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Evaluation of Treatment Responsivity in a Psychopathic Prison Treatment Sample

A thesis
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ABSTRACT

Although punishment still dominates the criminal justice system, the progression of research on offending and imprisonment has led to a general consensus that rehabilitation programmes are the appropriate method to effectively reduce both recidivism and prison populations. Hence, many effective offender treatment programmes have been developed. This thesis evaluated phase one of a 10 month pilot treatment programme which used the theories and principles of effective programming to develop an effective programme for male high risk violent offenders assessed with elevated psychopathic personality (High Risk Personality Programme; HRPP), a population of offenders that is often regarded as treatment resistant. Specifically, phase one of the HRPP was designed to address the participants' responsivity barriers (namely, antisocial interpersonal style) in order to increase self-efficacy, therapeutic alliance, treatability, and readiness, and to reduce perceived coercion in order to aid engagement and success in treatment. A sample of 11 male HRPP inmates had data collected before and after their 17-week first phase of the 10 month three-phase programme. Treatment contact comprised four sessions per week, including three group sessions of 2.5 hours, and 1 individual session of one hour, as well as a two-hour group cultural session that focused on Maori cultural identity (10 of the 11 men were Maori). The battery of tests employed included the Self-Efficacy Questionnaire; the responsivity and readiness scales of the Treatment Readiness Responsivity and Gain Scale; the Corrections Victoria Treatment Readiness Questionnaire, the Paulhus Deception Scale, and the therapist and client versions of the Working Alliance Inventory Short Form, the Perceived Coercion Scale, and an evaluation questionnaire. Demographic data was also collected. The results indicated that the majority of the participants came to the intervention ready or motivated to change. Perceived coercion remained low throughout the programme, representing the participant's voluntary status. On average participants' levels of self-efficacy and treatability (except callousness) improved significantly over the course of the treatment. Differing levels of improvement were found for the client and therapist perspective of the therapeutic alliance, indicating they interpreted the alliance differently. Participants with high PCL-R factor one scores showed a decrease in coercion, compared to an increase by their counterparts with low PCL-R factor

one scores. Participants with high PCL-R factor one scores also had higher overall scores on the CVTRQ readiness measure, and the participant's perspective of the therapeutic alliance. Individually, six of the treatment participants made significant improvements on at least five of the seven responsivity measures. These findings and their implications for treatment of psychopathic offenders are discussed, along with the relevance of the study's responsivity measures, the strengths and limitations of the research project, and future research in this area.

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CHAPTER ONE

A Review of the Literature

1.1 Introduction

Historically, and with varying degrees of success, prisons have been used to punish, segregate, deter, and apply retribution to offenders for crimes committed. However, research now suggests that a punitive approach to crime is not the answer to reduce the multifaceted problem of reducing both crime and prison populations (Andrews & Bonta, 2006). A more effective focus may be of rehabilitation which occurs through, among other things, developing and implementing effective programming.

New Zealand (NZ) has a number of offender rehabilitation programmes for its growing prison populations but none that are specifically designed for the "criminal psychopath", an often serious repeat offender with interpersonal and affective personality deficits (e.g., lack of remorse). A conservative estimate suggests that, due to many considerations (e.g., cultural tolerance), these offenders constitute approximately 10% of prison populations (Wilson, 2003). This thesis evaluated the efficacy of a 17 week responsivity phase (phase one) of a 10 month pilot programme, developed in an attempt to treat violent imprisoned offenders with a PCL-R score of 27 or more (likely psychopathic offenders) in NZ.

The following literature review will describe and critically review previous literature on the methods of effective offender treatment programming. It will also review the concepts and latest theory regarding the treatment of psychopathic offenders. Research on factors, such as readiness and therapeutic alliance, that are theorised as necessary in order for offenders to succeed in treatment, are also reviewed.

Three issues are important to consider before starting this thesis. First, although it is more commonly accepted to use the term 'high risk or high needs offender', the label "psychopath", which is regarded by many as derogatory, has been used, as this research targeted the criminal psychopath. Thus, the use of this term is not meant in a derogatory fashion. Second, although psychopathy and Antisocial Personality Disorder (APD; American Psychiatric Association, 2000) have an asymmetrical overlap and are often incorrectly used interchangeably (Ogloff, 2006), this study focuses on psychopathy pertaining to criminal

behaviour and excludes the use of the APD diagnostic criteria. Third, although the author has used NZ research where available, a lack of research in some areas regarding psychopathy and responsivity has necessitated reference to international sources.

1.2 The Principles of Effective Intervention

The main objective of the NZ Corrections' treatment programmes is to reduce recidivism (reoffending). In order to do this NZ Corrections have developed programmes in accordance with empirically derived principles of best practice, including the Psychology of Criminal Conduct (PCC), the Risk, Needs, and Responsivity Principles (RNR) model (Andrews & Bonta, 2006), Programme integrity, Professional discretion, Cognitive Behavioural Therapy (CBT), and a Framework [developed] for Reducing Reoffending by Maori (FReMO; McFarlane-Nathan, 1999).

The PCC is used by NZ Corrections and many other countries around the world, as it is an empirically based theoretical foundation that helps explain and predict offending, and hence aids the rehabilitative process. The PCC is a culmination of some robust theories, such as Bandura's social learning theory, Sutherland's differential association theory, and Skinner's operant conditioning theory (for a summary of the theories see Andrews & Bonta, 1998, 2006). The PCC is based on the general premise that criminal attitudes and behaviours can be developed by associating with, and imitating, procriminal others. In addition, an increase in and generalisation of procriminal behaviour is generally a product of success and reinforcement (Andrews & Bonta, 1998, 2006; Ogloff & Davis, 2004). The five principles of classification for effective correctional treatment (risk, need, responsivity, programme integrity, and professional discretion) fit within this model.

The RNR model was developed by Andrews, Bonta, and Hoge (1990) as a response to Martinson's denigration of the effectiveness of correctional treatment programmes. Although treatment outcomes vary (Andrews, Zinger et al., 1990; Fishbein et al., 2006), and the model has limitations in regards to motivation and recognition of personal strengths (Ward, 2007), the RNR model focuses on risk management, offender rehabilitation, and reducing recidivism, and it is used to guide effective treatments (Andrews & Bonta, 1998, 2006; Dowden & Andrews,

2000; Howells & Day, 2002; Ogloff & Davis, 2004; Ward, Day, Howells, & Birgden, 2004). Although challenged by the Good Lives Model (GLM; see Ward & Brown, 2004), it currently remains the leading empirically based therapeutic model for correctional programmes.

The RNR model's first main principle is that of attending to the "Risk" that an offender presents, when deciding on treatment length and intensity. Essentially, those offenders at higher levels of risk of reoffending should receive longer and more intensive treatment than lower risk offenders (Andrews & Bonta, 1998, 2006; Bonta, Wallace-Capretta, & Rooney, 2000; Dowden & Andrews, 2000; Howells & Day, 2002; Ogloff & Davis, 2004; Serin & Kennedy, 1997). Several primary research studies have been conducted on the risk principle (Bonta, et al., 2000; Dowden & Andrews, 2000; Lowenkamp, Latessa, & Holsinger, 2006) that provide empirical support for its efficacy.

The second RNR principle "Need", for which there is again a considerable level of empirical support (Dowden & Andrews, 2000), is concerned with the areas that need to be targeted in treatment programmes, namely, criminogenic (dynamic risk factors) or noncriminogenic offender needs (Andrews & Bonta, 1998, 2006; Bonta, et al., 2000; Dowden & Andrews, 2000; Howells & Day, 2002; Ogloff & Davis, 2004). Criminogenic needs include dynamic factors, such as criminal attitudes and association with antisocial peers. Noncriminogenic needs include lifestyle variables, such as place of residence and self-esteem that indirectly affect criminal behaviour (Andrews, & Bonta, 1998, 2006). Due to their indirect effect, noncrimogenic needs are considered discretionary treatment targets (Ward, Mann, & Gannon, 2007).

The least researched of the three main RNR principles (Simourd & Hoge, 2000), and the focus of this research, is the "Responsivity" principle. Regarded as a noncriminogenic need (Ogloff & Davis, 2004), responsivity factors can be divided into internal or external factors, and general or specific responsivity factors (Serin & Kennedy, 1997) and involve client and programme characteristics that potentially facilitate, mediate, or moderate the participant's ability to engage or learn from treatment (Day & Howells, 2002). Thus, they are numerable and include, for example, age, culture, criminal experience, intelligence, education, mental stability, vocational training, social background, and personality. Though Hubbard and Pealer (2009) suggest that mental health and personality factors are

the main two responsivity barriers, it is widely acknowledged that any responsivity barrier can consequently affect treatment outcomes (e.g., Day & Howells, 2002).

The fourth RNR principle, “Professional Discretion”, recognises that therapists may have to temporarily depart from the prescribed programme, and use their clinical knowledge to make decisions regarding the client, their behaviour, and situational factors (Ogloff & Davis, 2004) or “override recommendations based on numerical scores alone” (Kennedy, 2001, para. 7). According to their research, Andrews and Bonta (1995) suggested clinical override is used in less than 10% of all programme decisions.

Researchers have established that the RNR model is more effective when there is “Programme Integrity” (Andrews & Bonta, 2006; see also Hollin, 1995). In order to deliver the programmes accurately, staff need to be highly competent, and they need to adhere to treatment protocol when addressing client issues (Day & Howells, 2002). Programmes should also be regularly monitored (Andrews & Bonta, 2006). Programme integrity also helps to create accurate data to facilitate the evaluation of client outcomes and programme development. Gendreau and Goggin (1996) suggest high levels of programme integrity can reduce recidivism by as much as 20-35%, as opposed to the current average treatment effect in correctional settings of 5-16%.

Another principle of effective programming in NZ is being responsive to Māori, who currently represent 14.9% of NZ’s general population (US Department of State Diplomacy in Action, 2010) but represent 51% of NZ’s prison population (Department of Corrections, 2010). NZ Corrections have developed and use a number of strategies to address offending and reoffending by Māori (Maynard, 1999). One of these is FReMO, a framework for reducing Māori offending. FReMO is a guiding document compiled from the Māori perspective, Tikanga Māori, and mainstream literature that is used to guide effective policy, intervention, and research targeted at reducing Māori offending (McFarlane-Nathan, 1999). Thus, NZ Corrections is attempting to address the cultural needs (which may be conceptualized as responsivity needs) of Māori in general, and particularly in interventions. Te Piriti, a sex offender programme, is one such example of a programme that incorporates Māori cultural principles. Moreover, Te Piriti has been evaluated as more effective for Māori male participants than its

mainstream counterpart sex offender programme Kia Marama (Nathan, Wilson, & Hillmans, 2003).

Interventions based on Cognitive Behavioural and Social Learning (SL) theories have been found to provide the best outcomes for general offending (Andrews & Bonta, 2006) and for violent offenders (Andrews, 2006; Dowden & Andrews, 2000; Serin & Preston, 2001). Although there are limitations to the use of Cognitive Behavioural Therapy (CBT), such as the fact that it targets only specific skills and has difficulties with skill generalisation (Lee, 1999), CBT and SL therapies are successful as they represent the psychology of human behaviour and are based on learning new habits, which fits with the PCC and RNR model. Social learning and CBT theories are successfully used in NZ's Kia Marama and Ti Piriti sex offender rehabilitation programmes, and it is suggested that CBT be applied to other classes of offenders as well (Blampied, 1999).

1.3 The Construct of Psychopathy

Whilst all psychopaths are high risk offenders (Hare, 2003), not all high risk offenders meet the criteria for psychopathy. Thus the psychopathic personality offender is a subtype of high risk offender. It is also a phenomenon plagued by controversy, leading to research and debate regarding its aetiology, dynamics, conceptual boundaries, acceptance as a syndrome, and treatability (Hare, Clark, Grann & Thornton, 2000; Lilienfeld, 1998). In fact some authors (e.g., Rice, Harris and Cormier, 1992) have labelled the psychopathic personality as “an essentially untreatable syndrome” (Salekin, 2002, p. 79). In 1988, Cleckley provided a seminal and foundational description for the modern concept of psychopathy. It comprised 16 characteristics:

Superficial charm and good intelligence; absence of delusions or irrational thinking; absence of nervousness; unreliability; untruthfulness and insincerity; lack of remorse or shame; inadequately motivated antisocial behaviour; poor judgement and failure to learn from experience; pathologic egocentricity and incapacity to love; poverty of major affective reactions; specific loss of insight; unresponsiveness in general interpersonal relations; fantastic and uninviting behavior with or without drink; suicide rarely carried out; trivial and impersonal sex life; and failure to follow a life plan. (pp. 338-364)

Many clinicians and researchers base their work on Clecklian psychopathy and there have been attempts to expand and refine the concept. For example, low

anxiety subtypes (primary psychopathy) with strong traits of narcissism, and high anxiety subtypes (secondary psychopathy) involving DSM axis I anxiety and mood disorders, have also been researched and debated (Blackburn, 2007). However, the modern day description of psychopathy has to be credited to Hare (1990), who developed the PCL and PCL-R out of Clecklian psychopathy (Salekin, 2002). Hare suggests that the psychopath's main defining traits are superficial charm, pathological lying, manipulation, grandiosity, callousness, lack of remorse, shallow affect, and failure to accept responsibility (Hare, 2003). Hare also, arguably (see Cooke et al., 2004), "included several items related to criminal behaviour" (Blackburn, 2007, p. 9) in his definition. Research on the concept and the ability to clinically assess the concept continues, but more agreement is needed regarding conceptual boundaries and higher order personality dimensions (Lilienfeld, 1998) as these can impact on defined treatment targets, treatment type to use, and treatment outcomes.

Another subject of debate among clinicians and researchers is the psychopath's treatability. Historically, the psychopath has been labelled as untreatable. However, under the "what works" guise, research on their treatability has resumed with some renewed enthusiasm. Some reviewers (e.g., Losel, 1998) have recommended research be based on more recent conceptual and theoretical developments regarding the PCC and using CBT. Simourd and Hoge (2000) suggested, as a result of comparing a psychopathic and nonpsychopathic sample, that factors of the psychopaths' personality, such as impulsivity, remorselessness, and grandiosity, may guide their learning (be a responsivity barrier) and/or interfere with their ability to succeed in treatment. Hubbard and Pealer (2009) also found, from a sample of 257 single Caucasian males, that those with a number of responsivity barriers, including low self-esteem, history of abuse, and personality problems, showed little prosocial change, and did not significantly reduce their cognitive distortions. The authors also found that responsivity barriers had twice as much impact on the results as risk level. Both Hubbard and Pealer (2006), and Simourd and Hoge (2000), suggested that personality needs should be managed in or prior to treatment.

1.4 A New Direction - Addressing Responsivity

As a result of research on high risk offenders in 2004 and 2005, and his research visits to the Dangerous and Severe Personality Disorders (DSPD) centres in England, N. J. Wilson (personal communication, October 8, 2010) concluded that psychopaths were treatable under certain circumstances, and that their personality pathology was a barrier to treatment engagement. Dr Wilson and the clinicians delivering the pilot treatment initiative used the PCC underpinning philosophy, the five principles of effective treatment, FReMO, and the direction developed regarding intervention type (e.g., CBT), to develop a comprehensive treatment programme for men with a PCL-R score of over 27 (one standard error of measurement from the standard cut-off score of 30; for details see p. 31) in NZ.

The 10 month, three-phase treatment programme, included a preparatory phase (phase one) wherein responsivity barriers, including interpersonal style, were addressed in order to help the participants improve in areas that are known to aid treatment engagement and success in the main treatment phase. Thus, the constructs the facilitators wanted to improve upon in this phase were readiness, responsivity (treatability), therapeutic alliance, self-efficacy, and perception of coercion. These constructs were measured pre- and posttreatment to evaluate both the process the facilitators used and the reciprocal responsiveness of the participants.

1.5 Readiness

Readiness or ‘state of readiness to change’ is a dynamic and multifaceted construct that is relatively new in psychological research. Ward et al. (2004) described readiness as “present when an individual has the ability to enter treatment, respond well, [and] finds relevance and meaning in the programme” (p. 647). Readiness is also suggested to be related to a number of other constructs that affect treatment engagement and outcomes, such as expectancy and compliance (Ward et al., 2004) and motivation and treatability (Serin, Mailloux, & Kennedy, 2007). Ward et al. (2004) also suggests readiness maps well on to Prochaska and DiClemente’s five stages of change (see Prochaska, DiClementes, & Norcross, 1992). Thus, as this phase was a primer phase and psychopaths have been labelled as resistant and very low in readiness, it was seen as appropriate to address and measure this construct.

As with any construct measured in research, many factors can influence its levels. Ward et al. (2004) theorized that internal factors, such as cognitions and volition, may mediate readiness. For example, the authors noted that mental illness positively correlated with attrition. Similarly, lack of empathy, lack of concentration, and lack of engagement, and certain aspect of treatment compliance, such as completing homework, are all associated with lack of readiness, lack of treatment success, and attrition from treatment. It has also been noted that literacy can affect readiness (Howells & Day, 2007; Serin & Preston, 2001). Ward et al. (2004) also theorized that external factors may moderate readiness. For example, appropriate setting factors, including a comfortable well-resourced setting, can improve treatment readiness (Howells & Day, 2007; Serin & Preston, 2001) as can the culture (e.g., staff attitude) in an organisation (Hodge & Renwick, 2002). In fact Ward et al. (2004) stated that readiness may be a function of the degree of support offered to the offender.

Howells and Day (2003, 2007) suggested that the psychopath's personality results in having an extremely low form of readiness for treatment. According to the multifactor offender readiness model (MORM; Ward et al., 2004) their low scores occur on all the internal factors. For example, they have non-existent or low levels of distress and a lack of guilt, shame and remorse. They also have an inability to access, experience, express, and reflect emotions which helps treatment readiness. Moreover, their egosyntonic identity affects their motivation or ability to change (Howells & Day, 2007; Magnavita & Carlson, 2003) and makes them resistant to change (Hemphill & Hart, 2002). The psychopath's apparent lack of readiness and engagement may also be a result of difficulties in forming a therapeutic alliance (Hemphill & Hart, 2002) and comorbidity with DSM:IV-TR axis one disorders (Howells & Day, 2007).

Two measures were selected to represent the construct of readiness for this thesis; the readiness section from the Treatment Readiness Responsivity Gain Scale: Short Version (TRRG:SV; Serin, Kennedy & Mailloux, 2005; see Appendix A) and the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey, Day, Howells, & Ward, 2007; see Appendix B). Serin et al's (2005) readiness measure captures the participants' willingness to engage in treatment, their desire to change, insight into their problems, whether benefits are seen in treatment, interest in treatment, the participants' distress regarding

offending, treatment goals, motivation and perception of support in treatment.

The CVTRQ is a slightly different measure of readiness. It consists of four factors, including attitudes and motivation, emotional reactions, offending beliefs, and self-efficacy, which, together, according to the authors, comprise readiness (Casey, et al, 2007). Each of these measures is relatively new in the industry with the CVTRQ found in more research literature than the TRRG:SV readiness measure. For a discussion regarding the validity and reliability of both measures, refer to pp. 27-28.

Research involving psychopathy and readiness

Few research studies were found involving both psychopaths and readiness. However, research exists on readiness and other related clinical samples, thus these studies were examined to give an indication of the validity of the measures used and expected outcomes. For example, in a study of 418 adult male convicted offenders (no measure of psychopathy employed) in 16 Australian prisons, Williamson, Day, Howells, Bubner, and Jauncey (2003) found from assessing readiness to change regarding anger problems, that “offenders benefited from treatment more when they entered treatment with higher scores on a readiness to change scale.

Day et al. (2009) studied 53 male offenders who attended a semi-intensive or intensive violence treatment programme. Although psychopathy was not measured, Day et al. found that scores on the violence treatment readiness questionnaire (VTRQ) positively correlated with mid-programme treatment engagement ($r = .46$) and self-efficacy ($r = .26$). Scores on the VTRQ also negatively correlated with coercion ($r = -.37$). Those with higher treatment readiness also reported higher levels of treatment satisfaction.

Taft, Murphy, Musser, and Remington (2004) found, from a sample of 107 partner-violent men whose psychopathic tendencies were measured by the Self-Report Psychopathy Scale-II (SRP-II; see Hare, 1990), that scores on ‘readiness to change’ mediated the negative correlation found between psychopathic characteristics and early and late working alliance inventory (WAI) scores. Taft et al. advocated that “participants with low readiness to change may not agree on the goal and task of treatment and may have trouble developing a warm and trusting relationship with someone they don’t agree with” (p. 353). The authors also

suggested “increasing motivational readiness may help enhance the working alliance” (p. 353).

Loza-Fanous (2003) conducted research with 325 minimum-medium security inmates (psychopathic tendencies were not measured) and found, with the exception of disruptive behaviour, that motivation for treatment (as measured by behavioural referents: attendance, level of participation, promptness, mastery of content, disruptive behaviour, completion of homework, and overall evaluation) had a positive influence on treatment participation and success. Disruptive behaviour negatively correlated with motivation, and it is acknowledged in the literature on institutional misconduct that those higher in psychopathy have been found to have more management difficulties (Walters, 2003). Loza-Fanous also found that problem recognition, which is a subfactor of the CVTRQ, was not predictive of treatment success. In fact, the author found that problem recognition negatively correlated with the level of programme participation and mastery of programme content. Thus, the author suggested that participants with high problem recognition may feel that treatment programmes may not resolve their problems.

Although psychopaths are theorised to have low levels of readiness, the research identified suggests that high levels of, or increased levels of readiness, correlate with a number of factors (e.g., satisfaction and engagement) that aid a positive treatment outcome. Readiness has also been found to mediate psychopathy and therapeutic alliance. Thus it would be beneficial in many ways to increase levels of readiness for the participants in this study.

Polaschek (2007) conducted an evaluation of a Violence Prevention Unit (VPU) in NZ, using, among a battery of psychometric tests, the TRRG:SV responsivity and readiness questionnaires. The details of this study are explicated in the following section (responsivity, as measured by treatability).

1.6 Responsivity as Measured by Treatability

High levels of offender responsivity in correctional programmes means that the programme facilitators delivered the treatment programme in a style and manner that the offender: resonated with, responded to, and learned from, and thus progressed in treatment. Responsivity barriers are numerous, however, with this programme the main responsivity barrier was theorised to be the personality of the

client group. The Responsivity component of the Serin et al.'s (2005) Treatment Readiness, Responsivity, and Gain, Short Version (TRRG:SV; see Appendix C) measures "an offender's general interpersonal style" (para. 10). As such, this responsivity measure was deemed suitable as a measure in this study.

Like Hubbard and Pealer (2009), who found that increased numbers of responsivity barriers inhibited prosocial change, many authors (e.g., Meloy, 1998; Simourd & Hoge, 2004; Ward et al., 2004) have suggested it is the personality of the psychopath that inhibits their treatability. For example, Meloy (1998) suggested that as a result of their "stranger object relations" psychopaths may be egocentric and disregard others in their social interactions. Losel (1998) suggested that their callousness and lack of empathy impedes emotional work in therapy, their ability to lie inhibits honest communication, and their superficial charm may also be used to manipulate. Hemphill and Hart (2002) suggested the psychopath may directly or indirectly attempt to dominate others or be preoccupied with a power differential/competitive drive, and hence weaken or sabotage treatment engagement and performance. Moreover, psychopaths have emotional deficits, such as arrogance, superficiality, and lack of introspection regarding their emotions, all of which may inhibit their interpersonal ability. On the other hand, Hemphill and Hart also advocate that psychopaths can be assertive, personable, persuasive, and articulate, and they usually have no cognitive deficits, which make them potentially effective in a prosocial world.

Although the TRRG:SV responsivity subscale does not address the psychopathic personality characteristics per se, it "measures an offenders general interpersonal style" (Serin, et al., 2005, para. 10), and although no convergent correlations of the two constructs were found in the literature, items on the TRRG:SV responsivity component overlap with items on factor one of the PCL-R (see Table 1.1). Serin et al. (2005) created norms for the measure and conducted some validation studies on it. The authors have suggested that the items measured need to be present for a participant to respond well in treatment.

Table 1.1

Comparison of the Items on the TRRG:SV Responsivity Subscale and Factor One of the PCL-R

TRRG:SV Responsivity items	PCL-R Factor one items
Callousness	Lack of Empathy
Denial	Lack of Remorse/Guilt
Procrastination	Grandiosity
Intimidation	Pathological Lying
Power and control	Shallow Affect
Rigidity	Superficial charm
Victim stance	Manipulation
Procriminal views	Failure to Accept Responsibility

Research involving psychopathy and interpersonal responsivity barriers

Three research projects were initially found using the responsivity component of the TRRG:SV, however as necessary detail was not present in Ross' (2008) study, the results could not be relayed. Thus, two research studies are summarised: Fishbein et al. (2006) and Polaschek (2007).

Fishbein et al. (2006) studied neuropsychological and emotional regulatory mechanisms underlying differential responses to learning, in a three-stage CBT treatment programme for 224 prison inmates, including offenders classified as psychopaths. The TRRG:SV responsivity, gain and readiness measures were also used to measure altered behaviour in these areas. The authors found that inmates scoring high on psychopathy performed poorly on many neuropsychological tasks, including measures reflecting impulsivity and cognitive inefficiency (for details see Fishbein et al., 2006, p. 21). The high psychopathy group also showed poorer responsivity to treatment (and less treatment gain as evaluated by staff). However, they showed greater improvement on the decision making task and reduced aggression compared to the low psychopathy group. The authors suggest that if participants are unresponsive in treatment, a neuropsychological and emotional attributes assessment may be needed and, if deficits are found, treated prior to or in treatment programmes as participants may not benefit from treatment programmes with such deficits.

Polaschek (2007) evaluated a NZ specialist prison treatment initiative, the Violence Prevention Unit (VPU) programme using a battery of tests including Serin et al's (2005) TRRG:SV (readiness, responsivity and gain measures). Most of the 34 participants were noted as psychopathic according to their high PCL:SV scores and had high violence-related criminogenic needs. Although the author stated the results of the TRRG:SV were poor, the changes were significant ($p < .001$). The pre- and posttreatment readiness means were 10.1 and 12.7 respectively and the pre- and posttreatment responsivity means were 9.9 and 13.2 respectively. Polaschek noted that these scores were lower in all areas than Serin et al's (2005) norms developed on prisoners' entry and completion scores of a cognitive skills programme. Polaschek also suggested that "as the programme measured violence and risk of violent recidivism the best measures were those that represented risk of violence or future violence. Thus, the TRRG:SV subscales were not sensitive to the focus of the VPU study, but as they changed by a similar amount they demonstrated a rehabilitation need" (p. 42). The results reiterate the need to use measures that represent the focus of the treatment initiative.

