

Treatment of Psychopathy: Reality or Oxymoron

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A partnership of:

Outline of Talk

- Treatment makes psychopaths worse?
- Evidence for efficacy of risk reduction treatment for psychopaths ?
- Any clearer if we stand back and look?

Treatment makes psychopaths worse

Fact? Myth? Controversy?

Treatment Program for Personality
Disorder offenders institutionalized at
Panetanguishene Mental Health
Centre, Panetanguishene Ontario,
Canada

Psychopathy and Recidivism Following Treatment

(Rice, Harris, & Cormier, 1992)

- Release from a program for personality disordered offenders
- Intensive group/individual therapy; 80 hrs/wk
- Minimum 2 yrs in program
- 176 treated patients; 146 untreated control patients

Treatment Program for Personality
Disorder offenders institutionalized at
Panetanguishene Mental Health
Centre, Panetanguishene Ontario,
Canada

A CBC video

The authors of the research said...

“The present results strongly suggest that the kind of therapeutic community described in this paper is the wrong type of program for serious psychopathic offenders”.

“The present results belie conventional wisdom about the immutability of psychopathy and show that inappropriate institutional environment for psychopaths can actually increase criminal behavior”.

Rice, Harris, Cormier, 1989, p 22.

(A maximum therapeutic community for psychopaths, Mental Health Centre, Penetanguishene, underline not in original text)

Does Treatment Really Make Psychopaths Worse? A Review of the Evidence

D'Silva, Duggan & McCarthy. *J. Personality Disorder*, 18 (2), 2006

A literature search ...produced 24 studies and ...none met our standard for an acceptable study. We conclude ...that the commonly held belief of an inverse relationship between high-scores on the PCL-R and treatment response has not been established. (abstract)

Psychopathy and Therapeutic Pessimism?

- Salekin (2002)
 - Systematic review of 42 treatment studies on psychopathy
 - Disagreement on defining features of psychopathy
 - Etiology not well understood
 - Few empirical investigations and even fewer follow up studies
 - “little scientific basis for the belief that psychopathy is an untreatable disorder” (p. 79)

Difficulties in working
therapeutically with offenders with
psychopathic traits

Therapy interfering behaviours among offenders with psychopathic traits

- Manipulations, lying, conning
- Irresponsibility
- Staff splitting
- Glibness, superficial charm/flirtatious
- Attempts or threats of self harm
- Anger, abusiveness & aggression

Consequences?

Treatment drop-out

Psychopathy and Treatment Noncompletion

Olver, Stockdale and Wormith (2011, *JCCP*)

- Meta analysis of 114 offender attrition studies
 - Psychopathy among the strongest predictors of noncompletion

Predictor	r_w	n	k
ASPD	.14	3,148	16
Psychopathy dx	.29	290	3
PCL-R	.18	782	6

Psychopathy & Treatment Drop-out

Olver & Wong (2009, *JCCP*; 2011, *Psychology, Crime & Law*)

- Psychopathy, treatment drop-out and recidivism, examined in 154 treated sex offenders

PCL-R rated on the sample sex offenders

- Total: $M = 20.2 (7.4)$
 - Attrition rate of 14.9%
 - Psychopathy significantly predicted drop-out
 - $r = .21$ for psychopathy dimensional score & drop-out
 - 26.7% psychopathic offenders failed to complete, which means 73.3% did complete

Psychopathy and Treatment Drop-out

Olver & Wong (2011, *Psychology, Crime & Law*)

- Psychopathy predicted noncompletion over and above measures of sex offender risk
- Affective facet a particularly strong predictor of noncompletion
- Responsivity issue

PCL-R facet	<i>r</i>	<i>B</i>	SE	Wald	<i>e^B</i>	95% CI (Lower, Upper)	
Interpersonal	.18*	-.029	.175	.027	.972	.690	1.37
Affective	.31**	.330	.165	3.99*	1.39	1.01	1.92
Lifestyle	.20*	.112	.137	.668	1.12	.855	1.46
Antisocial	.19*	.093	.115	.657	1.10	.876	1.38

* $p < .05$, ** $p < .01$

What happens if they do complete?

Olver & Wong (2009, *JCCP*) [PCL-R > or < 25 for psychopathic groups]

