2020

Association of Working Therapeutic Alliance and Psychopathy in Civilly-Confined Sex Offenders

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Walden University
2020

Abstract

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Kearie A. Newman

MS, Walden University, 2011

BS, University of Oswego, 2006

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

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Abstract

Over the past decade, researchers have focused attention on the therapeutic alliance (TA) and its impact in treatment outcomes. The literature on TA has been focused primarily on its impact on the client's participation, the accomplishment of goals, and treatment completion. However, very little of this research includes individuals who have psychopathy. Therefore, the purpose of this quantitative survey study was to explore the relation between the level of psychopathy (high versus low) and TA ratings of 16 therapists and 64 clients in the population of convicted civilly-confined male sex offenders. Bordin's theory grounded the study. Data were gathered from client and therapist surveys that were distributed to prospective groups in a civilly-confined client treatment setting in Upstate New York. Collected data were analyzed using an independent sample *t*-test. Results revealed no statistically significant difference between the ratings of TA generated by clients with low and high levels of psychopathy, nor was there a measurable difference between how clients with high and low levels of psychopathy perceived the agreement on treatment goals, collaboration on tasks, and the overall bond they shared with their therapist. The lack of a significant relationship between psychopathy level and TA held regardless of whether the client or therapist rated the TA. The findings of this study inform mental health care professionals in the development of more effective treatment plans and therapist training, by aiding in the breakdown of stigmas surrounding this population and assisting with their eventual reintegration into society.

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Acknowledgments

First and foremost, I would like to honor the memory of my mother, Geri-Ruth Eamer Theetge (1955-1983). Her memory will be with me always, and I know she would be proud of my academic endeavors. She graduated from high school with honors and was a former graduate of Onondaga Community College in Engineering Drafting before she passed at the age of 27 years old. My thoughts and prayers go out to her always.

I would like to express my deepest appreciation to my committee chair, Dr. Lisa Scharff, who has had the attitude and the substance of a scholarly professional. She continually and convincingly conveyed a spirit of adventure and development in regard to this research project. Without her guidance and persistent help, this dissertation would not have been possible. As my teacher and mentor, she has taught me more than I could ever give her credit for here. I am grateful to all of those with whom I have had the pleasure to work with during this project. Each of the members of my Dissertation Committee has provided me with professional guidance and taught me a great deal about both scientific research and being a scholarly learner.

Nobody has been more important to me in the pursuit of this project than the members of my family. My family has instilled in me hard work and the pursuit of my dreams and aspirations. I would like to thank my children, whose patience and understanding throughout this process have been immeasurable. They have been the ones who have inspired me to reach my goals and the desire to pursue a higher education. There have also been many friends and colleagues, too many to thank here, over the years of working on this project who gave so much support. And for that I am deeply grateful!

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Chapter 1: Introduction to the Study

Introduction

The question of whether or not psychopathic high-risk sex offenders are treatable and would benefit from a strong therapeutic alliance in therapy has been previously discussed in the literature (e.g., Abracen, Looman, Marquis, & Serin, 2005; Polascheck, Ross, & Ward, 2008). There is little empirical study on the topic, however, and most of the published literature "…does not support the supposition that those with psychopathic traits cannot form a therapeutic relationship with their therapist" (Blasko, Jeglic, & Walton, 2016, p. 15). Psychopathy itself is not recognized as a disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM 5; American Psychological Association [APA], 2015); however, researchers generally consider psychopathy to be a pattern of persistent antisocial behaviors (Ward & Beech, 2006).

It is a commonly held view that individuals with psychopathic traits cannot be treated, but this position has not been adequately supported by research (Abracen, Langton, & Looman, 2008; Blasko, Jeglic, & Walton, 2016). Researchers are just beginning to gain an understanding of psychopathic sex offender profile types as they apply to their risk to re-offend (Birt et al.,2000).

The term therapeutic alliance (TA) was originally a psychoanalytical concept, and psychodynamic clinicians generated much of the early research on TA. Therapist characteristics that promote a strong TA have been compared to the qualities of an interactive affective parent (Henry & Strupp, 1994). Recent research on TA has included many different theoretical frameworks, and researchers consider the TA as a prerequisite

to successful treatment outcome regardless of theoretical orientation (Michel, 2011). Although the definition of the TA can vary depending on the researcher, a good general definition of the TA is, "The basis of the therapeutic process in which patient and therapist become allies against mental illness and distress" (Michel, 2011, p. 13). Key concepts in the TA are collaboration between the patient and therapist, a creative process, shared goals, intimate interactive process, mutual bonding, and congruence between the patient and therapist (Michel, 2011).

A factor that plays a strong role in the TA is having a caring, sensitive, sympathetic, and helping therapist (Michel, 2011). Herman (1998) emphasized the interpersonal sharing and communication experience between the patient and therapist as having a strong influence in the TA. Recent research has focused on the influence of both the patient and the therapist, indicating that both have personality characteristics that can either promote or hinder the TA (Norcross & Wampold, 2011). Through this research study, I addressed a gap in the literature by examining the relation between client and therapist TA ratings in a population of civilly-confined sexual offenders who have been assigned to either low or high psychopathy treatment groups. The goal was to examine the relation between TA and psychopathy in this population.

Background

This study focused on examining the association of psychopathy and TA in a group of mandated therapy clients who were convicted of sexual assault, served time, and were civilly confined. The TA is considered to be an important component in the successful completion of treatment in high-risk sex offenders (Blasko & Jeglic, 2014;

Polascheck & Ross, 2010). It is generally well accepted that the TA impacts treatment effectiveness, and most researchers would describe the TA as being a byproduct of both the therapist's style and the perception of the client (e.g., Marshall & McGuire, 2003). The key characteristics in both therapists and clients that promote a strong TA include empathy, flexibility, reciprocal intimacy, healthy attachment, positive relationship, and a "generation of healing power" (e.g. Ackerman & Hilsenroth, 2003; Cottone & Feller, 2003; Meyer & Pilkonis, 2001; Muran & Safran, 2006). All of these are characteristics that most individuals high in psychopathy do not possess. Given that the TA may be an important factor in therapeutic outcome, it is important to develop the empirical research in this area in order to examine how psychopathy and the TA are associated.

The role of psychopathy in the ability to form a TA needs to be examined particularly in the area with civilly-confined sex offenders, because a large percentage of high-risk sex offenders also have high psychopathy (Birt et al.,2000). Most researchers would agree that psychopathy can be defined as "a psychological condition in which the individual shows profound lack of empathy for the feelings of others, a willingness to engage in immoral and anti-social behavior for short-term gains, and extreme ego-centricity" (Schouten & Silver, 2012, p. 13). Individuals with psychopathic traits have difficulty with both the ability to feel higher human emotions such as empathy, anxiety, guilt, and the ability to form loving attachments with others (Hare & Neumann, 2010). Psychopathy has been associated with difficulty completing treatment, as well as a higher risk to re-offend (Haldaman, 2012); however, this does not adequately support the position that individuals with psychopathic traits cannot be treated at all (Haldaman,

2012). It may indicate that individuals with high psychopathy need treatment that is specifically designed to address their unique characteristics.

Several researchers have demonstrated positive outcomes when there is a strong TA and healthy attachment style (e.g., Fernandez, Mann, Marshall, & Serran, 2003; Horvath & Symonds, 1991; Mann, Thornton, & Williams, 2000); however, there is little known about whether or how individuals with psychopathy can form a positive TA. Researchers have examined the role of the TA in offender rehabilitation as a possible key variable to elicit positive change (Ross et al.,2008; Walton et al.,2016). However, research examining both the TA and psychopathy is both minimal and largely outdated (e.g., Bandalos, Curry, Hanson, 2002; Blasko & Jeglic, 2014; Doren & Yates, 2008; Harris & Rice, 2006; Johansson, Kerr, & Louden, Skeem, Sndershed, 2007; Marshall & McGuire, 2003; Polascheck & Ross, 2010). Much of the literature in this field leans towards the idea that psychopathic individuals are incapable of forming a positive TA (D'Silva, Dugan, & McCarthy, 2004; Hare & Wong, 2005; Harris & Rice, 2006).

Historically, researchers have concluded that individuals high in psychopathy get worse in treatment (Clark, Grann, Hare, & Thornton, 2000; Cleckley, 1976; Seto & Barbaree, 1999). This is because treatment can give individuals with psychopathy a place to enable a manipulative agenda if not carefully monitored. Their motives may also not be genuine, which is a necessary component of the therapeutic process in order to make real lasting change. The majority of the research on TA also has not been conducted with the criminal justice population, which includes larger pools of individuals with high levels of psychopathy (Walton et al.,2016). McMurran (2002) reviewed published reports

on the topic and noted that most of the published literature has indicated that individuals with psychopathy have difficulty forming a positive TA due to their unique traits and characteristics. However, this appears to be an assumption rather than an empirically supported fact. Given the primary characteristics of anti-social behavior and lack of empathy that defines psychopathy (Scott, 2014), it is understandable why professionals might make the assumption that individuals who are high in psychopathic traits are difficult or impossible to treat with therapy. More recently, researchers (Olver & Wong, 2009; Salekin, 2002; Wilson & Tamatea, 2013) have pointed out that there is very little empirical evidence to support the position that psychopathic individuals do not respond to treatment. Individuals with psychopathic traits can show therapeutic improvement, and treatment can result in a reduction in violent behavior as well as sexual recidivism (Olver & Wong, 2009; Salekin, 2002; Tamatea & Wilson, 2013).

Recent research by Walton et al. (2016) focused on how the TA impacts treatment outcome in forensic populations, including sex offenders. This study utilized a sample of incarcerated sexual offenders ranging from 23- to 60-years old who were participating in a sexual offender treatment program in a maximum-security prison. The volunteer prison-based sex offender treatment program utilized a manualized cognitive-behavioral (CBT) treatment program that lasted 12 to 30 months depending on the programmatic intensity level needed by the offender. They found that regardless of the level of psychopathy, both therapists and clients alike reported an ability to form a TA (Walton et al.,2016). However, when the researchers examined sex offenders by their therapy placement separately (aftercare versus moderate-high intensity treatment) they found a significant

negative relation between the client ratings of personal bond between the therapist and client and psychopathy score (Walton et al.,2016). This indicates that while individuals with psychopathy may not feel connected to their therapists, they still can reach an agreement with their therapists about the therapeutic work that needs to be done and inevitably build enough of a TA to pursue that therapeutic work (Walton et al.,2016). Given the background of sex offenders with psychopathy and the varied backgrounds of those who treat them, there is a clear gap in the literature regarding investigation on how sex offenders with psychopathy can form a TA. There is also conflicting evidence and opinion regarding the development of the TA in populations with high psychopathic traits that makes continued well-designed empirical research vital.

Problem Statement

There are many differences in the process of therapy between mandated and non-mandated populations, including client ability to choose treatment goals (Ross et al., 2008). Mandated populations are typically informed of their treatment goals rather than given the freedom to choose their own goals (Ross et al., 2008). Because of this and other distinctions such as differences in the incidence of psychopathy and treatment length, research on the TA in non-mandated populations does not generalize to mandated populations such as sex offenders. There is a dearth of research in this area, and we know very little about how to engage mandated populations in therapy in a way that assists them in successfully completing treatment (Ross et al.,2008).

Given that the TA appears to be paramount in treatment outcome (Barkham, Cahill, & Hardy, 2007), and that this relationship is significantly different when working

with mandated as opposed to non-mandated populations (Ross et al.,2008), there is a need to investigate the role of the TA in clients who are mandated to participate in therapy. This would also apply to specific populations, such as clients with psychopathic traits, because not only are they typically mandated to treatment, but this group has unique personal characteristics within the mandated population that make it particularly difficult to treat them (Blythe, Ivanoff, & Tripodi, 1994; Rooney, 2009). This gap in the literature needs to be investigated further with high-risk psychopathic civilly-confined male sex offenders, as many are confined for years due to an inability to complete treatment (Miller, 2010). Information regarding the treatment process within this population may help inform the development of more effective and cost-efficient treatment programs thus benefiting the clients, their families, potential victims of inadequately treated individuals, treating professionals, and society in general.

Purpose

The purpose of the quantitative survey study was to investigate the relation between level of psychopathy (high versus low) and TA ratings in the population of convicted civilly-confined male sex offenders. Both client and therapist TA ratings were assessed. There is a lack of knowledge regarding how psychopathy is related to the working TA from the perspectives of both the client and therapist. Understanding this relation better may help the development of treatment programs and therapist training to deliver more effective treatment for the mandated psychopathic population.

This study used Bordin's theory of the working therapeutic alliance by utilizing Working Alliance Inventory (WAI; Bordin, 1979; Hanson et al.,2002). Since the original

WAI was created, there have been several different revisions (Bandalos et al., 2002; Bordin, 1979). For the purposes of the study the WAI short version was used (Bordin, 1979). Both client and therapist WAI ratings were used as dependent variables. The WAI was used to assess the TA (dependent variable), and prospectively collected from both the clients and therapists. Psychopathy (the independent variable) was assessed prior to treatment initiation using the Hare Psychopathy Checklist (PCL-R: Hare, 1998) in individuals who attended mandated group treatment at a treatment center in Upstate New York, and this information was used to assign treatment group setting. Using a cutoff score of 30 for the PCL-R, individuals were pre-assigned to either a high or low psychopathy treatment group. The two treatment groups (low versus high psychopathy) was compared on both the client and therapist ratings of the WAI.

If a significant group difference was identified in either comparison (client or therapist), the subscales of the WAI (goals, tasks, and bond) were examined for differences. Minimal client demographic information was collected prospectively for descriptive purposes, as well as the WAI administration for all participants (clients and therapists).

Nature of the Study

The nature of this study was a quantitative survey design with a collection of data from 64 male residents and 16 therapists (i.e., residents, social workers, rehabilitation counselors, and psychologists) at a secure civilly-confined sex offender treatment program (SOTP) in New York State. The quantitative approach was used in order to determine the association between level of psychopathy as assessed by the PCL-R and

the TA as assessed by the WAI. PCL-R scores were previously used to assign treatment groups. Both the clients and therapists completed the WAI; however, the data were collected and coded in such a way that the information collected from the residents who participated in the study remained anonymous. The therapists' information was kept confidential and did not contain their names, but anonymity cannot be guaranteed for this group due to their data being more readily identifiable.

