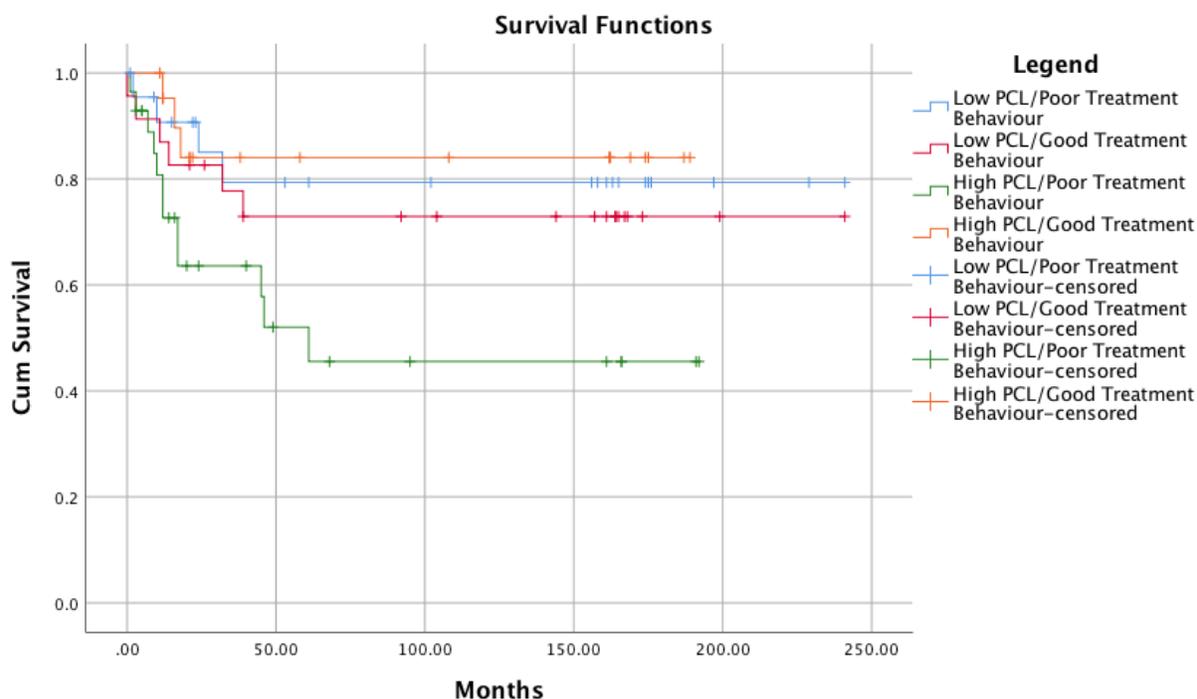


Figure 4: Kaplan-Meier Survival Plot for Non-Sexual Violent Recidivism by Group

Note. Censored cases in each category (i.e. Cases which did not recidivate but had shorter follow up times) are marked on the survival graph as indicated by the legend.

Chapter 5

5 Discussion

The current study aimed to evaluate the relationship between treatment behaviour and psychopathy as it pertains to recidivism. Relationships between psychopathy scores, treatment behaviours, and recidivism were evaluated from a predictive perspective as well as evaluating the impact of treatment on recidivism rates specific to the sample in this study. Psychopathy scores were not found to be predictive of future recidivism of any kind in this study. This is contradictory to numerous studies which have found PCL-R scores to be associated with increased risk of violent and general recidivism (Hare et al., 2000; Harris et al., 1998; Harris & Rice, 2006; Looman, Abracen, et al., 2005; Seto & Barbaree, 1999).

One possible explanation for this finding may stem from the pre-existing high-risk nature of this sample. While PCL-R scores have been shown to be associated with increased risk of future recidivism (Harris et al., 1998; Quinsey et al., 1998), the participants of RTCSOTP treatment program are by nature much higher-risk offenders overall. The average score on the Static-99R for this sample was 5.91 ($SD = 1.80$; $n = 101$) which is quite high when considering only 15% of individuals convicted of a sexual offence in Canada are expected to score higher than 4 on this measure (Hanson et al., 2012). Individuals rated high on psychopathy are by nature at a greater risk than others to reoffend, especially when considering that three measures on the scale are related to criminal history (juvenile delinquency, revocation of conditional release, and criminal versatility) (Hare, 2003) all of which have also been established as risk factors for recidivism among non-psychopathic offenders (Antonowicz & Ross, 1994; Harris et al., 1998; Lewis et al., 2013; Looman, Abracen, et al., 2005; Quinsey et al., 1998). Therefore, it is possible

that the high-risk nature of offenders rated high on psychopathy in general may account for future recidivism as opposed to psychopathy itself.