1.7 Therapeutic Alliance

Therapeutic alliance (TA) was evaluated in this study, as evidence shows that the TA (the "bond" that exists between the client and the therapist showing that they are working well together) is related to treatment success across varying treatment types and samples (Fuertes et al., 2007; Martin, Garske, & Davis, 2000). In fact, Bordin (1979) and others since (see Gelso & Carter, 1994; Marshall & Burton, 2010) have asserted that the TA is the core mechanism effecting therapeutic change; and accounts for one quarter of the treatment variance, regardless of treatment modality according to Horvath and Luborsky (1993) and most of the variance in treatment outcome, according to Preston (2000). Though Ward (2007) suggested, the therapeutic change depends on an offender having enough trust to absorb the skills and lessons of the therapy. Kennedy and Serin (1997) wrote that the TA affects compliance, motivation, readiness, and treatability. Thus therapeutic alliance affects treatment success.

Miller and Rollnick (2002) advocated it is the assessment and interpretations (dissonance) of dyadic factors in the therapeutic environment that produce resistance which impacts on the TA and outcomes. Thus, resistance is a

product of the client's interaction with the therapeutic environment. Factors in the dyad may include therapist characteristics and roles (e.g., warmth and directiveness), client characteristics and perceptions (e.g., history and expectations), client and therapist interactions, setting and contextual factors, the immediate therapy environment, programme factors, and group treatment (Miller & Rollnick, 2002; Ross, Polaschek, & Ward, 2008). It is not surprising, then, that level of social skill has been found to be related to the TA (Mallinckrodt, 1991). Different styles of attachment can also effect the therapeutic alliance (for a discussion see Ross et al., 2008). Taft et al. (2004) also found that fewer hostile-dominant interpersonal problems, married status, higher age and income, and volunteered attendance predicted higher working alliance ratings.

Several process factors (which, according to Miller & Rollnick, 2002, should facilitate the dyad) have been found to influence the therapeutic alliance. For example, Taft, Murphy, King, Musser, and DeDeyn (2003) found that group cohesion correlated to working alliance inventory (WAI) scores in a sample of partner-violent men. In a related study, Hersoug, Hoglend, Monsen, and Havik (2001) found that similarity of personal characteristics is not related to TA, but that similarity in values which may converge as the therapy progresses influences the clients' rating of the TA. Also, a preset therapy agenda can depersonalise a client, and thus negate the TA (Ross et al., 2008). Although a substantial amount of research conducted on psychopathy occurred prior to the CBT era (Salekin, 2002), existing research evidence suggests that the psychopath has many features that negate the formation of an effective working alliance.

Although psychopaths can display charm and mimic good interpersonal skills they also have great difficulty developing meaningful relationships with others (Hemphill & Hart, 2002). Andrews and Bonta (1998) and Preston and Murphy (1997) suggested that their suspicion, mistrust, egocentricity, deceit, and lack of insight into their own problems make them less amenable to the formation of an effective TA. In fact, these attributes make them treatment-resistant (Losel, 1995; Meloy, 1998; Skeem, Monahan, & Mulvey, 2002; Ward et al., 2004). Historical behavioural references for their lack of alliance have included countertransference reactions that compel classification and exclusion (Meloy, 1998), disruptive behaviour in treatment (Ward et al., 2004), and premature

attrition and termination from treatment (Serin & Kennedy, 1997; Ward et al., 2004).

Thus, research suggests that the therapeutic alliance is dynamic and malleable through a number of factors, and that the therapist can facilitate the development of the alliance, particularly when aware of the factors that contribute to it. Research also suggests that, although the psychopath shows social ability which can positively impact on the development of the alliance they can also have underlying attributes such as mistrust, that can create resistance and make it challenging for the facilitator to develop the alliance. As such, the development of the alliance is an important factor in this study.

The client and therapist version of the Working Alliance Inventory Short Form (WAI: S; see Appendix D & E respectively) were employed to investigate the TA. Tichenor and Hill (1989) found the WAI straight-forward to use, and found it had the advantage of measuring differing perspectives. For a definition of the measure, and descriptions of its validity and reliability, see p. 29.

The different research results obtained from using different perspectives of the WAI has created debate over whose perspective is most valid. Whilst some authors (e.g., Martin et al., 2000) maintain that it makes no difference who predicts the TA outcome, others (e.g., Horvath & Symonds, 1991; Taft et al., 2003) have found that the client is the best predictor of the therapeutic outcome. Ross et al., (2008) also found that the client's perception of the therapist and their qualities affects the TA and treatment effectiveness. In contrast, Tichenor and Hill (1989) suggested the WAI-T and WAI-C score perspectives were not related, and thus are not interchangeable. Gelso and Carter (1994) also suggested that the rating discrepancies are expected due to the different client and therapist roles, and intrapsychic and interpersonal reactions.

Research involving psychopaths and the therapeutic alliance

Few studies were found that examined psychopaths and the working alliance. However, other samples, such as violent partners with psychopathic tendencies, have been studied and were considered in this literature review. Studies examined the impact on intervention on the therapeutic alliance, as well as correlated psychopathy scores with WAI outcome scores.

Taft et al. (2003) studied the therapeutic alliance of a sample of 107 partner-violent men, some with psychopathic characteristics, engaged in a CBT

programme. Therapeutic alliance was measured pre- and posttreatment by the therapists and participants. Using the WAI-S, the therapists' pre- and posttreatment ratings were 54.21 and 55.47, respectively. Using the 36-item WAI, the participants' pre- and posttreatment WAI ratings were 193.77 and 201.56, respectively. As these two measures have been found to be interchangeable (see Busseri & Tyler, 2003) an aggregate of the WAI scores from Taft et al.'s study was calculated to compare the scores to the WAI-S used in his and this study. The pre- and posttreatment aggregate of the WAI was 64.59 and 67.19, respectively. The aggregate mean difference for the participants' ratings was 2.6. The mean difference for the therapist WAI-S was an improvement of 1.19. The authors did not relay whether any of the mean differences were statistically significant.

Taft, et al. (2004) studied the same sample of 107 partner-violent men, some with psychopathic characteristics, and found that higher age and marital status positively correlated with late client and therapist WAI ratings. Taft et al. (2004) also found that psychopathic characteristics negatively predicted WAI ratings both early and late in therapy, and that interpersonal problems did not mediate this relationship, whereas readiness to change did. Taft et al. suggested that participants with low readiness to change may not agree on the goal of, and tasks involved in, the treatment, and may have difficulties developing a warm and trusting relationship with someone they do not agree with. These authors and others (e.g., Day et al., 2009; Joe, Simpson, & Broome, 1998) suggested that the working alliance may be established or predicted via enhancing motivational readiness to change.

Ross (2008) studied the therapeutic alliance of 50 high risk violent offenders in NZ. Before 15 participants withdrew, 52% of the sample scored above 18 on the PCL:SV (Hart, Cox, & Hare, 1995; the score with a high correlation to a diagnostic score for psychopathy in the full measure, the PCL-R). Although Ross found a positive linear correlation over four time periods on all three WAI perspectives for her sample, she found the WAI Observer version (WAI-O) to be most accurate. For the psychopathic subgroup, a significant negative correlation was found between their PCL:SV total scores and the WAI-O. Ross also found significant positive correlations between Serin et al.'s (2005) treatment readiness measure and WAI-O scores, and motivation to change and WAI-O scores (for scores see Table 1.2, Ross, 2008). Ross found that

criminal attitude mediated the effect of ‘motivation to change’ on the WAI, and psychopathy mediated criminal attitude, although this did not reach statistical significance.

Table 1.2

“Bivariate Correlations of Offender Client Profiles and WAI-O Scores”
(Ross, 2008)

WAI	Goal	Task	Bond	Total score
PCL-SV Total score	-.30*	-.30*	-.26*	-.31*
Treatment Readiness	.04	.05	.22	.12
Motivation	.53**	.48**	.46*	.53**

* $p < .05$; ** $p < .01$

1.8 Self-Efficacy

Self-efficacy, the belief in one’s own performance ability, is an idiographic cognitive attribute that “is required for an offender to be able to engage in treatment, change their behaviour and feel confident about maintaining it” (Chambers, Eccleston, Day, Ward, & Howells, 2008, p. 281). It also contributes significantly to readiness (Bandura & Locke, 2003), and motivation (Bandura, 1995) and affects a treatment’s ability to reduce criminogenic needs (Ward et al., 2004). Thus it was deemed a barrier to treatment that needed to be addressed in this pilot programme.

Bandura (1995) advocated that a person's belief in their abilities or self-efficacy influences their attempts at, and avoidance of tasks, as well as correlates with effort applied and persistence or abandonment of tasks by the person in question in the face of difficulties. Bandura (1986) also advocated that self-efficacy can be task or context specific, and can be influenced by incentives. Moreover, people motivate themselves in response to their anticipated outcome by use of forethought and control processing. Thus, people plan and act in response to the goals they want to achieve (Bandura, 1995) and those with higher self-efficacy expend more energy and persist more with their goals (Loza-Fanous, 2003). Finally, Bandura (1986, 1997) claimed that once established, efficacy

abilities tend to generalize to related situations, as well as to buffer occasional failures.

Chambers et al. (2008) suggested that offenders have various levels of self-efficacy regarding offending and prosocial behavior. The authors also suggested that in order to develop beliefs supportive of changing to prosocial behavior, offenders first have to go through the process of taking responsibility for their offending behavior, and have to want to change. Otherwise, previous experience in programmes may also affect their self-efficacy beliefs. Hemphill and Hart (2002) advocated that attributes such as arrogance, the psychopath's desire for and tolerance of novelty and a desire to feel superior to others may also motivate them to achieve.

For the current research the Self-Efficacy Questionnaire (SEQ; refer Appendix B) was employed. Developed by Loza-Fanous (2003), the SEQ is comprised of eight questions designed to measure a person's confidence in task performance in a treatment setting (higher scores indicate higher levels of confidence). For a discussion on the validity and reliability of the SEQ refer to page 27.

Research involving psychopaths and self-efficacy

Three studies were found involving psychopathy and self-efficacy. In the Loza-Fanous (2003) and the Sappington (1996) studies, the percentage of psychopaths is unknown (although the Sappington study used high-security prisoners) hence the relevance to the present sample is unclear. Also in each study self-efficacy is applied to the situation differently, hence care is needed when comparing these studies result's to the present study.

McMurran et al. (1998) studied self-efficacy, self-esteem, and motivation, as measured by Prochaska and DiClemente's stages of change (see Prochaska, et al., 1992), in 115 mixed gender classified psychopaths in a psychiatric hospital. The authors found that self-efficacy correlated significantly with the 'action stage' of change ($r = .31$; $p = .001$). Other authors (e.g., DiClementes & Hughes, 1990) proposed that high self-efficacy in the precontemplation and contemplation stages may be a sign of denial and minimization of the problem. McMurran et al. (1998) also found self-efficacy and maintenance to be negatively correlated. The authors suggest the negative correlation denotes difficulties at that stage.

Sappington (1996) conducted research on 48 maximum security prisoners

(mean length of sentence = 21.9 years; no psychopathic tendencies measured), who had attended anger management classes. Among other demographic variables, the author measured the relationship between self-efficacy beliefs, response outcome variables, and adjustment in prison. The author found that “those who believed their behaviour did not effect their treatment and those who believed they could not control their actions were likely to have more adjustment problems [in prison]” (p. 60). The author also found that low levels of both self-efficacy and self-regulation were particularly pertinent to the older inmates and longer time-serving prisoners in the sample.

Loza-Fanous (2003) conducted a study on 325 minimum- and medium-security offenders (psychopathic tendencies were not measured) who were attending various treatment groups (e.g., substance abuse and cognitive skills programmes). Loza-Fanous tested whether treatment participation and success were predicted by a number of responsivity factors including, self-efficacy. Loza-Fanous used simple and multiple regression analysis and controlled for demographic and risk variables. It was found that context specific self-efficacy was a predictor of programme participation and success as measured by attendance, level of participation (accounting for 9% of the variance), mastery of content (4% of the variance), completion of homework (5.3% of the variance), and overall evaluation (3.7% of the variance). In contrast, Loza-Fanous found that promptness and disruptive behavior, “the two variables most influenced by external factors” (p. 109), were not predictors of programme participation and success. Loza-Fanous also found that high problem recognition, a subfactor of the CVTRQ, may hinder programme participation and hence success. Loza-Fanous suggested that participants with high problem recognition may feel that treatment programmes may not resolve their problems.

Sappington’s (1996) results suggest that understanding the effect of one’s behaviour and belief in performance ability clearly impact on change to prosocial behaviour. Similarly, Loza-Fanous’ (2003) results suggest that the presence of self-efficacy is predictive of programme success as measured by behavioural referents such as programme participation and completion of homework. Thus, self-efficacy is an important factor to measure in this research as it would likely impact on the study’s results.

1.9 Coercion

Coercion is a well-researched factor in the criminal justice system. The term is often used interchangeably with terms such as: officer recommendation, compulsory programmes, legal pressure, and being mandated to take certain programmes. It is also suggested that the very essence of being in the criminal justice system means coercion exists (Wild, 1999), whilst others (e.g., Gardner et al., 1993) suggest that coercion is subjective and depends on the client's experiences and perceptions. Thus, coercion was measured in this study to note the degree of client voluntariness and any impact this may have on treatment effects.

Several considerations, for example treatment intensity, can impact on coercion, and hence treatment outcome (Parhar, Wormith, Derkzen, & Beauregard, 2008). However, in general, voluntary entry into treatment programmes maximises the participants' attitude regarding the programme (Rigg, 2002; Winick & Wexler, 2002), suggests intrinsic motivation, and appears to increase a person's chance of treatment success (Winick & Wexler, 2002), regardless of the setting (Parhar et al., 2008). On the other hand, pressure to attend treatment generally involves external motivation, and can negatively influence treatment outcomes (Day, Tucker, & Howells, 2004), particularly in custodial settings (Parhar et al., 2008). There are, of course, exceptions to the rule; Farabee, Prendergrast, and Anglin (1998) and Prendergrast, Farabee, Cartier, and Henkin (2002) both found that involuntary participants gained equivalent success to their voluntary counterparts in drug treatment programmes.

Several authors have also studied motivation in relation to coercion. Prendergrast et al. (2002) suggested that high levels of coercion do not mean an absence of motivation, whereas Parhar et al. (2008) indicated that motivation and coercion may be confounded when assessing mandated versus voluntary treatment. In a different light, Day et al. (2004), Parhar et al., and Wild, Newton-Taylor, and Alletto (1998) suggested that motivation is part of a process when mandated to treatment, whereby offenders move on a continuum from extrinsic motivation (coercion) to intrinsic motivation, where they internalise motivating values and self-regulation (if treatment is delivered appropriately). The internal motivation acquired lasts after the external contingencies are removed and aids treatment success.

A large amount of literature was found regarding factors that influence coercion. For example, Day et al. (2004) suggested a person's personality, being fully informed about treatment, perceived unpleasantness of treatment, and understanding the objective of the legal system can all influence their perception of coercion. Wild et al. (1998) found that referral source can influence perception of coercion. High levels of trait reactance (resistance to threats against freedom) impacts perceived coercion and the likelihood of poorer treatment success (Dowd, Wallbrown, Sanders, & Yesenosky, 1994). Parole eligibility and lowered security classification also influenced participation in rehabilitation programmes (Day et al., 2004; Grubin & Thornton, 1994).

Although the participants in this study were volunteers, the perception of coercion may still have been present. For example, as prisoners mainly serving lengthy prison sentences, they may have felt less than free to decline to participate in treatment, or they may have felt pressured through a corrections officer's recommendation. Offenders can also be motivated towards achieving a lower security ranking or obtaining early release via parole (Day et al., 2004; Grubin & Thornton, 1994). Due to their interpersonal style, psychopaths may also feel coerced when cooperating or submitting to treatment demands (Daffern et al., 2010; Daffern, Howells, & Ogloff, 2006).

The Perceived Coercion scale (PCS; see Appendix B) was chosen to examine coercion. Based on the Minnesota Perceived Coercion Scale (MPCS), which was developed out of psychiatric hospital entry interviews, the PCS used in this study was adapted to offending, and it comprised seven items, two more than the MPCS. The questions attend to the participants' perceptions regarding the seven domains: influence, control, choice, freedom, motivation, hope, and idea, that together comprise the construct of the adapted PCS. The PCS is regarded as easy to use amongst a battery of tests and is considered psychometrically sound (Daffern et al., 2010; Gardner et al., 1993).

Research involving psychopaths and perceived coercion

Two studies were found to illustrate psychopathy and coercion. Daffern et al. (2010) studied the coercion levels of 39 psychopathic participants mandated indefinitely to a secure psychiatric hospital. Contrary to their hypothesis, the authors found that levels of perceived coercion at admission (using the MPCS; mean = 3.03) were comparable to other involuntary civil hospital admissions and

forensic study clients (see Hoge et al., 1997; McKenna, Simpson, & Coverdale, 2003). Thus, the sample “was not sensitive to the demands of hospitalization including adherence to routine, engaging meaningfully in treatment, and relinquishing interpersonal dominance” (p. 440). The authors acknowledged methodological limitations, such as limited variability in perceived coercion, and the perceived coercion scores taken in only one time period. The authors also suggested that “admitting coercion may have undermined the participant’s reputation as autonomous and dominant individuals” (p. 440).

Rigg (2002) conducted a study regarding coercion and motivation, with 30 high and low risk sex offenders who were attending two separate sex offender treatment programmes (psychopathy was not indicated in the sample). Rigg measured coercion using the Admissions Experience Interview (AEI), the scale from which the PCS was adapted. The AEI comprises a 30 minute interview, that involves both open-ended and structured components and four summary questions (which are in the PCS), where the participant chooses from a range of answers. The motivation questionnaire was a compilation of questions, selected from several different psychometric tests that covered reasons for attending treatment programmes. Rigg found that the mean level of coercion for those attending treatment was .76 from a possible score range of 5.5 ($SD = 1.16$). Rigg also found that although the majority of participants felt free to refuse treatment, some offered explanations for feeling coerced such as the parole board suggesting attending programmes in order to be considered for parole. The mean score for motivation was 3.4 from a range of 4 ($SD = .1$), and the mean score for amotivation from the same range was .3 ($SD = .1$). The largest external motivating factor for attending treatment in this study was the prospect of a transfer to a lower security prison area, particularly for the high risk offenders.

Although this study involved a sex offender sample it gives an indication of an attainable coercion score for a voluntary sample, as well as a possible main reason for attending treatment. With a mean of .76 from a range of 5.5, the aggregate from a range of 7 would be .96. Moreover, an aggregate for the Daffern et al. (2010) study, which was 3.03 out of 5, would be 4.2 out of 7. Thus, in this study, gaining a PCS mean score of .96 would be consistent with attending voluntarily or uncoerced and a mean score nearer 4.2 would be consistent with attending involuntarily.

1.10 PCL-R Factor One Scores as a Mediator of Treatment Success

The PCL-R is known as the ‘golden standard’ for measuring psychopathy (Morana, Arboleda-Florez, & Camara, 2005). Its validation includes identifying psychopathy dimensionally, as a taxon, and assessing risk of recidivism. Studies have also analysed the effects of high scores on each of the two principle factors contained in the measure (Hemphill & Hare, 2004). This includes, depending on the context in which they are evaluated, PCL-R factors one and two contributing to violent and general recidivism (Hemphill & Hare, 2004) and high scores on factor one, which measures dimensional personality traits, mediating the positive effects of treatment (Hobson, Shine & Roberts, 2000; Morana et al., 2005). Rice et al. (1992) stated many years ago, from evaluating the performance of psychopaths in a therapeutic community, that psychopaths learn more about manipulating and deceiving others in treatment than they do about helping themselves. Thus, as this was a treatment programme for psychopaths, it was appropriate to measure the mediating effects of PCL-R factor one scores.

Research evidence involving mediation effects of PCL-R factor one scores

From a NZ study of 199 offenders, Wilson (2003) found a high negative correlation between PCL-SV factor one scores and time to reimprisonment for violent offences ($r = -.41$). That is, the offenders with higher PCL-SV factor one scores were quicker to be reimprisoned for violence.

Hare, Clark, Grann and Thornton (2000) provided details of an English prison study, where a psychopathic sample was divided into low (cut off score nine) and high PCL-R factor one groups. The authors found that treatment had no effect on the low PCL-R factor one group. However, the high PCL-R factor one group who undertook treatment had a higher rate of recidivism than their no treatment high factor one counterparts. Thus “the reconviction rate for high factor one offenders was 58.8% if they had not been treated, but 85.7% if they had been in treatment ($p < .01$; p. 637).”

1.11 The Research Hypothesis

Phase one of this pilot project, on the rehabilitation of the psychopath, draws on the latest and most efficacious theories and research regarding the PCC, the five principles of effective research, FReMO, CBT and knowledge of the psychopathic personality. It uses this knowledge base to effectively prepare the participants in the areas that have been theorised and researched to help offenders with success in treatment. The research questions developed to evaluate the efficacy of phase one of the treatment were:

1. Will the intervention bring about a stage of readiness to change in the participants?
2. Can the well trained clinicians providing programme facilitation address the participants' responsivity barriers to help increase their levels of self-efficacy, therapeutic alliance, and treatability? Can the clinicians address responsivity barriers to help decrease the participants' perception of coercion?

It has also been theorized by some authors (e.g., Hobson et al., 2000; Morana et al., 2005) that the psychopaths' core personality traits, which are captured in PCL-R factor one scores, make them less amenable to treatment. Thus, another research and evaluation question generated was:

3. Will participants with high PCL-R factor one scores do less well in this initial phase of the treatment programme?

CHAPTER TWO

Methodology

2.1 Ethical approval

Prior to commencing the study, a detailed masters research proposal was sent to the Ethics Committee of the Psychology Department of The Waikato University, as well as the Ethics Committee for External Research within the Department of Corrections, NZ. Both committees reviewed the proposal and granted approval to conduct the research.

2.2 Participants

The participants for this pilot experimental violent offenders programme consisted of 12 volunteer inmates, all male adults from various prisons in NZ. The 12 volunteers met the initial selection criteria of scores of ≥ 18 on the PCL:SV; and/or scores of $\geq .7$ on the Risk of reConviction times Risk of reImprisonment model (RoC*RoI; Bakker, O'Malley, & Riley, 1998), indicating high risk of further serious violent reoffending; and a history of significant instrumental violence. Details of the entry criteria and offence demographics of the participants are shown in Table 2.1. These include the mean, median, mode, and standard deviation of the participants' age, RoC*RoI score, sentence length, number of imprisonments, number of offences, and PCL-SV scores. The PCL-SV (of which only eight were available) was used in the selection process. Where participants were sentenced to non-predetermined sentence lengths of Preventative Detention or Life Imprisonment, the latest available (2006) average statistics for NZ were used for the calculations (6.7 years and 14.3 years respectively; see Morrison, Soboleva, & Chong, 2008). The participants' offence backgrounds ranged from having committed several less serious offences such as motoring offences, theft, and grievous bodily harm, to murder. Of the 12 participants, ten identified as Maori, one identified as NZ European, and one identified as being a Pacific Islander.

Table 2.1

Participants' Offence Demographics

Demographic Variables	Range	Mean	Median	Mode	SD
Age	18-48	28.09	26.0	19, 26, 31, 33	8.47
PCL-SV Score (8 participants only)	17-21	19.13	19.5	20	1.36
RoC*RoI Score	.36-.89	.70	.76	.80	.158
Sentence Length (years)	2.25-14.3	6.75	6.7	3.5	2.52
Number of Offences	5-126	48.90	30.0	30	37.32
Number of Imprisonments	1-8	3.36	4	1, & 4	2.20

NB. A low sentence length mean and a high RoC*RoI mean indicates having committed several minor offences.

2.3 Psychometric Measures

A battery of self-report and interview-style psychometric tests, as well as an evaluation questionnaire, were employed for this experimental programme. These included the Self-Efficacy Questionnaire (SEQ; Loza-Fanous, 2003); the MacArthur Perceived Coercion Scale (PCS; Gardner et al., 1993); the Working Alliance Inventory Therapist: Short Form (WAI-T S; Tracey & Kokotovic, 1989) and Client: Short Form (WAI-C S; Tracey & Kokotovic, 1989); the Treatment Readiness, Responsivity and Gain Scale: Short Version (TRRG:SV; Serin et al., 2005; of which only the readiness and responsivity questionnaires were employed); the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ; Casey et al., 2007); the Psychopathy Checklist: Screening Version (PCL:SV; Hart et al., 1995); the Psychopathy Checklist Revised (PCL-R; Hare, 1991); and the Paulhus Deception Scale (PDS; Paulhus, 1998: Appendix B). The programme evaluation questionnaire was developed specifically for this research initiative by the author (see Appendix F).

Self-Efficacy Questionnaire

The Self-Efficacy Questionnaire (SEQ; Loza-Fanous, 2003) is an eight item self-report questionnaire. It uses a 5-point Likert scale (from 1 = not at all confident through to 5 = extremely confident) to rate a person's level of confidence regarding performing tasks in treatment. Total scores are obtained by summing item responses (after reversed-scored questions are rescored). Higher scores indicate higher levels of confidence. The test is reported to have an internal consistency or reliability of above .80 (Loza-Fanous, 2003).

Perceived Coercion Scale

The MacArthur Perceived Coercion Scale (PCS; Gardner et al., 1993) was employed in this pilot study. However, it was adapted in two ways. The first adaptation included replacing the original word "hospital" with "treatment programme" to make the questionnaire more appropriate for the participants. The second included two extra questions. Thus, the PCS involved seven items (for more details see Appendix E), intended as indicators of a single latent variable: perceived coercion regarding entering a treatment programme. The PCS uses a true/false scoring method (for a discussion regarding the dichotomous scoring method, see Gardner et al., 1993). True is scored as 0 and false as 1. Lower scores indicate lower levels of perceived coercion.