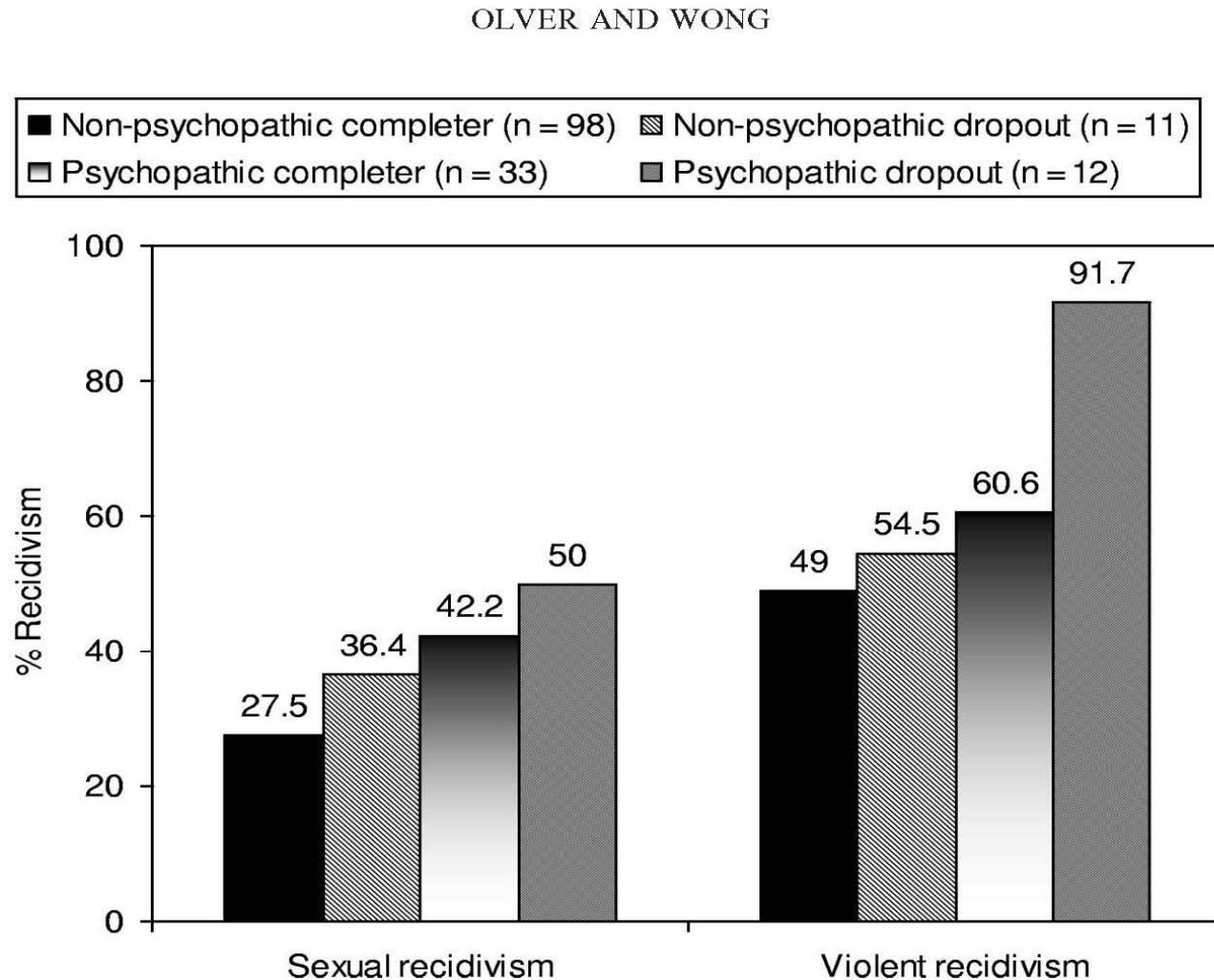


Figure 1. Relationship of dropout to sexual and violent recidivism as a function of psychopathy.

Unless we know where we want to go, we
won't know how to get there

Mark Twain

Treatment Objectives

Psychopaths are often detained because of the risks of their violent behaviours rather than the disorders of their personality.

Objectives in treatment of offenders with psychopathic traits

- Reduce risk of violence & sexual violence through treatment interventions
- Reduce violent & sexual recidivism in the community

Functional Impairments.

WHAT TO CHANGE ?

Using PCL-R - operational definition of psychopathy

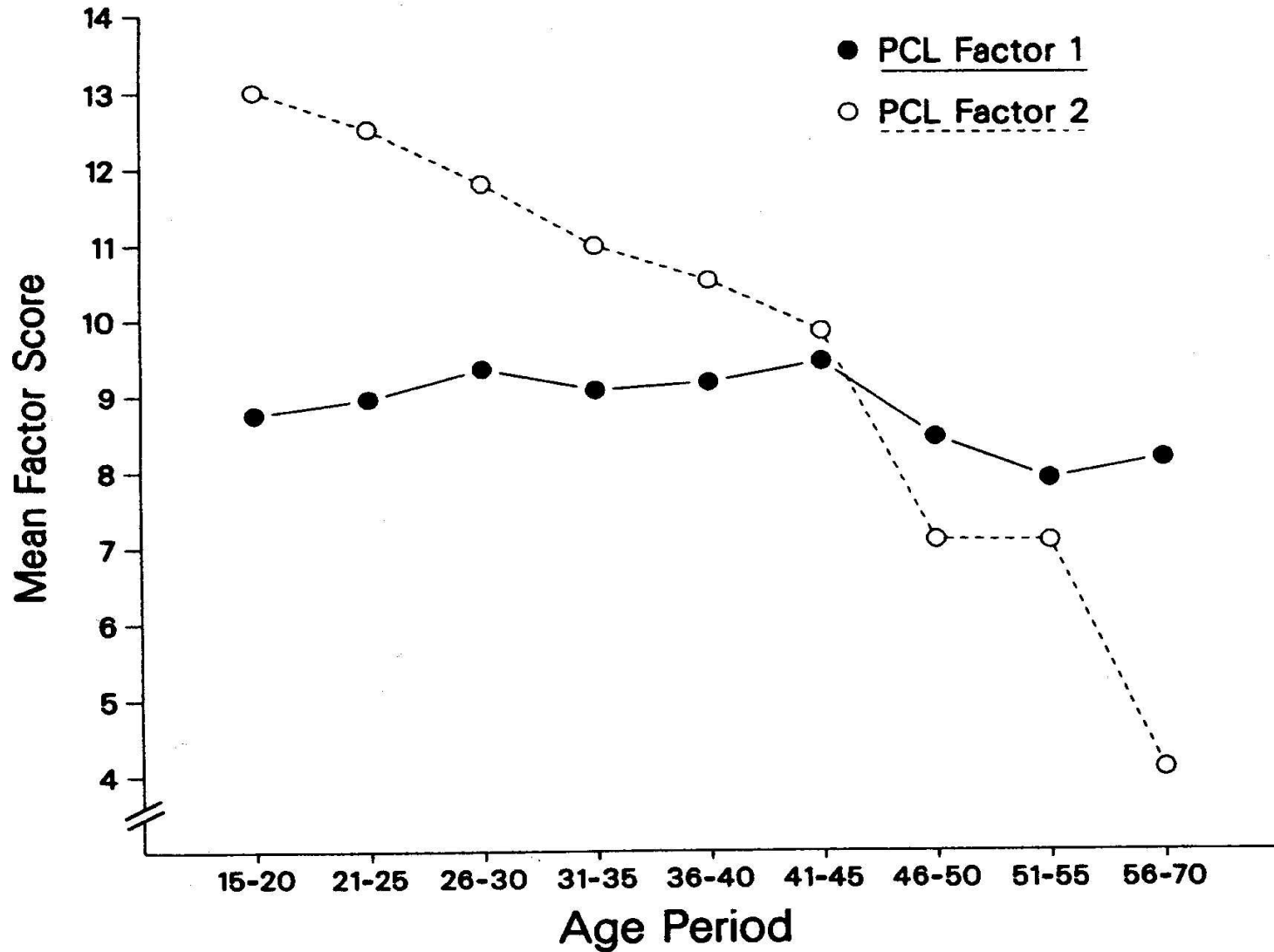
- Change Factor 1 ? Change traits or (**Traits extremity**) (Hart)
- Change Factor 2 ? Change lifestyle/antisociality linked to violence (**Functional impairment**)
- Change both ? Interaction of F1 and F2?

