Treatment of Secondary Psychopathy: A Proposed Application of Decompression Treatment

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Previous research has achieved little success in the pursuit of an effective treatment regime for psychopathy, leaving many researchers skeptical as to whether psychopathy is treatable at all. However, the same researchers often unintentionally adhere to an underlying fallacy, by assuming that psychopathy is a uniform construct. By reducing psychopathy to its primary and secondary variants, it quickly becomes apparent that this distinction is key with respect to treatability. In particular, the two psychopathy variants have three major etiological differences in regards to emotional processing, reward sensitivity, and attachment style mechanisms. Accordingly, a relatively novel corrections/clinical hybrid model titled 'decompression treatment' (DT) naturally becomes relevant to the discussion. Designed to be an alternative to conventional corrections placement, DT has exclusively handled the most serious of offenders since its inception, including violent inmates, mentally disordered offenders, and most notably, adolescents manifesting psychopathic traits. The model relies on three core principles: first, is minimizing the amount of potentially harmful stimuli present in the corrections environment; second, is providing a reward system to those who exhibit prosocial behaviour; and third, is building positive relationships between patients and staff. Fittingly, these three principles directly correlate with the lived experiences of secondary, but not necessarily primary, psychopaths. After making a case for the models application in the secondary psychopath population, the discussion concludes with an examination of the strengths, weaknesses, and caveats of the model. Ultimately, DT lends itself to be a promising treatment option for secondary psychopaths.

Keywords: decompression treatment, secondary psychopathy, primary psychopathy, corrections, rehabilitation

Psychopathy, in general, is characterized by a host of affective, interpersonal, and cognitive idiosyncrasies of a destructive nature; for instance, psychopaths can be deceitful, cunning, manipulative, antagonistic, egocentric, without guilt or empathy, and so forth (Skeem, Monahan, & Mulvey, 2002). Moreover, statistics estimate that psychopaths make up 1 percent of the general population and an alarming 25 percent of the prison population (Yildirim & Derksen, 2015). Given the nature and prevalence of psychopathy, it follows that criminal justice professionals ought to have a range of treatment strategies at their disposal. However, efficacious treatments are lacking (Douglas, Nikolova, Kelley, & Edens, 2015), and criminal psychopaths arguably present the most difficult clinical profiles to treat. For instance, relative to non-psychopaths, psychopaths are more likely to be disruptive in treatment settings, to have high attrition rates, and to show slower, if any, treatment improvements (Yildirim & Derksen, 2015). Generally speaking, contemporary forensic researchers widely underscore the importance of early, comprehensive interventions as a means of preventing adult criminality (Dodge et al., 2015). However, the continuity of psychopathy from childhood to adolescence to adulthood is still a matter of debate (Corrado, DeLisi, Hart, & McCuish, 2015). Thus, early identification and intervention efforts for psychopathy are a particular challenge, leaving criminal justice professionals to deal largely with adult manifestations of the disorder. In sum, psychopathy, and its corresponding treatment options, clearly constitute a disproportionate relationship.

Throughout the literature, Dr. Hare's Psychopathy Checklist-Revised (PCL-R) is considered the gold standard for measuring psychopathy (Yildirim & Derksen, 2015). With that said, the PCL-R was devised from a Caucasian adult male offender sample, thereby having constricted generalizability outside these demographic parameters (Hare, Clark, Grann, & Thornton, 2000). Therefore, unless stated otherwise, the research below – which utilizes PCL-R measures – is primarily applicable to individuals who match the original sample demographics. In brief, the PCL-R consists of 20 items each scored zero, one, or two, yielding a total score out of 40, where 30 or above is indicative of psychopathy. The tool consists of two factors and four facets. Rather than providing a strict operational definition of primary and secondary psychopathy, the itemized components of Factor 1 (interpersonal and affective facets) and Factor 2 (lifestyle and antisocial facets) of the PCL-R are used in the present article to define each variant (Douglas et al., 2015). This approach provides the most organized and comprehensive conceptualization of both variants based on the literature to date. Examples of Factor 1 items include pathological lying, failure to accept responsibility, and grandiose sense of self-worth. Examples of Factor 2 items include impulsivity, criminal versatility, and parasitic lifestyle. For a complete list of factor items, see Hare et al. (1990).