The PCS correlates highly with scores on the MacArthur Admission Experience Survey (Gardner et al., 1993) and scores on "The Coercion Ladder" (CL; $r = .65$) though the PCS was comparably more sensitive to low impact coercion (Hoyer; 2007). The PCS appears to have temporal stability with internal consistencies found ranging from .82 (Wild et al., 1998) to .90 (Nicholson, Ekenstam, & Norwood, 1996), though consistency is not validity (Gardner et al., 1993).

Treatment Readiness, Responsivity and Gain Scale: Short Version

The readiness subscale of the Treatment Readiness, Responsivity and Gain Scale: Short Version (TRRG:SV; Serin et al., 2005) measures "willingness to engage in the treatment process" (para. 8), whereas the responsivity subscale of the TRRG:SV measures an "offenders compliance with and response to therapeutic intervention and treatment programmes in general" (treatability; Serin et al., 2005, para. 10). As both measures have a semi-structured interview format, they both require clinical judgement in assessing and scoring participants'

responses. Each scale is comprised of eight items. Each item has a score range of 0 (unready or unresponsive) to 3 (completely ready or responsive). Thus, the lowest possible obtainable score is 0, and the highest, which indicates higher levels of readiness/responsivity, is 24. From a sample of 265 male offenders attending a cognitive skills programme, Serin and colleagues found that the readiness and responsivity scales have an internal consistency of .83 and .82 respectively. Both scales obtained a mean factor loading of .67 and reported good to excellent factor loading ranges of .60-.77, and .59-.75, respectively.

Correction Victoria Treatment Readiness Questionnaire

The 50-item Correction Victoria Treatment Readiness Questionnaire (CVTRQ; Casey et al., 2007) was used in this research initiative, however 30 items were later omitted as the author had recently revised the questionnaire. Thus, this study employed only the 20-item self-report CVTRQ, which maps on to the Multifactor Offender Readiness Model (MORM; Ward et al., 2004) and assesses a person's readiness to participate in a cognitive-based treatment programme. The measure comprises four subfactors: factor 1: attitude and emotions (F1; items 1-6; score range 0-30); factor 2: emotional reaction (F2; items 7-12; score range 0-30); factor 3: offending beliefs (F3; items 13-16; score range 0-20); and factor 4: efficacy (F4; items 17-20; score range 0-20). Participants rate the degree to which they agree or disagree with questionnaire items on a 5-point Likert scale. After rescoring the eight negatively keyed items a total score ranging from 20-100 is derived. Higher scores indicate a higher degree of readiness, with ≥ 72 established, as a result of ROC curve analysis, as a cut-off score for readiness to participate and engage in treatment (Casey et al., 2007). Casey et al. (2007) found that the CVTRQ had high internal consistency ($\alpha = .83$), and converged and discriminated with other similar and dissimilar measures, including Serin's Treatment Readiness Scale (STRS), the self-report adaptation of the TRRG:SV readiness scale (see Table 2.2).

Table 2.2

Correlations Casey et al. (2007) Found Between the CVTRQ and Measures that are also Employed in this Experimental Programme

Measure	CVTRQ	F1	F2	F3	F4	STRS	SEQ	PCS
CVTRQ	1.00	.73***	.76***	.70***	.53***	.56***	.23**	-.29***
F1		1.00	.33***	.38***	.22**	.70***	.32***	-.30***
F2			1.00	.40***	.19*	.36***	.10	-.27***
F3				1.00	.23**	.28***	.13	-.13
F4					1.00	.12	.21**	-.02
STRS						1.00	.35***	-.48***
SEQ							1.00	-.16
PCS								1.00

p <.01, *p <.001.

Working Alliance Inventory Short Scale

To gain information from different perspectives on the strength of the client therapist relationship, the Working Alliance Inventory's Therapist Short Form scale (WAI-T S) and Client Short Form scale (WAI-C S) were employed. These measures are self-report questionnaires that examine the respondent's perception regarding (a) agreement on therapy goals or tasks, (b) agreement on the method to achieve these goals, and (c) the bond development between the therapist and client (Bordin, 1979). "The goal and task aspects of the inventory represent the cognitive aspect of care, whilst the liking-bond aspect of the inventory represents the emotional aspect of care" (Fuentes et al., 2007, p. 31). The WAI-S has 12 items and uses a 7-point Likert scale to yield a total score (ranging from 12-84) and three subfactor scores (as mentioned above).

The WAI-S comprises the four top factor loadings of each subscale of the Working Alliance Inventory (WAI; Horvath, & Greenberg, 1989) and has limited research validating it, compared to the WAI. However, the research conducted to date is promising. Tracey and Kokotovic (1989) found that internal consistency (using Cronbach's Alpha) for both the WAI-T S and WAI-C S total scores were

.87 and .93 respectively. Internal consistency of the subscales ranged from .68 to .87 for the WAI-T S and from .85 to .88 for the WAI-C S. Busseri and Tyler (2003) also found that scores on the WAI and WAI-S were interchangeable.

Paulhus Deception Scale

The Paulhus Deception Scale (PDS; Paulhus, 1998) was employed in this evaluation, to detect any self-deception or socially desirable responding. The PDS is a 40-item self-report questionnaire that is scored using a 5-point Likert scale. It consists of an overall scale (the PDS total score) and two subscales: the Self Deception Enhancement (SDE) scale and the Impression Management (IM) scale. The SDE subscale reflects denial and self-delusion regarding a realistic self view. Although the PDS manual does not provide a single cut-off score for the SDE subscale, high scores indicate “rigid overconfidence akin to narcissism” (Paulhus, 1998, p. 9) and low scores indicate a realistic self view.

The IM subscale measures a person’s ability to purposefully enhance how others perceive them. Scores from 8 to over 12 on the IM scale indicate possible to definite faking good, and a score under two or under one indicate possible faking bad, and definite faking bad, respectively. Scores on each scale are summed to give a total score (range = 20 to 140), reflecting the degree to which a person is engaging in desirable responding. The total score is then turned into a t-score to indicate the number of standard deviations from the mean the t-score is compared to the normed group created by Paulhus (1998). According to the manual, scores of 61 and over indicate above-average self-biases meaning the respondents may be faking good in their answers in questionnaires. Scores above 70 are of absolute concern and the participant’s data should be rejected from the sample. Similarly, scores of 39 or less show below-average self-biases, meaning the respondents may be faking bad in their answers in questionnaires. Scores below 30 are of absolute concern and the participant’s data should be rejected from the sample. There are also four combinations of score results that can be interpreted from the PDS manual, for example high SDE and low IM scores indicate narcissistic tendencies (Paulhus, 1998).

The PDS has been subjected to over fifty validation studies, and has a high level of internal consistency (Paulhus, 1998). Cronbach’s Alpha coefficients have been found to range from .70 to .75 for the SDE scale, .81 to .84 for the IM scale and .83 to .86 for total scores (Paulhus, 1998). In terms of convergent validity, the

IM scale was found to correlate highly with the MMPI Lie scale (Paulhus, 1998). “Self-deception enhancement converges with optimism and reversal on the Defense Mechanisms Inventory, and positive reappraisal and distancing and escape avoidance as measured by the Ways of Coping Scale” (Paulhus, 1998, p. 26). The SDE and IM subscales showed inter-correlations of .20, .23, and .32 in three separate factor analyses studies (Paulhus, 1998).

Psychopathy Checklist Revised

The Psychopathy Checklist Revised (PCL-R; Hare, 1991) is a 20-item rating scale that uses semi-structured interview, file, and collateral information in a specific scoring system to yield both dimensional and total classification scores (ranging from 0-40) for psychopathy. Although 30 is the author’s recommended cut-off score for defining psychopathy (Wormith, Olver, Stevenson, & Girard, 2007), this study uses a cut-off score of 27 to decrease the likelihood of false positives, and to capture any deviation from true scores, as 27 is one standard error of measurement from 30, and the PCL-R assessments were primarily conducted by one person (for a discussion on PCL-R cut-off scores see Hare 2003; Morana et al., 2005; Wilson, 2003).

Although debated (see Cooke & Michie, 2001; Hare & Neumann, 2006) the PCL-R comprises a two broad factors structure, and four narrow facets. Factor one consists of interpersonal and affective characteristics, such as callousness, lack of remorse, grandiosity, and deceitfulness. Factor two accounts for social deviance and impulsive lifestyle items, such as criminal versatility, lack of goals, juvenile delinquency, and poor behaviour control (Guy & Douglas, 2006; Hare, 1991, 2003). The PCL-R has been found to be highly reliable, with coefficient alphas of .80 or better, for single raters ($\alpha = .80$; Hare et al., 2000) and an average of two raters ($\alpha = .90$). Wormith et al. (2007) also found the PCL-R correlates highly with other risk measures, including the LSI and DSM III APD ($r = .77$ to $.80$), suggesting they all measure recidivism risk or at least a predisposition to criminality/antisociality. Gendreau, Goggin, and Smith (2002), Hemphill and Hare (1998), and Wormith et al. (2007), also found that the PCL-R total score and factor two scores, but not factor one scores, have strong predictive accuracy for general, sexual and violent convictions and reincarceration. Conversely, Serin (1995) opined that the PCL-R may not be able to measure personality change, due to it scoring style and reliance on lifetime traits and behaviour.

Psychopathy Checklist Screening Version

The Psychopathy Checklist Screening Version (PCL:SV; Hart et al., 1995), described by many authors (e.g., Cooke, Michie, Hart, & Hare, 1999; Hart et al., 1995) as a shortened yet parallel version of the PCL-R, was used in this study as an entry criterion measure to assess presence of psychopathic personality traits. The PCL:SV has 12 items, each rated on a three point ordinal scale (from 0 = traits do not apply to 2 = traits definitely apply). Scores range from 0-24 with a cut-off score of 18 indicating psychopathy (Hart et al., 1995). Past research suggests the PCL:SV has two parts which are representative of the two main factors of the PCL-R, interpersonal affective characteristics and antisocial lifestyle characteristics (Hare, 1991, 2003). However, using two correctional samples, Guy and Douglas (2006) found that the PCL:SV correlated highly with the PCL-R on total score, and pertaining to four facets (using Cooke and Michie's three factor model plus the additional antisocial facet that Hare added). The correlations were: total score $r = .94$, facet one $r = .92$, facet two $r = .93$, facet three $r = .94$ and facet four $r = .88$ ($p < .01$). Similar factor structures have been found by Hill, Neumann, and Rogers (2004) and Neumann, Kosson, Forth, and Hare (2006). Using Cronbach's Alpha, the PCL:SV also has an internal consistency of .84, which is similar to the PCL-R (Hart et al., 1995). Wilson (2003) also found in a NZ study that the PCL:SV total score had the ability to predict serious violent reoffending by high risk offenders.

Risk of Reconviction multiplied by the Risk of Imprisonment

The Risk of reConviction multiplied by the Risk of reImprisonment (Roc*RoI; Bakker, O'Malley & Riley, 1998) actuarial measure was one of two instruments employed in this study to identify and obtain a high risk offender sample. The RoC*RoI is a computer-based statistical model which uses static risk factors such as an offender's criminal history and demographics, to produce a statistical probability regarding the offenders probability of reconviction within five years, seriousness of offence, and likelihood of reimprisonment. The score range is 0-100, with the latter being a 100% risk of serious recidivism within five years of release (Bakker, O'Malley, & Riley, 1999). The RoC*RoI was validated on 133,000 NZ offenders from the years of 1983, 1988, and 1989 (Bakker et al., 1999). Although some anomalies have been identified, such as the RoC*RoI's lack of accuracy with youth, sex offenders, and drink drivers (Wilson, 2004), the

RoC*RoI has an accuracy of 86% for predicting reimprisonment (Bakker et al., 1999). Subsequent studies have also helped validate the RoC*RoI. For example, Nadesu (2007) found, from a sample of almost 5000 offenders, that 90% of those with a RoC*RoI score of over .9 were reimprisoned within 12 months. In a sample of 199 NZ offenders, Wilson (2003) also found the RoC*RoI had high predictive ability, with an AUC of $\geq .80$, and was significantly related to time to reconviction ($r = -.43$) and reimprisonment ($r = -.49$), as well as to imprisonment length for reoffending.

Evaluation questionnaire

An evaluation questionnaire was also devised specifically for this treatment programme. It was designed to gather some qualitative information (feedback), regarding what the participants liked or valued and learnt about themselves in phase one of the treatment programme. Taking the form of a structured interview, the questionnaire was comprised of eight short-answer questions. The questions covered topics such as: past participation in anger and violence courses; likes and dislikes about the current programme; attrition and reasons for attrition from past courses; whether and how the client would change dislikes; and whether they had noticed any changes in themselves as a result of the course.

2.4 Research Procedure

To find suitable participants the Senior Research Advisor for NZ Correction's Psychological Services (Dr Wilson) sent out details on the proposed treatment programme, and the selection criteria, to sentence planners and unit managers seeking nominations of suitable participants. Subsequently, while this study's ethical approval application was in the process of being approved, research staff visited prisons around the North Island of NZ and contacted potential nominees and interviewed them regarding interest, and willingness, and to check them for suitability. During the initial contact interview, the inmates had the objectives, content, length, and conditions of the entire treatment programme explained to them, to ensure informed consent was provided. The need to transfer to a segregated high security unit at Waikeria Prison for twelve months was also explained. The location (the oldest part of Waikeria prison, built in 1912), being housed in a high security setting, and being segregated were viewed by many

participants as constituting a significant reduction in status, and a restriction on activities, and the transfer was seen as a far less comfortable institutional environment.

The prospective participants either agreed to participate or declined following their interview with Psychological Services researchers. Fifteen prison inmates volunteered to participate in the 10 month intervention programme. The participants also consented verbally, initially, then later in writing, to phase one of the project being evaluated. From the 15 volunteers, 12 participants were selected, and the other three were waitlisted in the event of one of the selected participants withdrawing. One participant withdrew prior to the beginning of the programme and a waitlisted volunteer was then selected for the programme. The participants were transferred to Waikeria prison, located in the Waikato region, where, for the duration of the initial and later phases of the programme, they were housed in a high security segregation unit.

Phase one of the programme lasted 17 weeks, was grounded in Cognitive Behaviour Therapy (CBT), and was aimed at getting the participants psychologically and interpersonally ready to enter the second and main phase of the treatment programme. To achieve readiness to engage in phase two of the programme, the 12 participants attended four intervention sessions per week. The sessions included three group sessions of two and a half hours each, and one individual session of approximately one hour per week. Intervention sessions were held at a special programming area in the prison to which the participants were transferred daily. Weeks one and two of the programme involved a powhiri (a Māori formal welcoming ceremony) and general introductions; an explanation of the objectives of the study (refer Appendix G for the written explanation regarding the evaluation of phase one); and any administrative issues, of which there were many, including the need for a smoking area, and the supply of biscuits! Also in week one, informed consent was gained in writing (refer Appendix H for the written consent form) and participants were informed of the right to withdraw at any time without penalty. The remaining 15 weeks were focused on the programme facilitators' intentions to build a therapeutic alliance with the participants. The facilitators simultaneously focused on creating the conditions and support to increase the participant's levels of readiness and ability to change, as well as educate them on the barriers to change (including an

understanding the psychopathic personality), in order to enable the men to enter and potentially succeed in the next phase of the programme.

Three registered senior Clinical Psychologists employed by NZ Correction's Psychological Services directly facilitated the entire programme. One was a male of Māori descent and two were female, one of European and one of Pacific Island descent. All three clinicians had many years experience working with offenders. In addition, the NZ Correction's Senior Research Advisor, Dr Wilson, also a senior Clinical Psychologist, managed the pilot project, and, to ensure continuous programme delivery, provided programme facilitation back-up and weekly clinical supervision to the aforementioned psychologists. The use of experienced Clinical Psychologists was intended to help address offender responsiveness, therapist consolidation, and effective communication. An experienced Māori Cultural Advisor was appointed to help with cultural and Māori aspects of the intervention (culture-specific programming).

The research method employed for the pilot project was a within-subjects design, as this would show each individual's improvements during phase one of the treatment programme. Besides demographic data which was collected during the recruitment period, the main body of pretreatment data was collected during weeks three and four of the programme (pretreatment but postintroduction weeks). Posttreatment data from phase one was collected during weeks 15 to 17 of the programme, with three exceptions. Due to workload constraints, posttreatment data for two of the participants was collected two to three weeks posttreatment, and one participant's data was collected almost eight weeks posttreatment. Regarding the latter participant, a delay occurred when the psychologist responded to personal distress experienced by the participant. Finally one participant was evicted from the programme for assaulting another participant, thus, posttreatment data was collected from only 11 participants.

The nine measures used for data collection are listed under "psychometric measures" in this section. Five measures were self-report and four of these (CVTRQ, PCS, SEQ, PDS) were compiled together in a package to disguise the questionnaire type. The WAI-C S, the other self-report measure, was administered separately albeit simultaneously. Each facilitator oversaw four participants regarding data collection, helping those with literacy difficulties (there were one illiterate and two low-literacy participants). Facilitators checked completed

questionnaires for unanswered items, however, some missing entries still occurred. The programme facilitators filled out the WAI-T S regarding the same four participants they were overseeing, and in the same data collection weeks as above. Three of the questionnaires, including the TRRG:SV readiness and responsivity scales, were guided interview-style, whereupon clinical judgement was required. They were administered (with the facilitators selecting the option that most appropriately described the participants behaviour and assigning the appropriate score) pre- and postintervention. For the evaluation, the facilitators wrote the participants' answers verbatim in the space provided on the form. Again, each facilitator gathered data from four participants. To adhere to ethical requirements, all questionnaires were identified by a code to maintain anonymity. All the questionnaires were boxed and used confidentially by the evaluator at the Hamilton Psychological Services office. The demographic data collected during the recruitment phase included age, gender, ethnicity, sentence length, index crime, PCL-SV scores, PCL-R scores, and RoC*RoI scores.

2.5 Data Analysis

The coding system for participant anonymity was continued, and all the raw data from the psychometric measures, including any recoding and negative scoring, along with demographic data, were entered into SPSS version 16.0 for Windows and Microsoft Excel. Regarding missing values, the average score(s) for that particular questionnaire was used. To ensure rater reliability, all data entry was rechecked, and then randomly rechecked whilst being analysed. The discrepancy regarding the version of the CVTRQ used in the study, compared to the recent version found in the literature still existed. Test author Andrew Day was contacted and the researcher was informed that the 50-item CVTRQ version had been refined, and, that only 20 items were now sufficient to validly measure readiness. Therefore, the extra items were omitted from the study.

To compare group means, both parametric and nonparametric t-tests were initially used, however as reliability does not mean validity and 18 of 20 tests gained the same results, only the Wilcoxon nonparametric T-tests were used. The T-tests were one-tailed with an alpha level set at .05. The only assumptions that need to be obliged regarding the Wilcoxon nonparametric T-tests are random sampling. The samples may be less than 30, but there are concerns about the

accuracy of the p-value when the sample is less than 16. Nonparametric tests are also vulnerable to outliers, though not as much as the parametric tests. As shown in Figure 2.1, four out of twelve data sets contained outliers. However, as indicated, all the outliers except one were posttreatment low-liers, thus they moderated outcomes.

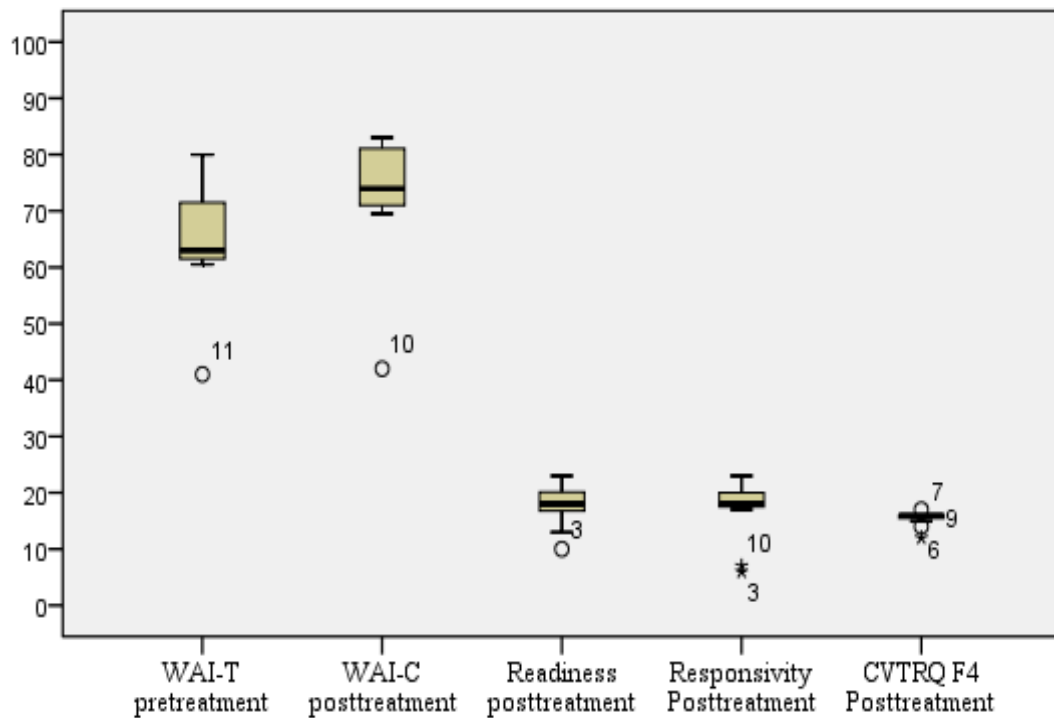


Figure 2.1. Outliers Present in the Data Sets.

Cohen's d (d), which uses the means and standard deviations (SD) and not sample size, was used to calculate the magnitude of the treatment effect (refer Becker, 1999, for the online calculator). Cohen (1988) defined effect sizes for t -tests as "small, $d = .2$," "medium, $d = .5$," and "large, $d = .8$," but stated that "although effect size is relative to many aspects inherent in diverse fields of behavioural science inquiries, more is to be gained by having a common conventional frame of reference" (p. 25).

A number of factors, including age, inmates' original prison location, number of times imprisoned, number of offences, and RoC*RoI scores were analyzed to investigate whether they impacted on the tests results. Age was categorized by a median split into ≤ 26 and > 26 (which was 31, as there was a five year gap in the sample's age spread). RoC*RoI research also shows that risk lowers at age 25 across offenders, and that a degree of protectedness increasingly

occurs after this age cutoff (N. J. Wilson, personal communication, June 25, 2009). The original location of the inmate was used as a category, as leaving family and familiarity was indicative of motivation to change. Eight participants had traveled from other prisons and three were from differing areas of the Waikeria prison campus. The number of previous imprisonments was categorized into ≤ 2 and > 2 , which happened to be four imprisonments. N. J. Wilson (personal communication, June 25, 2009) advocated that four or more imprisonments represented a significant repeated punishment to the offender, and they become more motivated to change their behaviour. The number of offences was set at ≤ 30 and > 30 . Thirty was the median and mode for number of offences (mean number of offences = 48). Thirty as the mode also fell into the lower half of the group, thus became inclusive for the lower bracket of offenders. Regarding RoC*RoI, .70 is the cut-off score used by the NZ Corrections to indicate high risk of reoffending and high risk of reimprisonment (and accounts for approximately 30% of imprisoned offenders in NZ (N. J. Wilson, personal communication, October 28, 2010)).

Wilcoxon T-tests were conducted to compare the means of each psychometrics tests results. Each individual's psychometric results and evaluation questionnaire results were summarised and tabled (see Appendices L-N). Participants were labelled from 1-11 throughout the evaluation, thus each time participant one is referred to they are the same person).

Spearman's Rho correlations (for non-parametric samples) were used to test for convergence of similar constructs, and divergence of differing constructs, encompassed in the questionnaires.

A series of split-plot analysis of variances were conducted to test for potential mediating effects of participants with high PCL-R factor one scores.

The results, along with the literature reviewed, culminated in a discussion regarding both the study's findings and any themes that emerged, its strengths and limitations, any improvements that could be made in future research, and how the results could help this offender group's rehabilitation.

CHAPTER THREE

Results

3.1 Introduction

The evaluation of the effectiveness of phase one of the treatment initiative (that was intended to address responsivity issues) occurred for eleven HRPP programme completers as one participant failed to complete the programme.

After analysing the Paulhus Deception Scale (Paulhus, 1998) scores for validity of responses, a series of T-tests compared the completion groups outcomes on all the programmes therapeutic engagement measures, including readiness (hypothesis one) and responsiveness structured assessment protocols (hypothesis two): therapeutic alliance, self-efficacy, perceived coercion, and treatability. A series of split plot analysis of variance (SPANOVA) tests were conducted to test for any possible mediating effects of PCL-R factor one scores (hypothesis three). A bivariate analysis tested the significance of each psychometric measure and the participants' responses. Finally each participant's psychometric results were summarized along with their evaluation of their therapy experience and the programme's effectiveness.

3.2 Paulhus Deception Scale Results

Scores above eight and below two on the PDS's subscales, and scores outside of the 30-70 range of the total score indicate less or invalid responding (see p. 30 for details). The scores on the PDS (see Table 3.1) show that no participant scored below two or higher than eight on the self-deception enhancement (SDE) scale, while four participants scored one on the impression management (IM) scale and a single participant scored eight on the IM scale. With regard to pretreatment total scores, four participants had t-scores one standard deviation (SD) from the mean, and no participants had t-scores more than 2 SDs from the mean (outside of the 30-70 score range). Posttreatment, no SDE scores were below two or above eight. Analysis of the IM scale indicated that a new subgroup of four participants scored one, and two participants scored eight. When the PDS posttreatment total scores were examined, no participant obtained a score more than two SDs from the mean, but three participants scored more than one SD from the mean.

Table 3.1

Identification of Participants' Pre- and Posttreatment Responding Regarding the IM, SDE, and Total Scores (T-scores) of the PDS

	Pretreatment						Posttreatment					
	IM		SDE		Total (t-score)		IM		SDE		Total (t-score)	
	≤2	≥8	≤2	≥8	≤39	≥61	≤2	≥8	≤2	≥8	≤39	≥61
Participant Number	2	3			2	3	5	4			5	8
	6				5		6	8			9	
	8				9		9					
	9						10					

NB no participants were outside the 30-70 t-score range

As a result of the PDS findings, a Spearman's Rho correlation was conducted on the IM scores, PDS total scores, and responses on the other study measures. It was hypothesized that any bias in responding on the PDS would correlate with biased responding on the other study measures. Pretreatment only the Self-Efficacy Questionnaire (SEQ) and IM scores had a positive correlation ($r = .62$ and $p = .04$). Posttreatment, no significant positive correlational relationships were found across all the study measures.