Similarly, treatment behaviour was not found to be predictive of future recidivism. These findings are consistent with previous studies (Looman, Abracen, et al., 2005; Seto & Barbaree, 1999) which found no differences in recidivism rates of offenders based on performance in treatment alone. Furthermore, using a similar model in Cox Regression analyses as employed in the current study, Langton et al. (2006) also found no relationship between treatment behaviour and recidivism even when considering different forms of recidivism independently. Although, in two analyses of the current study, relationship to any recidivism and non-violent recidivism, treatment behaviour became a significant predictor of recidivism when controlling for other responsivity factors such as denial and motivation. This may be indicative of the relationship between treatment behaviour and responsivity issues considered external to measures of treatment behaviour in this study, such as denial.

Seto and Barbaree (1999) found offenders who denied sexual offences and who minimized responsibility scored significantly poorer on measures of treatment behaviour. Denial has been established as a common factor and significant responsivity issue in the treatment of sexual offenders (Abracen & Looman, 2004; Beyko & Wong, 2005; Levenson et al., 2010) and has been related to poor treatment outcomes (Gully et al., 1990; Moore et al., 1999). Nevertheless, these findings are far from conclusive as other studies have found that the presence of denial did not interfere with treatment outcomes (Beyko & Wong, 2005). It has been further speculated that therapist characteristics may be negatively influenced by the presence of denial in sexual offenders resulting in condescending or confrontational approaches (Glaser, 2003). These factors may introduce additional responsivity issues and are inconsistent with findings that

effective treatment relies on a strong therapeutic alliance (Andrews & Bonta, 2010; Antonowicz & Ross, 1994). It is possible that, as opposed to being directly related to recidivism, treatment behaviour may be associated with established risk factors such as motivation, denial and therapeutic alliance resulting in an indirect relationship to recidivism. This conclusion is further supported by findings of the current study which was partially successful in distinguishing recidivism rates of offenders with psychopathic traits compared to those without psychopathic traits by measures of treatment behaviour.

The current study partially confirmed the findings of Langton et al. (2006) which suggested that individuals rated high on psychopathy and poorly on treatment behaviour recidivated faster and at higher rates than those rated low on psychopathy regardless of treatment behaviour ratings. This finding was confirmed when analyzing any recidivism and non-violent recidivism. In contrast, when evaluating sexual and violent recidivism, no significant differences were found between any of the groups. This study also confirms the findings of Langton et al. (2006) and Looman et al. (2005) which speculated that a subgroup of sexual offenders rated high on psychopathy may be more responsive to treatment than others. More specifically, this study concurred with the findings of Langton et al. (2006) which found that individuals rated high on psychopathy and good on treatment behaviour could not be meaningfully distinguished from low-psychopathy groups post-treatment. In addition, when looking specifically at violent and sexual recidivism, recidivism rates of individuals rated high on the PCL-R could not be meaningfully distinguished from those in the low PCL-R groups, suggesting that treatment may be equally effective among high-risk populations regardless of psychopathy scores. As a whole, these results indicate that psychopathy should be considered a responsivity issue to be addressed in treatment in order to improve outcomes for high-risk offenders with psychopathic traits.

The principle of responsivity in treatment development, as previously described in the RNR model, refers to the notion that treatment delivery should be geared to the specific level and learning style of the client (Antonowicz & Ross, 1994; Lewis et al., 2013; Looman, Dickie, et al., 2005; Quinsey et al., 1998). Responsivity issues can be classified as either external or internal factors (Looman, Dickie, et al., 2005). In the treatment of sexual offenders, external responsivity factors include therapist characteristics (i.e. Interpersonal sensitivity and awareness of social rules) and setting characteristics (i.e. community or institution) have shown some relationship to treatment outcomes although more research is needed in this area (Looman, Dickie, et al., 2005). In contrast, internal responsivity factors refer to client characteristics which could influence their ability to benefit from treatment such as treatment (Looman, Dickie, et al., 2005). Some internal responsivity factors relevant to sexual offenders include readiness and motivation, denial and minimization, and personality (Looman, Dickie, et al., 2005). Psychopathy has been proposed as an internal responsivity issue for treatment for offenders of all types (Looman, Dickie, et al., 2005). Research studies examining psychopathy as a responsivity issue for treatment have begun to emerge reporting significant and clinically meaningful results (Olver, 2016; Olver et al., 2013; Olver & Wong, 2011).