Research Questions

The research questions, as well as the null and alternative hypothesis that guided this study, were as follows:

RQ1: Do resident therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

$H_0$1: There will not be significant differences by psychopathy group, as determined by the PCL-R scores, in resident ratings of therapeutic alliance, as assessed by the WAI.

H_a1: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in resident ratings of therapeutic alliance, as assessed by the WAI.

RQ2: Do therapist therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

$H_0$2: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in therapist ratings of therapeutic alliance, as assessed by the WAI.

H_a2: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in therapist ratings of therapeutic alliance, as assessed by the WAI.

Theoretical Framework

The theoretical framework for this study is based on Bordin's (1979) working alliance theory. The working alliance theory is grounded in the broader work of attachment theory, as the ability to formulate close bonds directly impacts the TA. Bordin hypothesized that the TA between the therapist and the client influences treatment outcome. This theory emphasized how the collaborative therapeutic relationship assisted in the client's ability to overcome personal suffering and self-destructive behavior. Bordin described three specific ingredients in the working alliance. These included "an agreement on the goals that the therapist and resident must work on, collaboration on the tasks that must be worked on to achieve the goals and an overall bond that facilities the collaboration between therapist and resident" (Bordin, 1979, p. 255). According to this theory, if the elements of a positive working alliance exist throughout the course of therapy, a positive outcome is inevitable.

Bordin's (1979) framework associated the quality of the therapeutic bond with the degree of agreement on the therapeutic goals and tasks between the therapist and the client (Ross et al.,2008). Based on this model, Safran (1998) judged the "quality" of the TA on any negative shifts that may create a therapeutic rupture in the TA. This foundational theory of the TA can be used to examine the key elemental therapeutic characteristics that foster the TA, which is hypothesized to foster therapeutic growth.

It has been indicated that the development of a collaborative relationship with individuals who have psychopathic traits has been difficult to establish (Hare, 1998). Therefore, an investigation of TA in this population has implications regarding treatment

readiness and successful treatment completion. Theories such as Bordins (1979) have significant implications for the treatment of individuals who have psychopathic traits and their investment in therapy: if the TA traits are not incorporated within psychotherapy, therapy may not be effective. Bordin's theory would predict that psychopathy plays a major role in the TA as well as the ability to successfully complete treatment. Specific therapeutic tasks need to be taken on and followed through within treatment, such as not being confrontational. If there is no agreement between the therapist and the client on the nature of the therapeutic tasks, treatment will be unsuccessful. Seto and Quinsey (2006) stated that future research with individuals high in psychopathy needs to focus on whether or not treatment targets should be more of "proximal causes, psychotherapeutic traits, or behavior without specifically targeting proximal causes (or the primary cause-psychopathy)" (p. 598). Having this information will help us better understand how to help the psychopathic population be successful in treatment. Although this is only a piece of the puzzle, there is a need to examine how individuals with psychopathic traits who are in treatment view treatment goals and therapist interactions as a first step.

Definition of Terms

Civil-Confinement is the involuntary commitment for persons with certain sexual offenses (generally violent sex offenders) who are believed through a court of law to have a mental abnormality upon completion of a prison sentence (Find Law, 2018).

Interpersonal Schemas are deeply rooted cognitive structures and beliefs that help define a person's identity and relationship to others (Young, 2013).

Mandated sex offender (sexual abuser) is an individual who has committed a sex crime and has some kind of authority over them (superior court, sex offender registry, official) commanding them to pay their debt back to society in regards to their sexual acts (complete prison time, go to treatment, register as a sex offender, do community service) (Rooney, 2009).

Therapeutic alliance/therapeutic relationship (therapeutic alliance or the helping alliance) refers to the relationship between a healthcare professional and a client (or patient). It is the means by which a therapist and a client hope to engage with each other, and effect beneficial change in the client (The National Institute of Mental Health, 2016).

Working therapeutic alliance or working alliance is the identification of three interdependent components of the alliance: bond, tasks, and goals. The bond is the quality of the relationship formed in the treatment dyad that then mediates whether the patient will take up the tasks inherent with working toward the goals of a treatment approach. At the same time, the clinician's ability to negotiate the tasks and goals with the patient will also affect the nature of the therapeutic bond. This multifaceted view of the alliance underscores the complexity of the factors involved (Bender, 2005).

Psychopathy is personality disorder in which manifests amoral and antisocial behavior that often includes a lack of ability to love or establish meaningful personal relationships, extreme egocentricity, failure to learn from experience, failure to feel guilt from performing violent acts, a lack of empathy and remorse, etcetera. (Hare, 1993).

Assumptions

The primary assumption was that the participants would understand and be able to complete the WAI scales and that the information would be valid and an honest representation of the rater. Another assumption was that the individuals were assigned to high or low psychopathy groups accurately, as the PCL-R scores were not accessed, and group assignment served to distinguish the groups. As with any self-reported information, it is assumed that the participants were honest and accurate. Therapists, including, residents, social workers, psychologists, and rehabilitation counselors were participants, and it is assumed that they rated the TA accurately and to the best of their ability. The research goal was to study psychopathy and its relation to working TA in civilly-confined male sex offenders. Each client participant was given anonymity, as the WAI scores were examined by group assignment (high versus low psychopathy) rather than by individual.

Limitations

There are limitations intrinsic to the use of a convenience sample, and therefore with this study. Although this SOTP is more likely to contain the target population who are likely to volunteer to participate, recruiting sex offenders from a single civilly-confined psychiatric facility has limitations due to this population having particular characteristics that may set them apart from the general sex offender population. This population was limited to only males and therefore could not be generalized to women with psychopathy. Also, participants may have had other types of mental health issues that could have affected the TA, and those potential confounding influences were not assessed. Staff, therapists, were also participants, and some of them may have had their

own level of countertransference that may have influenced the ratings. Given that psychopathy level determined treatment group assignment, the groups are not mixed in psychopathy level, and there may have been group differences in atmosphere that may have not been directly linked to psychopathy, such as therapist expectations or demand characteristics, which may influence TA. The findings were not generalizable to women with psychopathy given the population was all male. In addition, although terms such as *therapeutic alliance* and *psychopathy* have been defined for the purpose of this study, other researchers may have different views about how these terms should be defined, and therefore generalizability may be limited given the lack of a consensus in the definitions used in this field of research.

Delimitations

This study was designed to examine the relation between psychopathy as defined by the PCL-R and the working alliance as defined by the WAI. Male sex offenders from a civilly-confined psychiatric treatment facility in Upstate New York were the participants, ranging from 21 to 90 years of age. Only participants who could read and understand the English language and were at least 21 years of age were utilized for this study. The findings of this research cannot be generalized beyond this specific population but may be used to inspire future research with similar populations in other geographic area to determine generalizability.

Significance

This project is unique because it addressed the need for research regarding the relation between psychopathy and the TA in a civilly-confined population. There is a

need for further examination of psychopathy and how that may or may not impact the TA with mandated civilly-confined sex offenders. The outcome of this research may have significant implications for social change in the treatment of civilly-confined populations and may also have implications for the growing number of individuals with psychopathic traits who are civilly-confined. There are significant long-term cost and space availability issues in treatment programs for these individuals. The increasing numbers of those being civilly-confined have contributed to arguments by advocates that civil-confinement is a downward spiral (Miller, 2010). Another social issue for this population is the belief that once an individual is detained, they will never be free again (Hasson & Ward, 2014). The expense of holding these individuals for years also adds to the dilemma regarding how these dynamics relate to progress in treatment.

Many convicted offenders being held in civil-confinement have complex trauma issues related to the loss of contact with their families, an inability to remain employed, and the struggle to be independent and integrate into the community (Criminal Justice Handbook Series, 2012). For these reasons, it is important for researchers to find better ways for this population to build a strong TA with their clinicians so that they can progress through treatment. Examination of whether and how psychopathy is related to the working TA promotes therapeutic civilly. Studies such as this one may help clinicians and researchers identify efficacious treatments that would benefit the individuals who are civilly-confined and improve the quality of therapy for those with psychopathic personality traits.

Civil-confinement carries a high cost to the resident, their family, and society as a whole. It typically costs a secure treatment facility $175,000 for each civilly-confined individual (Craig et al.,2010). Further research on psychopathy and the TA could help determine how to help this population successfully complete treatment, and as a result leave civil confinement. Successful treatment would result in a decrease in the offender's degree of dangerousness and a lower risk to re-offend. Assisting psychopathic sex offenders to successfully complete treatment under civil-confinement via better understanding how psychopathy relates to the TA in this population may help develop treatment to rehabilitate them and help their families function better psychologically and financially. In addition, more effective treatment can ease the overcrowding of civil-confinement centers and represent less cost to society in general, reflected in both a reduced re-offense rate and lowered treatment costs. There is a clear benefit to those who might be victims of potential re-offenders if more effective ways to treat those convicted of sexual offenders in identified.

Treatment facilities, the court system, and the parole board determine whether civilly-confined individuals under the Civil-Confinement law (Mental Hygiene Law of 2008, Article 10.01), are sexually violent predators and no longer a risk to society. The legal process may result in these individuals having extended treatment time, and as a result decrease their potential of being released into the community. However, further research on high-risk psychopathic sex offenders concerning their ability to internalize treatment could assist the legal process in better understanding when they are ready to go back into society.

When civilly-confined sex offenders are deemed less dangerous by the court system they are gradually released, typically out on highly supervised parole called Strict and Intensive Supervision and Treatment (SIST: Office of Justice Programs, 2016). Programs such as SIST help with overcrowding in civil-confinement centers along with providing the offender with an opportunity to be out in the community. Overcrowding in Civil-Confinement centers and prisons has become increasingly concerning (Wangenheim, 2009). Lawmakers underestimated the amount of space that would be needed for this population when sex offense laws were passed (Wangenheim, 2009). Overcrowding typically results in a lower therapist to resident ratio, which could be a disservice to the high-risk psychopathic sex offender (Wangenheim, 2009).

Successful reintegration of high-risk sex offenders who have been released from prison has long been a community focus (Baker, Brannon, Fortney, & Levenson, 2007); however, adequate research focused on variables related to treatment outcome in this population has been lacking. There has been an increase in high-risk psychopathic sex offender's remaining civilly-confined since the initiation of new Civil-Confinement laws (Marshall & McGuire, 2003). An investigation targeted at identifying factors that may allow high-risk sex offenders to successfully move through treatment may aid in the development of treatments that could lower their risk of re-offense (Andrews & Bonta, 2007). In the minimal research that has been done on the Civil-Confinement of high-risk sex offenders and their ability to form a TA, there has been some groundwork laid in demonstrating the importance this alliance may have in the high-risk sex offender

population (Bender, 2005). Some of this groundwork has been used for the framework of attachment theory, along with specific characteristics of what the TA encompasses.

Summary

Additional research is needed to understand psychopathy and the therapeutic process in civilly-confined sex offenders (Blasko et al., 2016). Davis, Garske, and Martin, (2000) found that regardless of therapy orientation, there was a consistent moderate relation between TA in a meta-analysis of 79 studies. Blasko et al. (2016) found that regardless of the level of psychopathy, both therapists and clients alike reported an ability to form a TA. There is indication from these two studies that while individuals with psychopathy may not feel connected to their therapists, they still can reach an agreement with their therapists about the therapeutic work that needs to be done and inevitably build enough of a TA to pursue that therapeutic work (Blasko et al.,2016). The purpose of this quantitative survey study was to examine the association of psychopathy and the TA in a group of male mandated therapy clients who have been convicted of sexual assault, served time and are in civil confinement. Recent evidence has suggested that psychopathic characteristics are treatable (Blackwood, 2012); however, there appears to be no literature on this topic with civilly-confined sex offenders. This is a unique population, and it is necessary to gather empirical data examining the relation between psychopathy and TA in this group. The goal of this study was to determine if group differences exist in the TA by psychopathy group. In Chapter 2, I provide a literature review of the TA and psychopathy, as well as the treatment of individuals with psychopathy. In Chapter 3, I provide information about the research design, procedures

used, participants, instrumentation, and the variables studied as well as the statistical analysis and ethical considerations.

Chapter 2: Literature Review

Introduction

Although researchers have established that having a strong TA increases treatment success with sex offenders (Blasko et al.,2016), there is a lack of research on the TA in high risk sex offenders with psychopathy, and many questions exist in the literature concerning the ability of individuals with psychopathic personality traits to succeed in treatment (Looman et al.,2005; Ross et al.,2008). There is some research on the TA that is focused on the general population of sex offenders; however, the characteristic of psychopathy and the relation of that characteristic to treatment outcome has not been examined (Blasko et al.,2016). Additional research is needed to understand how specific components of psychopathy, such as antisocial traits, are related to the TA (Beech & Ward, 2006). We need to better understand the extent to which individuals with psychopathy are treatable, as well as if and how the traits of psychopathy impact the TA (Beech & Ward, 2006).

There has been ongoing controversy among researchers regarding the origins of characterological traits of psychopathy including, congenital, biological, or behavioral (Cruise, Rogers, Salekin, Sewell, 2000; MacKenzie, 2014). Although the number of studies on the TA continues to grow, there is little information regarding whether individuals with psychopathy can formulate an adequate TA or be successful in treatment (Blasko et al.,2016).

Literature Search Strategy

The articles for this literature review were gathered by searching the following databases: PsycINFO, PsycARTICLES, Health and Psychosocial Instruments, and Academic Search Premier. Two reference works were also beneficial: *Mental Measurements Yearbook*, and the *SAGE Reference Encyclopedias*. The following keywords were used: *civil confinement, interpersonal schemas, mandated sex offender, therapeutic alliance/therapeutic relationship, working therapeutic alliance or working alliance,* and *psychopathy*. Articles published within the last 10 years and previous literature were included due to the limited availability of empirical studies on this topic, therefore the bulk of the research articles identified were five to 10 years old. There was limited availability of current empirical studies related to this topic. Identified articles were also reviewed for potential sources to inform the literature review and study development.

Theoretical Framework

Therapeutic Alliance

Bordin's theory of the working therapeutic alliance (TA) provides the theoretical foundation for the dependent variables and is used to establish a link between TA ratings and level of psychopathy (high versus low). It is broken down into three sections: (a) the first section provides a description of the theory; (b) the second section contains a description of the TA including its components, which are an agreement on the goals that the therapist and client must work on, collaboration on the tasks that must be worked on to achieve the goals, and an overall bond that facilitates the collaboration between

therapist and the client; And (c) the third section contains a description of attachment theory and how it relates to the TA, providing support for how individuals with psychopathy may have difficulty in establishing the level of attachment that is necessary in formulating a strong TA. The last section includes a critique of the theory and the limitations of Bordin's model.