3.3 Wilcoxon T-test Results

Using the Wilcoxon method of t-test analysis the CVTRQ scores were found to have a significant positive relationship ($T = -2.19$, $p = .02$; see Table 3.2). The mean difference was 4.58. Further analysis using Cohen's d ¹ found this to be medium in size ($d = .59$). Box-plot graphs for the total score (see Figure 3.1) show that the scoring was heterogeneous with a 26-point range both pre- and

¹ Cohen's d , which uses the means and standard deviations (SD) and not sample size, was used to calculate the magnitude of the treatment effect. Cohen (1988, as cited in Becker 1999) defined effect sizes as "small, $d = .2$," "medium, $d = .5$," and "large, $d = .8$,"

posttreatment. Details of the total and factor descriptive statistics are shown in Table 3.2.

For the CVTRQ subfactors, Figure 3.2 indicated that scoring was homogenous, with high scores for F1 and F3, while F2 was more widely distributed, and posttreatment outliers were found for F4. The CVTRQ subfactor T-test results indicated that only F4 had a statistically significant positive relationship ($T = -2.81, p = .00; d = 1.68$, see Table 3.2).

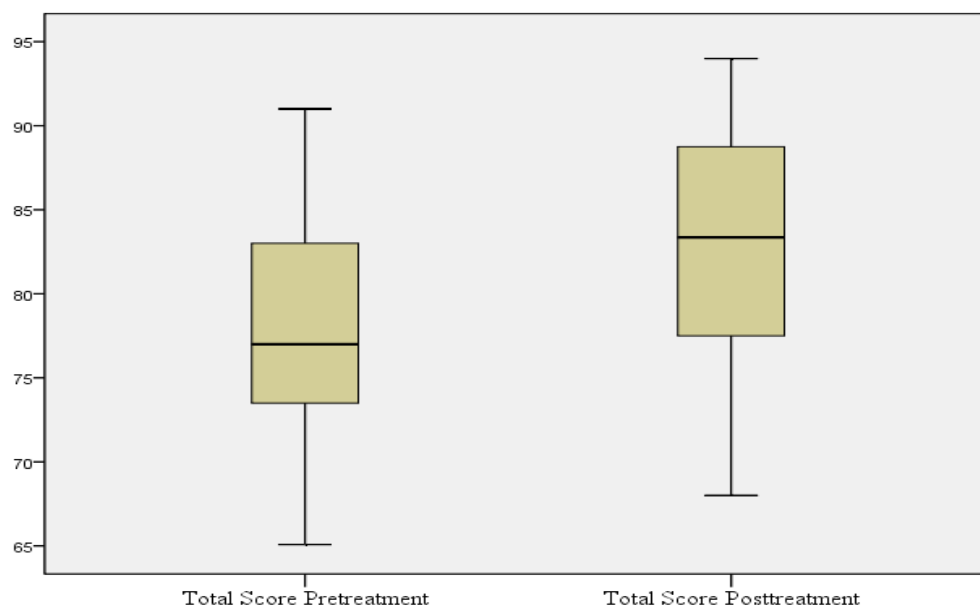


Figure 3.1. Distribution of the Participants' Pre- and Posttreatment CVTRQ Total Scores.

Table 3.2

Descriptive Statistics and Wilcoxon T-test Results for the CVTRQ Total and Subfactor Scale Scores

Psychometric (score range)	Mean (SD)		Median		Mode		Minimum and Maximum Score (Range)		<i>T</i>	<i>P</i>	<i>d</i>
	Pre	Post	Pre	Post	Pre	Post	Pre	Post			
CVTRQ Total Score (20-100)	78.41 (7.65)	82.99 (7.50)	77	83.36	83	77	65.08- 91 (25.92)	68-94 (26)	-2.19	.01	-0.59
F1 Attitudes & Motivation (6-30)	25.68 (2.77)	27.18 (2.52)	26	27	28, 29	30	21.40- 29 (7.6)	24- 30 (6)	-1.32	.09	-0.90
F2 Emotional Reactions (6-30)	23.18 (5.36)	22.77 (4.14)	22	24	20	24, 26	12-30 (18)	14-28 (14)	-.57	.29	.09
F3 Offending Beliefs (4-20)	17.64 (1.21)	17.58 (1.75)	17	17	17	17, 20	16-20 (4)	15-20 (5)	-.17	.43	0.04
F4 Efficacy (4-20)	11.73 (2.83)	15.45 (1.37)	13	16	13	16	8-16 (8)	12-17 (5)	-2.81	.00	-1.68

The effect of the intervention on readiness as measured by the TRRG:SV readiness subscale was not found to be statistically significant. Table 3.3 shows the descriptive statistics for the TRRG:SV, with the pretreatment mean being high at 17.45 (with six participants having a pretreatment score of 17 or more and with eight participants above this level posttreatment), thus leaving little room for positive change. The box-plot graphs for the TRRG:SV scales (see Figure 3.3) indicate that a low-scoring outlier reduced the posttreatment mean.

Table 3.3

Pre- and Posttreatment Descriptive Statistics for the TRRG-SV Readiness and Responsivity Scales

Descriptive Statistics	Readiness		Responsivity	
	Pre Treatment	Post Treatment	Pre Treatment	Post Treatment
Mean	17.45	17.80	12.18	17.02
Standard Deviation	3.56	3.70	6.32	5.45
Median	17.00	18.00	12.00	18.00
Mode	16.00	18.00	6.00	18.00
Minimum and Maximum Score (Range)	12-23 (11)	10-23 (13)	4-21 (17)	6-23(17)

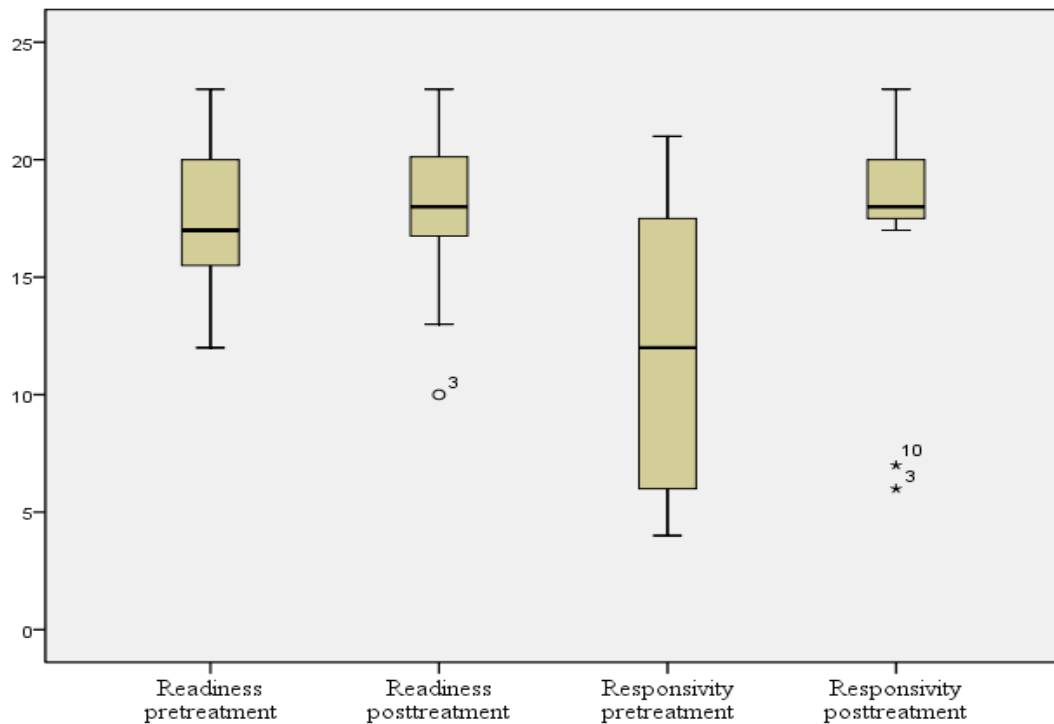


Figure 3.3. Distribution of the Participants' Pre- and Posttreatment Total Scores for the TRRG-SV Readiness and Responsivity Subscales.

To examine the second hypothesis in the study, research was conducted to see if the HRPP treatment initiative increased participants' responsiveness in treatment. Analysis of the TRRG:SV responsiveness subscale (measuring treatability) pre- and posttreatment, found a mean difference of 4.84, which was statistically significant ($T = -2.00, p = .02$). Applying Cohen's d to this mean difference found a large effect ($d = .82$). The box-plot graphs of the TRRG:SV responsiveness pre- and posttreatment scores (see Figure 3.3), and the descriptive statistics in Table 3.3, show that the scores varied pretreatment. Homogeneity increased at posttreatment but two participants had low scoring posttreatment outliers. An item analysis of the TRRG:SV responsiveness subscale (see Table 3.4) revealed that change occurred for the rigidity, intimidation, and power and control items. The change from pre- to posttreatment was least effective for the callousness item.

Table 3.4

Item Analysis of the TRRG:SV Responsivity Subscale to Define Areas of Treatment Effectiveness

Item	Mean (SD)	Mean (SD)	<i>d</i>	<i>T</i>	<i>P</i>
	Pre	Post			
1. Callousness	1.82 (.75)	1.82 (.75)	.00	.00	.50
2. Denial	2.00 (1.10)	2.64 (.67)	-0.70	1.31	.10
3. Procrastination	1.72 (1.01)	2.20 (.87)	-0.51	1.27	.10
4. Intimidation	.77 (.98)	2.18 (.75)	-1.61	2.84	.01
5. Power and control	1.50 (1.32)	2.18 (.98)	-0.59	1.89	.03
6. Rigidity	1.27 (1.10)	2.09 (.94)	-0.80	1.69	.05
7. Victim stance	1.64 (1.03)	1.91 (.83)	-0.29	.78	.22
8. Procriminal views	1.45 (1.04)	2.00 (.89)	-0.57	1.29	.10

The effect of the HRPP intervention on therapeutic alliance, as measured by the working alliance therapist perspective (WAI-T), was not found to be statistically significant ($T = -.76$, $p = .22$) even though the mean difference of 5.41 was found to have a medium effect size ($d = -.53$). The descriptive statistics shown in Table 3.5 and the box-plot graphs in Figure 3.4, indicate that the outcome was the result of a wide distribution of posttreatment scores. None of the WAI-T subfactor T-tests were statistically significant (see Appendix I).

The effect of the HRPP intervention on therapeutic alliance, as measured by the working alliance client perspective (WAI-C) was also found to be not statistically significant. The pretreatment range was large and a low-scoring outlier reduced the posttreatment mean (see Figure 3.4). The pretreatment mean scores were also high, leaving little room for a positive score change (see Table 3.5). Regarding the WAI-C Task subfactor, a statistically significant decrease in mean scores (1.5) occurred ($T = 2.35$; $p = .01$). The effect size of this mean difference was large ($d = 1.38$). The mean increase of 1.20 for the WAI-C subfactor, Bond, was also statistically significant ($T = -2.26$; $p = .01$). The effect

size for this mean difference was small in size ($d = -.34$). Lastly, the mean difference for the WAI-C Goal subfactor was not found to be statistically significant.

Table 3.5

Pre- and Posttreatment Descriptive Statistics for the WAI-T and WAI-C Scales

	WAI-T		WAI-C	
Descriptive Statistics	Pre Treatment	Post Treatment	Pre Treatment	Post Treatment
Mean	64.50	69.91	72.91	73.06
SD	10.15	10.17	7.35	11.41
Median	63.00	74.00	73.00	74.00
Mode	62.00	65.00	71.00	74.00
Minimum and Maximum Score (Range)	41-80 (39)	52-83 (31)	58-82 (24)	41-83 (41)

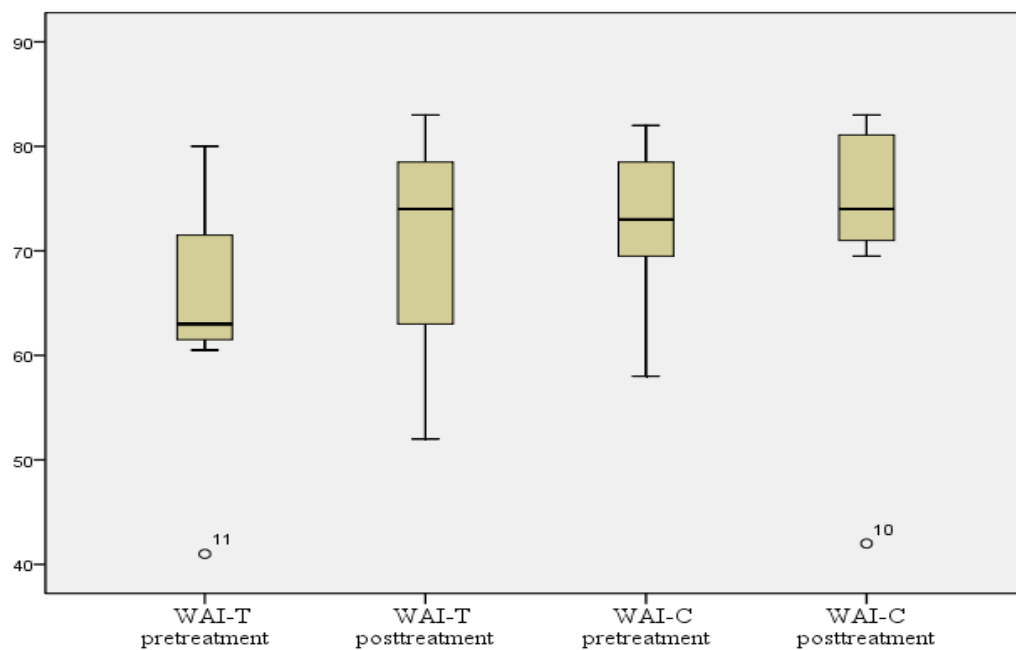


Figure 3.4. Distribution of the Participants' Pre- and Posttreatment Total Scores for the WAI-T and WAI-C Scales.

Analysis of the pre- and posttreatment perceived coercion scale (PCS) scores found a small, statistically insignificant increase in mean scores. Table 3.6 indicates that the PCS mean scores increased from 1.45 to 1.63. Box-plot graphs showing the distribution of scores can be seen in Appendix J. An item analysis (see Figure 3.5) revealed that no participant felt coerced pre- and posttreatment regarding choice and hope, whereas idea, influence, and motivation showed high or increased levels of perceived coercion posttreatment.

Table 3.6

Pre- and Posttreatment Descriptive Statistics for the PCS

Descriptive Statistics	Pretreatment	Posttreatment
Mean	1.45	1.64
Standard Deviation	1.13	1.21
Median	1.00	2.00
Mode	1.00	2.00
Minimum and Maximum Score (Range)	0.00-3.00(3)	0.00-3.00(3)

The mean difference of 3.14 for the Self-Efficacy Questionnaire (SEQ) results was statistically significant ($T = -1.79$, $p = .04$). The effect size was medium ($d = .51$). Table 3.7 and Figure 3.6 show that the range of scores was 22 for pretreatment administration and scores were higher and more homogenous at posttreatment completion.

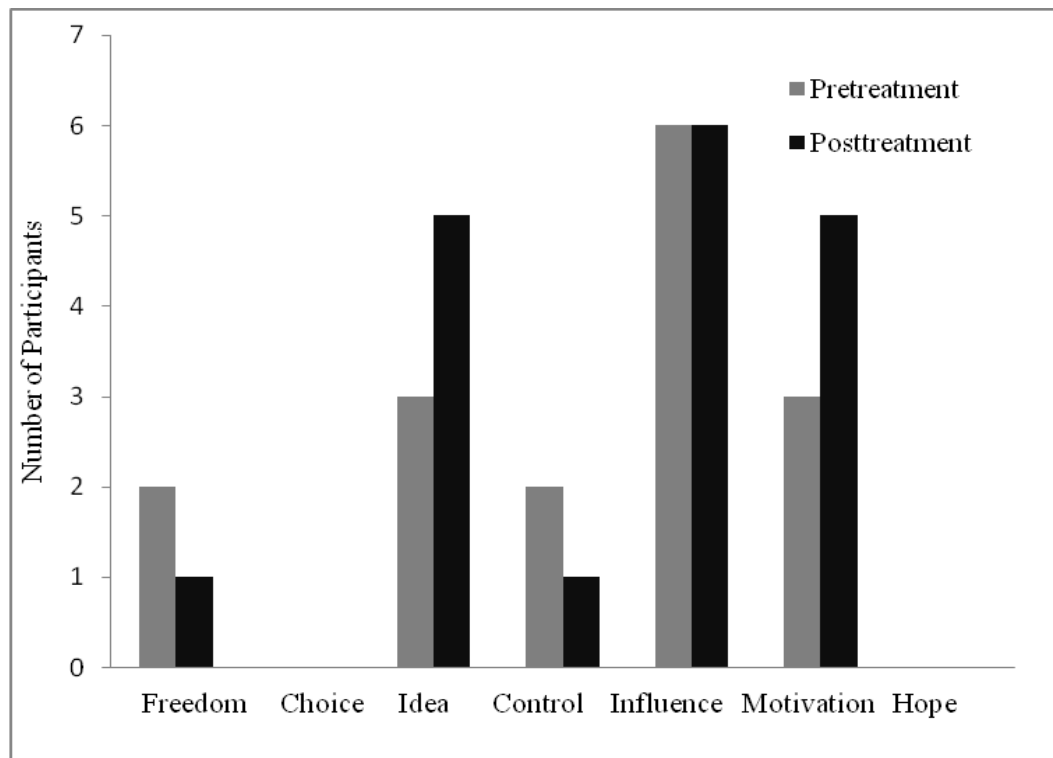


Figure 3.5. Pre- and Posttreatment Intervention Effects Regarding the Seven Domains that Comprise the PCS.

Table 3.7

Pre- and Posttreatment Descriptive Statistics for the SEQ

Descriptive Statistics	Pretreatment	Posttreatment
Mean	25.68	28.82
Standard Deviation	7.17	5.08
Median	28.00	32.00
Mode	13.00	32.00
Minimum and Maximum Score (Range)	13-35(22)	19-34(15)

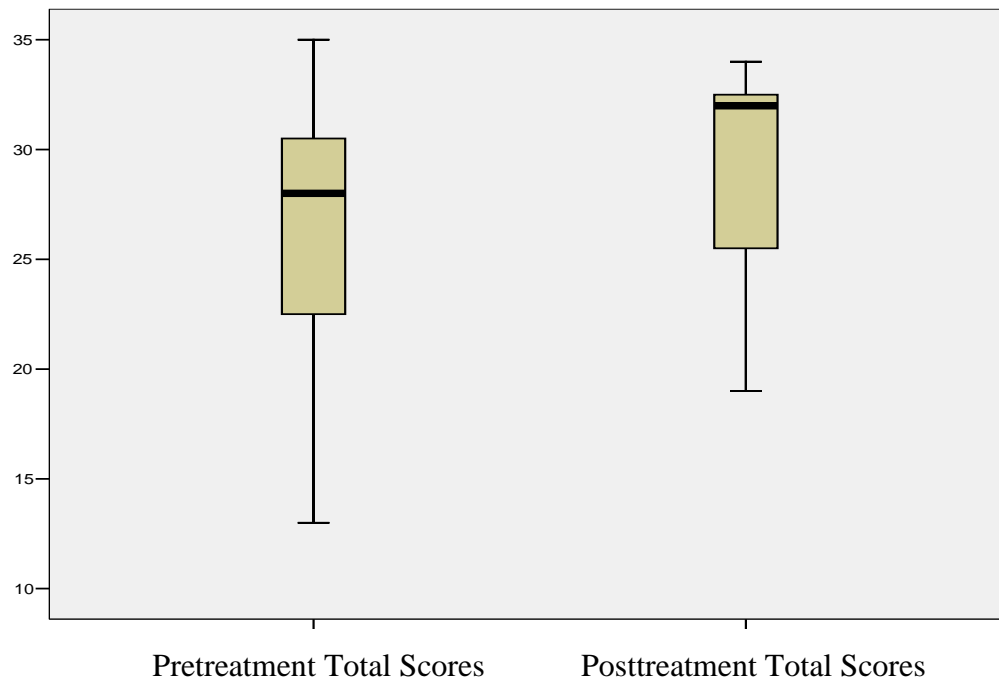


Figure 3.6. Distribution of Participants' Pre- and Posttreatment SEQ Total Scores.

3.4 Multivariate Analyses

In order to evaluate the mediation effects of PCL-R factor one scores (interpersonal style) on the other measures, a series of split plot analysis of variance (SPANOVA) tests were performed. The five underlying assumptions (see Pallant, 2005) regarding SPANOVA tests were investigated. The sample was randomly selected. All Epsilon values of Mauchly's sphericity test equaled one thus sphericity was assumed. All significance levels of Boxes M tests were $> .001$, thus homogeneity of intercorrelations was present. The Shapiro-Wilks tests of normality resulted in the WAI-C, TRRG:SV responsivity, and the F4 of the CVTRQ scores failing normality, and two data sets failed the Levene's homogeneity of variance test (the pretreatment coercion and the posttreatment TRRG:SV responsivity data sets). However, the SPANOVA tests were conducted with these circumstances (possible sampling error) noted.

Analysis of the PCL-R factor one mediation effects occurred on three levels. The first level, shown in the initial line of each category in Table 3.8 (e.g., self-efficacy), indicated any statistically significant changes ($p < .05$) that occurred from pre- to posttreatment. This change occurred for the CVTRQ total scores, CVTRQ F4, and, although not, significant was changing in the expected direction for responsivity and self-efficacy. Partial eta squared shows the

magnitude of the effect size, which, based on Cohen's (1988, as cited in Pallant, 2005) recommendations for analysis of variance are: .01 small effect, .06 moderate effect, .14 large effect. The second row regarding each measure in Table 3.8 shows that no group had any statistically significant pre- to posttreatment differences when the scores on each measures were regrouped according to high and low factor one scorers. The third and last row in each category in Table 3.8 shows any statistically significant group differences, of which there were three: the WAI-C: $p = .05$, $d = .36$; Coercion: $p = .00$, $d = .64$; CVTRQ total score: $p = .01$, $d = .53$. Figure 3.7 shows that the high factor one group's scores for the WAI-C were higher but they did not increase more than the low factor one group whose scores appeared to decrease. For the CVTRQ total scores (Figure 3.8), the high factor one group started and ended with higher pre- and posttreatment means than the low factor one group. Figure 3.9 regarding coercion results show that the low factor one group's coercion increased, whereas for the high factor one group coercion decreased. Thus, while the groups were different none of the groups mean differences were significantly different. Figures for the SEQ, WAI-T, Readiness, Responsivity, and CVTRQ F4 SPANOVA tests can be found in Appendix K.

Table 3.8

Results of the SPANOVA Tests Regarding the Interaction Effects of the PCL-R Factor One Groups on each Psychometric Measure's Scores

Measure	<i>df</i> , <i>df</i> error	Λ	<i>F</i>	<i>P</i>	Partial Eta Squared
Self-Efficacy (SE)	1,9	.66	4.56	.06	.34
High/low Factor		.81	2.08	.18	.19
SE*Factor	1		.89	.37	.09
WAI-T	1,9	.89	1.15	.31	.11
High/low Factor			.04	.84	.01
WAI-T*Factor	1		.71	.42	.07
WAI-C	1,9	1.00	.01	.93	.00
High/low Factor			.07	.79	.01
WAI-C*Factor	1		5.05	.05*	.36
Coercion	1,9	.98	.18	.68	.02
High/low Factor	1		.98	.35	.10
Coercion*Factor	1		16.05	.00*	.64
Readiness	1,9	.99	.08	.78	.01
High/low Factor	1		.07	.80	.01
Readiness*Factor	1		3.84	.08	.30
Responsivity	1,9	.69	4.09	.07	.31
High/low Factor	1		.38	.55	.04
Responsivity*Factor	1		1.97	.19	.18
CVTRQ	1,9	.59	6.35	.03*	.41
High/low Factor	1		.22	.65	.02
CVTRQ*Factor	1		10.14	.01*	.53
CVTRQ F4	1,9	.30	21.28	.00*	.70
High/low Factor	1		.57	.47	.06
CVTRQF4*Factor	1		.10	.76	.01

Λ = Wilks Lambda value

Significance level set at .05

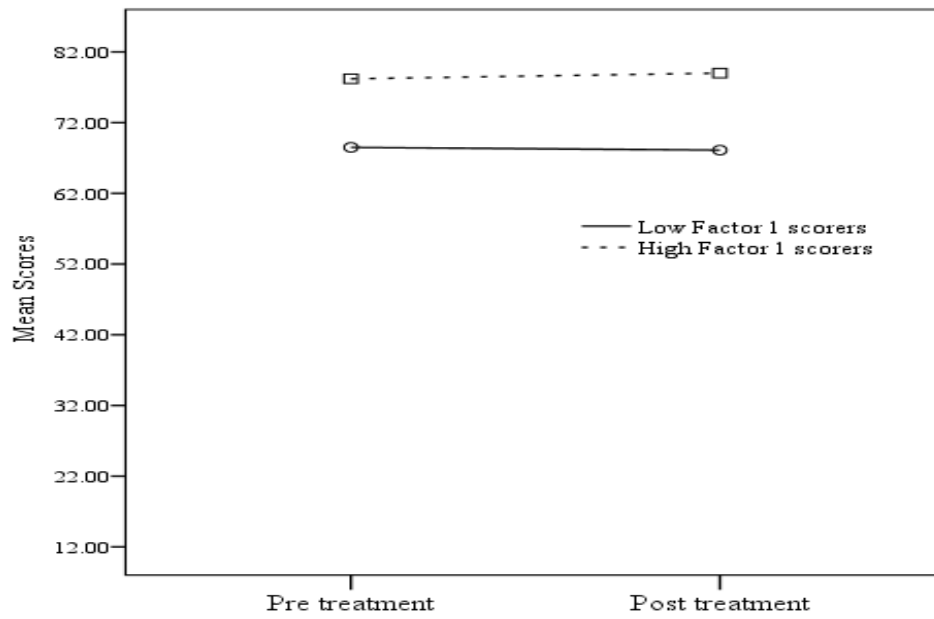


Figure 3.7. Mean Differences for the High/Low PCL-R Factor One Groups Regarding Pre and Posttreatment WAI-C Scores.