The focus of change should be on something

1. Likely to be changeable
2. Positive change lead to reduction in violence

How much can F1 & F2 change?

PSYCHOPATHY: EFFECTS OF AGE



To what extent are F1 and F2 linked to violence?

Assess links of F1 and F2 to violent reoffending: meta analyses

(Yang, Wong & Coid, 2010, *Psychological Bulletin*)

- Used multilevel regression model & within subject design to address earlier methodological issues.
- Assess F1 and F2 links to violence reoffending
- Total 28 studies; 174 effect sizes; Ss 6,223 to 6,348 minimum.

Effect sizes

(Yang, Wong & Coid, 2010,)

- PCL-R AUC .65
- F1 AUC .56 *Confidence interval overlaps with .5*
- F2 AUC .67

- F1 did not appear to be linked with future violence for men
- F2 significantly linked to violence

Is there an interaction between F1 & F2 in predicting violence beyond simple additive effects in violence prediction?

Kennealy et al., 2010 *Psychological Assessment*

- For those who are quite high risk, does having core psychopathic traits (F1) increase risk of violence ?
- Meta analyses: 32 effect sizes; n=10,555

Is there an interaction between core psychopathic characteristics (F1) and social deviance (F2) in predicting violence?

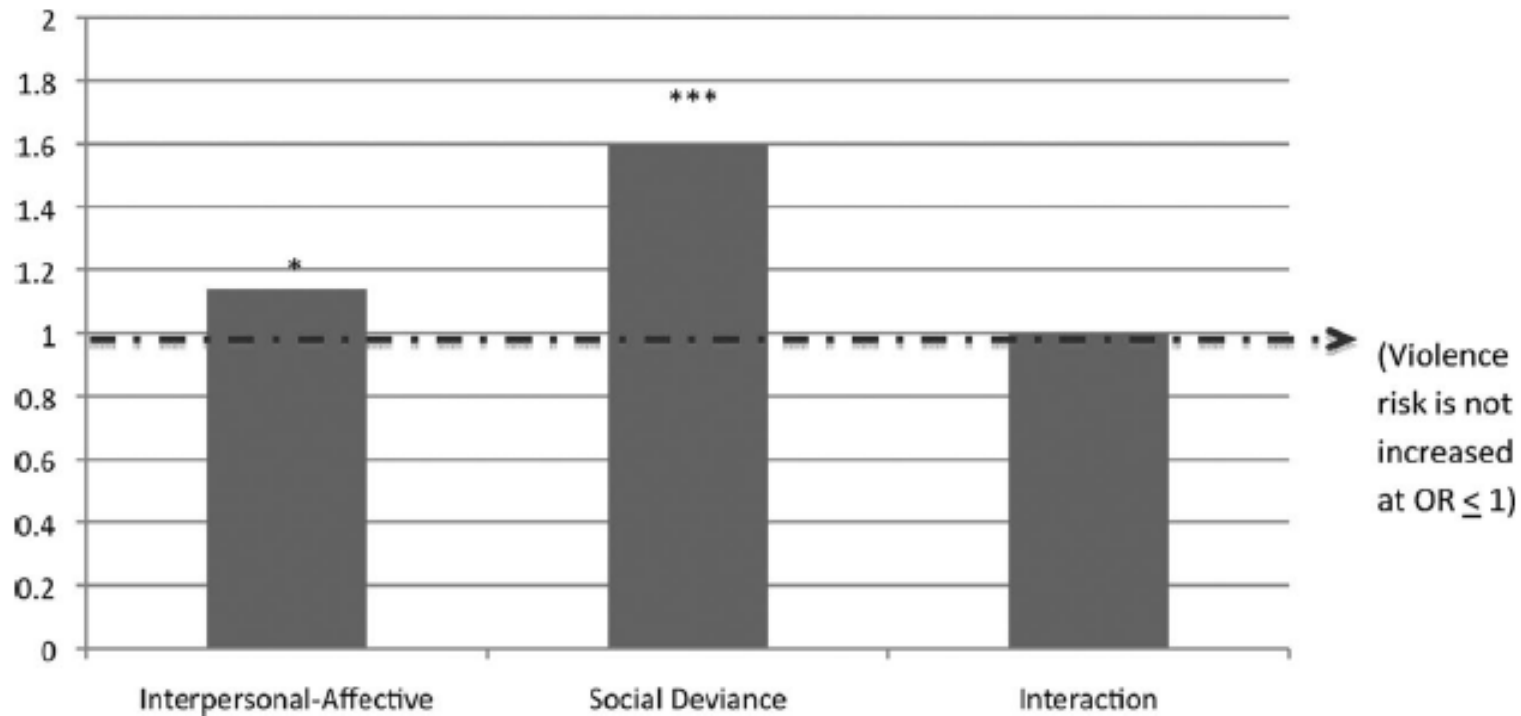