Several theoretical models have been grounded in the concept that "treatment takes place in the context of relationships" (Booth et al.,2007, p. 4). Bordin (1979) believed that the working alliance was an important transtheoretical concept in psychotherapeutic treatment. His transtheoretical working alliance theory is a widely accepted concept in the literature (Booth et al.,2007). Bordin's model of the working alliance (1979) is a combination of attachment theory and reality-based psychotherapeutic treatment designed to focus on the "here and now" relationship between the client and the therapist (Bordin, 1979). The goal of building a strong TA is to develop positive change within the client. Previous studies have demonstrated that the TA is a robust predictor of client change, and therefore treatment outcome (Muran & Safran, 2006). Prior models of the TA such as psychoanalysis and Roger's client centered therapy focused on the "real" relationship between the therapist and client as being Upstate to the change process (Booth et al.,2007). Bordin assumed that the TA is a condition of treatment that facilitates change and is driven by specific therapeutic components regardless of orientation or approach. The TA was perceived by Bordin as the change agent in and of itself (Bordin, 1979).

A working TA can be thought of as the formulation between the client seeking change and the therapist offering to act as a change agent. A working TA incorporates a mutual understanding and agreement about change goals and the necessary tasks to move toward those goals. According to the theory, there is an establishment of therapeutic bonding that happens when each partner works towards reaching and maintaining those goals (Bordin, 1979). When individuals attempt to achieve change, they also attempt to establish power to achieve the change that they are trying to make. This is heavily dependent on the strength of the TA (Bordin, 1979).

Attempting to make changes within the client can create strain on the client and the therapeutic relationship. The resolution of those strains through the working alliance is an important factor in the client's success at making those changes (Bordin, 1979). The alternative path involves the client not collaborating with their therapist, which could result in being unsuccessful at making the necessary changes to complete treatment. If a client experiences a decrease in self-efficacy and resources, they may not be able to cope independently (Bordin, 1979). If a client is lacking in the self-confidence required to make therapeutic change or if the individual lacks effective coping processes, that person will likely not be motivated to change, which usually means that they will also not be motivated to collaborate with the therapist (Bordin, 1979). Strains and ruptures can result in the relationship losing its active force in the change process (Bordin, 1979; Greenson, 1967; Rank, 1945; Rogers, 1951). Assisting a client in developing the necessary steps to achieve their goals through the TA by dealing with strains or ruptures in the therapeutic relationship contributes to the process of change (Bordin, 1979).

Earlier theorists such as Greenson, Rank, and Rogers believed that the therapeutic process was a not a process where the therapist established what was "wrong" with the client, but rather a potential for healing power (Marshall & McGuire, 2003). This concept is similar to the concept of the treatment relationship in psychoanalysis. Psychoanalytic theory posits that the client perceives and responds to the therapist based on previous relationships in a process called transference (e.g., Greenson, 1967; Sterba, 1934). Countertransference is when the therapist perceives and responds to the client based on previous relationships (e.g., Greenson, 1965; Sterba, 1934).

Researchers have considered the TA an important component of treatment for high-risk sex offenders (Walton et al.,2016). It is thought that the TA may assist these clients in successfully completing treatment and lower their risk to re-offend (Blasko & Jeglic, 2014; Polascheck & Ross, 2010). Bordin's theory is still viewed by many, "as the theory that put the alliance process at the center of psychotherapy research" (Gorman, Muran, Safran, Stevens, & Winston, 2007, p. 464). The simplicity with which Bordin's theory bridges the dichotomy of technical and process elements is a strength (Horvath & Symonds, 1991). Although Bordin's theory does not include details about the "mechanisms, development, conjoinment, and the affecting of change" with the underlying elements of his theory, his theory does evoke a descriptive model of the TA (Day, Casey, & Ward, 2006, p. 3). This theory also has fertility and heuristic value based on the predictions and avenues of inquiry that have been precipitated (Ward et al.,2006). Researchers now recognize that the mechanisms that underlie Bordin's theory are more complex than originally envisioned (Ward et al.,2006). Bordin's theory lacks explanatory

depth (Ward et al.,2006); however, the core of the model is still largely based on a succinct theory of the TA and provide an elegant definition of the working alliance (Ross, et al.,2008).

Researchers recognize that the TA includes both therapist and client characteristics (Ross et al.,2008). The therapist characteristics include who they are as a person and the effects of professional training (Ross et al.,2008). This could be broken down into professional qualities (trainable aspects) and personal qualities (characteristics that are difficult to develop through training; Ross et al., 2008). Both professional and personal qualities may contribute to the therapeutic bond and inevitably promote a positive TA (Havik, Hersoug, Hoglend, & Monsen, 2001). Some researchers have focused exclusively on therapist variables that may impact the TA (Marshall et al., 2003), and others have noted the importance of client characteristics, stating that, the client is not a "blank slate or passive receiver of the therapeutic process" (Ross et al., 2008, p. 467).

Ross et al. (2008) believe that clients bring "distinctive personalities, experiences, capacities, goals, and expectations to their role" (p. 467). Client personality characteristics have been found to predict the TA (Ross et al., 2008). Researchers have found that clients who were submissive, isolated, and friendly were more likely to develop a positive TA than clients who were hostile, aggressive, and dominant (Bauer, Horowitz, Korda, & Puschner, 2005; Muran, Schuman, Segal, Waller-Samstag, & Zindal, 1992). Individuals with personality disorders will often challenge the development and maintenance of the TA due to the extent and chronicity of interpersonal symptoms

(Strauss et al., 2006). The majority of individuals with psychopathy are also diagnosed with personality disorders (Wilson, 2004). Psychopathic characteristics are believed by most researchers to have a detrimental effect on the TA; however, there is surprisingly little evidence to support this view (Ross et al., 2008).

Literature Review

Determinants of the Working Alliance

As suggested by Bordin (1979), there are several determinants of the TA, including an agreement of the goals to work on, collaboration on the tasks that must be worked on to achieve those goals, and an overall bond that facilitates the collaboration between therapist and client (Bordin, 1979).

Agreement on goals. The first determinant of the working alliance is the agreement on goals that the therapist and client will work on (Bordin, 1979). Bordin believed that the key to building a strong TA stemmed from the careful search accomplished by the client and therapist to find the change goal. This search would fully capture the client's story and include their struggle, pain, and frustration (Bordin, 1979). The TA can be established utilizing different therapeutic approaches such as CBT, client centered therapy, or a psychoanalytic approach (Bordin, 1979). This does not automatically lead to commitment from the client, and negotiation is a key element in the process. This is an integral part of the TA that assists in the arrival of a meaningful change goal (Bordin, 1979). Even though the client may be eager to pursue goal setting in treatment, the therapist needs to honor the process of the exchange of thoughts and ideas

around the change goal (Bordin, 1979) In addition, the client needs to understand the process of setting goals, even though the therapist is directing it (Bordin, 1979).

Reaching an agreement on the change goal is an important component of building the TA. Developing a mutually agreed upon change goal requires that the therapist is sensitive to the client's past pains and frustrations so that they can assist the client in developing a new direction that is less painful and frustrating for the client (Bordin, 1979). This will hopefully maximize satisfaction for the client throughout the therapeutic process. Bordin claimed that paying attention to how the client formulates reasons for seeking help will help the therapist understand the events and experiences that led up to the client coming to the decision to seek help (Bordin, 1979). In sex offender treatment, the client is often mandated to treatment due to their crimes. This, combined with the personality factors that are often present with criminal behavior, could make it difficult to come up with a mutually agreed upon change goal. Bordin believed that there were certain therapeutic steps that the therapist should take in order to diminish resistance to coming up with a mutually agreed upon goal.

Bordin believed that helping the client join forces, so to speak, with the therapist helps amplify the client's own personal experiences rather than the therapist's own intuition. This assists the client in having a natural flow of their own account of experiences and diminishes resistance (Bordin, 1979). This also assists the client in understanding the relevance of the question being asked by the therapist and encourages the client to relate that therapeutic work to their change goal. This then forges a bond that includes trust and respect, because the client feels like their concerns are being heard and

taken seriously (Bordin, 1979). The client will also feel like an equal participant in the process. If the client perceives a lack of resources to accomplish the goals, the therapist should step in and give the client support to avoid a block in movement (Bordin, 1979). This should not take the place of the client's own resources and independent effort (Bordin, 1979), because the client should not feel helpless or a loss of independence. The therapist should also help the client look at the dominant themes in their story and identify a change goal that is intimately related to those themes (Bordin, 1979). The kind of mutual understanding that is necessary to develop an adequate change goal is not a simple or brief process and includes special attention to the collaboration on the tasks that are utilized to achieve this change goal. Often clients mandated to sex offender treatment are dissatisfied with the reasons they are in therapy (American Counseling Association, 2015). They did not seek out change for themselves but were mandated to make change. In such instances, Bordin believed that it is important to process situations in treatment and then help the clients discover how much they are themselves part of the difficulty so that a proper change goal can be developed (Bordin, 1979).

Collaboration on tasks. The second determinant of the working alliance is the collaboration on tasks. Throughout Bordin's work, he tried to dispel confusion between goals and tasks. For example, if the therapist is using CBT with a client, in sex offender treatment, the task might be for the client to write down their cognitive distortions about sexual thinking. The goal being the client will change those distortions so they will not re-offend. The therapist is the primary source in the selection of the tasks, but in order for

the client to remain an active partner, they should have an understanding of the relevance of the task activities that they are being asked to do (Bordin, 1979).

Bordin referred to the tasks as being the specific activities that the therapist and client engage in in order to foster change (Bordin, 1979). The therapist participates in this process in the role of a coach, prescribing specific therapeutic tasks that are based in different traditions of psychotherapy. These prescriptions represent proposals for client action (Bordin, 1979). For example, a prescription might be helping the client practice a different way of acting. In sex offender treatment, this might include having the client avoid walking down certain streets in the community (such as streets that contain sexual media) that may be triggers for sex offending behavior.

The client's tasks should be carefully selected and examined in a way that has a direct relation to the change goal. Having concrete descriptions of the therapeutic tasks assists in helping the client work on integral parts of the change goal (Bordin, 1979). The tasks should be explicitly or implicitly directed by the therapist and processed in a way that distinguishes them from the service of building the TA (Bordin, 1979). There should be careful attention to the state of the TA throughout the process of working on the therapeutic tasks. Bordin called this process the therapist doing "field observations" (Bordin, 1979, p. 29). The TA and the therapeutic tasks are used to look at performance levels of the client (e.g., the client's ability to complete homework assignments). Individual tasks can develop into a family of tasks that work together to achieve the change goal. Bordin looked at this process as two parallel yet interacting paths in that the client is on one path of engaging in the therapeutic task and the therapist is on another

path observing the client's change (Bordin, 1979). The TA should be monitored throughout this process in order to understand if it has been ruptured in any way by the therapeutic tasks.

Overall bond. This third determinant in TA is the association of the experiences developed in a shared activity (Bordin, 1979). Partner compatibility is one of the core conditions of the bond (Bordin, 1979). Compatibility may vary depending on the task that is being worked on (Bordin, 1979). It is expressed and felt by the partners evolving respect for one another as well as having a shared understanding of the therapeutic work and goals. Trust and commitment are vital parts of the relationship (Bordin, 1979). Poor object relations can inhibit the client's capacity to form a positive bond with the therapist (Bordin, 1979). Although therapy facilitates the development of object relations, clients with personality disorders may have difficulty forming a bond (Bordin, 1979). The capacity of a client with psychopathic characteristics to formulate the relational component needed to form a strong bond may be also limited (Walton et al.,2016). This combined with the client's goals and tasks may hinder the capacity for change (Bordin, 1979). The expectations of a client who has antisocial personality disorder may influence the extent to which they are willing to develop a goal or work on the tasks assigned by the therapist. These important functional relations need to be examined closely in the process (Bordin, 1979). Bordin opined that therapists who are committed to and skilled in building the TA can reduce the likelihood of interference in the relationship bonding (Bordin, 1979).

Strain Concept

Given that this study focuses on psychopathy, it is important to note Bordin's opinion concerning the strain in the therapeutic relationship. Strain is of Upstate importance in the TA. He wrote that there are three Upstate elements in the working alliance that help foster change: "strength of alliance, power of therapeutic tasks, and the dynamics of the strains in the alliance" (Bordin, 1979, p. 18). A major precursor of strain in the therapeutic relationship is resistance (Bordin, 1979). Psychoanalytic theory suggests that resistance can be expressed in transference, forms of opposition that are defended-based, and interference in therapeutic work (Bordin, 1979). Bordin believed that it was crucial to work through resistance in order to establish movement in treatment (Bordin, 1979). He believed the factors that drove clients to want to engage in the working alliance process was their interpretation of whether or not the therapeutic partnership was meaningful and whether or not they were able to participate in the therapy work (Bordin, 1979). The collaborative process is based on the relationship within the therapeutic partnership rather than outside relationships, meaning that the client is struggling with self-defeating propensities along with the therapist (Bordin, 1979). If this can be worked on and resolved, the client will eventually achieve a different, more satisfying mode of response that will be generalized to outside relationships and situations (Bordin, 1979). Bordin believed that once the client is committed to the change goal and understands the relevance of the tasks, ruptures and strains in the therapeutic relationship can be pointed out to the client (Bordin, 1979). Bordin also believed that this pointing out process assisted in the recognition of self-

defeating behaviors driven by ruptures in the relationship (Bordin, 1979). Bordin called this the "moment of truth" in the change process (Bordin, 1979, p. 20).

Link Between Attachment and the Therapeutic Alliance

Attachment theory examines lifelong patterns of interactions, or attachment style, that people exhibit in their relationships (Ainsworth, Blehar, Wall, & Waters, 1978; Bowbly, 1973, 1980, 1983). Much of attachment theory stems from psychodynamic theory (Ainsworth et al., 1978; Bowbly, 1973, 1980, 1983). Ainsworth (1989) believed that infants form a bond with their primary caregiver in their first year that then develops over time. The attachment relationship is determined by the degree of the infant's desire to have proximity to the caregiver, which in turn forms a cognitive template that the child applies to all other important relationships throughout the life span. Although this theory is still widely accepted, researchers have argued that the cognitive template that the child forms based on their initial relationship can be "modified, replaced, or elaborated when other meaningful relationships occur in the child's life" (Barrett & Pietromonaco, 2010, p. 10).