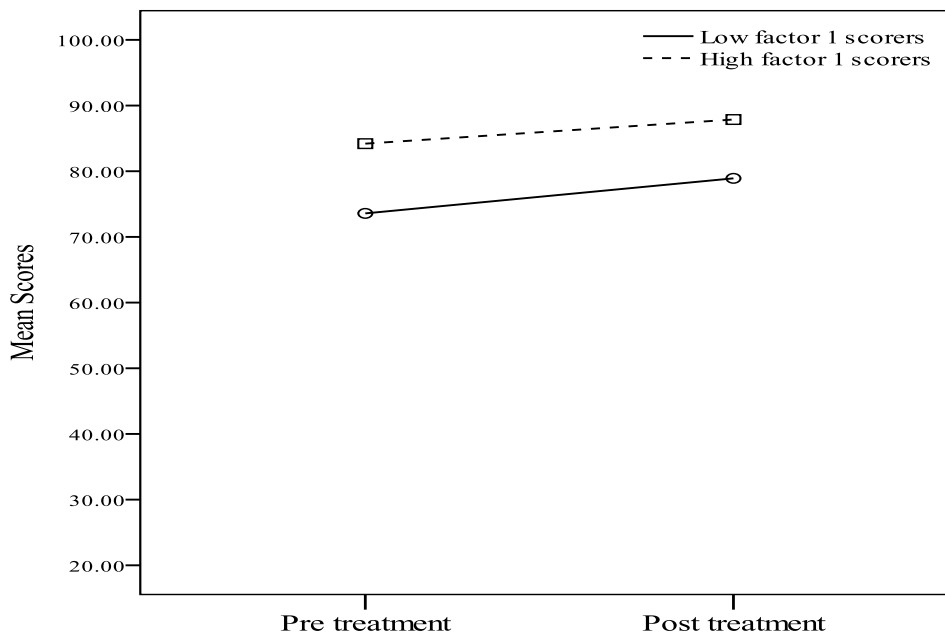


Figure 3.8. Mean Differences for the High/Low PCL-R Factor One Groups Regarding Pre- and Posttreatment CVTRQ Total Scores.

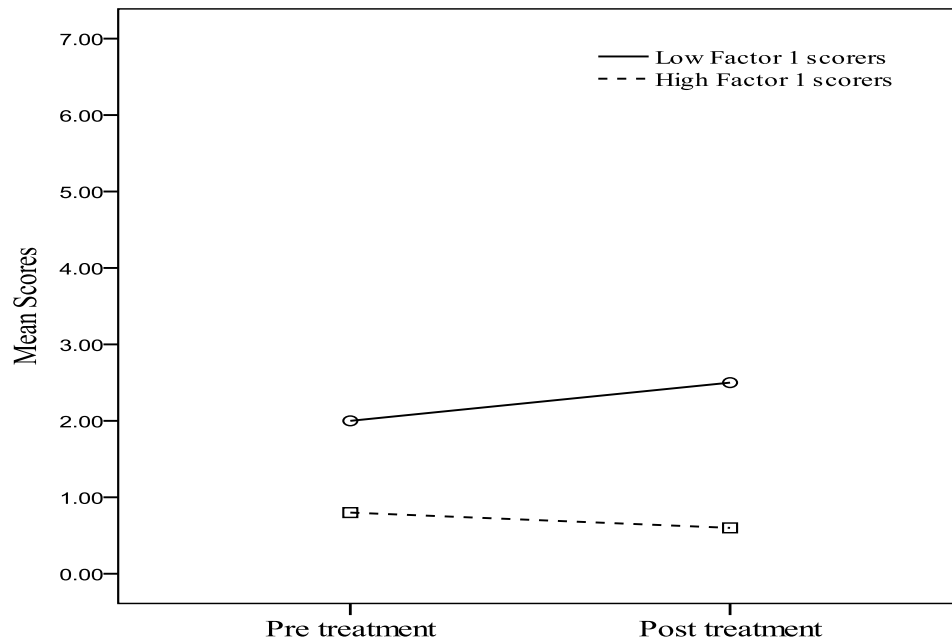


Figure 3.9. Mean Differences for the High/Low PCL-R Factor One Groups Regarding Pre- and Posttreatment PCS Scores.

3.5 Validation of the Study's Psychometric Measures- Bivariate Analyses

Spearman's Rho correlations were conducted among all pre and all post treatment measures, to assess participants' responses and the psychometric properties of the tests used. It was hypothesized that the more similar the constructs were that were being measured the more they would correlate. Although some correlations gained statistical significance, this was not expected due to the small sample size. With few exceptions, correlations in the expected direction were found between all the data sets. As per Tables 3.9, 3.10, and 3.11, the PCS data negatively correlated with the six dissimilar measures both pre- and posttreatment. Pretreatment the SEQ and F4 of the CVTRQ negatively correlated with the WAI-C ($r = -.30$ for both measures correlations). The pretreatment WAI-T data negatively correlated with the CVTRQ ($r = -.10$). Six statistically significant positive correlations were found among the data sets.

Table 3.9

Pretreatment Spearman's Rho Correlation Coefficients

Scales	PCS	SEQ	WAI-T	WAI-C	READ	RESP	CVTRQ	CVTRQ -F4
PCS	.00	-.51	-.06	-.08	-.71*	-.26	-.51	-.20
SEQ		.00	.26	-.30	.40	.16	.17	.42
WAI-T			.00	.00	.29	.71*	-.10	.22
WAI-C				.00	.30	.08	.57	-.30
READ					.00	.41	.20	.09
RESP						.00	.31	.18
CVTRQ							.00	-.01
CVTRQ F4								.00

Tests are two tailed with an alpha level set at .05

*indicates statistical significance with an alpha level of .05

** indicates statistical significance with an alpha level of .001

Table 3.10

Posttreatment Spearman's Rho Correlation Coefficients

Scales	PCS	SEQ	WAI-T	WAI-C	READ (p)	RESP	CVTRQ	CVTRQ -F4
PCS	.00	-.27	-.03	-.60*	-.45	-.35	-.43	-.19
SEQ		.00	.05	.24	.15	.10	.91**	.46
WAI-T			.00	.03	.23	.23	.19	.06
WAI-C (p)				.00	.58 (.06)	.69*	.23	.20
READ					.00	.90**	.12	.32
RESP						.00	.06	.50
CVTRQ							.00	.31
CVTRQ F4								.00

Tests are two tailed with an alpha level set at .05

*indicates statistical significance with an alpha level of .05

** indicates statistical significance with an alpha level of .001

The results of the Spearman's Rho correlation coefficients for participants' change in scores from pre- to posttreatment were mixed. The TRRG:SV responsivity scale was the most sensitive measure regarding pre- to posttreatment score changes whereas the two WAI measures were the least sensitive regarding score changes (see Table 3.11).

Table 3.11
Change Score Correlations

	PCS	SEQ	WAI-T	WAI-C	RESP	READ	CVTRQ
PCS	.00	-.58	-.09	.18	-.13	-.26	-.03
SEQ		.00	.34	-.20	.37	.24	.12
WAI-T			.00	-.01	.73*	.57	.51
WAI-C				.00	.03	.01	-.27
RESP					.00	.78**	.68*
READ						.00	.48
CVTRQ							.00

Tests are two tailed with an alpha level set at 0.05

*indicates statistical significance with an alpha level of .05

** indicates statistical significance with an alpha level of .001

3.6 Individual Results

Individual improvements were calculated according to raw scores. The participants' responses on the evaluation form were also summarized. Moreover, a subgroup of the HRPP participants improved markedly on many of the psychometric measures. Summaries of the individual results can be seen in Tables Appendices L.1, M.1, and N.1. Table L.1 (p. 126) shows the raw scores and change scores for each participant on each psychometric measure. Table M.1 (p. 129) summarizes the PCL-R scores, evaluation questionnaire results, and psychometric measure results. Table N.1 (p. 133) is a summary of participant's demographics and mean percentage improvement indicating participant's rank order of improvement.

Participant one's PDS scores remained within one SD of the mean throughout the programme. Participant one improved his total scores on only two of the study measures and two of the possible 10 subfactors of these assessment

tools. He also usually started with very high scores on the measures leaving little room for improvement. In the posttreatment evaluation questionnaire participant one wrote that he “wanted to do [an] everyday counselling course”, thus the course was not as he expected. Although he had done two other courses, he liked the depth of this course and the new skills it provided (skills he never knew he needed). Participant one least liked “having to get to grips with the group”, however he recognized the “value” that working in a group provided. He also disliked, and would have changed the prison environment he was residing in, to participate in the HRPP. During the course participant one noticed that he engaged differently with others, was more motivated, set goals, and that he could not hide his positive attitude towards the programme.

Participant two's pretreatment PDS score was 1.6 SD below the mean and .7 of a SD above the mean at posttreatment. Participant two increased his total scores on six out of seven of the study measures, as well as seven of the possible 10 subfactors contained in these assessment tools. Participant two had completed other interventions prior to participation in the HRPP, and wrote that although this courses material was challenging he liked the length of the course as it gave him time to work through issues. He reported that he learnt about acceptance of himself and others, and how to better manage his emotions. Participant two expected more free time during the programme, and disliked the down-grade in security levels of the HRPP prison and its poor hygiene. Hence, he suggested a nicer environment with better exercise and toilet facilities for future programmes.

Participant three improved on the total score of two of the study measures, and on five of the possible 10 subfactors. His scores did not reveal any specific patterning or theme. His PDS score began at 1.6 SD below the mean and ended at .4 of an SD below the mean. Participant three did not fill out an evaluation questionnaire following programme completion.

Participant four increased his total scores on five of the seven study measures, and increased his scores on seven of the 10 possible subfactors of these assessment tools. His pre- to posttreatment PDS score remained within one SD of the mean. He perceived that coercion existed in three domains throughout the programme, yet he increased his scores, ranging from 11-13.5 points, on the CVTRQ total score, WAI-T, and the TRRG:SV responsivity questionnaire. Participant four did not complete an evaluation questionnaire.

Participant five improved his total score on six of the seven study measures, and eight of the possible 10 subfactors. His PDS score dropped from 1.6 to 1.9 SD below the mean at posttreatment. This participant wrote that he had completed three other courses, and that the HRPP was not as he expected. “Understanding distorted thoughts” and “recognizing high-risk situations” were the aspects he liked most about the course. The changes he noted in himself were “more insight, less use of gang signs, [and] accepting of others”. Although he reportedly understood the situation, he disliked the fact that one participant left the course prematurely. Consequently, he said that future courses should have more psychiatric and literacy support to prevent similar participant retention issues.

Participant six improved his total scores on three of the study’s measures and on scores of three subfactors. His posttreatment PDS score was one SD from the mean. Participant six wrote that he liked “the tutors and their style of support as it increased his trust”. He increased in the bond factor on both the WAI measures. He “expected change to be difficult and consequently did not have high expectations about treatment gains”. Participant six expected money for course participation to compensate for a lack of opportunity to engage in prison based employment while in treatment, and as this did not occur would have preferred the chance to work to fund his cigarettes. He also “disliked and would have changed being confined to socializing only within the HRPP group and living in a segregated unit”. Participant six had completed several courses including several alternatives to violence programmes and Straight Thinking courses. He had also attended previous individual counselling sessions, however due to lack of faith in his counsellor’s understanding of violence, he had withdrawn.

Participant seven increased his total scores on four measures and on scores of four of the psychometric’s subfactors. His PDS score changed from .4 SD above the mean at pretreatment to one SD below the mean at posttreatment. Participant seven decreased 21 points on the WAI-T scale, yet his own perception of treatment saw an increase of seven points on the WAI-C. He also increased his scores on F4 of the CVTRQ but decreased scores on the SEQ. This participant remarked that he liked “gaining insight into ... [his] own behavior and those [inherited]”. He disliked being away from his family and, thus, would alter the programme in the future by providing one at his local prison. Participant seven

wrote that he learnt new “psychosocial skills, goal-setting, and communication skills”, and wrote that he became “committed to change”. Participant seven had no unmet expectations of the course, and had engaged in no previous treatment.

Participant eight improved his total scores on five measures and on scores relating to seven subfactors from the psychometrics. This participants pretreatment PDS score was one SD below the mean and his posttreatment score was 1.6 SDs above the mean. He increased his scores on five questionnaires, ranging from 1 to 16 points. Participant eight wrote that although “it did his head in at times” he liked the course’s “intensity and length”, writing that it suited his needs as in the past “due to the short course length he was able to evade participation”. He liked the insight gained regarding “all or nothing” cognitions. This man also found he “gained more emotional control and learnt to be more observant”. He disliked the high security level of the prison, however, he recognized it provided opportunities for him to practice his new skills and thus was unsure about recommending changes to this security situation. Participant eight experienced no unmet expectations regarding the course. Lastly, this participant noted he had participated in, and completed, three previous treatment programmes, including Montgomery House, Straight Thinking, and the Alternatives to Violence Programme.

Participant nine improved his total scores on six of the seven study measures (mostly in small increments except six points on the SEQ) and on scores relating to six of the subfactors from the psychometrics. His decrease in total score was on the WAI-C. He reduced 6.5 points pertaining to the Goal factor. His pre- and posttreatment PDS scores were 1.6 and 1.3 SDs below the mean respectively. Although this participant had not participated in any previous similar courses, the course was as he expected. Participant nine liked the practical exercises in the programme. He also noticed changes in his “attitude, his ability to trust, his style of thinking, his negative attitude towards others, his reaction to high-risk situations, and his increased thinking before reacting”. On the other hand, he found “talking about and processing past information in detail frustrating as he wanted to move on from his past”. Hence, he wrote he would possibly change this aspect of the course. He also would have liked the Tikanga component delivered by his favourite Maori cultural advisor.

Participant ten improved his total score on three of the seven study measures and on four of the 10 subfactors from the psychometrics. His improved scores ranged from .5 to 13.6 points. He decreased scores on the WAI-C, WAI-T and the TRRG: SV readiness questionnaire. The decreases ranged from -1 to -16 points. His pre and posttreatment PDS scores were .1 and 1 SD below the mean respectively. His PCS score increased by 3 points to end on 3 points out of 7 at posttreatment. Participant ten did not fill out an evaluation questionnaire.

Participant eleven increased his total score on six of the seven study measures and on seven of the 10 subfactors from the psychometrics. This included an increase of 42 points on WAI-T, compared to a 7.17 point increase on the WAI-C. He also increased 15 points on the TRRG:SV responsivity questionnaire, yet his level of perceived coercion was three points throughout the course of his treatment. His pre- and posttreatment PDS scores were 1 and .7 of an SD below the mean respectively. This participant found that the course helped him to “understand his personality, gain trust, and gain more control over his violence”. He also liked the abstention from drugs, and learning to cope with sobriety. Participant eleven disliked revealing his personal history, and disliked the role plays due to lack of confidence, however, he partook, revealing the course increased his confidence. Participant eleven preferred the programme’s individual therapy, as he found the therapists understood him and his passive-aggressive behaviour. This participant had completed four previous courses, for example, a parenting skills and the Straight Thinking course. He found he had no unmet expectations regarding this course, and would not change anything including the aspects he disliked.

CHAPTER FOUR

Discussion

4.1 Introduction

The High Risk Personality Programme (HRPP) pilot treatment project was intended to be responsive to the psychopath's personality within phase one of an experimental treatment programme, in order to help participants reduce their feelings of coercion and increase their levels of self-efficacy, therapeutic alliance, treatability, and readiness to change behaviour. Responsivity research has found that these factors are associated with cooperation, motivation, engagement, general treatability and treatment success, and, hence would aid success in the remaining behaviour change focused phases of the treatment programme.

The results of phase one of the programme will first be discussed on a group basis according to each measure, and then in terms of individual changes. Following the discussion of the individual changes, the the mediation effects of the two PCL-R factor one categories regarding interpersonal style are discussed. The strengths and limitations of the study are then considered. It should also be noted that due to the small sample size, all results and discussion regarding the project are tentative and need to be interpreted with caution.

4.2 Paulhus Deception Scale

The PDS was used to help validate other psychometric test answers, as, although not substantiated on self-report measures (MacNeil & Holden, 2006; see also Kropp, 1994; Poythress et al., 2001), some authors (e.g., Hare, 2003) suggest that characteristically psychopaths lie, deceive, and manipulate, and, thus, may answer questionnaires in a biased manner.

Pretreatment, a number of participants had scores that indicated impression management (participants 2, 5, and 9). Posttreatment, participants five and nine continued to have scores indicating impression management, with participant eight also found to have a score indicating an overly positive self report.

The results showed that some impression management or deceptive answering may have occurred pretreatment, but this was not apparent at posttreatment examination (t-scores were closer to the mean), and a positive correlation may be expected with self-efficacy and impression management, due to the similarity in constructs. Moreover, Mills and Kroner (2006) found in a sample of violent offenders that high scores on the IM scale reported lower antisocial attitude. Polaschek (2007) also suggests that socially desirable responding may not be ‘noise’ as previously suggested in the literature, but part of the predictive accuracy of self-reports.

In summary, the results are very tentative due to sample size, and possible high rates of deception in completing questionnaires. Thus caution in interpreting the results is needed.

4.3 Readiness to Change

Did treatment readiness improve (hypothesis one) as a result of the HRPP intervention? Although the distribution of the readiness data showed some anomalies, the main findings of the results of the CVTRQ and the TRRG:SV readiness subscale indicated, except for the emotional reaction subfactor (F2) of the CVTRQ, that the participants entered phase one of the programme ready to change. The change score correlations for the two readiness measures was moderate ($r = .48$) and the significant mean difference found in the CVTRQ total score was a product of the results of F4. The CVTRQ F4 scores will be discussed with the SEQ results in pp. 68-69.

Both readiness measure data sets had low-scoring outliers which moderated the results, and indicated either a measurement error (e.g., careless answering; Pallant, 2005), a heavy tailed distribution, two distinct sub-populations, or inherent natural variation (Barnett & Lewis, 1995). In terms of possible psychopathic subtypes, Skeem, et al. (2003) advocated for primary and secondary psychopathy, while Murphy and Vess (2003) advocated for four subtypes (narcissistic, borderline, sadistic, and antisocial). The most popular psychopathic subfactors identifying different population groups are the four subfacets, (derived from the two higher order factors), identified in Hare’s PCL-R (though Cooke & Michie (2001) suggested three factors; Skeem, et al., 2003). In fact any moderating variable as a result of dissimilarities in aetiology and

phenotypes can create a subtype. Measurement error was also possible and will be discussed in the limitation paragraph of this section.

According to a cut-off score of ≥ 72 , established using ROC curve analysis by Casey et al. (2007) for the CVTRQ, 9 of the 11 participants who completed the study measures entered the programme ready for treatment (10 participants at posttreatment). Also for the Offending Beliefs (F3), mean scores of 17.6 pre- and 17.57 out of 20 posttreatment indicated that the participants were not in denial about their offending behaviour. With mean scores of 23 pre- and 25 posttreatment, out of a possible score of 30, a similar inference can be drawn about the Attitude and Motivation subfactor (F1). The pre- and posttreatment means of the TRRG:SV readiness subscale were 17.45 and 17.79 respectively from a possible score of 24, compared to Serin et al's (2005) offender norms of 12.54 pre- and 16.61 posttreatment. Whether the means at 72.59% and 74%, of the highest possible pre- and posttreatment score respectively, indicate that, in general, treatment readiness existed is a matter for further research. Change scores in CVTRQ were moderately associated with change scores in the TRRG:SV Readiness subscale ($r = .48$). This indicates similar changes in scoring, and that a similar amount of sensitivity occurred in the measures for the participants. This further supports the notion of the participants being treatment ready.

N. J. Wilson (personal communication, 25 June 2009) suggested that the scarcity of treatments available to these offenders, due to the lack of treatment options in high security settings, may have influenced the participants' motivation to attend the treatment programme. Hirschi, Hindelang and Weis (1980) also wrote that volunteers (as these participants were) are more motivated. To extrapolate from Ward et al's (2004) theory behind the CVTRQ, on average these participants came to treatment with a positive attitude and were motivated. They were not in denial about the problem and impact of their offending. The programme also helped increase the participants' belief in their performance ability in order to change. Accordingly, these results were due to the meaning and relevance the participants found in the programme. Furthermore, the small decrease in mean scores for the Emotional Reaction subfactor (F2) of the CVTRQ (regarding distress, guilt and regret at offending) suggests, in accordance with Ward et al. (2004), that those classified as psychopathic typically have low scores on internal factors, such as low levels of distress and guilt. This suggests that this

area may be more difficult to treat during the first phase of the HRPP, that the treatment was ineffective in this area, or that the psychometric measure used in this area was not sensitive to any change or to the type of change occurring within the participant.

4.4 Treatability as Measured by the Responsivity Scale of the Treatment Readiness Responsivity Gain: Short Version

Hypothesis two of the HRPP pilot project was intended to address responsivity barriers. The first of these was treatability, as measured by the TRRG:SV Responsivity subscale.

In spite of there being two low-scoring outliers in the TRRG:SV responsivity subscale posttreatment data set, a statistically significant difference was found between the pre- and posttreatment means. Thus, with the exception of callousness, therapy appeared to be generally effective at increasing the participants' prosocial attitude or interpersonal style regarding offending and general behaviour. The results also indicated that the measure was sensitive to the changes occurring for the participants. Similarly, the participants may have had more knowledge and fewer barriers to overcome in this area.

Although their research had a different focus, these findings do not concur with Fishbein et al. (2006), who found that the psychopathic subgroup in their study performed worse on many neuropsychological tasks, including tasks reflecting impulsivity and cognitive inefficiency, and showed poorer responsivity to treatment. Similarly Polaschek's (2007) VPU responsivity results, using a NZ sample of high-risk violent offenders, most of whom were also high in psychopathy, were 9.9 pre- and 13.2 posttreatment, compared to this study's responsivity scores of 12.18 pre- and 17.02 posttreatment, and Serin et al's (2005) established offender norms for a cognitive skills programme of 13.68 pre- and 17.21 posttreatment. Polaschek (2007) suggested that the scores she obtained indicated that "at best they are contemplating whether they recognise the items in the tests as applying to them" (p. 42).

The item analysis results illustrated that the intervention was particularly effective regarding rigidity, power and control, and intimidation. It was also effective, though not reliably, regarding denial, procrastination and procriminal views, with no indicated effectiveness for callousness.

Frick (1998) suggested that callousness is a trait that develops in childhood as a function of a unique temperamental style, and needs to be addressed preventatively through a combination of prosocial parenting and psychotherapy. Callousness is also an item in factor one of the PCL-R (Hare, 1991, 2003), which stems from Clecklian psychopathy, and is suggested as a trait in the narcissistic variant of psychopathy, which is characterized by “grandiosity, entitlement and callous disregard for the feelings of others” (Murphy & Vess, 2003, p. 21). As such, callousness is likely to be maintained by core personality characteristics, and may not be amenable to change in the short term, and it may even be a response to the conditions of incarceration, especially in higher security prison settings.

4.5 Perceived Coercion

Although perceived coercion was found to be statistically insignificant in this study, the score did change. The posttreatment mean of 1.63, out of a maximum of 7, indicated low levels of perceived coercion. Moreover, only three participants scored 3 out of a maximum of 7 at posttreatment, and the rest of the participants started and remained with a coercion score of 3 or less throughout the study. The mean score in this study is less than that found by Daffern et al. (2010) and others (see Hoge et al., 1997; McKenna et al., 2003) who had a mean finding of 3.03 (using MPCS; range = 5; and which on aggregate is 4.02 out of 7) for psychopaths mandated indefinitely to a secure psychiatric hospital. However, it is higher than Rigg’s (2002) mean of .76, and higher than the calculated aggregate score of .96 (out of 7), for a high and low risk volunteer sex offender sample.

Although the PCS questions “were intended as indicators of a single latent variable” (Gardner et al., 1993, p. 314), and were developed with unidentical thresholds due to ‘noise’ to increase the questionnaires sensitivity for each response (Gardner et al., 1993), an item analysis revealed some patterns in participants’ responding. For example, six participants felt they were influenced to attend the programme. Also, at posttreatment, five participants felt that they were referred as opposed to self-referred, and five felt it was not their idea to attend the programme. All participants agreed that they chose to attend the programme, and all agreed that something good may come from attending the programme. This mixed pattern of influence is similar to Rigg’s (2002) findings whereby inmates

attending a sex offender programme admitted to receiving varying degrees and types of pressure to attend the programme, alongside their own willingness to attend the treatment programmes. The emerging theme also concurs with Monahan et al. (1995), who concluded that “researchers must transcend the ... dichotomy of the voluntary/involuntary legal status” (p. 259). Monahan advocated that there are “conditions to coercion as well as a relationship with these conditions” (p. 259). The results also concur with Wilds’ (1999) suggestion, that the very essence of the criminal justice system means that coercion exists, as well as with Gardner et al.’s (1993) and Ward et al.’s (2004) findings that, ultimately, coercion is subjective, depending on the client’s experiences and perception of their experiences.

Other authors, while reiterating a similar concept, frame it in terms of possible moderators’ effecting levels of coercion. Likely moderators include individual differences (Wild et al., 1999), high levels of trait reactance (Dowd et al., 1994), and parole eligibility (Day et al., 2004; Grubin & Thornton, 1994).

There was also no knowledge of any pressure from clinicians, family or friends (Gardner et al., 1993), or whether the participants attended in order to gain positive consequences, such as, prison privileges or to help gain early release on parole. However, the findings suggested that motivation existed for the participants, which according to Rigg (2002) and Winick & Wexler (2002) along with voluntariness helps maximise the participants’ attitude regarding the programme, and increases a person’s chance of treatment success regardless of the setting. The findings also concur with Ward et al. (2004), who wrote that for those subject to coercion, but who agree with the need for and helpfulness of treatment (as per item seven of the PCS: something good may come from attending this programme) coercion is not such a problem. This is also evident from participants’ high scores on the readiness questionnaires.