Figure 1. Unique utility of PCL scales and their interaction in predicting violence, based on 32 effect sizes. The figure depicts the “clinically significant” odds ratio, indicating any increase in the odds of violence for every one standard deviation increase on the PCL scale or interaction. PCL = Psychopathy Checklist; OR = odds ratio. * $p < .05$. *** $p < .001$.

F2 $d = .40$; F1 $d = .11$; interaction = .00

F1 & F2 did not interact to increase power in predicting violence.

F2 would predict better than F1 or interaction in 81% & 96% of studies.

Core F1 psychopathy traits & treatment outcome?

- Possibly a responsivity factor.

“The emotional facet in Factor 1 of the PCL-R and never being married were found to be the most salient predictors of treatment dropout and correctly identify about 70% of the cases”.

Olver & Wong, 2011 *Psychology, Crime & Law*.

Objectives in treatment of offenders with psychopathic traits

- Reduce risk of violence & sexual violence through treatment interventions targeting F2 – criminogenic issues

For sexual & non-sexual offenders:

Need dynamic risk tools to

- Assess risks of violence/sexual violence
- Identify treatment targets
- Measure treatment change & associated risk changes

Violence Risk Scale (VRS) &

Violence Risk Scale – Sexual Offender version (VRS-SO)

(Wong, Gordon, Olver, Nicholaichuk)

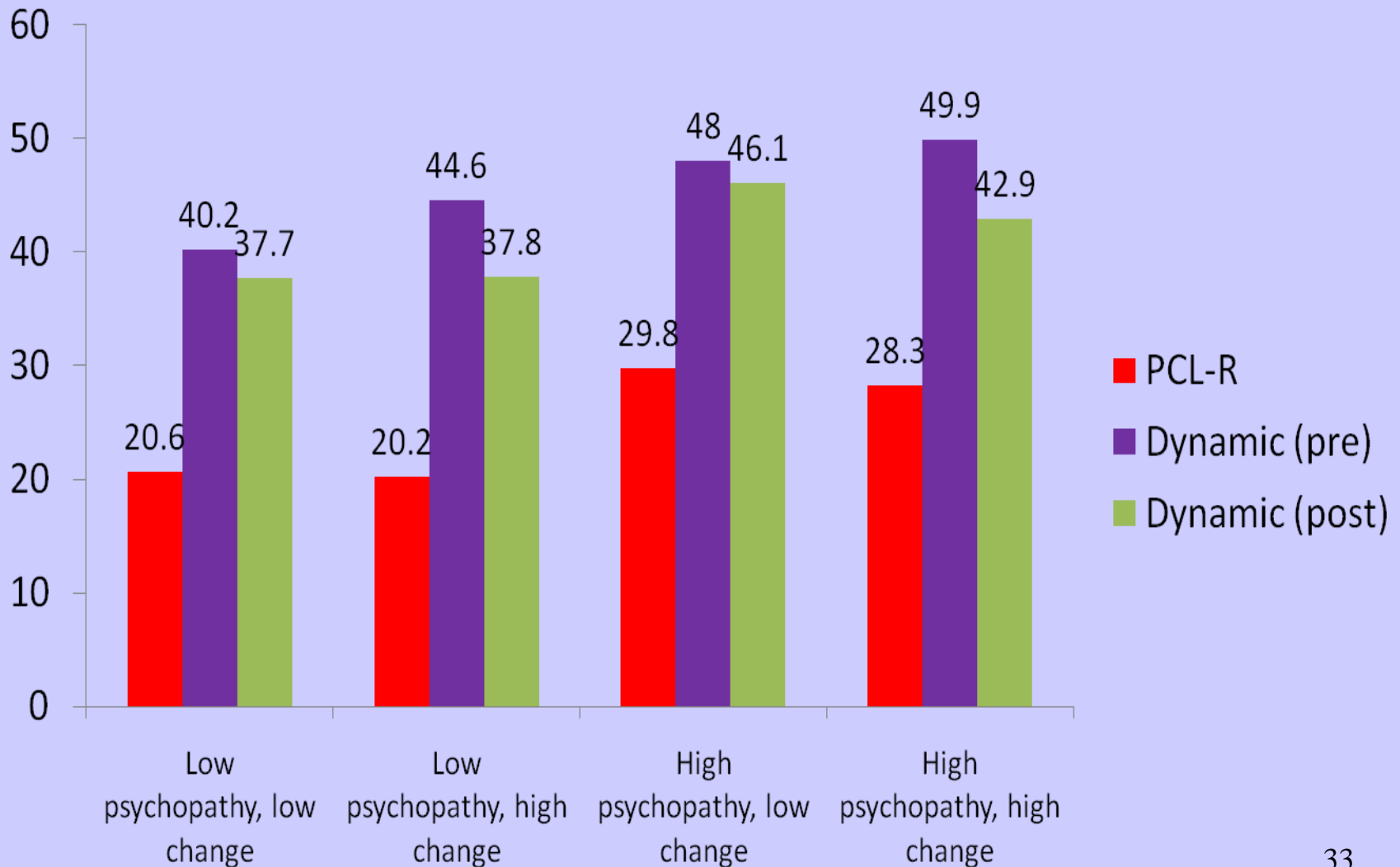
Therapeutic Responses of Psychopathic Violent non-sexual Offenders

