

Treatment responsivity in criminal psychopaths

Despite general pessimism in the research community about the effectiveness of psychopathy treatment,⁽²⁾ correctional staff are encouraged to pursue intervention (treatment or incapacitation) with psychopathic offenders for a variety of legal and ethical reasons.⁽³⁾ Perhaps the most important of these reasons is that criminal psychopaths have a high rate of violent recidivism.⁽⁴⁾

This article, therefore, reviews current issues in the identification, treatment and management of criminal psychopaths - highlighting the apparently moderating effect that a diagnosis of psychopathy has on offender compliance with, and response to, treatment. Assessment The primary assessment tool for psychopathy is the Hare Psychopathy Checklist (revised), a 20-item rating scale that assesses information from offender files and interviews. Each item is scored based on its presence "within" the offender (ranging from 0 = not present, to 2 = completely present).

This instrument has proven reliable⁽⁵⁾ and, perhaps most important, it identifies a more specific group of offenders than other assessment strategies (such as the Antisocial Personality Disorder criteria).⁽⁶⁾ As a result, the checklist is being increasingly relied on across North America to diagnose psychopathy. However, it may be somewhat optimistic to believe that this more stringent diagnosis yields a homogeneous group of offenders with respect to treatment needs.⁽⁷⁾

The focus on personal characteristics conceptualizes psychopathy as a personality disorder with enduring traits, suggesting that treatment should focus on personal change and control rather than on a medical cure.⁽⁸⁾ In short, treatment should involve a risk-management approach.⁽⁹⁾

Treatment might, therefore, be best viewed as part of a broader risk-management strategy, particularly for high-risk offenders. Risk is not reduced by treatment as much as managed by the offender's improvement in self-regulation⁽¹⁰⁾ and by the monitoring and avoidance of highrisk situations in the community.⁽¹¹⁾

This concept has been successfully applied to both sex offenders⁽¹²⁾ and offenders with substance abuse problems,⁽¹³⁾ and researchers have considered its use with violent offenders.⁽¹⁴⁾ However, the specific role of this relapse-prevention approach in enhancing treatment requires further investigation.

Finally, if treatment outcome studies are to be meaningfully compared, a standard assessment strategy must be adopted. However, the use of the Hare Psychopathy Checklist (revised) in assessing personality change may be limited by the restricted nature (0, 1 or 2) of its item scoring and its focus on lifetime traits and behaviour.

Improved measurement techniques are, therefore, needed to better identify treatment targets and assess gains, preferably through a multi-method approach. Treatment targets should be criminogenic needs, not merely symptoms, although the reduction of symptoms is important to improving the offender's quality of life.⁽¹⁵⁾ Treatment effectiveness Treatment integrity is central to treatment effectiveness. However, theory is not static, and programs considered state of the art may eventually find their integrity

diminished as the field of study evolves. For example, programming may include elements (such as nude encounter groups) that would no longer be included in contemporary programs.

Recent studies⁽¹⁶⁾ have also revealed that psychopaths tend to exploit unstructured programs, masking their resistance with verbal skills. Further, psychopaths have been found to have much higher attrition rates than nonpsychopaths.⁽¹⁷⁾ These results would seem to be related to the apparent lack of treatment effectiveness with psychopaths, and are major obstacles for correctional workers trying to provide appropriate intervention.

Unfortunately, few examinations of the effectiveness of intervention with criminal psychopaths have met high methodological standards (such as the use of control groups or multiple-outcome measures).⁽¹⁸⁾ However, recent efforts to address these concerns found no decrease in recidivism with improved methodological rigour.⁽¹⁹⁾

This is certainly disconcerting, but it should not overshadow recent theoretical advances, nor compromise our understanding of good correctional treatment.⁽²⁰⁾ Despite increasing consensus as to the assessment of psychopathy and the characteristics of good correctional programming, the treatability of psychopaths remains unresolved.

For example, a recent study⁽²¹⁾ revealed that although Antisocial Personality Disorder tends to reveal itself while an individual is still young (80% of the study sample experienced their first symptom by age 11), half of this study sample no longer experienced symptoms by age 29 (80% by age 45). Unfortunately, the more specific diagnosis of psychopathy is more resistant -there is limited reduction in symptoms over time.⁽²²⁾

A further concern is that the reliable measurement of treatability seems problematic.⁽²³⁾ One study has proposed, however, that treatability components (such as an offender's prior response to a strategy) be specifically examined to move beyond general impressions of whether an offender is "treatable."⁽²⁴⁾ The use of certain self-report measures also appears promising (see the Baxter article in this issue). Responsivity Treatment responsivity emphasizes matching a particular intervention to an offender.

Consideration of criminogenic needs and risk levels are intended to optimize effective treatment. It has, however, been argued that psychopaths have a particular style of interpersonal interaction and manner of processing information that must be considered in designing treatment.⁽²⁵⁾

This would certainly help explain the recurring difficulties of psychopaths' noncompliance with treatment. To these offenders, treatment is often merely a vehicle for securing particular goals (such as early release or a shorter sentence), not a process in and of itself.

Most treatment providers recognize this self-centred motivation for "commitment" to treatment but, regardless, few are completely pessimistic about the usefulness of the treatment. Many do, however, differ as to the form such treatment should take.⁽²⁶⁾

One consideration is that laboratory evidence of passive avoidance deficits (failure to learn to avoid

negative events, by not responding) suggests that psychopaths are more reward- or incentive-oriented, and will persist in pursuing a goal despite cues to the contrary.⁽²⁷⁾ It is also, therefore, probably unrealistic to expect psychopaths to learn to pause and reflect.

Psychopaths' persistent rulebreaking behaviour and egocentricity would also seem to make them immune to appeals based on morality or concern for others, and recent suggestions that psychopaths have deficits in emotional language skills⁽²⁸⁾ hint that this impoverishment may have a neurological basis.

If psychopathy does affect treatment effectiveness, then perhaps an analogy can be drawn between psychopaths and low functioning offenders. Treatment programs specifically developed for low-functioning offenders match treatment to these offenders' ability to process and integrate information (see the Boer article in this issue). Clinicians view these offenders as having a disability and skill deficits that interfere with their ability to interact with people more appropriately.

If psychopathy is similarly viewed, then treatment becomes, in part, the recognition of, and compensation for, the offender's disability - with the goal of improving the offender's interaction with others.

Along the same lines, substance abuse treatment has turned toward challenging offender beliefs using a problem-solving framework,⁽²⁹⁾ while sex offender programming routinely forces the offenders to resolve any issues of denial or minimization *before* treatment begins.⁽³⁰⁾ These strategies could arguably be adapted for use in treating psychopaths. Discussion Criminal psychopaths have proven to be a highly resistant group of offenders. Existing intervention strategies have been largely ineffective, and methodological improvements alone seem unlikely to generate substantive gains. As well, the recognition of general responsivity factors should limit unsophisticated conclusions about treatment gains.

There are some suggested means of treating psychopaths, such as the incorporation of cognitive-style research into the assessment and treatment processes, but they require judicious implementation. Further, the identification of specific treatment targets must be improved.

Finally, the measurement of the treatment process and any resulting gains must be improved before progress can be expected. Hopefully, recent gains in our understanding of assessment, the course and duration of psychopathy, and the obstacles to intervention will also result in more effective programs.

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