4.6 Perspectives on the therapeutic alliance

The therapeutic alliance, as measured by the WAI-C and the WAI-T, was also a potential responsivity barrier measured as part of the second hypothesis of the study. The WAI results suggested a partial therapeutic alliance existed pretreatment. The means were 72.91 and 64.5 out of 84, for the WAI-C and WAI-T respectively. The increase of .15 and 5.41 for each measure, respectively,

was not significant, although the WAI-T mean difference carried a medium effect size ($d = -.53$), and significance may have occurred with a larger sample. The current results concur with Taft et al. (2003), who found that a partial working alliance existed for a sample of partner-violent men, some with psychopathic characteristics, but did not increase from early to late in therapy. It also concurs with Taft et al. (2004), who found that interpersonal problems did not mediate the therapeutic relationship. Although Ross (2008) used the WAI-O, as she (and other researchers, e.g., Fenton, Cercero, Nich, Frankforter, & Carroll, 2001) found it to be a more accurate measure over a four time period, Ross also found a negative correlation between the working alliance and those with high PCL:SV scores in her study.

The significant increase in the WAI-C bond subfactor scores tentatively indicated that the participant's relationship with the therapist was seen favourably by a number of participants. The significant decrease in the WAI-C task subfactor scores tentatively suggested that the parties involved disagreed on tasks (programme factors or content) to achieve treatment goals. No significant increase occurred for the WAI-C for agreement on treatment goals. No significant changes occurred for any of the WAI-T subfactors. A number of variables may have contributed to any of these null results, including the sample size, moderators, the psychopathic personality, or the sensitivity of the measures. For example, Ross (2008) suggested that therapists who work with violent offenders may have a set of therapeutic skills that are not able to be detected by the WAI. Also the small number of items in the subfactors decreases their sensitivity to change. Similarly, Tichenor and Hill (1989) found that the WAI-C and WAI-T scores are not related to each other.

The Spearman's Rho correlation matrix showed some interesting correlations between both WAI's and the study's other measures, including the SEQ, Serin's readiness and responsivity scales, and the total score and F4 of the CVTRQ, but excluding the PCS. Pretreatment, the WAI-C scores correlated lower with the other measures (range = $-.30$ to $.30$) than the WAI-T scores (range = $.26$ to $.71^*$). At posttreatment, the WAI-C correlated higher (range = $.24$ to $.69^*$) with other measures than the WAI-T (range = $.05$ to $.23$). As expected, the WAI-T and WAI-C correlations were weak ($r = .00$ pretreatment; $r = .03$ posttreatment; $r = -.01$ change score). These results indicated that the participant and therapist

perceived the alliance differently pre- and posttreatment, and that the WAI-T and WAI-C may be measuring different phenomena.

Gelso and Carter (1994) suggested that rating discrepancies are expected due to the different client and therapist roles, and their intrapsychic and interpersonal reactions (for example, from differing attachment styles). Preston and Murphy (1997) also suggested that the difference in perception may be due to the therapist measuring the ‘mimicked’ relationship, that the psychopath is noted as motivated and effective in establishing.

Tichenor and Hill (1989) also “found that the client and therapist perspectives were not related and thus are not interchangeable” (p. 198). Notwithstanding Horvath and Symonds (1991), and Taft et al. (2003), advocate that the client is the most accurate predictor of the working alliance and treatment outcome, whereas Martin et al. (2000) found, from a meta-analysis, that it makes no difference who predicts the TA. Ross (2008) and Fenton et al. (2001) found that the WAI-O, which was not used in this evaluation, is the most accurate predictor of treatment outcome. When one takes the objective stance of the observer into account in scoring the WAI-O, this is not an unexpected result.

4.7 Self-Efficacy

Both self-efficacy measures, the SEQ and the CVTRQ F4, showed a statistically significant increase in group means. Individually, six participants increased scores by more than 10% on the SEQ, and nine participants increased scores by more than 10% on the CVTRQ F4. These consistent findings suggest that the intervention was an effective influence on levels of self-efficacy, which impacts on treatment success, and that the measures were sensitive to the changes that occurred.

Chambers et al. (2008) suggested that, if an offender has increased their self-efficacy regarding offending behavior, it means they acknowledge and take responsibility for their problems, have a desire to change, and set goals with the belief they can attain prosocial skills. The authors also add that previous experience in programmes can also affect self-efficacy beliefs. The outcome concurs with the CVTRQ F3 results, which indicated that the participants were not in denial regarding offending beliefs. Alternatively, Hemphill and Hart (2002) advocate that attributes such as arrogance influence the psychopaths desire for and

ability to tolerate novelty situations, and a need for superiority may strongly motivate them to achieve. Other authors, such as Sappington (1996) and Loza-Fanous (2003), also found that self-efficacy was a predictor of adjustment in prison, and may be a good predictor of participation and success in the next phase of the treatment programme, respectively.

Bandura and Locke (2003) advocate that self-efficacy contributes significantly to readiness. McMurrin et al. (1998) found that readiness as measured by Prochaska and DiClemente's stages of change (see Prochaska et al., 1992), correlated with self-efficacy ($r = .31$; $p = .001$). Day et al. (2009) found that readiness, measured by the Violence Treatment Readiness Questionnaire (VTRQ, an adaptation of the CVTRQ), correlated with self-efficacy ($r = .26$). However in this study, the participants started treatment with a degree of readiness, whereas self-efficacy improved throughout treatment. As a result of this specific baseline data, the correlations between the SEQ and the TRRG:SV readiness was .24 and between the SEQ and CVTRQ .12, lower than the other authors' findings. Neither of these correlations were statistically significant, which was likely the result of the HRPP sample size.

4.8 Individual Results

Although the treatment programme was evaluated on a group basis, individual results uncovered particular differences (Hirschi et al., 1980), and revealed how the facilitators were able to respond to each participant's idiosyncrasies. For example, in this study, six of the participants did well in the programme, improving on at least five measures. The TRRG:SV responsivity subscale was the most improved-upon measure, with nine participants improving their total scores. Moreover, the three participants that improved by the highest percentage (one participant by 62.4%), and on the most measures, improved the most on the TRRG:SV responsivity subscale. The three participants who improved the least had mixed results, including improvements on between two and four of the study's psychometric measures, as well as some major decreases on the other measures (see Tables L.1, M.1, & N.1, pp. 126-133). Participant one appeared to plateau on his pretreatment scores, leaving little room for improvement. He also improved on only two measures.

Seven participants increased scores on the TRRG:SV readiness subscale. Eight participants increased scores on the CVTRQ total score, including seven participants on F1 (attitude and motivation), and three participants on F2 (emotional reaction). Four participants increased scores on F3 (offending beliefs), although participants on this measure had high pretreatment scores. Although the participants entered the programme treatment ready to change, according to Ward et al. (2004), seven and eight participants improved on the CVTRQ total score and readiness subscale respectively. This result suggests that the measures were sensitive to the small changes that occurred. Ten participants increased scores on the F4 of the CVTRQ, and eight participants increased scores on the SEQ, suggesting that the programme and facilitators were responsive to efficacy deficits and needs, as well as the measure being sensitive to change. Similarly, the nine score increases and significant mean difference on the TRRG:SV responsivity subscale suggested that the programme facilitators were very responsive to the factors in this subscale. Coercion scores were low throughout the study except for three participants suggesting that there was a lack of facilitator responsiveness toward them or their barriers to change. For the mixed results that occurred for the WAI-T (seven participants increased scores: top increase 42 points, top decrease 21 points), and the WAI-C (six participants increased scores and five participants decreased scores), the results suggest a number of possibilities. For example, the therapeutic alliance can be a complex and individualized area to address whereby any process issue, disagreement or differences in ideas could impact on the alliance. Moreover, Preston and Murphy (1997) suggest that, ultimately, the therapeutic alliance is contingent upon the client's ability to establish a positive interpersonal relationship. For the participants that did not respond well in general, Hubbard and Pealer (2009) advocate that "the more issues an offender has the less likely the treatment will accomplish its objective" (p. 79). Thus, for some participants, the barriers and phenomena targeted may not have been the areas initially assessed as treatment targets, and some participants may have had many highly complex and deeply embedded psychopathologies that were difficult to influence during the first phase of the HRPP. Finally, a number of moderators or mediating factors may have impacted on any part of the programme, inhibiting success.

4.9 Moderating Variables

Demographic moderators were analyzed in this study, and were indicated for six of the seven top improving participants. Thus, what affected the treatment outcome demographic variables or the intervention? As per Table N.1, although the top improver was local, those who transferred to Waikeria Prison to participate in the programme took the 2nd to 8th rank in improvement. N. J. Wilson (personal communication, June 25, 2009) suggested that moving prisons indicated increased motivation, as most left more comfortable prison settings to attend the HRPP. Hirschi et al. (1980) also wrote that self-selection is evidence of motivation.

Five of the seven top improving participants were older than 31 years of age. These results concur with research by Andrews and Bonta (2006), Hare and McPherson (1984), and Hare (1998) who found that general and violent criminal activity dramatically reduces after age 40, with most desisting by age 50 (Hare, McPherson, & Forth, 1988). Bakker et al. (1999) also found that only 53% of NZ prison inmates over age 40 reoffend, compared to 95% of prison inmates under age 20. Hare et al. (1988) suggested that the desistence is due to either burnout, maturational lag (the development of strategies to remain out of prison) or older offenders realise behaviour change is needed to ensure a better future. Thus, age or maturation may have been a contributing factor to the success of these participants in the programme.

Five of the seven top improving participants had committed over 30 offences, and six of the seven top improvers had been imprisoned four or more times. N. J. Wilson (personal communication, June 25, 2009) suggested that those with repeated periods of imprisonments may eventually recognise the escalating punishing aspects of crime, and realise the need to change to gain rewards. Similarly, Ward et al. (2004) put offender change in terms of the Health Belief Model (see Chew, Palmer, Slonska, & Subbiah, 2002; Janz & Becker, 1984), that is, “a catalyst occurs to prompt change, the pros for change outweigh the cons, and they view themselves as susceptible to reoffend which they take seriously” (pp. 652-653).

The moderators able to be included in the current study were by no means all that could have been used to understand individual change variance. For example, Taft et al. (2004) found from a sample of 107 partner violent men that higher age and marital status positively moderated outcomes. Perceived support as

measured by appraisal, esteem, belonging and tangible support, and/or IQ could also have moderated these treatment effects.

4.10 The Evaluation Questionnaire

The evaluation questionnaire was intended to allow participants to express, in their own words, their thoughts, feelings, and opinions about what they had learnt about themselves. It also allowed the participants to state what they liked and disliked about the programme, which would aid improving future treatment programmes. However, as it turned out, the design of the evaluation questionnaire meant it had limited value regarding qualifying individual outcomes, but it gave some helpful feedback about the course itself.

Regarding the participants' likes and dislikes, five of the eight respondents did not like the high security environment they were residing in, and one participant requested more hygienic facilities. The HRPP project manager, N. J. Wilson (personal communication, October 28, 2010), confirmed that the unit used to deliver the programme was old (built in 1912) with the high security level severely restricting rewarding activities for participants, who spent large periods each day in their cells. Most respondents stated that they would have changed this restrictive and uncomfortable prison setting. Conversely, one participant thought the prison created a good learning environment. One participant noted the need to engage in prison employment (as he usually did) to provide an income to purchase cigarettes, an opportunity denied by the high security in the unit. Serin and Preston (2001) wrote that the environment needs to be value-added, and comfortable, and to create an environment where change is possible. Serin (1997) advocated that "external factors in isolation do not impact on responsivity, they need to interact with offender characteristics to affect responsivity" (p. 14).

Three participants did not fill out an evaluation questionnaire. Moreover, it was noticed that open questions often had answers of only two to four statements applied to them, even though facilitators assisted in gathering the evaluation information. Marks (2004) noted that open ended questions do not always elicit very full responses. Thus, as the results were limited, they could not be used to help qualify the results gained by the psychometric measures and were left as qualitative summaries.

4.11 PCL-R Factor One Score Mediation Effects

Some studies (e.g., Hare et al., 2000) have found, depending on the context of the study, support for PCL-R factor one scores mediating treatment effects, factor two scores mediating violent offending and reoffending, and support for no mediation effects at all. This study found mediating effects for participants with high PCL-R factor one scores on three scales: the PCS, the CVTRQ total score, and the WAI-C.

For both the CVTRQ and the WAI-C scale, the high PCL-R factor one group had higher pre- and posttreatment means than the low PCL-R factor one group. The results of the CVTRQ suggest that the low PCL-R group had lower levels of readiness though they were just above Casey et al's (2007) cut-off scores of ≥ 72 for readiness. The high factor one group mediated high readiness scores, creating a ceiling effect at pretreatment, and, thus leaving little room to improve. These higher scores could also reflect levels of impression management, a facet of their grandiose personality, or genuine scores. For the WAI-C, although a ceiling effect appeared to occur for the high factor one group, other authors (e.g., Hart and colleagues, 1995; Ross, 2008) have suggested that high correlations between psychopathy and WAI ratings reflect the selfish, callous, and remorseless interpersonal style that is related to their relationship building.

For coercion, whilst the high PCL-R factor one group decreased in coercion scores, the low group increased. There are a number of possible causes for the results, for example N. J. Wilson (personal communication, July 7, 2010) suggested that the increase in coercion by the low PCL-R factor one group may have been due to sensitivities or discomfort and pressure from the more predatory high factor one group. Rigg (2002) also found that resentment regarding treatment processes, such as unfairness, can influence coercion. This may have occurred for the low PCL-R factor one group, regarding not having been afforded procedural fairness, or not having had the cause of their anxiety addressed, for example not having had their concerns addressed regarding predation by the high factor one group.

These results, although, tentative, due to the range restriction when dividing the group into high and low factor one groups, suggest that high factor one scores or the psychopathic personality may mediate the therapeutic alliance as perceived by the participants. Having high factor one scores may also effect

authentic responding (creating a ceiling effect), and suggest confidence, or some other trait regarding answering questionnaires. The coercion results suggest those with low psychopathy carried anxiety regarding others behaviour, or the high factor one group exhibited more motivation and less coercion (which are correlated as per other authors findings). It needs to be reiterated that these results are only indicators.

4.12 Validation of the Participants' Responding and the Psychometric Measures Employed

Although many pretreatment correlations were as expected there were also some anomalies. For example, the readiness and responsivity scores correlated with each other and all other similar measures scores. As expected the PCS scores correlated negatively with all other questionnaires. The WAI-C and WAI-T each had two anomalous correlations, the SEQ had one anomalous correlation, and the two WAIs correlated at .00 (for details refer to page 55). At posttreatment all measures correlated in the expected direction though some measures correlated lower than expected. Some measures such as the SEQ and CVTRQ also gained significance ($r = .91$). The results also suggest that answering may have become more accurate at posttreatment (there were less anomalies).

The posttreatment correlations of this pilot project were also compared with other author's findings (see Table 4.1). Casey et al's (2007) measures were scored at midpoint in a cognitive skills programme regarding 177 medium-high risk offenders. Day et al. (2009) attempted to validate the violence treatment readiness questionnaire (VTRQ) an adaptation of the CVTRQ. Day et al. also scored their measure at midpoint of a semi-intensive violence intervention programme regarding 94 convicted male offenders. Ross (2008) used the WAI-O in her study of 50 offender's therapeutic alliance as she found it had higher predictive validity. The results in Table 4.1 suggest that Day et al's (2009) and Casey et al's (2007) results appear to be more similar compared to those obtained in this study. The correlations that are comparable with other similar research were those found for the PCS and CVTRQ, and the PCS and Serin's Treatment Readiness Scale (STRS) which is the self report adaptation of the TRRG:SV readiness subscale. This suggests that motivation and levels of coercion may be similar for volunteer offenders. The high correlation of the CVTRQ and SEQ are

likely to be a result of the high CVTRQ F4 scores. Moreover, the lack of similar correlations between WAIs may be a result of the different perspectives used. Interestingly Ross established in her study that the observer version was more accurate.

Table 4.1

A Comparison of the Correlations Found Between the CVTRQ, STRS, and the PCS, SEQ, and WAI in this and Other Recent Studies

Measures	HRPP pilot project	Casey et al. (2007)	Day et al. (2009)	Ross (2008)
	CVTRQ	CVTRQ	VTRQ	
SEQ	.91*	.23	.26	
PCS	-.43ns	-.29	-.37	
STRS	.12ns	.56	.51	
	STRS	STRS	STRS	STRS
PCS	-.45ns	-.48	-.55	
WAI-O	.			.12
WAI-T	.23			
WAI-C	.58 (.06)			
SEQ	.15 ns	.35	.48	
PCS and SEQ	-.27ns	-.16		

The change score correlations of the data sets indicated and compared the areas and amount of change occurring for the participants across the course of the intervention. Thus the high and significant change score correlations for the WAI-T and TRRG:SV responsivity subscale, TRRG:SV readiness and responsivity subscales, and the CVTRQ and TRRG:SV responsivity subscale indicate consistent answering and consistent intrapsychic change occurring for the participants across these domains. As expected, the change score correlations of the PCS were inverse in direction to all other measures, except the WAI-C. The WAI-C also correlated negatively with the WAI-T (-.01), the CVTRQ (-.27), the SEQ (-.20) and it correlated positively with the PCS (.18). Thus the change score

correlations of the WAI-C indicate there were barriers to the establishment of a therapeutic alliance but that this did not hinder the participants from succeeding in other related areas.

4.13 Strengths of the Study

The major factors that made this research project robust included following the five principles of effective programming, using CBT-based intervention, employing well-trained facilitators who understood the concept of psychopathy and who were responsive to the participants, employing a variety of well-validated psychometric measures; where some were duplicated, and attracting voluntary participants.

Andrews et al., (1990) advocate that cognitive behavioural therapy (which includes psychoeducation) and social learning approaches using techniques such as role plays and reinforcement are appropriate interventions for violent offenders. Sex offender rehabilitation programmes Kia Marama and Ti Piriti, which have been evaluated as successful, also use a social learning and CBT-based model (Blampied, 1999).

Three well-trained senior Registered Clinical Psychologists (including one Maori male and a Pacific Island female) facilitated the intervention. Another senior Clinical Psychologist (who is an approved PCL trainer) provided 'back up' to the therapists to ensure continuous programme delivery and assist with the individual therapy sessions. He also provided supervision for the facilitators to ensure programme integrity. Use of an experienced psychologist of Maori descent and a Maori Cultural Advisor experienced in treating violent offenders meant that cultural sensitivity was enhanced in the intervention. This concurred with what Ward et al. (2004) and Blampied (1999) suggest, regarding treatment success with Maori offenders.

Although the sample size was small which influenced the statistical power, the HRPP was experimental. Phase one consisted of four intervention sessions per week, including three group sessions of 2.5 hours, and one individual therapy session of one hour. The time involved meant that the facilitators could respond effectively to the participant needs, help with skill development and processing, and address responsivity barriers and, hence, bring about a state of readiness to change.

Although there are limitations to the use of self-report questionnaires with offenders (see limitations section; and Ross, 2008) this study also used interview-style questionnaires and a repetition of assessment measures such as, two measures of self-efficacy, two readiness measures, and the therapist and client versions of the WAI. Moreover the measures (except the evaluation questionnaire and the PCS which was adapted) had high internal consistency and were validated in other studies. Marks (2004) advocated that using similar measures and a repetition of measures increases the reliability and validity of a study. Use of the PDS also helped validate answering.

Lastly it is suggested that a research project is strengthened by involving a volunteer sample. The sample provided signed written consent to participate in the programme and were always aware and prompted that they were free to leave without adverse consequences. This is reflected in their pre- and posttreatment PCS means of 1.45 and 1.63, well below the 3.03 from a range of 5 found in Daffern et al's (2010) involuntary psychopathic sample and not dissimilar to Rigg's (2002) findings of .76 out of 5.5 for a sex offender sample. Hirschi et al. (1980) suggested and Rigg (2002) found, the very essence of volunteering in a prison means that there is an element of motivation although the reason for the motivation is unknown. For a fuller discussion on coercion see section 4.4 of the discussion chapter.

4.14 Limitations of this Research and Future Research Considerations

It is normal for a research project to have limitations. They may be a natural consequence, unavoidable, or simply part of the learning process. The major limitations of the current study included the small sample size, no control group, and lack of a literacy test (although no significant literacy issues were identified by the clinicians in the delivery of the HRPP). A minor limitation was the adaptation and dichotomous nature of the PCS and the design of the evaluation questionnaire.

Due to time and, resource constraints, and the experimental nature of the study, the sample comprised only eleven participants (the twelfth participant did not complete the programme) and although Cohen's (1988) special power tables were used in this study to estimate sample size needed, its small size means the projects results need to be treated with caution. It also created many limitations

for the study such as the chance of type one and type two errors (Bryman, & Cramer, 1990; Cohen, 1988). Also as gaining statistical significance is dependent on sample size, a large effect size can occur and not be statistically significant due to small sample size and low statistical power (Clark-Carter & Marks, 2004; for an example see the effect size for WAI-T total score results, p. 46). Lipsey (1989, as cited in Andrews & Bonta, 2006, p. 326) also suggested that size differences can be too small to detect in a small sample. The small sample size also meant that no inferences could be made about the larger psychopathic population (Heiman, 2000).

The small sample size also meant that no interpretation could be made of the outliers that occurred in the data sets. The outliers may have been true representations of the natural variation of psychopathy, or part of the possible response bias or sampling error. A larger sample may have revealed whether the data set's many outliers represented tail-enders or a variant of psychopathy. Although outliers are often rejected in large samples (Barnett & Lewis, 1995), Griffith, Stirling, and Weldon (1998) suggest that outliers, as unusual features of data, need to be carefully analysed as they can lead to important discoveries about the phenomenon in question.

Another limitation of the sample or the data was the skewed distribution that occurred, at times, and the violation of normality and homogeneity of variance. This made interpretation of the data difficult at times, however the data was left unchanged or transformed, as no interpretation could be made, due to sample size. Should replications of this research produce similar scores, a sampling distribution and a body of statistical evidence can be built up so that an inference to the population can be made (Heiman, 2000).

The test of mediation effects was also affected by sample size and no control group. Firstly the most appropriate test, a multiple regression, could not be conducted due to sample size. The range restriction within the data set before and after splitting the data set in order to conduct the SPANOVA tests meant that the tests were insensitive to any change that occurred. Moreover, although a within subject design measures a more authentic effect size (Lipsey, 1989, as cited in Andrews & Bonta, 2006) the use of a comparison control group would have better suited the SPANOVA tests as it would have created a more robust and sensitive test.

There are two problematic aspects to the literacy issue. The first and more minor issue is that one of the measures had 50 items and 30 were deemed unnecessary and removed. The length of this questionnaire could have been tiring. The second is that evidence of completed forms is not evidence of adequate reading skills. It is well known that reading difficulties are wide spread among those with problem behaviour and in prisons (Hirschi et al., 1980). Moreover, a self-report requires intellectual and analytical capacity and the capacity to quantify their responses using a numerical scale (Ross, 2008). Thus although the facilitators helped fill out the questionnaires where necessary, the addition of a literacy test may have illuminated a more accurate need for reading and writing support and thus increased validity of the evaluation.

Although not a great limitation, the PCS was adapted for offenders from use with psychiatric admissions and had two questions added that meant the knowledge base attached to this measure is not completely transferrable. This is particularly so regarding the correspondence analysis quantification to calculate scale scores. For example, where achieving a new security ranking is concerned the thresholds for coercion may be quite high (refer Gardner et al., 1993). Greenberg, Pritesh, and Seide (1993) defend the use of the PCS's dichotomous system saying people remain uncoerced as long as possible then shift categories thus creating a bimodal distribution. Rigg (2002) did not find this bimodal distribution in a correctional setting and concluded that "coercion is perhaps a more subtle phenomenon in correctional treatment settings" (p. 483). Monahan et al. (1995) also suggested that coercion is not a dichotomous variable, but a conditional variable.

The design of the evaluation questionnaire created limitations for the study. The evaluation questions could have been more specific to the psychometric measures used in the research initiative and hence able to qualify the results of each psychometric. It may have also been advantageous to enquire about the participant's reason for volunteering as this would have enlightened the situation regarding coercion and motivation.

The HRPP had a follow-up period with clinical contact, clinical notes, and reoffending data collected, however this aspect of the study was not within the scope of this study. Analyzing or attaching follow-up data to this study would have helped prove or disprove this study's outcomes and hence help validate its statistical and predictive power.

4.15 Conclusion

This research initiative was an evaluation of the first phase of a treatment programme, designed by NZ Corrections Psychological Service staff to treat violent imprisoned offenders who met psychopathy diagnostic criteria from the PCL-R. Phase one addressed responsivity barriers in recognition of the extensive research establishing that psychopathic offenders have higher numbers of responsivity barriers than other offenders. The evaluation had a quantitative as well as a qualitative approach in considering the effectiveness of the first phase of the programme in reducing responsivity barriers prior to delivery of the main intervention components of the programme.

It was a robust study that used well-validated psychometric tests (where possible) to measure important constructs relating to responsivity. It was based on sound theory and research. It employed programme facilitators with high levels of knowledge and skill relating to the treatment of high risk offenders. The limitation of the sample size was an artifact of the experimental nature of the intervention, and whilst it decreased statistical power it increased the facilitators ability to be flexible and creative in their efforts to address the participants' responsivity barriers.

Despite the limitations, six participants did very well in this research initiative increasing scores on at least five of the study measures over the course of treatment. A number of moderating variables appeared to support the success of some of the participants including: being over 31 years of age, experiencing multiple imprisonments, and volunteering to travel from another prison to attend the programme.

The patterns that emerged in the treatment were indicative of the above moderating variables, that is the clients entered the programme treatment ready as measured by both readiness measures. This occurred in spite of a small amount of perceived coercion. Still, the coercion was half the level found by authors

measuring coercion of involuntary psychopathic patients. The results also found that psychopaths are treatable (except for callousness) as measured by Serin et al's (2005) treatability measures. Self-efficacy significantly increased according to both psychometric measures. Although there was some improvement on the WAI-T as measured by a medium effect size this was not statistically significant. One of the most interesting occurrences of the treatment was the poor outcome of the WAI-C. First the different results obtained from the two WAI measures indicated the different perspectives of the therapist and participant. Second the lack of change seen by the WAI-C indicated that perhaps these are future targets, that is, to establish effective working alliances in the treatment of the psychopath; a finding which Ross (2008) also found was needed.