VRS assessed treatment change & violent recidivism in a high risk psychopathic sample

(Lewis, Olver, & Wong, accepted ; *Assessment*)

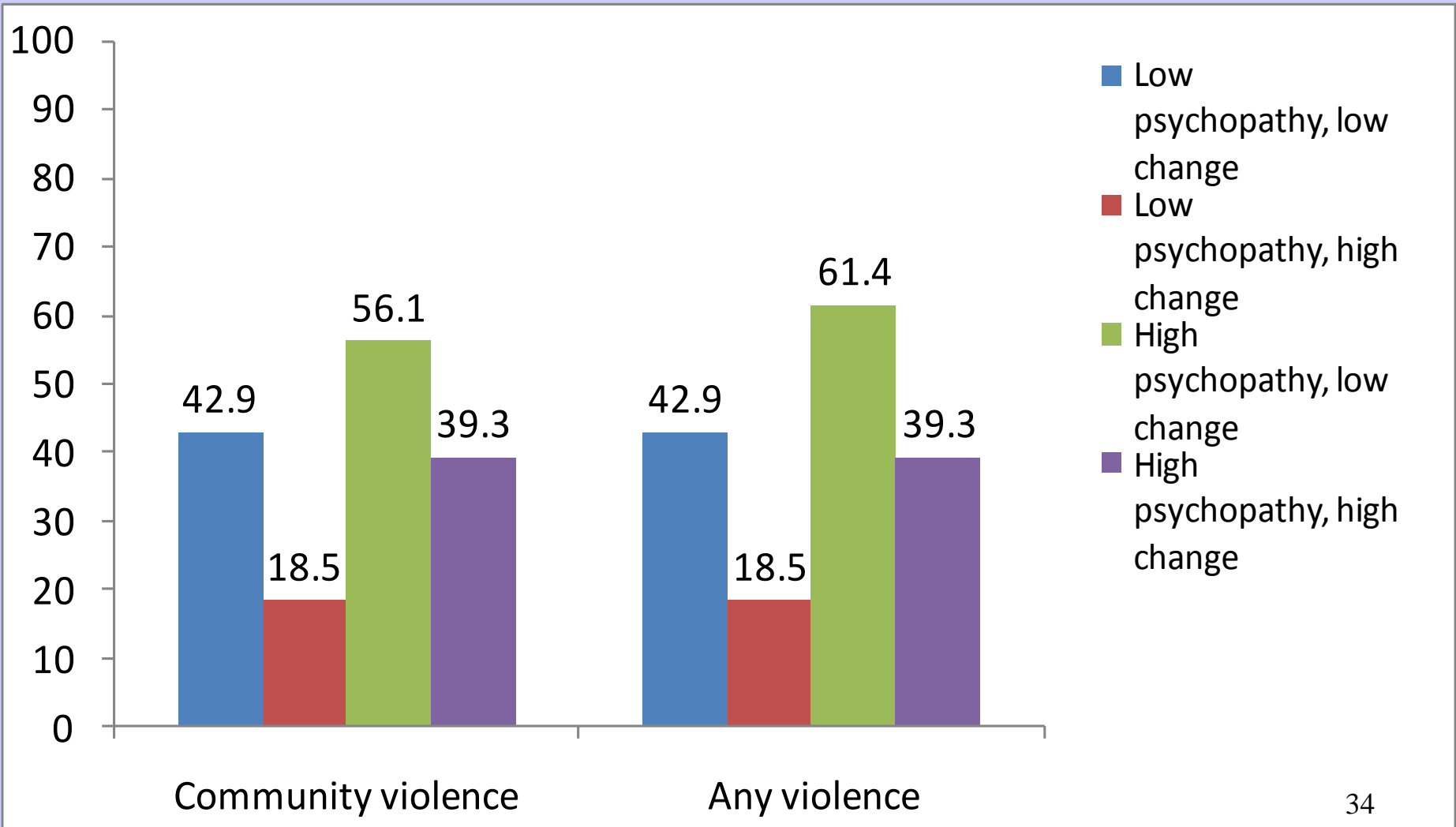
- 152 male federal offenders received in-patient violence risk reduction tx in max secure hospital in Canada
 - treatment prgm 6-8 months; target criminogenic needs, use CBT relapse prevention approaches. Based on RNR principles.
 - *VRS used to measure risk & risk change in tx (file review)*
 - 94% VRS score >50; mean score =61 (DSPD VRS mean score = 61 [Kirkpatrick et al., 2009])
 - 64%, PCL-R >25
 - 27% PCL-R > 30; sample mean PCL-R = 26 (DSPD mean 28.3 [Kirkpatrick et al., 2009])
- Followed up mean 6.6 yrs in community.
 - Outcome variables: violent & non-violent re-convictionsPolice records verified by fingerprinting.