Ainsworth et al. (1978) described two attachment styles that infants develop with their primary caregiver: secure and insecure. Sensitive responding by the parent helps develop a secure attachment, while a lack of sensitive responding results in an insecure attachment (Charnov, Estes, Gardner, Lamb, & Thompson, 1984). There is a varied conceptualization of attachment in the literature including avoidant, ambivalent, and resistant insecure attachment styles (Ainsworth et al., 1978; Bowbly, 1973, 1980, 1983). Other researchers such as Shaver and Farley (2004) call these attachment types anxiety

and avoidance. Working models of the concept of attachment style use a framework based on positive and negative perceptions of self and others (Bartholomew & Horowitz, 1991).

Researchers suggest that differences in attachment styles influence the ability to process in psychotherapy, and impact treatment outcome (Atkinson, Bagby, McBride, & Quilty, 2006; Bookwala et al.,2002; Fonagy et al.,1996; Meyer & Pilkonis, 2001). There are three areas where attachment styles may influence treatment: "client attachment and TA, therapist attachment and treatment process and outcome, and client attachment and treatment outcome" (Meyer & Pilkonis, 2001, p. 14). Dames and Roth (2000) identified that "securely-attached clients had strong therapy alliances and fearful-avoidant clients had weak therapy alliances" (p.421). Research on attachment also suggests attachment style can influence self-efficacy and the schemas derived from those attachments (Bradley, Brummett, & Roger, 2007). Schemas are categorical rules or templates that individuals use to interpret their world, which are then used to guide an individual's behavior (Blackburn, James, & Southampton, 2004; Piaget, 1962). It is believed that these schemas develop over the course of a child's cognitive developmental stages (Piaget, 1962). Individuals with psychopathy may have unhealthy attachment styles, which in turn may impact the ability to formulate a positive TA (Olver & Wong, 2011).

Critique and Limitations of the Theory

Bordin's theory remains the dominant model of the TA, and the WAI the most frequently used empirical measure in research on the TA. It has been extremely influential and useful in understanding the TA (Ardito & Rabellino, 2011). However,

Bordin's theory has also been accepted as "foundational without being critiqued systematically," meaning he set the groundwork for understanding the TA but neglected to methodically define specific constructs of the TA (Ross et al.,2008, p. 463). This is especially true when considering offender rehabilitation due to the unusually rich factors that could potentially threaten to disrupt the development of the TA, such as client behaviors (Ross et al.,2008). Bordin theorized that depending on the client's capabilities, the TA would influence their readiness to accept certain goals (Bordin, 1979). This has implications for clients who have psychopathic traits and are mandated to treatment because according to Bordin's theory if these clients cannot accept or formulate treatment goals, their ability to successfully complete treatment decreases (Egan, 2014; Young, 2013). Bordin's theory also has limited scope. He emphasized the importance of client characteristics and focused minimal attention on therapist characteristics. There is now considerable evidence regarding the importance of the therapist characteristics in the development and maintenance of the TA (Marshall & McGuire, 2003; Wampold, 2015). These characteristics include warmth, empathy, flexibility, self-awareness, and collaborative (Wampold, 2015).

Ross et al. (2008) point out that the second element of Bordin's theory, tasks assigned to the client, varies according to the therapy type and expected goals. This is relevant to mandated clients, as they are typically assigned tasks and goals, which is also true in this study population. The third element of Bordin's theory is the bond, which forms from building the trust and confidence that the tasks will bring the client closer to his or her goals. Bordin suggested that the nature of the bond developed as a consequence

of the types of goals and tasks the therapist and client were committed to undertaking (Bordin, 1979). Therefore, there were also questions with the population of the study as to whether or not they would be able to form an adequate bond with their therapist.

Some of Bordin's predictions have not been supported in the empirical research. For example, Bordin believed that the longer the therapy continues, the stronger the bond grows (Ross et al.,2008). However, researchers have found that the bond can be just as strong in brief therapy as in long term therapy (Fernandez, & Marshall, 2003; Saunders, 1999). Ackerman and Hilsenroth (2003) found that differences in bond are a function of therapist and client differences rather than therapy type. Bordin also proposed that bond was a function of tasks and goals (Bordin, 1979). However, Saunders (1999) reported that a positive bond predicted outcome irrespective of goals and tasks.

Horvath and Symonds (1991) noted that a strength of Bordin's theory is how he simplified the representation of the contrast between the technical and process elements of his theory. However, some researchers claim that this is also the greatest weakness with his theory, because it lacks explanatory depth (Ward et al.,2006). There is little supporting evidence for the theory's underlying mechanisms and constructs (Ward et al., 2006). Bordin's theory encompasses a descriptive model of the components of the TA and lacks explanatory details of how the goals, tasks, and bonds work together to create change (Ross et al.,2008). This implies that we do not have a complete understanding of the elements of the TA from Bordin's theory. In the past 25 years, however, no researchers have tackled the challenges of Bordin's theory mentioned above (Ross et al.,

2008). Therefore, there remains little published evidence that Bordin's theory is inaccurate or inadequate.

Ross et al. (2008) challenged this gap in the literature with the mandated offender population in mind, and revised Bordin's theory using a social-cognitive framework. The authors integrated what they perceived to be the best aspects of his work into this framework. These aspects included the goals, task, and bonds through a setting and contextual lens. Ross et al., (2008) opined that their revision begins to do justice to the complexity and importance of the development of the TA and is a step in the right direction towards understanding the elements of the TA. While this revised theory was not utilized in this study, it was important to keep in mind what these authors found in their research when considering the possible limitations of this study.

Therapeutic Alliance and Treatment Outcome

Researchers have provided evidence in support of the TA in relation to treatment outcome and are beginning to understand how the TA may assist individuals with psychopathy to successfully complete treatment (Walton et al.,2016). Walton et al. (2016) suggested that the forensic population as a whole can benefit from a strong TA in treatment. Indeed, sex offender treatment has been demonstrated to be more effective when there is a strong TA (Youssef, 2016). Sex offenders being treated for their sex offending behavior may have a dual diagnosis, such as a personality disorder and pedophilia. It is important to consider such dual diagnosis issues when treating sex offenders, particularly those with psychopathic traits. There is little empirical research

that supports the supposition that individuals with psychopathic traits cannot form a therapeutic relationship with their therapist (Walton et al.,2016).

In 2017, DeSorcy et al. conducted a study with a 111incarcerated adult male sex offenders. They examined the working alliance and its association with psychopathy in this population and used the WAI as one of their assessment measures. The WAI was completed three months into the inmate's treatment program and file-based ratings of the PCL-R were used to determine their psychopathy ratings using a cutoff score of 25. DeSorcy et al. (2017) found that components of the WAI scale demonstrated differential associations, specifically with the structural features of psychopathy. They found that the Affective facet of the PCL-R was significantly associated with weaker Bond scores on the WAI, and the Lifestyle facet of the PCL-R was significantly associated with lower Task scores on the WAI (Desorcy et al., 2017). They concluded that the "relationship between the correctional client and therapist matters" (DeSorcy et al., 2017, p. 18). They also found that having a stronger alliance translated into an "increased client retention and decreased attrition"; however, psychopathy was not associated with recidivism outcomes (DeSorcy et al., 2017, p.18). The authors reported that having prominent psychopathic traits did not prevent the formation of a healthy TA and prioritizing the task and goal components of the alliance maximized their participants' treatment gain and retention. This study is one of the very few studies that examined whether or not there was a link between the structural features of psychopathy and comments of the TA (DeSorcy et al., 2017). The authors emphasized the importance of replicating and extending it to other samples and settings. In this study, replication of the above listed

study was accomplished by examining the association between the WAI and psychopathy. However, this study examined the association of the WAI and psychopathy with civilly-confined sex offenders who have already completed their prison time. Treatment programming was sex offender specific including two treatment tracks that separate individuals with high psychopathy to low or no psychopathic traits identified. The majority of the civilly-confined males completed the WAI after they had been in treatment longer than three months, and the cutoff score for psychopathy was 30. Therefore, two of the main differences between the DeSorcy et al. (2017) research and this study was that the participants were not in a correctional environment and they had a longer opportunity to build a TA with their therapist. Given the challenge with the research population for this study, longer opportunity to build a TA with their therapist may give this specific population a better chance of building a working alliance with their therapist.

Targeted Treatment Programming for Individuals With Psychopathy

The majority of the literature on the topic of treating individuals with psychopathy contains the supposition that psychopathy is untreatable (for review, see Walton et al., 2016); however, the evidence regarding this is not clear and some researchers suggest this is not the case (Walton et al., 2016). “Most treatment ‘data’ consists of clinical anecdotes, and most of the efforts to conduct research on the topic have been poorly designed and controlled” (Hoffman & Kiehl, 2011, p. 16). Research on the treatment of individuals with psychopathy needs to be well thought out, targeted, and well designed. In addition, variables such as certain personality characteristics need to be controlled for (Hoffman &

Kiehl, 2011). Anecdotally, authors discussing their clinical experience have noted that for treatment to be effective in individuals with psychopathy it should be intense, long lasting, systematic, include individual treatment, and focus on slowly rebuilding social connections (Hoffman & Kiehl, 2011).

Although there are some promising results in the recent literature regarding the treatment of individuals with psychopathy, this research has been only done with juveniles (Hoffman & Kiehl, 2011). Hoffman and Kiehl (2011) reported that juveniles with psychopathic traits who were in treatment over a year had reductions in misconduct and recidivism rates (Hoffman & Kiehl, 2011). More studies need to be conducted to examine treatment in populations with high levels of psychopathy, including adults. This study sought to look at psychopathy and the TA using the framework of Bordin's theory.

Hare Psychopathy Checklist

Half of the participants recruited for this study participated in a treatment track for individuals with high psychopathy scores on the Hare Psychopathy Checklist. The Hare Psychopathy Checklist was developed from a two-factor model of psychopathy developed by Hare to better understand psychopathy and how to measure it (Hare, 2003). The Hare Psychopathy Checklist is the most popular assessment tool for psychopathy in the literature, and has been empirically supported (Looman et al.,2005). The two factors in the model are composed of characteristics that are highly correlated with each factor, and that best define psychopathic traits as elucidated by the research.

The first factor of the Hare Psychopathy Checklist, which is sometimes considered the most primary factor of psychopathy, captures interpersonal and affective

character deficits of psychopathy. Examples of these types of characteristics are shallow affect, superficial charm, manipulativeness, and lack of empathy (Lilienfeld, Patrick, Polascheck, & Skeem, 2011). Factor one has also been strongly associated with narcissistic personality disorder (Hakstain, Hare, & Harper, 1989). Individuals who score high on this factor tend to exhibit low anxiety, low empathy, low stress reaction, and low suicide risk (DeSorcy et al., 2017; Harper et al.,1989; Jackson & Zagon, 1989; Verona et al.,2001). Individuals who score high on this factor also tend to have high scores on achievement and social potency (DeSorcy et al.,2017; Patrick, Joiner, & Verona, 2001).

The second factor of the Hare Psychopathy Checklist deals with the antisocial characteristics of psychopathy, including criminal versatility, impulsiveness, irresponsibility, poor behavior controls, and juvenile delinquency (Harper et al.,1989). Individuals who score higher on this factor usually exhibit social deviance, sensation seeking, low socioeconomic status, and are at a higher risk of suicide (Harper et al.,1989; Verona et al., 2001).

Critique of the Hare Psychopathy Checklist

Robert Hare was a Canadian psychologist who developed the original PCL in the 1970's (Hare & Neumann, 2006). The PCL was used in psychology experiments with male offenders and forensic inmates (Hare, 2003). The PCL-R was later developed for use in indicating a dimensional score or a categorical diagnosis of psychopathy (Hare & Neumann, 2006). Today the PCL-R is used for clinical, legal, or research purposes. The reliability and usefulness of the PCL-R has been debated in the literature, specifically for the purpose of diagnosing a mental health disorder similar to antisocial personality

disorder (American Psychiatric Association, 2016). One critique of the PCL-R is that it is often misused in the legal system, as there is a discouragement to treat individuals who score high in psychopathy (Buffington-Vollum, Crusie, & Edens, 2001; Edens, 2001; Hare et al., 2000).

Hemphill (2004) has questioned the validity of the PCL-R because it does not consistently outperform purpose-built risk instruments, such as the Level of Service Inventory-Revised, which is a quantitative survey of offender attributes and their situations that predicts recidivism and violence. Benning, Hall, and Patrick (2004) also suggested that there should be three distinguishable factors (instead of two) to reflect affective, interpersonal, and behavioral symptoms. Other researchers have pointed out that the PCL-R does not always have reliable precise outcomes in regard to level of risk, meaning that there is not always a strong correlation between having traits of psychopathy and being at higher risk to re-offend (Bridges, Gacono, & Meloy, 2002; Carman, Gray, Hayward, MacCulloch, Rogers, & Snowden, 2003; Gendreau, Goggin, & Smith, 2002; Grubin, Meux, & Reiss, 2000). However, the PCL-R is still considered the gold standard by which to measure psychopathy by forensic clinicians and the justice system (Lilienfeld, Malterer, & Neumann, 2010). Researchers have also pointed out that the PCL-R is a reliable and valid instrument in the assessment of psychopathy in the male forensic population (Cooke, & Michie, 1997; Forth, Hakstain, Hare, Harpur, & Hart, 1990; Michie, Hare, & Hart, 1999).

Relationship Between the Therapeutic Alliance, Psychopathy, and Outcome

Researchers have suggested that individuals with psychopathic characteristics have a larger and greater number of criminogenic needs that make engagement in treatment difficult (Olver & Wong, 2009; Hoge & Simourd, 2000). Criminogenic needs are crime producing factors that are the focus of treatment, with the intent to reduce the risk to re-offend (Latessa & Lowenkamp, 2005). In general, the higher an individual's criminogenic needs are, the higher their risk to re-offend (Cormier, Harris, & Rice, 1992; Greenwood, Ogloff, & Wong, 1990). As discussed above, the TA is an important predictor of therapeutic success, and it may also assist in increasing client motivation to work on criminogenic needs in treatment (Constantino, Castonguay, & Holtforth, 2006; Gaston, Horvath, & Luborsky, 1993).