Other possible future research apparent from this pilot project includes replication of the study with additional samples in order to cross-validate the current findings, and analysis of the IQ and the wider personality profiles of the six participants that did well in the study. The latter could illuminate whether these six had any protective personality traits that mediated their success, such as low levels of callousness, and could be treatment targets in future research.

Finally, the method and procedure could be refined to improve reliability and validity of the study. The limitations and future considerations could be used to facilitate new research projects as well as improve future similar research. It is worth noting that research in this area is still in its infancy and the results of this study, while promising, are still tentative and not generalizable. However, these results may inform future NZ Corrections services attempts to develop a programme for psychopaths and high risk offenders in general.

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APPENDIX A

TREATMENT READINESS: SHORT SCALE**1. Problem Recognition**

This item assesses the offender's appraisal of their current situation. This is assessed in terms of their understanding and ownership of their problems. Those who accept full responsibility without rationalization would score a "3". Those who deny responsibility would score a "0".

Possible Questions:

- ☐ Did you hear a victim impact statement read in court? If so, how did that make you feel?
- ☐ How do you feel about yourself? Would you say you are satisfied or unsatisfied with who you are?

0	Views the problem is solely the result of others or circumstances (no ownership).
1	Views the problem as mainly the result of others or circumstances (marginal ownership).
2	Views self as a part of the problem (some ownership).
3	Views self as the major part of the problem (ownership).

2. Benefits of Treatment

This item is intended to tap into an offender's views regarding the overall benefits of participating in treatment. An offender who describes the long term benefits (e.g., lifestyle stability such as employment, relationships, no crime) *and* short term benefits (e.g., earlier release, fewer release conditions) of treatment would score a "3". Those who are unable to generate any benefits would score a "0".

Possible Questions:

- ☐ What do you think will happen if you do not participate in treatment? [or if you drop out]
- ☐ If you finish this treatment program, what types of benefits might you gain?

0	Sees no benefits of treatment.
1	Able to identify at least one long term <i>and</i> short term benefit of treatment.
2	Considers <i>limited</i> long term and short-term benefit of treatment.
3	Accurately considers long term <i>and</i> short term benefits of treatment.

3. Treatment Interest

This item addresses an offender's views about treatment. Those who describe treatment as beneficial to themselves *and* to others (e.g., family, friends, community) would score a "3". Those who cannot identify any benefits would score a "0".

Possible Questions:

- ☐ Why do you think someone would participate in a treatment program?
- ☐ What are your views about treatment in general? Do you think people benefit from it and how?

0	Not able to perceive benefits of treatment.
1	Perceives treatment as only beneficial for self.
2	Perceives treatment as beneficial for self <i>or</i> others.
3	Perceives treatment as beneficial for self <i>and</i> others.

4. Treatment Distress

This item is intended to address an offender's state of emotional distress regarding treatment. Offenders whose commitment to treatment is accompanied or prompted by emotional distress (notably anxiety or depression) warrant a score of "3", but only if they recognize the distress. Those who appear emotionally unconcerned and indifferent about the need for change score "0".

Possible Questions:

- ☐ How does the idea of participating in treatment make you feel? [If you are in treatment how did you feel before beginning treatment]
- ☐ What motivated you to consider participation in a treatment program? [looking for distress cues not cost/benefits]

0	Indifferent (absence of emotional distress) and sees no need for treatment.
1	Distressed, but does not motivate to consider change.
2	Distress motivates them to consider changing.
3	Evidence of emotional distress and wants to participate treatment.

5. Treatment Goals

Goal setting assesses the ability to identify and realistically create treatment goals. This item considers the knowledge and skills necessary for treatment gain. For example, someone with a lifelong history of substance abuse would score a “0” if their goal was abstinence without lapses following a 4 month program and a “3” if they are realistic about the new skills and knowledge necessary for treatment gain.

Possible Questions:

- ☐ If you were to participate in a treatment program what would you say were the issues you would need to address? How would you go about addressing these issues?
- ☐ How would you describe the treatment process? [try to get at whether they think that showing up for group will suffice or that more work is required than that]

0	Unable to set realistic treatment goals.
1	Unaware of skills <i>and</i> knowledge required for treatment gain.
2	Somewhat able to set realistic treatment goals.
3	Able to set realistic treatment goals.

6. Treatment Behaviors

This item assesses the offender’s motivation for treatment. Behavioral indication of good motivation should reflect, where applicable, timely attendance at interviews and/or groups; homework completion; compliance with prior treatment; and/or positive comments about treatment as a process not an outcome. More than one of these must apply to warrant a score of “3”.

Possible Questions:

- ☐ Have you participated in treatment before? If so, what is different this time?
- ☐ How did you find out about treatment? [i.e., what steps did he/she take in order to pursue treatment?]

0	Consistent behavioral indication of poor motivation.
1	Inconsistent indication of good motivation.
2	Somewhat inconsistent indication of good motivation.
3	Consistent behavioral indication of good motivation.

7. Motivational Consistency

This item highlights the importance of an offender's verbal statements *and* their actions regarding treatment. If an offender has not previously participated in treatment then this item refers to behavioral consistency outside of treatment (e.g., meets caseworker, etc...). Offenders who state they are motivated towards treatment, but show incongruence by poor attendance (late or infrequent), failure to complete homework, and/or state low motivation to other staff or offenders, warrant a score of "0". Those who consistently follow through would score a "3".

Possible Questions:

☐ [If you have participated in treatment before] How would the counselor or other group members describe you with respect to your participation? Did you go to all the sessions?

☐ [If you have not participated in treatment] How would your caseworker describe you? Have you attended all planned meetings with him/her?

0	Verbal and behavioral expressions of motivation are inconsistent.
1	Often inconsistent between stated motivation and actions.
2	Somewhat inconsistent between stated motivation and actions.
3	Complete congruence between verbal and nonverbal expressions of good motivation.

8. Treatment Support

This item assesses the degree of support for change by others significant to the offender. Allow the offender to determine who is important to them (preferably family, friends, employer, or clergy) and then probe for degree of support from them. Those having no support would score a "0". Those reporting strong support would score "3".

Possible Questions:

- ☐ Who would you say is the most significant person (s) in your life?
- ☐ What kind of support do you want from this person (s)? Would you say they are providing this support for you? How do they demonstrate this support?
- ☐ Does this person (s) believe you can change?

0	Reports <i>no</i> external support for changing.
1	Reports <i>minimal</i> external support for changing.
2	Reports <i>moderate</i> external support for changing.
3	Reports <i>strong</i> external support for changing.

Treatment Readiness Score Sheet

	Pre	Post	Change
1. Problem Recognition	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
2. Benefits of Treatment	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
3. Treatment Interest	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
4. Treatment Distress	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
5. Treatment Goals	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
6. Treatment Behaviors	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
7. Motivational Consistency	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
8. Treatment Support	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>

TOTAL	<input type="text"/>	<input type="text"/>	CHANGE	<input type="text"/>
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APPENDIX B

***Evaluation of Responsivity for
an intensive therapy program***

Program Assessment Measures

February 2007

Participant_____

Date_____

The following questions relate to how you feel about attending a violence program. Please read each statement and respond using the scale provided. For example, if you strongly disagreed with a statement you would circle the number 1. Please try to answer each of the questions, and remember, there are no right or wrong answers.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I am well organised	1	2	3	4	5
I am to blame for my offences	1	2	3	4	5
Treatment programs don't work	1	2	3	4	5
When I think of my offence I feel angry with other people	1	2	3	4	5
I hate being told what to do	1	2	3	4	5
I am not able to do treatment programs	1	2	3	4	5
I feel guilty about my offending	1	2	3	4	5
Programs are for wimps	1	2	3	4	5
Others are to blame for my offences	1	2	3	4	5
Being seen as an offender upsets me	1	2	3	4	5
Stopping offending is really important to me	1	2	3	4	5
I regret the offence that lead to my last sentence	1	2	3	4	5
Treatment programs are rubbish	1	2	3	4	5
I feel ashamed about my offending	1	2	3	4	5
I am upset about being a corrections client	1	2	3	4	5
I have not acted violently for some time now	1	2	3	4	5

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
When I think about my offence I feel angry with myself	1	2	3	4	5
I want to change	1	2	3	4	5
I don't deserve to be doing a sentence	1	2	3	4	5

In this next section we are interested in how you see yourself. Again read each statement carefully and circle the number that best describes you on a scale from 1 (not at all true) to 5 (very true). Please try to answer each of the questions, and remember, there are no right or wrong answers.

	not true		neither		very true
My first impressions of people usually turn out to be right	1	2	3	4	5
It would be hard for me to break any of my bad habits	1	2	3	4	5
I don't care to know what other people really think of me	1	2	3	4	5
I have not always been honest with myself	1	2	3	4	5
I always know why I like things	1	2	3	4	5
When my emotions are aroused, it biases my thinking	1	2	3	4	5
Once I've made up my mind, other people cannot change my opinion	1	2	3	4	5
I am not a safe driver when I exceed the speed limit	1	2	3	4	5
I am fully in control of my own fate	1	2	3	4	5
It's hard for me to shut off a disturbing thought	1	2	3	4	5
I never regret my decisions	1	2	3	4	5

I sometimes lose out on things because I can't make up my mind soon enough my mind soon enough	1	2	3	4	5
The reason I vote is because my vote makes a difference	1	2	3	4	5
People don't seem to notice me and my abilities	1	2	3	4	5
I am a completely rational person	1	2	3	4	5
I rarely appreciate criticism	1	2	3	4	5
I am very confident of my judgements	1	2	3	4	5
I have sometimes doubted my ability as a lover	1	2	3	4	5
It's alright with me if some people happen to dislike me	1	2	3	4	5
I'm just an average person	1	2	3	4	5
I sometimes tell lies if I have to	1	2	3	4	5
I never cover up my mistakes	1	2	3	4	5
There have been occasions when I have taken advantage of someone	1	2	3	4	5
I never swear	1	2	3	4	5
I sometimes try to get even rather than forgive and forget	1	2	3	4	5
I always obey laws, even if I'm unlikely to get caught	1	2	3	4	5
I have said something bad about a friend behind his or her back	1	2	3	4	5
When I hear people talking privately, I avoid listening	1	2	3	4	5
I have received too much change from a salesperson without telling him or her	1	2	3	4	5
I always declare everything at customs	1	2	3	4	5
When I was young, I sometimes stole things	1	2	3	4	5
I have never dropped litter in the street	1	2	3	4	5
I sometimes drive faster than the speed limit	1	2	3	4	5
I never read sexy books or magazines	1	2	3	4	5

I have done things that I don't tell other people about	1	2	3	4	5
I never take things that don't belong to me	1	2	3	4	5
I have taken sick-leave from work or school even though I wasn't really sick	1	2	3	4	5
I have never damaged a library book or store merchandise without reporting it	1	2	3	4	5
I have some pretty awful habits	1	2	3	4	5
I don't gossip about other people's business	1	2	3	4	5

The next set of questions is about how you feel about taking part in a treatment program. Again read each statement carefully and circle the number that best describes how confident you would feel in each of the situations described on a scale from 1 (not at all confident) to 5 (extremely confident). Please try to answer each of the questions, and remember, there are no right or wrong answers.

	Not at all confident	Not very	Somewhat	Very	Extremely confident
Talking in front of a group	1	2	3	4	5
Role-playing or play-acting in front of a group	1	2	3	4	5
Talking about your problems in front of people you don't know	1	2	3	4	5
Doing homework assignments	1	2	3	4	5
Discussing the details of your offence in front of the group	1	2	3	4	5
Keeping a journal of your thoughts, feelings, and behaviours	1	2	3	4	5
Disagreeing with another member of the group	1	2	3	4	5
Taking tests on what you have learned	1	2	3	4	5

In the following section we are interested in how you feel about taking part in the treatment program, Read each statement and then circle either True (T) or False (F) as it relates to you.

	True	False
I felt free to do what I wanted about coming into this treatment program	T	F
I chose to come into this treatment program	T	F
It was my idea to come to this treatment program	T	F
I had a lot of control on whether I came into this treatment program	T	F
I had more influence than anyone else on whether I came into this treatment program	T	F
If I had not been referred to treatment, I would have sought it on my own	T	F
It's possible that something good could come from this experience	T	F

Thank you for your time.

APPENDIX C

TREATMENT RESPONSIVITY: SHORT SCALE**1. Callousness**

This item describes offenders who have no concept of the injury they have caused others. Generally, they lack concern for others except when it can serve them. They present an air of ownership of others, with an expressed right to do as they please with impunity. Those who always put their own needs above those of others would score a “0”. Those who are able to be other centered would score a “3”.

Possible Questions:

- ☐ Can your family depend on you? Give an example of your dependability.
- ☐ You are in the desert and have one drink left...how would you feel about sharing it with your cellmate? With a friend? With a family member?

0	Uses people to meet own needs.
1	Indifferent about the needs of others.
2	Will consider the needs of family or close friends.
3	Takes others' needs into consideration.

2. Denial

This item measures the extent to which an offender rationalizes their criminal behaviour. Those scoring “0” deny their problems. These excuses can range from external reasons (e.g., drugs, alcohol, and social pressure) to internal concerns (e.g., bad childhood, past victimization, mental illness). Those offenders who fully recognize the extent of their problems and assume full responsibility would score a “3”.

Possible Questions:

- ☐ What part do you think you played in the present offense?
- ☐ What would you say is your biggest problem (s)? Are you concerned at all about this problem? How do you plan to deal with this problem?
- ☐ What does the police report say about the offenses? Do you agree with what was said in the report? Why/why not?

0	Denies he/she has a problem. “It’s everyone else’s fault”.
1	Refuses to accept they have a problem.
2	Accepts they have a problem, with reservations.
3	Assumes responsibility.

3. Procrastination

This item measures an offender's ability to set and meet goals in general. Those showing lack of effort, inability to follow through on plans, and lacking goals would be scored a "0". Those who are very task oriented and make very specific goals would score a "3". Being resistant, unwilling to do homework, and generally making excuses for failing to meet obligations should also be considered.

Possible Questions:

- ☐ Would others describe you as reliable? Give an example.
- ☐ How would friends describe your ability to follow through on plans?
- ☐ What are your goals in life?
- ☐ Give an example of a goal you set and achieved.

0	Doesn't follow through on plans.
1	Rarely follows through on plans.
2	Occasionally follows through on plans.
3	Very task oriented.

4. Intimidation

This item considers the intensity and expression of anger in interpersonal situations. Often their emotional expression of anger is excessive for the situation showing both an inability to evaluate the situation and poor self-control. Those who use their overt expression of anger to control and manipulate others would score a "0". Those who acknowledge that anger is a normal emotion and appropriately expresses it would score a "3".

Possible Questions:

- ☐ Have you ever felt so angry with someone that you felt like hitting them? Did you?
- ☐ Have others described you as having a 'short fuse'?
- ☐ Has anyone ever called you a 'bully'? Why?
- ☐ What do you do when you really want your own way?

0	Uses anger to intimidate others to get his way.
1	Willing to let anger help them meet their goals.
2	Aware and concerned about negative impact of his anger on others.
3	Doesn't intimidate others

5. Power and Control

This item is characterized by the degree to which the offender expresses entitlement when dealing with others. Their concept of fairness is solely egocentric, they respond poorly to criticism, and they must win at all costs. Offenders who score “3” would be described as respectful and fair, without a personal agenda. Those who view life as unfair and feel they own others would score a “0”.

Possible Questions:

- ☐ How do you feel about the sentence you were given? Do you think it was fair?
- ☐ Has life been fair to you or do you feel you got the short end of the stick?
- ☐ Would you rip someone off you did not know? Someone you knew?

0	When angered, controlled by views of entitlement and unfairness.
1	Feels life is unfair, so take what you can.
2	Feels life is unfair, look out for yourself.
3	Tries to be fair in resolving disputes.

6 Rigidity

This item considers an offender's ability to effectively problem solve. Those with the demonstrated ability to generate alternative solutions and be flexible would score “3”. Those who repeat ineffective solutions to problems and refuse to consider alternate solutions would score a “0”. This item should not be restricted to criminal behavior.

Possible Questions:

- ☐ Are there any concerns you have at the moment? How have you tried to deal with this problem? Are there any other ways of approaching this problem that you have yet to try?
- ☐ What kind of things have you tried in the past to stay out of crime? Are there any others things you have yet to try?

0	Rigid, sticks with a solution, even when it doesn't work.
1	Begins with an old solution, but can evaluate.
2	Considers new solution, but falls back on old ways.
3	Flexible, willing to try other things.

7. Victim Stance

This item describes offenders who are characterized by self-pity and present as being victims. Those offenders who appear unwilling to accept their culpability and look to others for support and to improve their situation would score a “0”. Those who don’t feel sorry for themselves and are able to learn from the consequences of their behaviors would score a “3”.

Possible Questions:

- ☐ How do you feel about your current situation?
- ☐ How can you improve your situation?
- ☐ What are you willing to do to make things better for you?

0	Wants others to fix it for them.
1	Just wants things to be better.
2	Willing to accept consequences of prior behaviour.
3	Accepts consequences and learns from them.

8. Procriminal Views

This item is intended to distinguish those offenders whose investment in crime is high from those who are essentially prosocial but whom have infrequently committed a crime. Those considered criminally-oriented (“0”) are reflected in their pride and self-righteousness in criminal thinking and values. This would be in contrast to those whose crime is situational and who lack criminal attitudes (“3”).

Possible Questions:

- ☐ Tell me what you think about what you did?
- ☐ How you think others would view your criminal behavior?
- ☐ How would you compare yourself to others in here (e.g., cell mate) with respect to what you did? Would you say your crime is more or less worse and why?

0	Presents pride in criminal views.
1	Criminal views present, but mainly due to lifestyle.
2	Some prosocial views noted.
3	Presents mainly prosocial views.

Treatment Responsivity Score Sheet

	Pre	Post	Change
1. Callousness	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
2. Denial	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
3. Procrastination	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
4. Intimidation	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
5. Power and Control	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
6. Rigidit	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
7. Victim Stance	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>
8.Procriminal Views	<input type="text"/>	<input type="text"/>	<input type="text" value="-3 -2 -1 0 +1 +2 +3"/>

TOTAL	<input type="text"/>	<input type="text"/>	CHANGE	<input type="text"/>
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APPENDIX D

WORKING ALLIANCE INVENTORY-CLIENT FORM

Below is a list of statements about your relationship with your therapist. Consider each item carefully and indicate your level of agreement for each of the following items. Please write down the rating scale because it makes it easier to answer items.

Does not Correspond at all		Corresponds Moderately			Corresponds Exactly	
1	2	3	4	5	6	7

1. My therapist and I agree about the things I will need to do in therapy to help improve my situation. 1 2 3 4 5 6 7

2. What I am doing in therapy gives me new ways of looking at my problem.
1 2 3 4 5 6 7

3. I believe my therapist likes me. 1 2 3 4 5 6 7

4. My therapist does not understand what I am trying to accomplish in therapy.
1 2 3 4 5 6 7

5. I am confident in my therapist's ability to help me. 1 2 3 4 5 6 7

6. My therapist and I are working towards mutually agreed upon goals.
1 2 3 4 5 6 7

7. I feel that my therapist appreciates me. 1 2 3 4 5 6 7

8. We agree on what is important for me to work on. 1 2 3 4 5 6 7

9. My therapist and I trust one another. 1 2 3 4 5 6 7

10. My therapist and I have different ideas on what my problems are. 1 2 3 4 5 6 7

11. We have established a good understanding of the kind of changes that would be good for me. 1 2 3 4 5 6 7

12. I believe the way we are working with my problem is correct. 1 2 3 4 5 6 7

APPENDIX E

WORKING ALLIANCE INVENTORY-THERAPIST FORM

Below is a list of statements about your relationship with your client. Consider each item carefully and indicate your level of agreement for each of the following items. Please write down the rating scale because it makes it easier to answer items.

Does not Correspond at all			Corresponds Moderately			Corresponds Exactly	
1	2	3	4	5	6	7	

1. My client and I agree about the things I will need to do in therapy to help improve my situation. 1 2 3 4 5 6 7

2. What my client is doing in therapy gives him new ways of looking at his problem. 1 2 3 4 5 6 7

3. I believe my client likes me. 1 2 3 4 5 6 7

4. My client does not understand what I am trying to accomplish in therapy.
1 2 3 4 5 6 7

5. I am confident in my client's ability to help himself. 1 2 3 4 5 6 7

6. My client and I are working towards mutually agreed upon goals. 1 2 3 4 5 6 7

7.1 feel that my client appreciates me. 1 2 3 4 5 6 7

8. We agree on what is important for my client to work on. 1 2 3 4 5 6 7

9. My client and I trust one another. 1 2 3 4 5 6 7

10. My client and I have different ideas on what his problems are. 1 2 3 4 5 6 7

11. We have established a good understanding of the kind of changes that would be good for him. 1 2 3 4 5 6 7

12. I believe the way we are working with my client's problem is correct.
1 2 3 4 5 6 7

APPENDIX F
EVALUATION QUESTIONNAIRE

Questionnaire to aid evaluation of responsivity issues for the Waikeria Prison intensive therapy program for high risk high needs offenders.

1. What did you like most about this treatment program?

(Facilitators, Tikanga Maori and culture, Attention, Learning, Location/environment, Activities, Temporary freedom, Change of routine, Making new friends, Awareness, Socialisation –governance, skills, culture, rules, norms, Social gain, Acceptance by others)

2. What did you like least about the treatment program?

(Facilitator, Tikanga Maori and culture, Attention, Learning, Location/environment, Activities, Change of routine, Not making new friends, Socialisation –governance, Skills, Culture, Rules, Norms, No social gain, Lack of acceptance by others)

3. Would you change what you disliked (question 2)?

3a. How would you change what you disliked?

4. Have you noticed any changes in yourself as a result from the treatment program?

4a. If so, what?

(Attitude, Using different language, Conversation skills, How I think about my self/others/tasks, Confidence – self and behaviour, Feelings, Consideration for others, Motivation to engage in activities, Interpersonal skills, Increased identity).

5. Was there anything you expected from the course but it didn't provide?

5a. If so, what?

(More free time, Rewards, Incentives, Guidance, Opportunity to open up/discussion, Self-efficacy, Increased skills, Autonomy, Maori values, Tikanga Maori)

6. Have you been in a treatment course for violence or anger before?

6a. If so how many?

7. How many of these past treatment programs did you complete?

7a. What was the reason(s) for not completing each of them?

(Did not identify with course content, Facilitators, Cultural underpinning, Boring, Too much homework, Group size, Upset routine, Did not learn anything, Too many rules, Got kicked off for my behaviour, Clashed with facilitators, Clashed with other commitments, Was moved by prison for organisational reasons)

APPENDIX G

An Explanation for Evaluating Responsivity Barriers Within the High Risk Personality Treatment Programme

The overall aim of the high risk personality programme is to help people lead better lives, lives that consist of personal and interpersonal success with family, friends, personal goals, and jobs, and lives with reduced reoffending and reduced violence.

The purpose of evaluating phase one of the treatment program is to assess how well it has helped participants engage effectively with the programme and later develop insight and skills to prevent future reoffending.

The evaluation consists of participants filling out some questionnaires describing:

- how they agree with the content, and goals of the programme
- the participants relationship with the people running the programme
- how much they want to engage in the programme and change behaviour
- how they are enjoying the programme and working with a group

The questionnaires are filled out at the beginning, and end of the programme. The questionnaires are the same each time and so they show any changes as participants work through the programme. At the end of the programme the facilitators will also ask you some questions about what you liked and disliked about the programme, and how your participation compared to participation in any other similar programmes.

The importance of the evaluation is that we can find out what worked well, what didn't, and how we could improve for future treatment programmes.

APPENDIX H

University of Waikato, Psychology Department

CONSENT FORM

PARTICIPANTS FORM

Research Project: Evaluating Responsivity Issues Within the High Risk
Personality Treatment Programme

Name of Researcher:

Name of supervisor (if applicable):

I have received an information sheet about this research project or the researcher has explained the study to me. I understand the methods used to collect data for the research project. I have had the chance to ask any questions and discuss my participation with the researcher and/or other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project, and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor or the Research Advisor for the treatment programme.

Participants Name: _____ Signature: _____ Date: _____

Waikato University, Psychology Department

CONSENT FORM

RESEARCHERS COPY

Research Project: Evaluating Responsivity Issues Within the High Risk
Personality Treatment Programme

Name of Researcher:

Name of supervisor (if applicable):

I have received an information sheet about this research project or the researcher has explained the study to me. I understand the methods used to collect data for the research project. I have had the chance to ask any questions and discuss my participation with the researcher and/or other people. Any questions have been answered to my satisfaction.

I agree to participate in this research project, and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor or the Research Advisor for the treatment programme.