In 2011, Olver and Wong conducted a study of 154 male sexual offenders who had participated in treatment at the Clearwater Sex Offender Treatment Program. The authors evaluated factors such as treatment dropout, psychopathy, and risk rating (Olver & Wong, 2011). Psychopathy, as evaluated using the PCL-R, was found to be predictive of drop-out from the program when controlling for Treatment Responsivity and Criminality factors of the Violence Risk Scale – Sexual Offender version (VRS-SO) (Olver & Wong, 2011). When examining the relationship between psychopathy and the VRS-SO, it was found that Factor 1, affective and

interpersonal factors, was significantly correlated with Treatment Responsivity factors (Olver & Wong, 2011). Later studies concurred with the conclusion that psychopathy, and most notably Factor 1 personality traits, were associated with responsivity issues in treatment (Olver, 2016; Olver et al., 2015) while Factor 2 is more strongly related to criminogenic needs such as violent behaviours (Wong & Olver, 2015).

Although research regarding psychopathy as a responsivity issue is still in its infancy, these findings have had a meaningful impact on clinical approaches to the treatment of psychopathy. In 2015, Wong and Olver developed the Risk-Need-Responsivity-2 Component (RNR-2C) model to adapt treatment and promote positive outcomes with psychopathic offenders. Component 1 is associated with Factor 1 affective and interpersonal factors of the psychopathic personality (Olver, 2016; Wong & Olver, 2015). While Factor 1 is not associated with violence or recidivism (Olver & Wong, 2013; Yang et al., 2010) it is associated with behaviours interfering with treatment (Olver & Wong, 2013; Wong & Olver, 2015). This includes disruptive and manipulative behaviours, treatment dropout, and poor therapeutic relationships (Olver & Wong, 2013; Wong & Olver, 2015). Therefore, Component 1 of this model focuses on addressing Factor 1 traits as responsivity issues and requires treatment providers to identify, manage, and contain these behaviours while making reasonable effort to retain the client in the program (Olver, 2016; Wong & Olver, 2015). Component 2 of the model is related to Factor 2 antisocial lifestyle components of the psychopathic personality (Olver, 2016; Wong & Olver, 2015). These factors are directly related to violence and recidivism (Yang et al., 2010) and are therefore associated with criminogenic needs of the offender (Wong & Olver, 2015). While some factors on this scale are static risk factors (such as criminal history), other, dynamic factors can be addressed as criminogenic needs using cognitive-behavioural

based approaches to modify cognitions and behaviours associated with their antisocial activities (Wong & Olver, 2015). The authors recommend using the VRS to monitor changes in dynamic risk factors as changes on this scale in the context of treatment programs has been associated with reductions in recidivism rates post-treatment (Lewis et al., 2013; Olver & Wong, 2013; Wong & Olver, 2015).

Although the efficacy of this newly developed treatment program has yet to be demonstrated through outcome studies, it clearly illustrates the utility and significance of incorporating psychopathy as a responsivity issue in treatment. Furthermore, this research marks significant progress from previously pessimistic clinical outlooks on the treatment of psychopathic offenders and represents several decades of developments and learning from treatment approaches that were less successful. The current study supports the notion that sexual offenders with psychopathic traits can benefit from treatment and indicates through interactions with treatment behaviour that clinicians should consider these traits as responsivity issues when treating offenders with psychopathic traits.

5.1 Limitations and Future Recommendations

A major limitation of this study was the lack of PCL-R data. PCL-R data for this study was collected from clinical assessments completed over 20 years ago which eliminated the possibility of retrieving this data through other means. Based on consistent findings from previous research (Andrews & Bonta, 2010; Hare et al., 2000; Quinsey et al., 1998) it is likely that PCL-R ratings would have been predictive of future recidivism had more data been available. Similarly, these effects would have been minimized had a larger sample size been available for the current study. By nature of the small sample size used in this study, effects of

incomplete data in even a small number of cases has significant impacts on the outcome and reliability of subsequent analyses.