The importance of the client/therapist relationship has been recognized as unquestionable in therapeutic success, regardless of the client's personality characteristics (Constantino, Castonguay, & Holtforth, 2006; Horvath et al., 1993). Although individuals with high levels of psychopathy have a constellation of behaviors and personality characteristics that make it challenging to build a TA, there has been scrutiny on studies of these characteristics with sex offenders. This has been mostly due to the lack of adherence to evidenced informed principles. One being the risk, need, and responsivity principle, which is a principle that was developed to assist in making treatment recommendations for sex-offenders based on their risk to re-offend (Hodge & Simourd, 2000). The risk, need, and responsivity principle suggests that low risk sex offenders do

not require the same sex offender treatment intensity and duration as high-risk sex offenders do (Hodge & Simourd, 2000).

Salekin (2002) reviewed 42 articles on the topic of treatment in individuals with psychopathic traits and opined that there is not enough evidence to support the claim that psychopathy is an untreatable disorder. Kernberg (1992); Martens (1997, 1999, 2002); Monahan, Mulvey, & Skeem, (2002); and VanMarle (1995) all claimed that capable experienced therapists using a combination of treatments (e.g., psychotherapy, neurological treatment, psychosocial guidance/counseling) along with favorable circumstances (e.g., friendship, maturation, confrontation, impressive events) might demonstrate favorable treatment outcomes with individuals who have psychopathy. Martens (2002) suggested that intensive involvement of individuals with psychopathy in treatment planning, with an adequate therapeutic attitude, could significantly enhance their ability to benefit from treatment.

The quality of the TA remains no less critical in individuals with psychopathy, and at this juncture there is still very little basis to conclude that individuals with psychopathy cannot form a TA, or that the way in which they may form a TA is not beneficial and will not have implications for treatment outcome (D'Silvia et al., 2004; Olver & Wong, 2011; Salekin, 2002). It remains unclear whether or not prominent psychopathic traits preclude the formation of the TA and there are "very few examinations of the linkages between psychopathy and the components of the TA" (DeSorcy et al.,2017, p. 18). DeSorcy et al., (2017) believed that their research had many implications for future research. This included "repeated administrations of the WAI to

track and measure change" between the correctional client and therapist (DeSorcy et al., 2017, p. 18). Given the importance that researchers have suggested the TA has on treatment outcome (Beyko & Wong, 2005), the relation between the TA and psychopathy needs to be established before it can be determined whether or not the TA is a predictor of treatment outcome with this population (DeSorcy et al.,2017).

Summary

This study was an investigation of the association between psychopathy and the TA in a group of male mandated therapy clients who were convicted of sexual assault, had served their time, and were in civil confinement. Researchers have noted that the relationship between the TA and psychopathy is unclear, and there needs to be a better understanding of this association. Further investigations of this relationship will promote positive social change for the individuals in treatment, the mental health providers that treat them, the institutions that house treatment programs, and the public that funds such treatment. This study was designed to compare the relative scores of psychopathy, based on the PCL-R scores and the empirically driven WAI. The next chapter includes a description of the research design.

Chapter 3: Research Method

Introduction

The purpose of this quantitative survey study was to investigate the relation between the level of psychopathy (high versus low) and TA ratings of clients and therapists in the population of convicted civilly-confined male sex offenders. There is some evidence to suggest that having prominent psychopathic traits does not prevent the formation of a healthy TA, which is contrary to the widely held professional opinion that it does (DeSorcy et al., 2017). Further, there seems to be evidence to suggest that individuals with psychopathic traits not only have the ability to formulate a healthy TA, but also can benefit from its effects (DeSorcy et al., 2017; Walton et al., 2016). Researchers have also demonstrated that there may be specific structural features of psychopathy that influence the ability to formulate a healthy TA (DeSorcy et al., 2017). This chapter includes information on the research design, the setting and sample, data collection and analysis, instrumentation and materials, data collection and analysis, and a discussion on the protection of human participants.

Research Questions and Hypotheses

In this study, I explored to what extent the level of psychopathy was predictive of TA ratings. The study had two hypotheses to be tested at the 0.05 level of significance.

RQ1: Do resident therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

$H_0$1: There will not be significant differences by psychopathy group, as determined by the PCL-R scores, in resident ratings of therapeutic alliance, as assessed

by the WAI.

H_a1: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in resident ratings of therapeutic alliance, as assessed by the WAI.

RQ2: Do therapist therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

H_01: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in therapist ratings of therapeutic alliance, as assessed by the WAI.

H_a1: There will be significant differences by psychopathy group, as determined by the PCL-R scores, in therapist ratings of therapeutic alliance, as assessed by the WAI.

Research Design and Approach

To address the research questions, this study had to be quantitative, as data from the variables must be compared to predict the relation between the variables. This approach also built on the DeSorcy et al.'s (2017) study, whose authors emphasized the importance of replicating and extending their research to other samples and settings. A qualitative study would not have been appropriate because observation through interviews would not provide the data necessary to make inferential assumptions. A quantitative methodology was chosen to enhance the likelihood that the results of this study could be generalized to other populations of mandated clients who have traits of psychopathy. Quantitative methodology is appropriate for determining whether a statistically significant relationship exists between the variables of interest (Bettany-Saltikov & Whittaker, 2014). I measured the variables for this study quantitatively in order for them to be statistically analyzed. I collected numerical, interval data from

survey responses, and quantitative methodology is the best for analyzing this type of information (Leedy & Ormrod, 2014). A survey design was used to collect information and compare groups. As such, conclusions about casual relations between variables cannot be definitively made, as there may be several other variables that differ between groups aside from the independent variable.

Surveys were used to collect data to address the research questions. The chosen survey instruments were the PCL-R and the WAI. Some demographic information was collected to determine the comparability of the groups. Survey research is amenable to quantitative methodology, which can determine the degree, direction, strength, and statistical significance of relations between variables (Bettany-Saltikov & Whittaker, 2014). The research questions in the study attempted to identify the differences of a value of the dependent variable across different categories of the independent variable. The PCL-R was administered to the client sample (with the exception of cases where psychopathy was determined by the assessment team to not be an issue), to determine which treatment group they should be assigned to and was not administered as a part of this study. Those individuals who scored at or above the cut-off score of 30 were assigned to a treatment group designed specifically for those with psychopathic traits, and those individuals were compared to a treatment group consisting of individuals who either scored below 30 or who did not take the PCL-R due to lack of observed psychopathic traits. The use of surveys to assess TA allowed for an efficient examination of the relation of the independent variable (level of psychopathy) to the dependent variable (therapeutic alliance ratings).

Population

Setting and Sample

The population of this study included clients and therapists (i.e., social workers, rehabilitation counselors, and psychologists) at a secure civilly-confined Sex Offender Treatment Program (SOTP) in Upstate New York State.

Client sample. In April 13, 2007, New York State enacted the Sex Offender Management and Treatment Act (SOMTA). This then led to the Article 10 Law, which created New York State's current civil management program (New York State Division of Criminal Justice Services, 2007). This law went into effect based on the Kansas v Hendricks case (Kansas v Hendricks, 1997), which drove the U.S. Supreme Court to determine that civil commitment is constitutional as long as it is for the purpose of incapacitation and treatment rather than punishment. The Supreme Court determined that in order to become civilly-confined one must have been determined by an expert to have a mental abnormality that includes both dangerous and a volitional inability to control their dangerousness (Kansas v Hendricks, 1997). Therefore, all of the client participants in the study had been determined to have a mental abnormality prior to being civilly-confined and a participant of the study.

The treatment groups in the SOTP were designed to treat sex-offending behaviors and reduce dangerousness. There were two separate treatment tracks called MAPPS and non-MAPPS. The MAPPS treatment track specifically addressed psychopathic traits and assisted with reducing the risk associated with these traits. Individuals who were assigned to this treatment track had scored a 30 or above on the PCL-R. The non-MAPPS groups

were specifically designed to reduce the risk to sexually re-offend and consisted of individuals who either did not have a PCL-R score, because they were not exhibiting those kinds of traits, or who scored 29 and below on the PCL-R (Upstate New York Psychiatric Center, 2007). The main difference between the treatment tracks is that the MAPPS track did not provide group psychotherapy. MAPPS groups were focused more on psychoeducation regarding the tactics they use to meet their needs.

Therapist sample The therapist sample consisted of social workers, rehabilitation counselors, and psychologists who had approved New York State degree titles, and were employed at a secure civilly-confined SOTP. The therapists on average had around 11 years of experience in their field of study and had been working at SOTP for an average of at least two years (Upstate New York Psychiatric Center, 2018).

Sampling Method and Data Collection

The type of sampling used was convenience sampling. Purposive convenience sampling is an acceptable sample technique when there is no specific selection of the target population (Borg, & Gall, 1996). This method of sampling was used to recruit individuals who were clients and therapists at a civilly-confined SOTP in Upstate New York. This recruiting process was selected in the hope of finding client participants who had already been defined by high and low psychopathy scores. Client participation was voluntary and anonymous. Therapist participation was voluntary and confidential.

Client sampling and data collection. I informed potential client participants about the study at the start of a treatment session. I introduced myself and explained the nature of the study to the attendees of the group. Each of the clients received an invitation

to participate in the study, which was at a different date a time, including the details of the voluntary nature of the study including the client's right to not participate, information clearly stating that their decision to participate or not would have no bearing on their treatment, and a description of the anonymous nature of their participation. When I visited the treatment group to provide more information about the study, I also informed potential participants of the dates, times, and locations that they could come and participate in the study if they wished to do so.

If the potential client participant chose to attend the study data collection session, I provided him with a WAI and a demographic form in an envelope. I did not collect consent forms in order to ensure that the data was anonymous, and to protect the client's privacy. In this session, the clients were given instructions regarding how to complete the survey. The client participants were asked to complete the questionnaires and told that no signatures would be taken in order to protect their privacy and provide anonymity. I collected the survey in a sealed envelope at the end of the session. A large group room was utilized, and I sat to the side of the room to make myself available for questions. I ensured that these conversations were discreet in order to maintain privacy.

I made myself available for debriefing by staying in the room until all of the participants had left and thanked the participants for their time. I informed the client participants that they can let their primary counselor know if they have any questions after they left the session, which included contact information. The WAI scores, group assignment, and demographic data was then entered in an electronic database for statistical analysis.

Therapist sampling and data collection. Therapists were informed about the study at a separate time from the clients in a private email. I introduced myself and explained the nature of the study to the therapists. Each of the therapist participants received an invitation to participate in the study and were informed about the voluntary nature of the study including the therapist's right to not participate and the description of the confidential nature of their participation. I made it clear that this research was a part of my dissertation and that their decision to participate or not has no bearing on their employment status. The facility that employed the therapists did not have access to the raw data. Each participant was informed of the potential dates, times, and locations that they could come and participate in the study. Not attending these sessions would imply that they were choosing to not participate in the study.

At the data collection session for the therapist participants, each participant was given a consent form that was to be signed and reviewed. They received several WAIs (therapist version), or one for each of their clients, and one demographic form in an envelope. The therapists were given instructions regarding how to complete the surveys and the consent form was reviewed and signed. After the consent forms were signed, the therapist participants then were asked to complete the questionnaires. They were instructed to keep their questionnaires grouped together by the group that their clients were in (MAPPS or non-MAPPS). The consent forms were collected, and the surveys and demographic forms were collected separately in a sealed envelope at the end of the session. A large group room was utilized, and I sat to the side of the room to make myself available for questions. I ensured that these conversations were discreet in order to

maintain privacy. I was available for debriefing and thanked them for their time. I also notified the therapists that I would be available for any questions that they may have. WAI scores on each client and demographic data was entered in an electronic database for statistical analysis.

Sample Size

The G*Power sample size calculator was used to establish the sample size regarding how many clients needed to be represented in each group for both the client and therapist analysis. G*Power is a power analysis program that is capable of conducting a priori analyses to determine how many subjects are necessary for a quantitative study (Buchner, Erdfelder, Faul, & Lang, 2009). I used a standard power level of 0.80 of 0.05 and a moderate effect size of 0.50 w to calculate an adequate sample size for an independent sample *t*-test, as defined by Cohen (1992). A moderate effect size was used to ensure that the potential relationships between variables was not too strict or too lenient. A sample size of 128 clients is needed to have sufficient power for the analyses with 64 individuals per group. In order to account for dropouts and potentially invalid and incomplete data, I aimed to recruit a sample size of 140 clients, with 70 per group.

Eligibility Criteria

The client participant inclusion criteria for this research was any client attending the MAPPS or non-MAPPS groups at the facility in Upstate New York who is 21 years of age or older who could read and understand English, and who had been regularly attending their treatment groups for at least a month. All clients were male, as the

population of the treatment facility is exclusively male. Individuals of any ethnic group or education level were eligible to participate.

The therapist participant inclusion criteria for this research was any therapist that had been hired by New York State as a social worker, psychologist, or rehabilitation counselor for the Office of Mental Health who had been working with the clients in the determined groups for at least a month. Therapists could be of either sex and any ethnic group or education level.

Instrumentation and Materials

This study used demographics questionnaires (see Appendix E & F), as well as the Working Alliance Inventory Short Version, and the Working Alliance Inventory-Therapist Short Form [Therapist] (see sample questions in Appendix B and C). Permission to use the WAI (see Appendix A) for this research was obtained from the authors of the surveys.

Working Alliance Inventory. The WAI (Bordin, 1979) was created to provide an instrument that could help researchers "measure the quality of the TA between the therapist and the client, based on the client's and therapist's perspective" (Greenberg & Horvath, 1989, p. 223). The WAI is intended to help researchers identify three interdependent components of the TA: bond, tasks, and goals (Bender, 2005). The WAI is both a client-rated questionnaire and therapist-rated questionnaire that uses a Likert scale with seven points to rate 12 example TA items on how strong the TA is with their clinician or client (Dijkstra & Paap, 2017). "The Likert scale used by the WAI for the client is anchored at each end with 'never' (1) and 'always' (7). The Goal, Task, and

Bond domains each have scores ranging from 1 to 7. Higher scores indicate a better therapeutic alliance" (Dijkstra & Paap, 2017, p. 118).

The WAI measures three domains of the TA (Dijkstra & Paap, 2017). These three domains use the key aspects of the TA that required active negotiation and participation between the therapist and client (Davis, Garske, & Martin, 2000).

> These include (a) agreement between patient and therapist on the goals of the treatment (Goal); (b) agreement between patient and therapist about the tasks to achieve these goals (Task); and (c) the quality of the bond between the patient and therapist (bond). (Dijksta & Paap, 2017, p. 118)

Each WAI takes approximately five minutes to complete. The total score of the 12 items and the summed scores of the three subscales of WAI including goals, tasks, and bond were used to measure the dependent variable of therapeutic alliance ratings.