Participants Name: _____ Signature: _____ Date: _____

APPENDIX I

Table I.1

Wilcoxon T-test Results for the WAI-T Total and Subfactor Scale Scores

WAI-T	Mean Difference	<i>T</i>	<i>P</i>
Total	5.41	-1.201	.12
Goal	-1.50	-1.131	.13
Task	-2.10	-1.249	.11
Bond	1.23	-1.162	.12

APPENDIX J

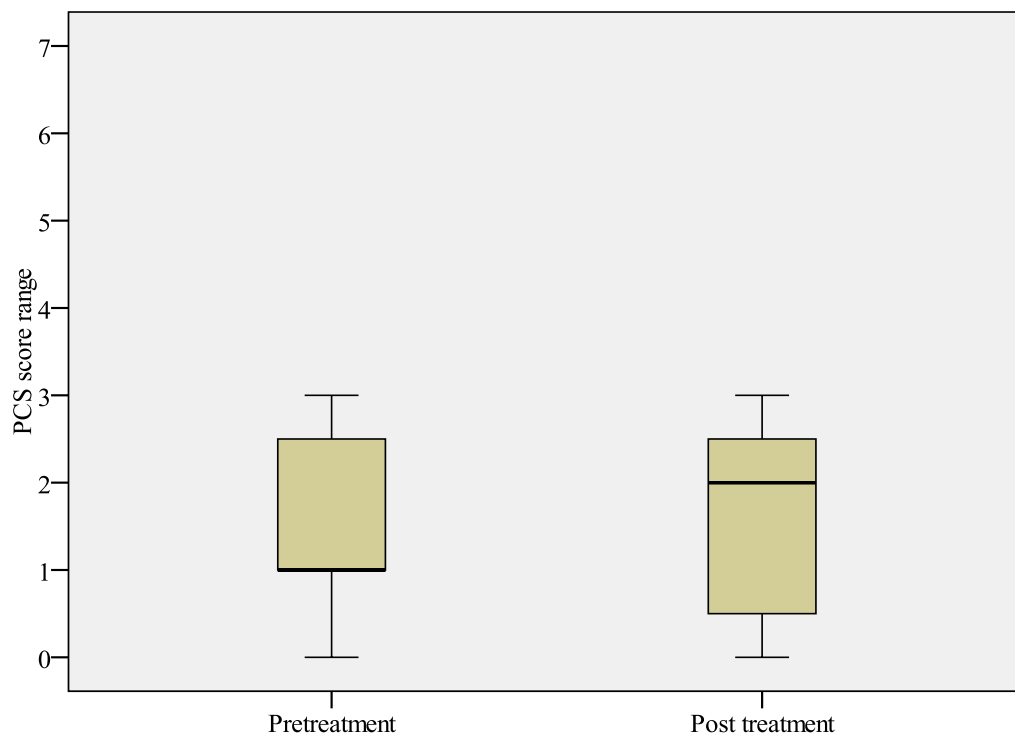
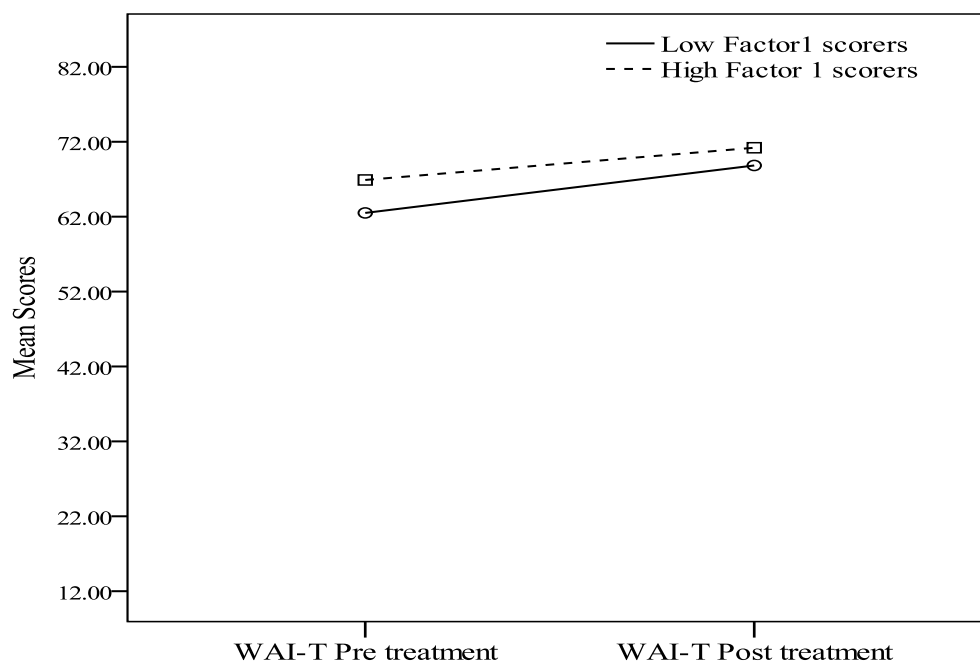
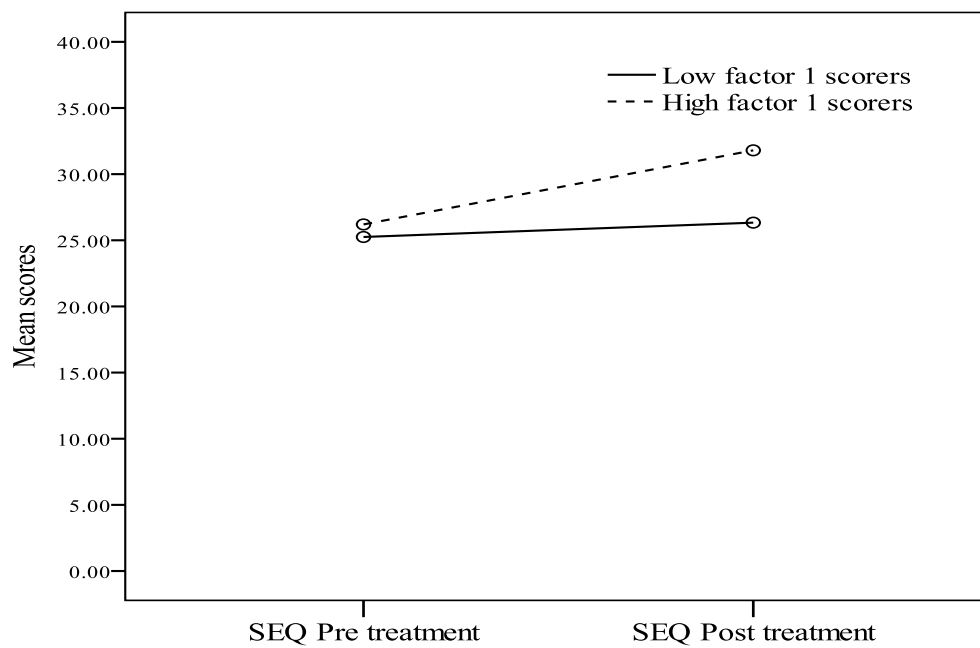
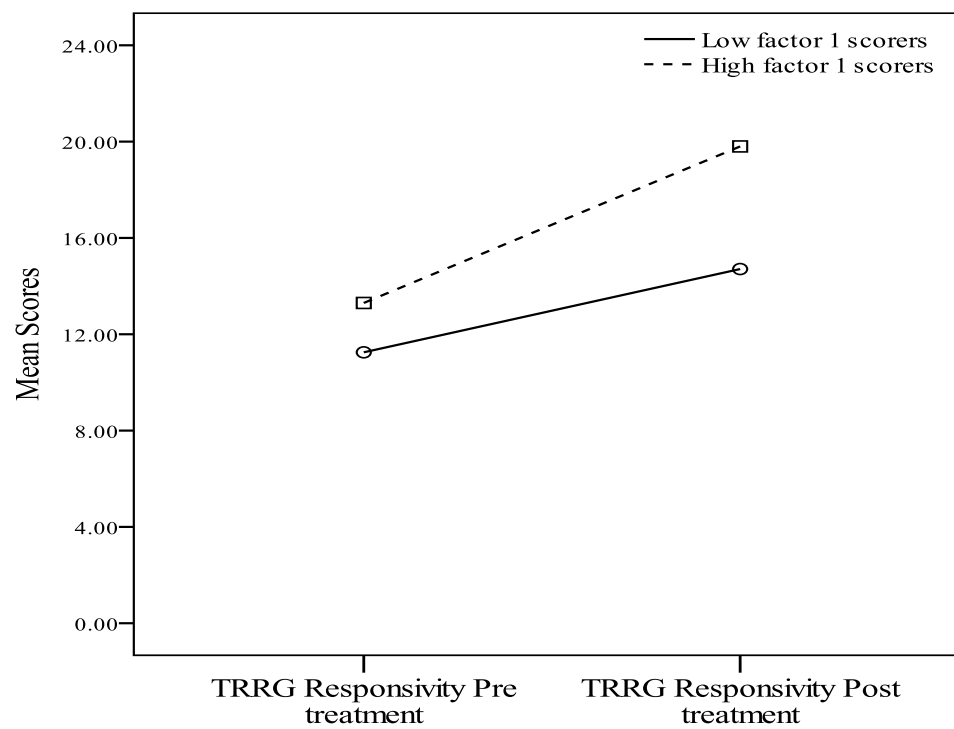
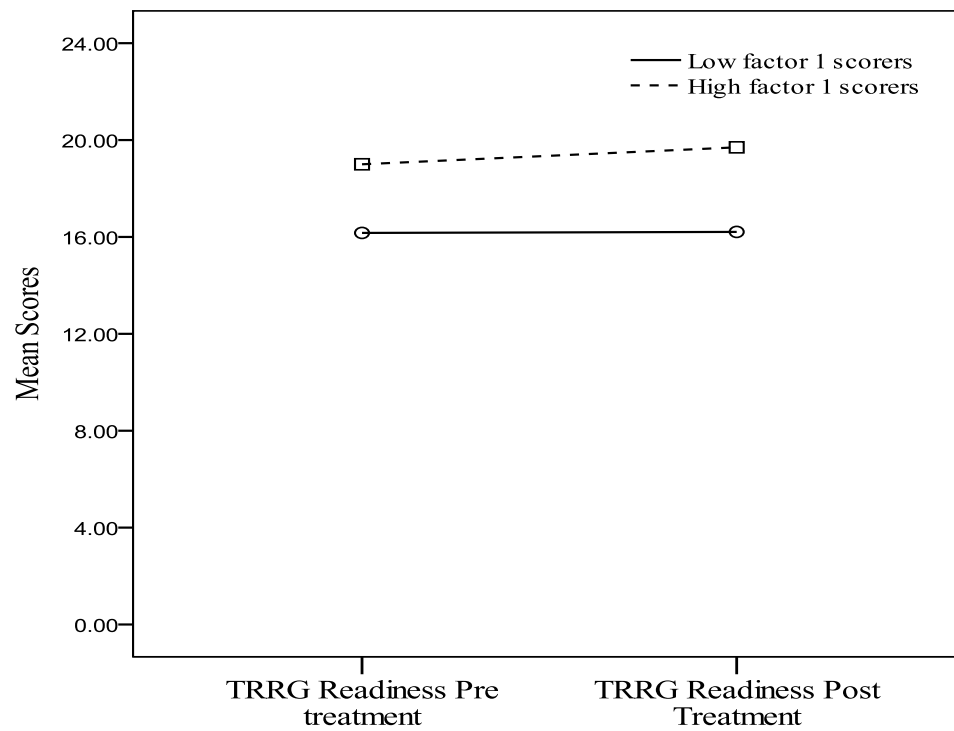


Figure J.1. Distribution of Participants' Pre- and Posttreatment PCS Scores.

APPENDIX K
Intervention Effects Regarding Each Measure with the Group Split into High and
Low PCL-R Factor One Groups





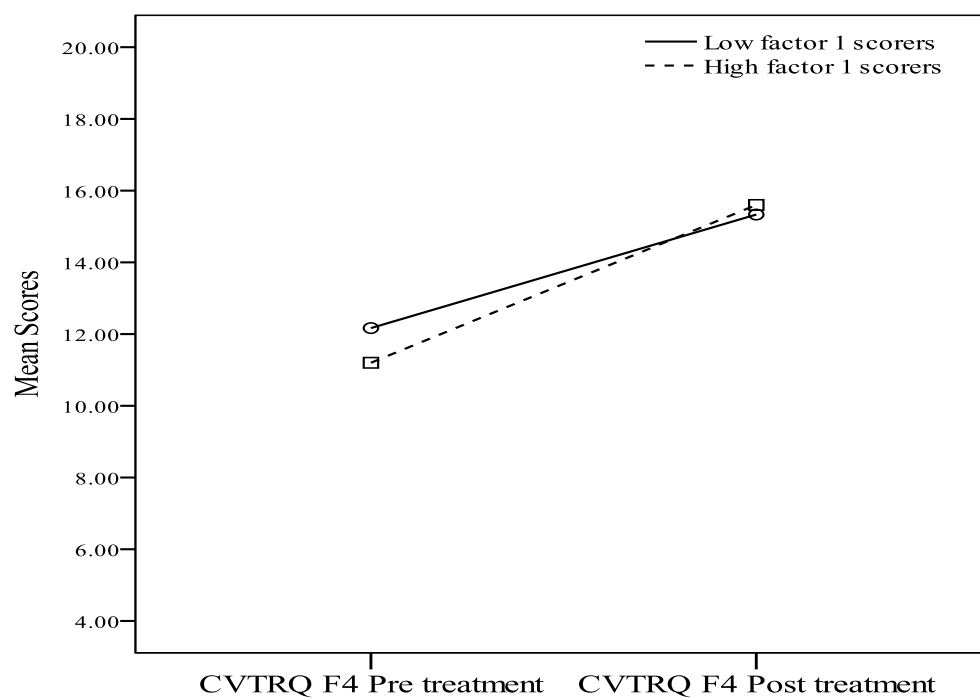


Table L.1
Participants' Pre- and Posttreatment Raw Scores and Change Scores

Participants	CVTRQ			CVTRQ Factor 1			CVTRQ Factor 2			CVTRQ Factor 3			CVTRQ Factor 4		
	20 (20-100) Items (score range)			6 (6-30)			6 (6-30)			4 (4-20)			4 (4-20)		
	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif
1	91.0	90.0	-1	28.0	30.0	2	27.0	26.0	-1	20.0	18.0	-2	16.0	16.0	0
2	87.0	94.0	7	29.0	30.0	1	29.0	28.0	-1	19.0	20.0	1	10.0	16.0	6
3	83.0	78.0	-5	27.0	24.0	-3	26.0	24.0	-2	17.0	15.0	-2	13.0	15.0	2
4	75.0	88.5	13.5	26.0	26.0	0	22.0	26.5	4.5	18.0	20.0	2	9.0	16.0	7
5	77.0	83.36	6.36	24.0	30.0	6	21.0	20.0	-1	17.0	17.36	.36	14.0	16.0	2
6	83.0	83.0	0	29.0	27.0	-2	30.0	26.0	-4	16.0	16.0	0	8.0	14.0	6
7	73.0	77.0	4	25.0	25.0	0	20.0	19.0	-1	17.0	16.0	-1	13.0	17.0	4
8	83.0	89.0	6	28.0	30.0	2	28.0	23.0	-5	19.0	20.0	1	8.0	16.0	8
9	65.08	68.0	2.92	23.08	25.0	1.92	12.0	14.0	2	17.0	17.0	0	10.0	12.0	2
10	71.4	85.0	13.6	21.4	28.0	6.6	20.0	24.0	4	17.0	17.0	0	13.0	16.0	3
11	74.0	77.0	3	22.0	24.0	2	20.0	20.0	0	17.0	17.0	0	15.0	16.0	1

Table L.1

Continued

Participant	Readiness (0-24)			Responsivity (0-24)			SEQ (8-40)			PCS (0-7)			WAI-C Total score (12-84)			WAI-C Goal (4-28)		
	Pre	Post	Dif	Pre	Post	Diff	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif
1	23.0	23.0	0	21.0	23	2	35.0	32.0	-3	0.0	0.0	0	81.0	82.0	1	25.0	28.0	3
2	17.0	18.0	1	12.0	18.0	6	29.0	34.0	5	1.0	0.0	-1	77.0	74.0	-3	26.0	22.0	-4
3	13.0	10.0	-3	17.0	6.0	-11	26.0	23.0	-3	1.0	2.0	1	65.0	72.0	7	20.0	24.0	4
4	12.0	16.0	4	6.0	17.0	11	30.0	33.0	3	3.0	3.0	0	71.0	70.0	-1	24.0	22.0	-2
5	16.0	19.0	3	10.0	20.0	10	28.0	32.0	4	1.0	2.0	1	71.0	74.0	3	22.0	24.0	2
6	21.0	17.5	-3.5	19.5	18.0	-1.5	14.0	27.0	13	1.0	0.0	-1	80.0	82.0	2	26.0	28.0	2
7	19.0	20.25	1.25	18.0	20.25	2.25	31.0	26.0	-5	2.0	2.0	0	68.0	75.0	-13	18.0	25.0	7
8	18.0	21.0	3	4.0	20.0	16	25.0	34.0	9	1.0	1.0	0	82.0	83.0	1	28.0	28.0	0
9	16.0	20.0	4	15.5	18.0	2.5	13.0	19.0	6	3.0	2.0	-1	76.0	69.5	-6.5	22.0	17.0	-5
10	22.0	13.0	-9	6.0	7.0	1	31.5	32.0	.5	0.0	3.0	3	58.0	42.0	-16	21.0	13.0	-8
11	15.0	18.0	3	5.0	20.0	15	20.0	25.0	5	3.0	3.0	0	73.0	80.17	7.17	22.0	28.0	6

Table L.1
Continued

Participant	WAI-C Task			WAI-C Bond			WAI-T Total Score			WAI-T Goal			WAI-T Task			WAI-T Bond		
	Pre	Post	Diff	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Dif	Pre	Post	Diff
1	28.0	26.0	-2	28.0	28.0	0	80.0	79.0	-1	27.0	26.0	-1	28.0	27.0	-1	25.0	26.0	1
2	28.0	28.0	0	23.0	24.0	1	61.0	79.0	18	20.0	25.0	5	20.0	26.0	6	21.0	28.0	7
3	24.0	24.0	0	21.0	24.0	3	62.0	65.0	3	21.0	22.0	1	20.0	23.0	3	21.0	20.0	-1
4	26.0	24.0	-2	21.0	24.0	3	63.0	74.0	11	23.0	24.0	1	20.0	26.0	6	20.0	24.0	4
5	25.0	24.0	-1	24.0	26.0	2	70.0	75.0	5	23.0	24.0	1	24.0	25.0	1	23.0	26.0	3
6	27.0	26.0	-1	27.0	28.0	1	63.0	58.0	-5	21.0	18.0	-3	20.0	19.0	-1	22.0	21.0	-1
7	25.0	26.0	1	25.0	24.0	-1	73.0	52.0	-21	24.0	20.0	-4	23.0	16.0	-7	26.0	16.0	-10
8	28.0	27.0	-1	26.0	28.0	2	60.5	65.0	4.5	20.5	22.0	1.5	20.0	22.0	2	20.0	21.0	1
9	26.5	25.0	-1.5	27.5	27.5	0	74.0	78.0	4	25.0	26.0	1	24.0	24.0	0	25.0	28.0	3
10	21.0	13.0	-8	16.0	16.0	0	62.0	61.0	-1	21.0	22.0	1	20.0	20.0	0	21.0	19.0	-2
11	28.0	27.0	-1	23.0	25.17	2.17	41.0	83.0	42	15.0	28.0	13	14.0	28.0	14	12.0	27.0	15

Table M.1

Summary of Participants' PCL-R Scores, Programme Evaluation Responses, and Measures Improved on

Participant	PCL-R Score	Measures improved on (points improved)	Program topics liked	Changes perceived in self	Program topics least liked	Changeable program aspects	Program expectations	Courses previously attended
1	Total Score: 33.3 Factor 1: 13 Facet 1: 5 Facet 2: 8 Factor 2: 17.8 Facet 3: 8.7 Facet 4: 9	RESP (2) WAI-C Goal (3) PCS (nil)	-Provision of skills -New skills learnt -Depth of course	-Increased interaction with others -Increased motivation -Goal setting -Attitude to program	-Unfamiliarity of the group -High security environment	-Provide a better prison unit for the program -Provide more facilities	-Wanted counselling course	-Maori focus unit course
2	Total Score: 32.6 Factor 1: 13 Facet 1: 6 Facet 2: 7 Factor 2: 17.8 Facet 3: 8.7 Facet 4: 9	SEQ (5) PCS (nil) RESP (6) READ (1) CVTRQ F1 (1) F3 (1), F4 (6) WAI-T Goal (5) WAI-T Task (6) WAI-TBond (7)	-Length of course -Time available to work through issues -Challenging material	-Better management of emotions -Learnt more self acceptance	-High security environment -Poor facilities ie hygiene. -High prison security level	-Provide better prison unit for the program -Provide better exercise and toilet facilities	-Expected more free time -The setting was a disincentive	-Straight thinking -Other prison programs
3	Total Score 30 Factor 1: 10 Facet 1: 5 Facet 2: 5 Factor 2: 18 Facet 3: 9 Facet 4: 9	CVTRQ F4 (2) WAI-T Goal (1) WAI-T Task (3) WAI-CGoal (4) WAI-CBond (3)						

Table M.1

Continued

Partici pants	PCL-R Score	Measures improved on (points improved)	Program topics liked	Changes perceived in self	Program topics least liked	Changeable program aspects	Program expectations	Courses previously attended
4	Total Score 31 Factor 1: 10 F1: 4 F2: 6 Factor 2: 19 F3: 10 F4: 9	SEQ (3) RESP (11) READ (4) CVTRQ F2 (4.5) F3 (2), F4 (7) WAI-T Goal (1) WAI-T Task (6) WAI-T Bond (4) WAI-C Bond (3)						
5	Total Score: 34 Factor 1: 13 F1: 6 F2: 7 Factor 2: 19 F3: 10 F4: 9	SEQ (4) RESP (10) READ (3) CVTRQ F1(6) F2 (.36), F4 (2) WAI-T Goal (1) WAI-T Task (1) WAI-T Bond (3) WAI-C Goal (2) WAI-C Bond (2)	- Understanding distorted thoughts -Insight into high risk situations	-Insight about self -Less use of gang signs -Acceptance of others	-Sad seeing a colleague leave the program	-Add psychiatric support	Nil	-Straight thinking , -Anti violence program (AVP) -An unrecalled program.
6	Total Score: 36 Factor 1: 13 Facet 1: 6 Facet 2: 7 Factor 2: 20 Facet 3: 10 Facet 4: 10	SEQ (13) PCS (nil) WAI-C Goal (2) WAI-C Bond (1)	-Style of facilitation - Increased trust of facilitators	-Realistic about the program -Change is difficult -Links to core beliefs	-Unable to work and afford cigarettes -Social isolation	-Change the prison segregation	-Money for participation	-AVP, -Straight thinking -Counselling

Table M.1

Continued

Partici pants	PCL-R Score	Measures improved on (points improved)	Program topics liked	Changes perceived in self	Program topics least liked	Changeable program aspects	Program expectations	Courses previously attended
7	Total Score: 31.8 Factor 1: 12 Facet 1: 5 Facet 2: 7 Factor 2: 17.5 Facet 3: 9 Facet 4: 6.2	READ(1.25) RESP(2.25) CVTRQ F4 (4) WAI-C Goal (7) WAI-C Task (1)	-Insight into own and familial behaviour	-Better goal setting -Better communicatio n -Increased commitment to change -Exhibiting more skills	-Isolation from family	-Provide a local program	-Nil	-Nil
8	Total Score: 34 Factor 1: 14 Facet 1: 7 Facet 2: 7 Factor 2: 18 Facet 3: 9 Facet 4: 9	RESP (16) READ (3) SEQ (9) CVTRQ F1(2) F3 (1), F4 (8) WAI-T Goal (1.5) WAI-T Task (2) WAI -T Bond (1) WAI-CBond (2)	-Course intensity and length -Individualised approach - Understanding cognitive distortions	-Less cognitive distortions -Increased emotional control -Observing environment more	-High security environment (though it provided opportunities to see personal change)	-Nil	-Nil	-Montgomery house -AVP -Straight thinking

Table M.1 *Continued*

Participants	PCL-R Score	Measures improved on (points improved)	Program topics liked	Changes perceived in self	Program topics least liked	Changeable program aspects	Program expectations	Courses previously attended
9	Total Score: 29 Factor 1: 11 Facet 1: 4 Facet 2: 7 Factor 2: 16 Facet 3: 8 Facet 4: 8	SEQ (6) PCS (<1) RESP (2.5) READ (4) CVTRQ F1 (1.92) F2 (2), F4 (2) WAI-T Goal (1) WAI-T Bond (3)	-Experiential learning	-Better attitude -Increased ability to trust -Ways of thinking -Less impulsive -Less negative thoughts about others	-Revisiting past offending - Detailed processing was frustrating	- Revisiting past offending / would prefer to focus on present	- Tikanga with favourite facilitator	-Nil
10	Total Score 32.5 Factor 1: 12 Facet 1: 5 Facet: 7 Factor 2: 17.5 Facet 3: 8.7 Facet 4: 8.7	SEQ (.5) RESP (1) CVTRQ F1 (6.6) F2 (4), F4 (3) WAI-T Goal (1) WAI-T Bond (3)						
11	Total Score: 28.4 Factor 1: 12 Facet 1: 5 Facet 2: 7 Factor 2: 14 Facet 3: 6 Facet 4: 8	SEQ (5) RESP (15) READ (3) CVTRQ F1 (2) CVTRQ F2 (1) WAI-T Goal (13) WAI-T Task (14) WAI-T Bond (15) WAI-C Goal (6) WAI-C Bond(2.17)	-Individual facilitation -Opportunity to gain sobriety	-Increased trust - Increased confidence - More understanding of personality -Increased control of my violence	-Disclosing personal experiences -Role plays	nil	Nil	-Montgomery house - AVP -Parenting course -Straight thinking -Mans action group.

Table N.1

Participants' Demographics and their Mean Percentage Improvement on all Psychometric Measures in Ascending Order

Partici- pants	No. of Measures Improved on	Mean % Improve- ment	Median Improve- ment	Range of Improvement by %	Highest Improved Measure	Age	No. Imprison- ments	No Offences >30	PCL- R Total Score	PCL- R Facet1 score	Location	RoC* RoI
11	6	23.22	12.48	0 – 62.4	Resp	>26	≥4		28.4	5	Local	<.70
4	5	14.65	15.28	-1.39 – 45.76	Resp	≤26			31	6	Away	≥.70
5	6	14.28	12.48	4.17 – 41.6	Resp	>26	≥4	>30	34	5	Away	≥.70
2	6	12.66	14.28	-4.17 - 25	WAI-T	>26	≥4	>30	32.6	4	Away	<.70
8	5	10.63	6.25	-15.63 – 62.4	Resp	>26	≥4	>30	34	6	Away	≥.70
9	6	8.62	10.4	-9.03 – 18.75	SEQ	≤26	≥4	>30	29	6	Away	≥.70
6	3	4.28	0	-14.56 – 40.63	SEQ	>26	≥4	>30	36	5	Away	≥.70
1	2	.69	0	-9.38 - 8.3	Resp	≤26			33.3	7	Away	<.70
10	3	.64	1.56	-37.44 – 42.84	PCS	≤26			32.5	4	Local	<.70
7	4	-2.22	5	-29.17 – 9.72	WAI -C	≤26			31.8	5	Away	≥.70
3	2	-10.61	-6.25	-45.76 - 9.72	WAI-C	≤26			30	5	Local	≥.70