Comparisons of PCL-R, VRS dynamic item totals, and change scores across four psychopathy-change groups

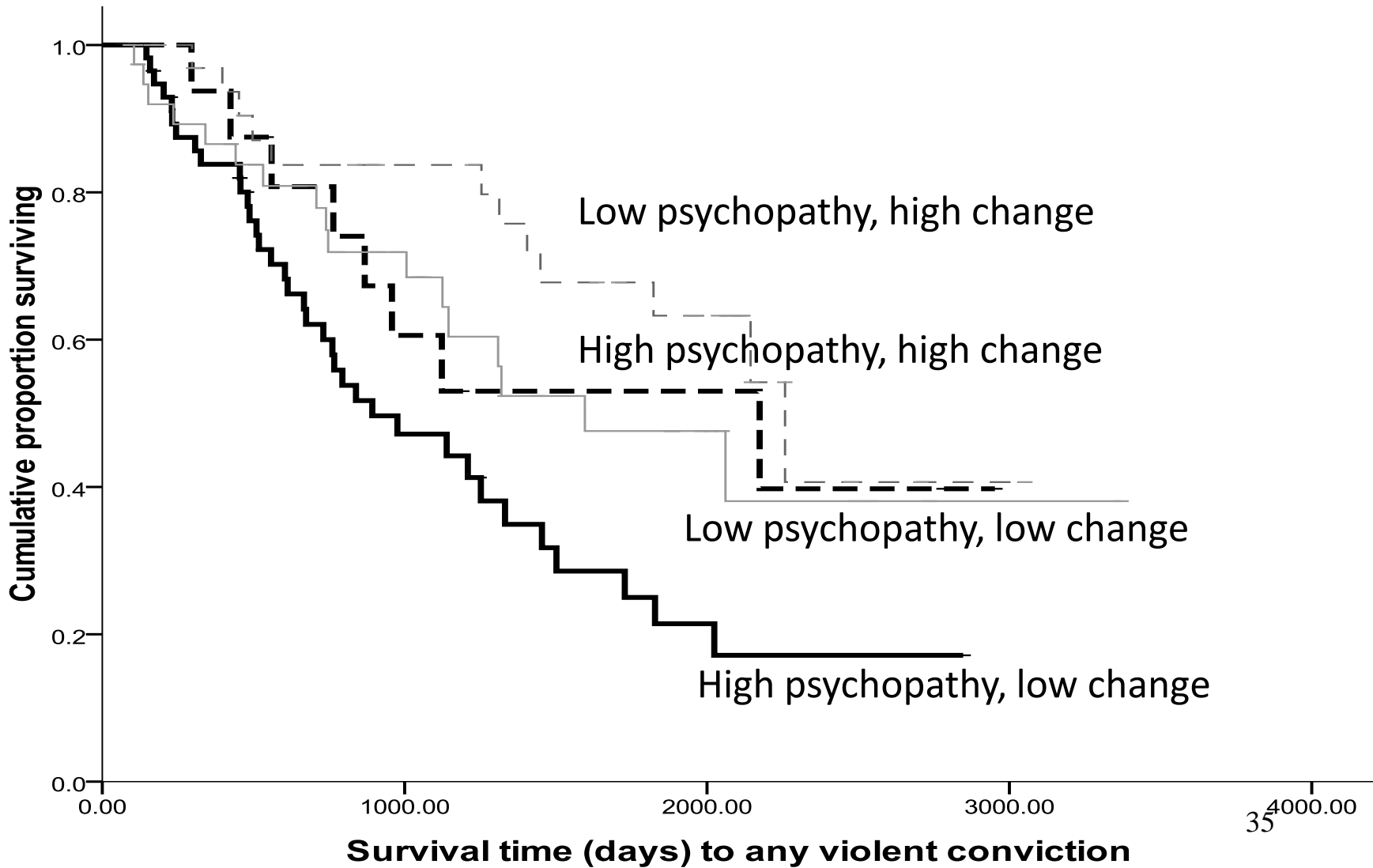


Rates of violent recidivism as a function of level of psychopathy and change over a fixed 3-year follow up

Lewis, Olver & Wong, accepted; *Assessment*



Survival curves: Any violent recidivism as a function of treatment change and psychopathy



PCL-R descriptives and relationship to treatment change

PCL-R	<i>M</i>	<i>SD</i>	Range (lower, upper)	Percentile	<i>r</i> VRS change
Interpersonal facet	3.5	2.1	0 – 8	56.3	-.18*
Affective facet	5.4	1.8	0 – 8	66.4	-.30**
Lifestyle facet	6.8	1.5	1 – 9	66.7	-.14
Antisocial facet	7.9	1.7	1 – 10	80.0	-.18*
Factor 1	9.0	3.4	1 – 15	57.1	-.26**
Factor 2	13.0	2.3	1 – 17	58.9	-.20*
Total score	26.0	5.3	6.3 – 36.8	67.2	-.27**
Psychopathy BR					
25 cutoff	63.6%				
30 cutoff	27.3%				

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Psychopathy BR					
25 cutoff	63.6%				
30 cutoff	27.3%				

Results suggest

For a high risk & psychopathic sample (similar to DSPD sample)

- a) Reduction in risk with treatment was linked to reduction in violent reoffending.
- b) Affective facet has a unique association with less change among the 4 facets.
- c) Need to use a dynamic risk assessment tool to assess risk change in treatment.
- d) Use Cox regression survival analysis to control for follow-up time, F1, F2, length of time from treatment to release, and ethnicity, the link between more change - lower recidivism still holds.