Another limitation to this study, which is also noted by Langton et al. (2006), is that no consideration was given to the conditions of release of the offenders. That is to say that no distinction was made between offenders released to the community with or without supervision (i.e. probation or parole) or in the types of supervision employed (i.e. curfew, conditions, random check-ins, etc.). This limitation becomes especially important when considering that breach of probation or conditional order was considered a form of non-violent recidivism in this study. Therefore, offenders with supervision may have had a greater risk of recidivism than those without because of the risk they may violate conditions of their supervision. Furthermore, although it may be assumed that many offenders were released with some form of supervision because they were serving a federal sentence, the nature of supervision and differences thereof between offenders may have influenced risk of recidivism (i.e. those with stricter conditions may be more likely to reoffend).

A third limitation to this study was a lack of consideration of sex offender type. Although results are not conclusive (Looman, Dickie, et al., 2005), some studies suggest that sex offender type (i.e. child molester, rapist, etc.) may also be considered a responsivity issue in treatment (Allam et al., 1997; Polizzi et al., 1999). It has also been suggested that PCL-R scores may vary significantly by offence type (Porter et al., 2001) and age of victims (Porter et al., 2000). Furthermore, this study did not account for personality diagnoses such as Antisocial Personality Disorder, which may increase risk of recidivism as well as account for similarities between offenders who met the cut off for psychopathy and those who did not. Future studies may wish to

consider offender type, psychiatric diagnoses, and nature of release when evaluating the relationship between psychopathy and treatment outcomes.

This sample is significantly high risk compared to those of many other studies. While in some regards that may constitute a limitation of this study, it may also be an important area for future research. By definition, psychopathic offenders are among the highest-risk to reoffend regardless of offence type. Therefore, their treatment success should not be compared to offenders who are moderate to low risk to reoffend. This may pose difficulties in evaluating the success of certain treatment programs as some treatment facilities do not admit clients with certain responsivity issues which are characteristic of high-risk sexual offenders, such as denial, and therefore are not treating the highest-risk clients (Abracen & Looman, 2004, 2016). Treatment studies from the RTCSTP provide clinically meaningful results as they admit clients exhibiting such characteristics as denial and minimization and target these factors directly in treatment (Abracen & Looman, 2004, 2016). Further research is needed comparing treatment outcomes of psychopathic offenders and high-risk non-psychopathic offenders in order to eliminate the possibility that the high-risk nature of psychopathic offenders is not responsible for poor treatment outcomes for these offenders as opposed to psychopathy itself.

Finally, future studies should examine interactions between treatment behaviour and established responsivity factors. While behaviour in treatment does not appear to be directly related to future recidivism, there is some evidence to suggest that treatment behaviour may influence recidivism indirectly through interactions with factors such as denial and therapeutic alliance. By examining the relationships between these factors, it may be possible to identify aspects of treatment behaviour indicative of underlying responsivity issues. As such, these

factors could inform treatment targets in order to address responsivity issues directly and increase treatment efficacy.

5.2 Conclusion

Treatment of sexual offenders with psychopathic traits has been an area of significant debate despite limited research. The current study did not find psychopathy to be independently related to future recidivism among a sample of high-risk offenders. Furthermore, the results of this study indicated that some offenders rated high on psychopathy could not be meaningfully distinguished from offenders rated low on psychopathy post treatment. In regards to general recidivism, offenders scoring high on psychopathy and poor on treatment behaviours continued to recidivate at higher rates than offenders rated low on psychopathy. In contrast, offenders rated high on psychopathy and good on treatment behaviour illustrated no significant differences from offenders rated low on psychopathy. When examining sexual and violent recidivism, no significant differences in recidivism rates were found between any of these groups, indicating that all high risk offenders had similar recidivism rates in these categories post-treatment regardless of psychopathy score. Further research comparing recidivism and treatment outcomes of offenders with psychopathic traits and similarly high risk offenders without psychopathic traits is needed to further elucidate the relationship between psychopathy and treatment outcomes.