Reliability and validity of WAI. The WAI has high internal consistency (Horvath & Greenberg, 1989). The subdomains of Cronbach's alpha range from 0.81 to 0.90, and the total score is 0.91 (Dijksta & Paap, 2017). These estimates have high reliability, including test-retest reliability of 0.93 (95% CI 0.83 to 0.97; Dijksta & Paap, 2017). The WAI also correlates well with other therapeutic alliance measures, which gives it good construct validity (Johansson, Kerr, Louden, & Skeem, 2007). Examples of this are the California Psychotherapy Alliance Scale ($r = 0.80$) and the Helping Alliance Questionnaire ($r = 0.74$; Dijksta & Paap, 2017). "Furthermore, higher scores on the WAI are associated with better treatment outcomes, conforming that WAIs construct validity in accordance with Bordin's theory" (Dijksta & Paap, 2017, p. 118; Martin et al.,2000).

Goal and Task domains have consistently failed in confirmative factor analyses (Dijksta & Paap, 2017). This most likely suggests that these two domains are measuring similar constructs (Dijksta & Paap, 2017). Given this, many researchers recommend using the overall mean of the WAI instead of its subscales (Dijksta & Paap, 2017).

Demographic information. Descriptive and demographic information of the client consisted of client's education level, previous treatment, and the treatment track they were currently in was collected as part of the demographic information form. Demographic information collected by therapists was their state title, age, sex, and their orientation (see Appendices E and F).

Data Analysis

The data for the dependent variable of therapeutic alliance ratings was expressed in a continuous score obtained from the summed scores from of the Likert scales used in the WOC. The independent variable of level of psychopathy was a dichotomous variable with two levels of high and low (based on treatment group assignment). I used the statistical analysis software program of SPSS for hypothesis testing. Before completing the analysis, I screened the data for detection and correction of invalid data or outliers (Warner, 2012). There was an additional code developed for any missing data that may have been present. I discarded incomplete surveys with more than 50% missing responses, and they were not utilized as part of the data collection. A mean substitute was utilized to replace the data.

Descriptive statistics (e.g., percentage, frequency, mean, and standard deviation) was calculated for the data derived from each of the subscales of the instruments used in

this research, as well as the demographic data. Frequency of occurrence and percentages was calculated for the categorical variables such as gender and age group. Upstate tendency measures of mean, standard deviation, minimum and maximum values was used to summarize data of continuous measured variables. I ensured the data met all of the necessary assumptions for the parametric analysis used for this study, including (a) the independent variable should be a categorical variable with two categories and the dependent variable should be continuous, (b) there should be no outliers in the dataset, (c) the data of the dependent variables should be normally distributed, and (d) homoscedasticity. These assumptions must be met, or the data transformed in order to use the chosen hypothesis tests. It was possible that should the data not have met the necessary assumptions I would have needed to use a non-parametric analysis.

An independent sample *t*-test was conducted to determine the differences in the WAI ratings to measure the dependent variable of TA ratings of clients and therapists in the population of convicted civilly-confined male sex offenders between the two psychopathy groups of high (MAPPS) and low (non-MAPPS) levels of psychopathy. An independent sample *t*-test was appropriate, as the dependent variables of TA ratings are continuous measures, while the independent variable of level of psychopathy is a categorical measure with only two categories. The *t*-statistic is used to determine if the independent variable significantly impacted the dependent variable.

Protection of Human Participants

Ethical guidelines as indicated by the Walden University Institutional Review Board (IRB) was adhered to throughout the study process. Inclusion of human

participants in the study necessitated approval from the IRB [Approval #1300327-7]. To protect the anonymity and safety of the client research participants, I implemented the following safeguards; (a) study participants were asked to complete surveys without identifying information, (b) no identifying information was obtained on any of the research surveys, and (c) participants were not asked to do anything that would compromise their health or safety in the context of this study. Data was collected and compiled into manila envelopes as outlined above. The hard copy data (completed WAIs and demographic questionnaires) was secured in a cardboard box and removed from the treatment facility. I then copied the hard data into my password-protected personal computer for data analysis. No identifying information was entered into the computer, and the data file itself was password protected. Upon completion and publication of the study, all hard copy data will be stored for five years in a locked cabinet that only I can access, per ethical standards. After the five-year storage period, data will be discarded per the ethical guidelines and standards during that period of time.

The only potential risk to participants was the possibility of psychological distress while completing the WAI survey. If such situation were to occur, participants were instructed that they can end their participation in the study at any time. They could have also spoken to their primary treatment counselor if they were distressed by participation. If a therapist became distressed, they also could end their participation at any time and then could speak to me directly.

Threats to validity. I implemented different strategies to address the validity of the study. According to Horvath (1991), the WAI is a useful and practical way to help

researchers examine and measure the TA. This provides high face validity as participants can choose the best category that describes their own experience. To enhance that face validity, I used a purposive inventory (WAI-SR), that was suitable for a variety of participants. Another strategy used was reviewing the instructions on the WAI with both the client and the therapist in an effort to decrease errors. Internal validity may be compromised with participants who have cognitive delays and/or other mental health issues when completing the WAI. In order to address this issue, I was clear, simple, and concise when giving the instructions for the survey. Participants were also given opportunity to ask questions about the instructions at any time.

Summary

In this chapter, I provided an overview of the research methods for this study, including research questions, type of data collected, procedures for data collection, sampling procedures, sample size information, and ethical considerations. A quantitative survey design was used for this study. A review of the reliability of the questionnaire that was administered to the participants was provided. This study attempted to look at the relationship between the TA and psychopathy within a population of civilly-confined sexual offenders located in Upstate New York. At this time, there is not enough adequate research demonstrating that therapeutic programs are effective at creating a strong enough TA to reduce the risk of its clients that have psychopathy. The success of this study necessitated collaboration of treatment staff, a time and space for this researcher and volunteer participants to meet, and volunteer participants' willingness to complete the necessary data for the study. This study provided information that may be useful in

improving the treatment programming throughout Civil-Confinement facilities, thereby improving client's wellbeing and the opportunity to reduce their risk before they are sent back out to the community.

Chapter 4: Results

Introduction

The purpose of this quantitative survey study was to investigate the relationship between the level of psychopathy (high versus low) and TA ratings of clients and therapists in a population of civilly-confined male sex offenders. The following are the research questions that guided the study:

RQ1: Do resident therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

RQ2: Do therapist therapeutic alliance ratings differ by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy?

To address these research questions, data were collected from client and therapist participants at a secure civilly-confined sex offender treatment program in New York State. All participants completed the WAI (Bordin, 1979) to measure the quality of the TA between therapist and client. The collected data were analyzed to determine the relationship between the level of psychopathy of the client and the TA scores of the therapist and client. This chapter contains the results of the data analysis procedures conducted to address the research questions. The demographics of the sample are discussed, followed by a description of the data analysis used to test the hypotheses.

Data Collection

A total of 64 responses were collected from the clients (target participant enrollment was 140), and 75 responses were collected from 16 therapists (target participant enrollment was 30). As data collection started, many of the potential client

participants did not believe the data would be collected anonymously and verbalized to others that they did not trust the process of the study. This reduced the number of individuals who were willing to enroll, and also potentially created a response bias in the data. Only the clients who were confident that the study would not alter or impact their legal case came to the informational session to learn more about the study. Clients who choose not to attend the informational session were not able to ask questions to resolve their concerns. Therapists that were recruited were social workers, psychologists, and rehabilitation counselors; however, none of the rehabilitation counselors elected to participate.

Data collection took approximately two months to collect. An information session about the study was presented in a commonly utilized group room where interested clients where informed about the study. After hearing the information about the study interested clients received an invitation to participate in the study, which was at a different date a time, and included the details of the voluntary nature of the study including the client's right to not participate. Upon completing the recruitment process a schedule was made and clients were met individually in a private room to take the survey. Therapists were notified and recruited by email and given their surveys at a separate date and time that they were able to mail back through inter-office mail in a secure sealed envelope. Some clients saw more than one therapist. Among the 64 client forms, 29.7% (n =19) were classified as having a high level of psychopathy, and 70.3% (n = 45) were classified as having a low level of psychopathy. Psychopathy was determined by scores on the PCL-R (Hare, 2003) with a score of 30 and above indicating a high level of

psychopathy. Table 1 presents the number of WAI questionnaires that were completed by participant and psychopathy group.

Table 1

Frequency Distribution of WAI Responses by Psychopathy Group

	Therapist responses		Client responses	
	N = 75	%	*N* = 64	%
Psychopathy				
High	20	26.7	19	29.7
Low	55	73.3	45	70.3

Results

Demographics

The demographic characteristics of the clients are presented in Table 2. Among the 64 clients who provided data, 34 were undergoing the conventional treatment track for individuals without psychopathic characteristics, while 18 were in the treatment track for individuals with psychopathic characteristics. The remaining 11 were on the treatment track for individuals who are cognitively impaired, and one of those 11 was on the treatment track for individuals who are cognitively impaired and have psychopathic characteristics. Based on these classifications, 45 (70.3%) clients were under the conventional and cognitively impaired treatment tracks for individuals with low psychopathy, while 19 (29.7%) clients were being treated in groups for individuals with high psychopathy. Some of the clients provided feedback on multiple therapists, which altered the data points from the number of respondents. Client demographic information is summarized in Table 2.

Table 2

Demographic Characteristics – Client Data (N = 64)

	N	%
Treatment groups		
Cognitively impaired (CI)	11	17.2
Psychopathic characteristics	18	28.1
CI with psychopathic characteristics	1	1.6
Conventional	34	53.1
Educational level		
1st to 4th grade	1	1.6
5th to 8th grade	4	6.3
9th to 12th grade	29	45.3
13th grade and higher	20	31.2
GED	10	15.6
Previous treatment		
Yes	60	93.8
No	4	6.3
Psychopathy		
High	19	29.7
Low	45	70.3

A series of chi-square analysis procedures were conducted to determine whether there were statistically significant demographic differences between patients with high and low levels of psychopathy. As shown below in Table 3, the analysis indicated that patients with high and low levels of psychopathy significantly differed with regard to treatment track (χ^2 [3, N = 64] = 64.000, p < .001), as would be predicted, but not with regard to education level (χ^2 [11, N = 64] = 14.798, p = .192) or previous treatment (χ^2 [1, N = 64] = .045, p = .832).

Table 3

*Client Chi-square Analysis Results (Psychopathy*Demographic Characteristics)*

	Pearson Chi-Square		
	Value	*df*	Asymp. Sig. (2-sided)
Treatment track	64.000	3	.000
Education level	14.798[a]	11	.192
Previous treatment	.045	1	.832

Based on the results of the chi-square analysis, further examination of the differences between patients with low and high psychopathy in terms of treatment track was conducted. As shown below in Table 4, patients with low psychopathy were treated using CI or conventional treatment methods, while patients with high psychopathy were treated with MAPPS.

Table 4

*Client Cross-tabulation (Psychopathy*Treatment Track)*

		Psychopathy		
		Yes	No	Total
Treatment Track	CI	0	11	11
	MAPPS	18	0	18
	CI MAPPS	1	0	1
	Conventional	0	34	34
Total		19	45	64

Therapist demographics are summarized in Table 5. Sixteen therapists responded to the questionnaires with a total of 85 individual therapist/client WAI forms. Seventy-four of the forms provided demographic data, and as the forms were filled in anonymously it was not possible to distinguish the individual characteristics of the 16 therapists. Therefore, the data is presented for the 85 therapist/client dyads. The majority

of the therapist forms with demographic information indicated female sex (90.7%) and individuals who served patients who had low levels of psychopathy (73.3%).

Table 5

Demographic Characteristics – Therapist Data (N = 74)

	N	%
Title		
Psychologist	12	16.0
LMSW	62	82.7
Social work assistant	1	1.3
Therapeutic orientation		
CBT	32	42.7
Solution focused	17	22.7
Motivational interviewing (MI)	13	17.3
Solution focused and MI	3	4.0
CBT, MI, and solution focused	7	9.3
Reality therapy, CBT	3	4.0
Gender		
Female	68	90.7
Male	7	9.3

Chi-square analysis procedures were conducted to determine whether there were statistically significant demographic differences between the therapist/patient dyads with high and low levels of psychopathy. As shown in Table 6, the results of the chi-square analysis procedures indicated that therapists who served patients with high and low levels of psychopathy significantly differed with regard to therapeutic orientation (χ^2 [5, N = 75] = 11.463, p = .043), but not with regard to gender (χ^2 [1, N = 75] = 2.807, p = .094) or state title (χ^2 [2, N = 75] = 1.155, p = .561).

Table 6

*Therapist Chi-square Analysis Results (Psychopathy*Demographic Characteristics)*

	Pearson Chi-Square		
	Value	Df	Asymp. Sig. (2-sided)
Title	1.155	2	.561
Gender	2.807	1	.094
Therapeutic orientation	11.463	5	.043

As shown in Table 7, therapists treating patients with low psychopathy tended to have a CBT or solution-focused therapy orientation. As noted above, these forms represent the same 16 therapists filling in 85 client forms, so the findings need to be evaluated in this context.

Table 7

*Therapist Cross-Tabulation (Psychopathy*Therapeutic Orientation)*

		Psychopathy		
		Yes	No	Total
Therapeutic Orientation	CBT	7	25	32
	Solution focused	4	13	17
	MI	7	6	13
	Solution focused and MI	0	3	3
	CBT, MI, and Solution focused	0	7	7
	Reality therapy, CBT	2	1	3
Total		20	55	75

Working Alliance Inventory Score Analysis

Descriptive statistics were calculated in the form of the mean, standard deviation, and range. Table 8 presents the means for the WAI and its subscales by psychopathy group.

Table 8

WAI scores– Clients

	Mean	SD	Min	Max
All participants				
WAI – total	42.02	11.74	12.00	60.00
Goals	13.72	4.63	4.00	20.00
Tasks	14.42	4.22	4.00	20.00
Bond	13.88	4.32	4.00	20.00
High psychopathy				
WAI – total	41.26	12.75	18.00	60.00
Goals	13.22	5.13	4.00	20.00
Tasks	14.00	4.44	4.00	20.00
Bond	14.04	4.48	4.00	20.00
Low psychopathy				
WAI – total	42.28	11.46	12.00	60.00
Goals	13.90	4.47	4.00	20.00
Tasks	14.57	4.17	4.00	20.00
Bond	13.82	4.30	4.00	20.00

The WAI scores collected from the therapists were also examined. The therapist version of the WAI only provides a total score and is not broken down into subscales. Table 9 presents the WAI data provided by therapists, compared by psychopathy group.