Therapeutic Responses of Psychopathic Sexual Offenders

Therapeutic Responses of Psychopathic Sexual Offenders

Olver and Wong (2009; *JCCP*)

PCL-R rated on 156 sex offenders

- Total: $M = 20.2$ (7.4)
 - Rapist/mixed (22.1) vs. Child/incest (16.9)
 - 29% (25-pt cutoff); 13% (30-pt cutoff)
- Factor 1: $M = 6.0$ (3.3)
- Factor 2: $M = 10.0$ (4.3)
- Use Violence Risk Scale – sexual offender version to assess risk and measure risk change

Linking Treatment Change to Sexual and Violent Recidivism Controlling for Psychopathy and Risk (Olver & Wong, 2009, *JCCP*)

	Sexual recidivism						Violent recidivism					
	B	SE	Wald	e^B	95% CI		B	SE	Wald	e^B	95% CI	
					lower	upper					lower	upper
PCL-R	.053	.024	4.77*	1.05	1.01	1.11	.110	.027	16.96**	1.12	1.06	1.18
Change	-.097	.077	1.59	.91	.781	1.06	-.211	.079	7.10**	.81	.693	.946
PCL-R	.016	.027	.348	1.02	.964	1.07	.090	.028	10.24**	1.10	1.04	1.16
Static	.242	.059	16.98**	1.27	1.14	1.43	.152	.053	8.29**	1.17	1.05	1.29
Change	-.191	.087	4.80*	.83	.696	.980	-.277	.087	10.10**	.76	.639	.899

* $p < .05$, ** $p < .01$

Linking Treatment Change to Sexual and Violent Recidivism Controlling for Psychopathy and Risk (logistic regression) (Olver & Wong, 2009 *JCCP*)

	Sexual recidivism						Violent recidivism					
	B	SE	Wald	e^B	95% CI		B	SE	Wald	e^B	95% CI	
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Results suggest

- Risk reductions were evident among sexual offenders with significant psychopathic traits; such reductions were linked to reduction in both sexual & violent recidivism.
- Must use dynamic risk tools to capture change

Summary

- No evidence that *appropriate* correctional treatment makes psychopath worse
- Risk reduction treatment for psychopaths: reality or oxymoron?
 - neither but cautious optimism
- Psychopathic personality traits (F1) interferes with treatment delivery – must be well managed/contained (Responsivity factor)

How do we know if changes have
taken place inside a
custodial/controlled setting?

Offence Analogue Behaviours (OAB)

Offence Reduction Behaviours (ORB)

Gordon, A. & Wong, S.C.P. (2010). Offense Analogue Behaviours as indicator of criminogenic need and treatment progress in custodial settings. In Daffern, M., Jones, L. & Shine, J. (Ed.). *Offence Paralleling Behaviour: An Individualized Approach to Offender Assessment and Treatment*. Wiley.

Olver & Wong (in press). Assessing Sexual Violence Risk and Evaluating Change with the Violence Risk Scale-Sexual Offender version. In H. Hobbeman & A. Phenix (Ed). *Sexual Offenders: Diagnosis, Risk Assessment and Management*, Springer.

OABs (Offence Analogue Behaviors)

- “Re-packaging” of violent/antisocial behaviors (**criminogenic needs**) into facsimile or analogues of them (OABs) because of highly controlled custodial environment.
- Presence of OAB indicates that root problem of antisocial behaviors are still present.
- Reduction of OAB with the appropriate challenges indicates that changes possibly have occurred.
- Treatment should target the individuals OABs.
- Addressing OABs swiftly may avert problems from spiraling out of control.
- Reduction in OABs can be used as proxy measures treatment improvements.
- Monitoring OABs are crucial in a violence reduction treatment regime.

ORBs (Offence Reduction Behaviors)

- ORB are like the opposite of OAB.
- If OABs are the bad behaviors, ORB are the good behaviors.
- Substituting ORBs for OAB should be the overall goal of treatment.
- Treatment improvement should be demonstrated by gradual decrease in OABs together with gradual increase in ORBs.
- It is key in treatment to closely and carefully monitor both OABs and ORBs.