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Appendix A



Laurentian University
Université Laurentienne

APPROVAL FOR CONDUCTING RESEARCH INVOLVING HUMAN SUBJECTS

Research Ethics Board – Laurentian University

This letter confirms that the research project identified below has successfully passed the ethics review by the Laurentian University Research Ethics Board (REB). Your ethics approval date, other milestone dates, and any special conditions for your project are indicated below.

TYPE OF APPROVAL / New <input checked="" type="checkbox"/> / Modifications to project / Time extension	
Name of Principal Investigator and school/department	Charlotte Aelick, Psychology, supervisor Paul Valliant
Title of Project	Recidivism and Treatment Behaviour Among High-Risk/High-Need Sexual Offenders with Psychopathic Traits
REB file number	6017266
Date of original approval of project	April 24, 2019
Date of approval of project modifications or extension (if applicable)	
Final/Interim report due on: <i>(You may request an extension)</i>	April 24, 2020
Conditions placed on project	Please provide the CSC REB Approval certificate once received

During the course of your research, no deviations from, or changes to, the protocol, recruitment or consent forms may be initiated without prior written approval from the REB. If you wish to modify your research project, please refer to the Research Ethics website to complete the appropriate REB form.

All projects must submit a report to REB at least once per year. If involvement with human participants continues for longer than one year (e.g. you have not completed the objectives of the study and have not yet terminated contact with the participants, except for feedback of final results to participants), you must request an extension using the appropriate LU REB form. In all cases, please ensure that your research complies with Tri-Council Policy Statement (TCPS). Also please quote your REB file number on all future correspondence with the REB office.

Congratulations and best wishes in conducting your research.

Rosanna Langer, PHD, Chair, Laurentian University Research Ethics Board

Appendix B

SEX OFFENDER TREATMENT PROGRAMME REGIONAL TREATMENT CENTRE (ONTARIO)

TREATMENT CONTRACT

I, _____ FPS# _____
of _____ Institution consent to participate in a 7 month sexual offender
treatment programme at the Regional Treatment Centre (Ontario).

The treatment programme has been explained to me. I understand that I will be admitted to the RTC (O) to take part in a treatment programme consisting of both group and individual therapy. Treatment will address my assessed needs and may cover areas such as

- 1) Autobiography
- 2) Victim Awareness
- 3) Relapse prevention
- 4) Human Sexuality
- 5) Social Skills
- 6) Arousal Reconditioning
- 7) Psychopharmacology

As well, I understand that the completion of pre and post-treatment phallometric testing is considered an important part of the treatment process and will be required.

I understand that as part of the program requirements I will be asked to present my autobiography in group. This presentation will include information regarding my offense history. In cases where information regarding the autobiography contradicts or is significantly different than information contained on file the clinical team reserves the right to question such discrepancies.

I agree to cooperate fully in treatment, and understand that failure to participate in either individual or group sessions may lead to my discharge. I also agree to follow unit rules, which include abstaining from the use of drugs and alcohol, no verbally or physically threatening behaviour directed toward other inmate/patients or staff, and respecting the confidentiality of those involved in treatment. Violation of these rules may be seen as grounds for dismissal from the programme. I will be given a copy of the unit rules upon admission.

I understand that approximately mid-way through the programme my progress will be reviewed in a formal case conference and I will be given feedback regarding my progress at this time. As well, I may expect feedback regarding my progress in treatment on a more informal basis throughout treatment.

While completion of treatment in no way guarantees an offense-free future, completion of properly designed treatment programmes has been shown to lead to reductions in both sexual and non-sexual re-offending in comparison to untreated groups.

I understand that one of the functions served by the RTC (O) is to provide training for students from various educational facilities in the area. As a result some of the people with whom I interact during the treatment programme may be students here on placement.

LIMITED CONFIDENTIALITY

I understand that professional confidentiality will be maintained, but there are important limitations to that confidentiality. I understand that the information obtained in treatment will be summarized in a report and that anything I say may be quoted in that report. I also understand that the Treatment Team will consult with my Case Management Team during the treatment process. The Final Treatment Report will be placed on the Psychology, Treatment Centre, and Case Management files, as well as on the CSC nation-wide computer system (OMS). I also understand that a copy of the report is available to me. I understand that case management staff, the National Parole Board and anyone else with legal authority will have access to the report. For example, in the event of a release which the Warden considers to be a high risk release, and in the case of detained offenders being released on Warrant Expiry, information contained in the report may be included in information released to community treatment facilities and the police.