Table 9

WAI Scores –Therapists

	Mean	SD	Min	Max
WAI – total scores				
All participants	32.07	8.50	13.00	49.00
High psychopathy	33.45	8.82	21.00	49.00
Low psychopathy	31.59	8.40	13.00	45.00

As part of preliminary data analysis procedures, the dataset was tested regarding the assumption of normality. The Kolmogorov-Smirnov statistics for the WAI scores of the clients and therapists indicated that the datasets did not significantly differ from a normal distribution. Hence, the assumption of normality required for a parametric test was fulfilled. The data was also tested regarding the assumption of homoscedasticity. The *p*-values for all the Levene's statistics were greater than 0.05, indicating that variances in the WAI total and subscale scores were equal in both the therapist and client samples. Thus, the assumption of homoscedasticity was met.

Research Question 1

The first research question focused on whether residents' therapeutic alliance ratings differed by level of psychopathy (low versus high) in a population of convicted male sex offenders in mandated group therapy. To address this research question, independent samples *t*-tests were conducted on the total WAI scale as well as the three subscales. The results indicated that the differences between the scores of the clients with high psychopathy and those with low psychopathy were not statistically significant for the WAI total score or for any of the three subscales. The results are shown in Table 10.

Based on these results, the null hypothesis cannot be rejected for the first research question.

Table 10

Results of Independent Samples t-tests –Therapeutic Alliance Versus Psychopathy (Client scores)

	t value	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% CI of the Difference Lower	Upper
WAI-Client	-.359	88	.721	-1.02271	2.85040	-6.69	4.64
Goals	-.604	88	.547	-.67813	1.12240	-2.91	1.55
Tasks	-.553	88	.581	-.56716	1.02481	-2.61	1.47
Bond	.212	88	.832	.22258	1.04924	-1.86	2.31

Research Question 2

The second research question was focused on whether therapists' therapeutic alliance ratings differ by their clients' level of psychopathy (low versus high). Independent samples *t*-tests were conducted on the total WAI score as well as the three subscales. The differences between the mean therapist-rated WAI scores of clients who have high psychopathy versus those with low psychopathy were not statistically significant. The results are shown in Table 11. The instrument used for the therapists was slightly different from the clients, and therefore did not correspond to the same subscales. Based on these findings, the null hypothesis for the second research question cannot be rejected.

Table 11

Results of Independent Samples t-test –Working Alliance Inventory Total Score by Psychopathy Group (Therapist Scores)

	t value	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	95% CI of the Difference Lower	Upper
WAI-Therapist	.886	83	.378	1.86724	2.10813	-2.33	6.06

Exploratory Analyses

Exploratory Chi-square analyses were conducted to determine whether previous treatment history was associated with differences in the psychopathy of the clients, and this comparison was not significant (χ^2 [1, N = 64] = .045, p = .832). Chi-square analysis procedures were also conducted to determine whether the therapists' gender or therapeutic orientation were associated with differences in the psychopathy of the clients. Differences in the therapists' gender was not significantly associated with the differences in the psychopathy of the clients (χ^2 [1, N = 75] = 2.807, p .094), however; the therapists' therapeutic orientation was associated with differences in the psychopathy of the clients (χ^2 [5, N = 75] = 11.463, p = .043). This was not surprising considering the finding that therapists who worked with the non-MAPPS therapists tended to have a CBT focus in comparison to the MAPPS therapists.

To further explore these differences, a one-way analysis of variance was conducted to determine whether therapist orientation was associated with differences in the WAI scores. As shown in Table 12, therapist orientation was associated with statistically significant differences in the WAI scores of the therapists (F [5] = 2.962, p = .018). A Tukey's LSD post hoc test indicated that the WAI scores for therapists using

CBT were significantly lower than therapists using solution-focused therapy (Mean Diff = -8.51838, p = .006). These results indicate that therapists who use solution-focused therapy have higher alliance scores as compared to therapists using CBT. No other statistically significant differences between the groups were identified.

Table 12

*Results of One-Way Analysis of Variance (Therapist Orientation*Working Alliance Inventory Score)*

	N	Mean	SD	df	F	Sig.
CBT	32	29.19	7.50	5	2.962	.018
Solution-focused	17	37.71	8.57			
MI	13	34.54	8.23			
Solution-focused and MI	3	34.33	7.57			
CBT, MI, Solution-focused	7	34.43	2.51			
Reality therapy, CBT	3	33.33	11.59			
Total	75	32.91	8.26			

Summary

The purpose of this quantitative survey study was to investigate the relationship between level of psychopathy (high versus low) and WAI ratings of clients and therapists in the population of civilly-confined male sex offenders. The two research questions focused on determining whether there were statistically significant differences in the client and therapist WAI scores of patients with high and low psychopathy. Data was collected from a sample of clients and therapists at a secure civilly-confined sex offender treatment program in Upstate New York. The participants were asked to complete the WAI to measure the quality of the therapeutic alliance between the therapists and clients.

I used independent samples *t*-tests to analyze the data, and the results indicated that there were no statistically significant differences in the WAI therapeutic alliance

scores, for both the client and therapist ratings, between the high and low psychopathology groups. Thus, the null hypotheses for both of the research questions could not be rejected. Therapist orientation was associated with differences in psychopathy, but therapist gender was not. These results are discussed in relation to existing literature in Chapter 5. I also discuss the conclusions and recommendations of the study in that chapter.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

Few researchers have attempted to investigate the degree to which psychopathic, high-risk sex offenders are treatable and would benefit from a strong TA (Walton et al.,2016) despite the fact that the TA has been identified as critical in treatment outcomes (Barkham et al.,2006). An aim of this study was to investigate the relationship of level of psychopathy (high vs. low) to both therapist and client TA ratings in convicted civilly confined, male sex offenders. Individuals with psychopathic traits often lack the ability to form loving relationships with others and are thought to be incapable of feeling higher emotions such as guilt and empathy (Hare & Neumann, 2010). Consequently, individuals who are sex offenders and who are also high in psychopathy are typically assumed to be untreatable and at a high risk of re-offending (Haldaman, 2012). This assumption, however, appears to be based more on anecdotes than empirical evidence. It is particularly important to study the role that the TA plays in the treatment of high-risk psychopathic, civilly-confined sex offenders because members of this population are often confined for years due to an inability to complete treatment (Miller, 2010). They also possess unique personal traits, such as lack of empathy, impulsivity, irresponsibility, and grandiose sense of worth to name a few, that further complicate their treatment (Rooney, 2009).

There is a dearth of information regarding how mandated populations such as civilly-confined sex offenders can be engaged in therapy in a way that will lead to successful completion of treatment (Ross et al.,2008). Mandated populations are usually

informed of their treatment goals rather than given the freedom to choose them (Ross et al.,2008), which is a significant difference from other types of therapy. It is important to gather information about the relationships that individuals participating in mandated treatment form with their therapists. There has been a lack of understanding regarding how psychopathy is related to TA from the perspective of both client and therapist, and the current study represented an attempt to address this gap in the literature. I performed a quantitative study using Bordin's theory of the working therapeutic alliance (Bordin, 1979) as a framework to accomplish this objective. Data gathered from this study has the potential to stimulate the development of more effective and cost-efficient treatment programs for members of this population. Improved treatment programs would benefit not only the people enrolled in them, but also their families, potential victims of repeat-offenders, mental health care professionals, and society more generally.

The participants in this study were male clients and therapists (social workers, psychologists, and rehabilitation counselors) at a secure civilly-confined SOTP in Upstate New York. Following the recruitment and selection of potential participants using convenience sampling, confidential survey data was collected from 90 clients and 85 therapists. Participants were asked to fill out demographics questionnaires as well as different versions of the WAI (Greenberg & Horvath, 1986) in order to measure the TA between client and therapist. TA was then compared between low and high psychopathy groups. In this chapter, I review what the findings of the study may mean and how they can be employed to benefit social change. I also review the limitations of the research and discuss potential future directions in the field.

Interpretation of the Findings

I did not find a significant difference between clients with high and low psychopathy on the WAI scale or its three subscales. In addition, I did not find a significant difference in therapist TA ratings between the high psychopathy and low psychopathy groups. Therapist age, client treatment track, and therapist orientation were all found to be significant predictors of psychopathy.

This study was grounded in Bordin's (1979) theory of the working TA. TA has been demonstrated to be a strong predictor of client change and treatment outcome (Muran & Safran, 2006). Within this framework, the strength of the therapeutic bond between client and therapist is influenced by the degree of agreement on therapeutic goals and collaboration towards these goals (Ross et al.,2008). Bordin's theory would predict that psychopathy plays a significant role in the development of the TA and thus the ability to complete treatment. The results from this study, however, do not support this argument. There was no statistically significant difference between the ratings of TA generated by clients with low and high levels of psychopathy, nor was there a measurable difference between how clients with high and low levels of psychopathy perceived the agreement on treatment goals, collaboration on tasks, and the overall bond they shared with their therapist. The lack of a significant relationship between psychopathy level and TA held regardless of whether the client or therapist rated the TA.

Blasko et al. (2016) examined how the TA impacts treatment outcome in forensic populations, including sex offenders, and found that therapists and clients were able to form a TA regardless of the level of client psychopathy. Although these results would

suggest that the TA is not heavily influenced by the presence of psychopathy, the researchers also found that there was a significant negative relationship between client ratings of the client-therapist bond and psychopathy score when the participants were examined separately by therapy placement group (Blasko et al.,2006). I did not detect a similar group difference in the current study. Reasons for the incongruence in these results could be related to different treatments that the clients were receiving and the fact that the participants in the Blasko et al. study were detained in a maximum-security prison, while my study recruited from a secure civilly-confined sex offender treatment program. In addition, the current study was under-powered, as recruitment of participants resulted in fewer than expected client WAIs, and this may have impacted the findings.

Group Comparisons from the Client Perspective

Agreement on treatment goals. Agreement on goals that the therapist and client will work on together is the first determinant of the TA in Bordin's theoretical framework (Bordin, 1979). In order for a strong, working relationship to develop between the client and therapist, it is essential that the client feel that they are playing an integral role in designing their own treatment plan (Bordin, 1979). This is especially important for clients such as civilly-confined sex offenders who are mandated to receive treatment. Because they did not seek out change on their own accord and were instead forced to receive treatment, these clients are often dissatisfied with their treatment plans (American Counseling Association, 2015). Such feelings may in part explain why clients in both sample populations felt largely the same about the TA, as both groups may have been dissatisfied with their treatment in general.

Collaboration on tasks. Client-therapist collaboration over tasks that are included in the treatment program is the second determinant of the TA within Bordin's (1979) working model. No significant difference was found between how clients with high levels of psychopathy and how clients with low levels of psychopathy rate their task-related TA. This result comes as somewhat surprising, as previous research has identified that individuals with psychopathy will often be more hostile, dominant, and aggressive, and these are behaviors that would preclude the development of a successful TA (Bauer, Horowitz, Kordy, & Puschner, 2005 & Muran et al.,1992). There are, of course, more variables acting on the development of the TA than psychopathy alone, all of which were outside the scope of the present research and may have influenced the findings.

Overall bond. The association of the experiences developed in a shared activity is Borden's (1979) third determinant of the TA. Feelings of trust, commitment, and mutual respect are essential for the formation of a strong TA. Previous researchers have acknowledged that clients with psychopathic characteristics may find it difficult to formulate the relational component of the bond (Blasko et al.,2016). Clients with antisocial personality disorder (a common diagnosis among psychopathic populations) might be less willing to develop a goal or work on a task with their therapist (Wilson, 2004). This suggests that clients with high levels of psychopathy would have significantly lower levels of TA than clients with low levels of psychopathy; however, this was not the case in my findings.

Group Comparisons From the Therapist Perspective

There was no statistically significant difference in TA ratings by group in the WAI scores rated by therapist. The therapist plays a key role in strengthening the TA by encouraging agreement on treatment goals. Helping the client join forces with the therapist places more emphasis on the client's own experiences rather than the therapist's intuition (Bordin, 1979). While Bordin's theory focuses more on the importance of client characteristics and less on those of the therapist, other researchers have argued that therapist characteristics that encourage the successful formation of mutually agreed upon treatment goals include warmth, empathy, flexibility, and a collaborative nature (Wampold, 2015). Psychopathy level was not related in therapist-rated TA in the current study.

Therapeutic orientation was associated with differences in client psychopathy; however, this association was not strong enough to produce significantly different TA ratings between clients and therapists from the two sample populations. Therapists who prescribed to a solution-focused orientation where shown to have higher alliance ratings than those who prescribed to a CBT orientation. It is possible that this difference may be because solution-focused therapy tends to be goal driven and assists in solving problems. Individuals with psychopathy in mandated care may feel better heard or helped by this approach, which would correspond with the tasks and goals aspect of Bordin's theory. It is important to note that this finding was not a part of the hypothesis-testing analysis; therefore, future research examining the possible relation between orientation and TA in this population is needed to support this finding.

According to Bordin (1979), skilled therapists can reduce the likelihood that psychopathic traits and difficulty forming relationships will interfere in the development of the TA. While there was no significant group difference in therapist-rated TA, there was an association between therapist age and psychopathy of the client. Therapist age was the only significant predictor of client psychopathy group, perhaps because older therapists tend to be more experienced and better able to handle the challenges associated with working with psychopathic clients. It may be also true that experienced therapists would have received more training hours that align with the characteristics of a positive therapeutic alliance. This assumption would fit into Bordin's postulations but would require further analysis that is beyond the scope of this study.

Review of the Research

Researchers are just beginning to understand how the TA can assist individuals with psychopathy complete treatment (Blasko et al., 2016), yet little research has been conducted on the association between levels of psychopathy and the development of the TA, especially in high-risk sex offenders. Youssef (2016) demonstrated that sex offender treatment is typically more effective when there is a stronger TA, while DeSorcry et al. (2017) found that prominent psychopathic traits in sex offenders did not preclude the development of a strong TA. The results of the present study support previous research on this topic in that no significant difference was found between how clients experiencing different levels of psychopathy rated the TA. Previous researchers have claimed that psychopathy has a negative impact on the development of the TA (i.e., Ross et al.,2008); however, a lack of significant findings in this study support DeSorcy et al.'s research in

that psychopathy level appeared to make no difference in the ability of Civilly-confined sex offenders to form a TA. These findings need to be supported by future research in order to address the limitations of the current study.