An integrated treatment approach to reduce
the risk of violence of offenders
with psychopathic traits:

Review of some key works
& recommendations

“An integrated approach to treatment of personality disordered offenders”

Livesley, 2007. *Psychology, Crime & Law*

1. Combination of treatment approaches from different models based on evidence or rational considerations.
2. Coordinated and integrated delivery of treatment.
3. Facilitate development of a more integrated & coherent personality functioning

Key recommendations Livesley, 2007

- PD: multiple problem & psychopathology; treatment program – multifaceted. Target specific problems with specific intervention. (one size doesn't fit all!)
- Use both group and individual work.
- Multiple intervention should not be delivered as separate & unrelated modules.
 - “An approach that assigns patients to an array of modules tailored to their individual problems is inappropriate ...” (denies the opportunity for the individual to integrate the learning and develop cohesive personality/behavioral functioning).
- “Development & maintenance of collaborative relationship...” – the core of treatment process. 51

Multi-Systemic Therapy (MST)

Henggeler et al., 1998

- “One of the defining features of MST: attend to system ... associated with identified problems” p36.
- “... a core feature of MST is its emphasis on altering the social ecology of youth and families (to) promote positive adjustments...” p43
- Key features include “...24 hours per day and 7 day-per-week availability of (help)...” p43.
- “Support MST treatment integrity is a priority at all levels of program implementation...” p45
- “..focus on those youth who are truly at high risk ...” p44

Risk, Need & Responsivity (RNR)

Principles: goal to reduce recidivism

Psychology of Criminal Conduct Andrew & Bonta, 1994-2010

- Adjust tx to risk level; provide higher intensity treatment to high risk offenders – Risk principle
- Target criminogenic need for treatment – Need principle
- Attend to general and specific responsivity issues: Responsivity principle (learning style, literacy, tx readiness)
- Maintain treatment integrity
- Build on the offender's strength (Good Life Model, Ward & Maruna, 2007; also see Andrew et al., 2011)



*National Institute for
Health and Clinical Excellence*

Quick reference guide

Issue date: January 2009

Antisocial personality disorder

Treatment, management and prevention

NHS NICE Guidelines for Treatment of Psychopathy & DSPD

- ...Consider CBT focused on reducing offending and other antisocial behaviours...
- ...adapt these interventions by extending the nature and duration of the interventions and by providing booster sessions, continued follow up and close monitoring.
- ...offer treatment of any co-morbid disorders...
- ...staff should receive high level of support and supervision...

Motivational Interviewing (MI)

Miller & Rollnick, 2002

4 Key principles: p36-41

- **Express empathy**
- **Develop discrepancies**
 - Discrepancies between some important pro-social goal & obstacles in getting there (current ‘problem’ behaviors)
- **Roll with resistance**
 - Don’t get into arguments, verbal combats – they love it!
 - Deflect rather than oppose
 - “Take what you want and leave the rest” p40.
- **Support self efficacy**

Relapse Prevention/Harm Reduction

Laws, 1998; also Marlett, Marques

- Identify situations/risk factors leading to lapses and relapses
- Formulate relapse prevention plan to reduce lapses and relapses
- Reduce severity of outcome rather than outright desistance

An integrated treatment approach to
reduce risks of violence of offenders
with psychopathic traits:

Some recommendations

An integrated treatment approach for offenders with psychopathic traits

- Who to treat?
- What to treat?
- How to treat?
- Does it work?

Who to treat?

- Focus on high risk violent offenders (RNR, MST, NICE)
- Assess psychopathy using validated tools:
 - For PCL-R, attend to both F1 and F2 characteristics not just total scores
 - For sexual offenders: assess criminality & sexual deviance in conjunction with psychopathy
- Use dynamic (not static) risk assessment tools that can assess risk & changes in violence risk (RNR, MST)

What to treat?

- Identify clearly all violence linked criminogenic risk & situational factors as treatment targets (RNR, MST, JL, RP)
- Use dynamic risk assessment tools that can assess criminogenic factors linked to violence & changes in violence risk (RNR, MST)
- Identify strengths (RNR, GL, MST, JL)
- Attend to & treat co-morbidity (RNR, JL, NICE, MST)

How to treat?

Treatment programs & delivery

- Provide structured, evidence based or “rationally derived” treatments that address different treatment targets (RNR, MST, JL, NICE)
- Integrate treatment module delivery – no salami tx (JL, MST)
- Use group & individual work (JL, RNR, NICE, MST)
- Maintain treatment integrity (RNR, MST, JL, NICE, MI)

How to treat?

Treatment staff

- Support staff & develop their skills to work with these individuals: (RNR, MST, JL, NICE, MI)
- Responsivity factors: treatment engagement is key (MI, RNR, MST, JL, NICE)
 - Treatment readiness
 - Staff willing & skilled to work with these individuals (MI, JL, NICE)
- Maintain positive working/therapeutic alliance (MI, RNR, MST, JL, NICE)

How to treat?

Treatment ecology

- Attend to system/ecology of treatment: 24/7 (MST)
 - clinical, correctional, support, management staff – staff within the whole environment
- Treatment environment should provide opportunities for offenders to apply and generalize their learning
- Positive behaviors must be recognized & reinforced
- Monitoring offender 24/7 & share information regarding their behaviours – positive & negative (OAB/ORB)
 - Walking the walk or just talking the talk ?

Does it work?

Treatment process and outcome evaluations

- Evaluate treatment outcomes (ALL)
 - Short, medium and long term outcomes – institutional behaviors and long term risk reduction.
 - Reduction of offending + severity & frequency (harm reduction) (RP)

Offence Analogue Behaviours
(OAB)

Offence Reduction Behaviours
(ORB)

Who monitor the OAB/ORB?

Everybody

All staff in contact with the offender

Who should be providing
intervention and help to offender?

Everybody

All staff in contact with the offender

Treatment of Offenders with Psychopathic Traits

- A team approach
- An eclectic combination of what works and what could work
- Skill up staff
- Attend to treatment ecology

Take Home Message

Hope

That's all folks

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