I understand that the Treatment Team, as professional, may be obliged by law to report to the appropriate authorities any disclosures made by myself that reveal in sufficient detail any previously unreported offense.

I also understand that if there is concern that I might harm myself or someone else the treatment team is obliged to intervene even if confidentiality must be broken.

I understand that under the Ontario Child and Family Services Act a professional, must report child abuse to a Children's Aid Society. Therefore if I give specific information about child abuse that is not already known to Children's Aid, that information might need to be given to Children's Aid.

RESEARCH

I understand that the results of my participation in treatment and assessment may be used for research purposes. However, I have been assured that such results will not be made public in any way which may identify me personally.

PROGRAMME COMPLETION

Upon completion of the treatment programme I will be returned to my parent institution. Institutional transfers will not be initiated from the RTC (O). Additionally, participation in the treatment programme in no way guarantees favorable decisions for detention reviews, PFVs, transfers or conditional release.

Note: The programme is not considered to be completed until the final reports are finished.

Thus, you may be required to stay at the RTC for a period of time after the completion of the groups.

I understand the above, and have had the opportunity to ask questions, and hereby agree to the treatment which is being offered me.

I understand that I am free to withdraw from the treatment or participation in research at any time that I choose.

SIGNED: _____
DATED: _____
WITNESSED: _____
NAME OF WITNESS: _____

Appendix C

Coding Decisions for Recidivism Data

Sexual Offences

- Sexual Assault
- Sexual Interference
- Invitation to Sexual Touching
- Sexual Exploitation (if hands on)
- Child Pornography (possession, distribution)
- Indecent Phone Call
- Sexual Assault Causing Bodily Harm
- Sexual Assault with a Weapon
- Attempted Rape
- Aggravated Sexual Assault
- Gross Indecency
- Indecent Assault
- Voyeurism
- Incest

Non-Sexual Violent Offences

- Assault Causing Bodily Harm
- Assault with a Weapon
- Attempted Murder
- Murder

- Manslaughter
- Criminal Negligence Causing Death
- Kidnapping
- Abduction
- Forcible Confinement
- Aggravated Assault
- Choking
- Administering a Noxious Substance
- Assault Causing Bodily Harm
- Assault with a Weapon
- Assault
- Assaulting a Peace Officer
- Armed Robbery
- Robbery with Violence

Non-Violent Offences

All Other Convictions that are not Violent or Sexual

- Obstruct Justice
- Robbery
- Arson and Fire Setting
- Threatening
- Threatening with a Weapon, Dangerous Use of or Pointing a Firearm
- Theft over \$5000
- Theft Under \$5000

- Mischief
- Fraud
- Break and Enter
- Possession of a Prohibited or Restricted Weapon
- Procuring a Person for or Living on the Avails of Prostitution
- Trafficking Narcotics
- Dangerous or Impaired Driving
- Causing a Disturbance
- Obstructing a Peace Officer
- Theft of a Credit Card
- Wearing a Disguise with Intent to Commit an Offence
- Forgery
- Identity Theft
- Attempted Theft
- Attempted Break and Enter
- Possession of Break-in Instruments
- Harassment
- Harassing Phone Calls
- Intimidation
- Forcible Entry
- Possession of a Weapon/Firearm
- Pointing a Firearm
- Possession of a Scheduled Substance

- Production of a Scheduled Substance
- Personation with Intent to Gain Advantage
- Carry a Concealed Weapon
- Use of a Firearm
- Overcome Resistance
- Deal with Firearm or Restricted Weapon Contrary to Regulations
- Attempt to Obstruct Justice
- Possession or Use of Forged Documents with Intent
- Possession of Counterfeit Mark
- Double Doctoring
- Council to Commit Robbery
- Utter Forged Document
- Care/Control of Motor Vehicle While Impaired
- Unlawful Assembly
- Flight While Pursued
- Take a Motor Vehicle Without Consent
- Unlawfully in A Dwelling/House
- Disqualified Driving
- Escape Lawful Custody
- Unlawfully At Large
- Prowl by Night
- Conspiracy to Commit an Indictable Offence
- Imitation Firearm

- False Pretences under \$5000
- Failure or Refusal to Provide Sample
- Possession of Proceeds or Proceeds of Property Obtained by Crime
- Failure to Comply