Limitations of the Study

Research on the role of the TA in treatment outcomes of psychopathic client populations such as civilly-confined sex offenders is still in the early stages of development. Although this study contributed to the growing field by finding that there was no statistically significant relationship between level of psychopathy and TA, it is prudent to examine the limitations inherent in the design and execution of this study in order to identify how future research could be improved.

A quantitative design was chosen for this research because this allows for the comparison of numerical data to predict the existence (or lack thereof) of a relationship between the independent and dependent variables. Quantitative methodology is best suited for analyzing numerical, interval data gathered from survey responses (Leedy & Ormrod, 2014). However, one of the limitations of employing a quantitative methodology is that, while the results reveal information about relationships between variables, they are not conducive to explaining why these relationships exist. For example, in the present study I found that there was no significant difference between how clients with high levels of psychopathy and clients with low levels of psychopathy rated the TA, but without interviewing the participants about their perceptions of the TA, my knowledge about this lack of a relationship is limited. Additionally, in a survey design, it is difficult to draw definitive conclusions about causal relations between variables due to the

potential presence of confounding variables. Therefore, future studies on how the TA influences treatment outcomes in psychopathic populations could employ a mixed methods design that incorporates quantitative survey data with qualitative feedback from interviews. Doing so would allow a more holistic picture of how the TA develops between psychopathic clients and their therapists and the role this relationship plays in their successful treatment.

In this study, I used convenience sampling to recruit the study participants. Convenience sampling was an appropriate sampling method for this study because there was no specific selection of the target population (Gall et al.,1996). However, the sample population for this study was recruited from a single facility and consisted solely of men; therefore, this population might have traits that may set them apart from the general sex offender population. The generalizability of this study was also limited because the results are only applicable to men belonging to a very specific population. Future studies could include civilly-confined or incarcerated females. Further, confounding variables such as other mental health issues could affect the TA but were not assessed in this study. DeRubies, Lorenzo-Luaces, and Webb (2014), studied the relation between the therapeutic alliance and depression in a sample of 24 patients, and found that the TA was not predictive of symptom change if the patient had experienced three or more episodes of depression. Information regarding previous treatment was not described by the researchers.

Another limitation that may have impacted the findings of this study was the way in which participants were assigned treatment groups. Because level of psychopathy

determined treatment group assignment, the groups were not mixed in psychopathy level, meaning that there could have been other differences in the groups not linked to psychopathy, such as therapist expectations and demand characteristics or the therapist age and orientation. Factors that were unrelated to psychopathy level such as these may have also influenced the TA but were not measured in this study. Other variables may have also played a role in the development of the TA, such as previous treatment and frequent changes in therapists. For example, Blasko et al., (2016) examined the role of psychopathic traits in the development of the therapeutic alliance among sexual offenders. They reported findings similar to this study, and the researchers speculated that if the participants received previous treatment and exposure to multiple therapists it may have improved their ability to create a TA (Blasko et al.,2016). Future studies, therefore, should control for other variables such as these.

Validity of the Study

There are two main types of validity: internal validity and external validity. The internal validity of a study is defined by the extent to which the independent variable (in this case, level of psychopathy) caused change in the dependent variable (in this study, TA rating). As this study was not a true experiment in the sense that the independent variable could not be directly manipulated, it may have not been the only potential factor influencing the dependent variable. Thus, the internal validity of the research must be scrutinized. Although the WAI has a high face validity because participants were able to choose the category that best fits their own experiences (Horvath, 1991), internal validity may have been comprised if other factors aside from psychopathy level influenced the

TA. civilly-confined sex offenders are a unique population in that they may have a dual diagnosis, such as personality disorder or pedophilia. Indeed, the majority of individuals with psychopathy are also diagnosed with personality disorders (Wilson, 2004). Other mental health issues could potentially have a significant influence on the way in which participants completed the questionnaire assessing TA, and this study included no provision to account for this.

External validity relates to the generalizability of the results. As previously discussed, because the sample size was relatively small, homogeneous, and only included males, the results from this study should not be generalized across the broader population of sex offenders. The findings can only be generalized to the setting in which the data was collected. Research with other populations in which psychopathy is a prominent feature may result in different findings.

Limitations to Participation

The original goal of this study was to recruit 140 clients to participate in the survey, with approximately 70 clients in each psychopathy-level group. However, only 90 clients participated in this study, with 23 in the high-psychopathy group and 67 in the low-psychopathy group. Thus, there was a low number of participants, and the lack of power may have impacted the results.

Several factors could have influenced a client's likelihood to participate, and it is important to consider what these factors were and how they can be accounted for so future research can produce more generalizable results. Clients that were experiencing other mental health issues (i.e., personality disorder, depression) might have been less

likely to participate due to an inability to do so. Furthermore, despite the fact that a guarantee of anonymity was communicated to potential participants during the recruitment process, some potential participants may have refrained from joining the study out of fear that personal information or responses could be leaked and have a negative impact on future court appearances. The social environment within a Civil-Confinement facility can be similar to that in a prison (Wangenheim, 2009) and clients could have been peer pressured into participating or not participating. Challenges such as these are inherent in many quantitative survey studies, so it is important to initially recruit from a large population in order to achieve an ideally sized sample population.

Recommendations

This research represents one of the first studies to focus specifically on how psychopathy is related to the development of the TA from both the client and the therapist perspective. Further research on this topic should be conducted in order to develop a better understanding of how psychopathy may be related to the TA and treatment outcomes. Such research can help practitioners develop more effective treatment plans for populations such as civilly-confined sex offenders, who are typically detained for long periods of time (Hassan & Ward, 2014). As previously mentioned, the sample size of this study was relatively small with 90 clients and 85 therapists participating; therefore, future research could focus on recruiting a larger sample size to obtain more generalizable results. Because the sample population in this study was largely homogeneous, with all clients being male and residents in the same treatment program, future studies should include a broader spectrum of participants. This would be

especially useful for investigating whether certain demographic factors such as race, education, and previous mental health history can influence the TA.

A benefit of a quantitative survey methodology is that results are less likely to be biased; as participants are not directly interviewed, they are more likely to disclose sensitive information. However, other methodological approaches could also be fruitful in the study of psychopathy and the development of the TA. For example, future studies could employ a phenomenological approach, or use a mixed methods approach to collect more detail rich data. By using such an approach, researchers can piece together a more in-depth understanding of the lived experiences of a given sample population. In the context of the topic of the present study, this could help the researcher flesh out how psychopathy may influence the development of the TA through semi-structured interviews of participants about their treatment experience.

Implications of the Findings

The data from this study contains significant implications for social change in the treatment of civilly-confined populations, the mental well-being of clients who are held in civil confinement, and the high costs such confinement poses to the resident, their family, and society more broadly. Some mental health advocates have argued that Civil-Confinement can lead to a downward spiral (Miller, 2010), and that once an individual is detained, they will never be free again (Hassan & Ward, 2014). These arguments are based on the (unproven) assumption that it is difficult or near impossible to treat clients with high levels of psychopathy, such as civilly-confined sex offenders (Oliver & Wong, 2009). Because there is a widely held consensus that the TA plays an important role in

successful treatment outcomes (Hardy et al.,2007), it is prudent that the development of the TA in psychopathic individuals be examined so that mental health care professionals can develop more effective treatment plans. Additionally, research on the role of the TA in such a population can help breakdown stigmas surrounding this population and aid with their eventual reintegration into society.

Many offenders held in Civil-Confinement are detained for long periods of time and suffer from complex trauma issues due to a loss of family contact, an inability to remain employed, and struggles with maintaining independence and reintegrating into society (Criminal Justice Handbook Series, 2012). Therefore, it is crucial that researchers devise more effective ways for this population to develop a strong TA with their clinicians. Building strong rapport with their therapist would help clients feel less isolated and would aid in their treatment progress, and further research in this field may also benefit providers in developing strategies for forming strong therapeutic bonds. Studies such as this can help both researchers and clinicians develop treatments that would provide greater benefits to civilly-confined individuals and improve the quality of treatment for clients with psychopathic traits. This is especially important given this study did not find a significant difference between individuals who had psychopathy and those that did not. Future research around this may assist in finding out why. Further exploration around treatment environments that foster the therapeutic alliance will be valuable in efforts to treat individuals with psychopathy and lower their risk to re-offend.

Due to the nature of their crimes, civilly-confined sex offenders are often viewed as a danger to society and having little chances of recovery. Future research on the

relationship between psychopathy and the TA could help identify ways to better help this population, resulting in a lowered risk of re-offending and a consequential decrease perceived dangerousness. Formulating a better understanding of how psychopathy relates to the TA in psychopathic sex offenders under civil-confinement can also boost the effectiveness of rehabilitation programs, helping the clients and their families function better both psychologically and financially. Moreover, because it typically costs $175,000 to confine each individual at a secure treatment facility (Audrey, Corey, & Craig, 2010), more effective treatment plans can alleviate financial strain at the institutional level. Finally, more effective treatment that results from an improved understanding of the TA in psychopathic populations can reduce overcrowding at Civil-Confinement facilities. This could result in increased therapist-to-client ratios, which could also help improve clients' overall treatment (Wangenheim, 2009).

Conclusion

Researchers have considered the TA an important component of treatment for high-risk sex offenders (Blasko et al.,2016). The TA may assist these clients in successfully completing treatment and lower their risk to re-offend (Blasko & Jeglic, 2014; Polascheck & Ross, 2010). Recognizing the need for a better understanding of the role of the TA in psychopathic, Civilly-confined populations, the purpose of this study was to address the research gap by investigating the relation between level of psychopathy (high versus low) and TA ratings in the population of convicted Civilly-confined male sex offenders. I employed Bordin's theory of the working therapeutic alliance (Bordin, 1979) as the theoretical framework for this study. One key significance

of this study is that it helps to fill a gap in the literature regarding the development of the TA in psychopathic populations. Developing a better understanding of how psychopathic individuals gain a strong therapeutic alliance, including those who are civilly confined, has a wide range of implications for the clients themselves and for society more broadly.

Individuals with psychopathy are generally seen as untreatable, but this view is not backed up by empirical evidence (Ross et al.,2008) or the data gathered for the current study. Future studies should focus on developing an understanding of how the TA forms between clients with psychopathy and their therapists can help researchers and clinicians identify more effective treatment methods. This, in turn, can increase clients' sense of well-being and help them reintegrate into the community. Although the results of the study are limited in their generalizability, they offer an important insight into how psychopathy can affect the development of the TA.

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Appendix A: Brief Working Alliance Inventory

March 19, 2018

Dear Ms. Alguire,

You have our permission to use the Working Alliance Inventory (WAI) in your research for your dissertation titled, The Association of Working Therapeutic Alliance and Psychopathy in Civilly-confined Sex-Offenders, through Walden University. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

_____ _____

Appendix B: Working Alliance Inventory-Short Version

Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space -- as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. I believe___likes me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___and I collaborate on setting goals for my therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. ___and I respect each other.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. ___and I are working towards mutually agreed upon goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. I feel that___appreciates me.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. _____ and I agree on what is important for me to work on.

⑤	④	③	②	①

Always Very Often Fairly Often Sometimes Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

① ② ③ ④ ⑤

Seldom Sometimes Fairly Often Very Often Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤ ④ ③ ② ①

Always Very Often Fairly Often Sometimes Seldom

11. _____ and I have established a good understanding of the kind of changes that would be good for me.

⑤ ④ ③ ② ①

Always Very Often Fairly Often Sometimes Seldom

12. I believe the way we are working with my problem is correct.

① ② ③ ④ ⑤

Seldom Sometimes Fairly Often Very Often Always

Note: Items copyright © Adam Horvath. Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12;

Bond Items: 3, 5, 7, 9

Appendix C: Working Alliance Inventory-Short Version Therapist Form

Working Alliance Inventory – Short Revised - Therapist (WAI-SRT)
Instructions: Below is a list of statements about experiences people might have with their client. Some items refer directly to your client with an underlined space -- as you read the sentences, mentally insert the name of your client in place of ___ in the text.

IMPORTANT!!! Please take your time to consider each question carefully.

1. ___ and I agree about the steps to be taken to improve his/her situation.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

2. I am genuinely concerned for ___'s welfare.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

3. We are working towards mutually agreed upon goals.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

4. ___ and I both feel confident about the usefulness of our current activity in therapy.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

5. I appreciate ___ as a person.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

6. We have established a good understanding of the kind of changes that would be good for ___.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

7. ___ and I respect each other.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

8. ___ and I have a common perception of his/her goals.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

9. I respect ___ even when he/she does things that I do not approve of.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

10. We agree on what is important for ___ to work on.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

Appendix D: Therapist Invitation to Participate in the Study

Dear Colleague,

I am handing out questionnaires as part of a dissertation research study to increase our understanding of how and/or if individuals with psychopathy can build a strong therapeutic alliance with the clinicians whom they work with. As a clinician who regularly works with this population you are in a position to give valuable first-hand information from your own perspective.

The questionnaire will take you about 5-10 minutes per client that you work with. I am trying to capture your perspective on how you view the therapeutic alliance with your clients. Your responses to the questionnaire will be kept confidential, and will only be used for my dissertation research study. Each grouping of questionnaires will be assigned a number code to help ensure that personal identifiers are not revealed during the analysis and write-up of the findings.

There is no compensation for participating in this study, and if you choose not to participate it will have no bearing on your employment or evaluation. However, your participation will be a valuable addition to my research and findings could lead to a greater understanding of psychopathy and how their clinician's view their ability to formulate a therapeutic alliance.

If you are willing to participate please come down to the treatment mall at…. If you have any questions please do not hesitate to ask.

Thank you,

Kearie A Alguire

Appendix E: Demographic Questionnaire

Please complete the following demographic questions. This information is confidential; please do not add your name or any other identifying information. Your honesty in answering the questions is greatly appreciated.

1. What treatment track are you currently in? _____
2. What is your highest education level? _____
3. Have you had previous treatment in the past? _____

Appendix F: Demographic Questionnaire (Therapist)

Please complete the following demographic questions. This information is confidential; please do not add your name or any other identifying information. Your honesty in answering the questions is greatly appreciated.

1. What is your current state title? _____
2. What is your current age? _____
3. What gender are you? _____
4. What do you consider to be your main therapeutic orientation? _____

Appendix G: G*Power Sample Size Computation Results