Accordingly, Factor 1 is representative of primary psychopathic traits. To illustrate, absolute primary psychopaths exhibit a deficient affective core, abnormal (i.e., overly-relaxed) psychophysiological measures, interpersonal malice (e.g., to gain promotions in vocational settings), and distinct language irregularities. Conversely, Factor 2 is representative of secondary psychopathic traits. To illustrate, absolute secondary psychopaths exhibit extensive rule-breaking/trouble-making behaviours, extreme impulsivity/antisociality, abnormal (i.e., overly-anxious/negative emotionality) psychophysiological measures, and more Cluster B personality traits (e.g., borderline, histrionic, and narcissistic). Importantly, however, most psychopaths manifest both Factor 1 and Factor 2 symptoms, although one side of the spectrum typically dominates (Douglas et al., 2015).

Unfortunately, researchers have yet to determine the prevalence of primary psychopathy relative to secondary psychopathy, or relatedly, the prevalence of traits that compose each variant. However, Factor 2 of the PCL-R, which is used to define secondary psychopathy in the present article, has consistently been an empirically superior predictor of general and violent recidivism outcomes compared to Factor 1 (i.e. primary psychopathy), although this finding is controversial in itself (Corrado et al., 2015). That is, past criminal behaviour is being used to predict future criminal behaviour, because criminal behaviour forms part of the definition of Factor 2 (but not Factor 1) of the PCL-R. Such reasoning is tautological, and has been

disapproved by many scholars (Douglas et al., 2015).

Although primary and secondary psychopaths likely inflict a similar *degree* of harm on society, the *type* of harm inflicted reportedly varies (Yildirim & Derksen, 2015). Broadly, traits characteristic of secondary psychopathy mostly associate with offenses of an overt nature, such as violent crime, property crime, or drug crime. Conversely, traits characteristic of primary psychopathy associate with offenses of an overt and covert nature, such as white-collar crime, interpersonal crime, or organized crime. Thus, given the openly damaging nature of secondary psychopathy, it can be argued that such individuals draw more public attention and hence a greater desire for a sociopolitical response than their primary counterparts, who typically operate more behind the scenes.

As alluded to above, researchers have produced little to no consistent, successful treatment paradigms for psychopathy. Furthermore, research that does trend toward positive outcomes has yet to be of a high-quality nature (i.e. randomized controlled trial). In fact, one matched groups design study consisting of 292 forensic patients followed for an average of 10.5 years found that treatment initiatives actually increased violent and general recidivism tendencies among psychopathic patients – while indicating the reverse to be true for non-psychopathic patients (Rice, Harris, & Cormier, 1992, as cited in Skeem et al., 2002). Nevertheless, the above study contained serious methodological flaws. For example, the researchers failed to use random assignment, post-release differences were not considered, and patients were subjected to inhumane treatment.

Moreover, and more importantly, like so much of the extant literature on psychopathy treatment, this study failed to disentangle the conceptual underpinnings of the personality disorder – a notion that has broad and substantial treatment implications. Primary and secondary psychopathy evidently differ on etiological and symptom manifestation grounds, and arguably, on prognostic grounds as well (Yildirim & Derksen, 2015). For example, although not mutually exclusive, primary psychopathy predominately has a neurobiological/genetic etiological basis, whereas secondary psychopathy predominately has an environmental etiological basis. Given that it is more difficult to treat an innate (as opposed to environmental) condition, this fact at least partially explains the largely ineffective primary psychopathy treatment outcomes seen to date (Yildirim & Derksen, 2015). Accordingly, it is surprising how little research has attempted to make this distinction, alternatively, hyper-fixating on primary psychopathy at the expense of secondary psychopathy. Here, the emphasis is placed on secondary psychopathy. Upon close examination, the nature of secondary psychopathy infers better treatment outcomes, thereby mitigating the clinical gloom surrounding psychopathy and providing a useful starting point.

In particular, 'decompression treatment' (DT) constitutes an exemplary treatment option. Meant for the most serious of offenders, DT represents a correctional/clinical hybrid model which serves as an alternative to traditional prison system placement following the commission and sentencing of a crime (Caldwell, McCormick, Umstead, & Van Rybroek, 2007). DT was originally designed to erode antagonistic bonds between troubled inmates and prison staff (Monroe, Van Rybroek, & Maier, 1988). Thus, admission to DT was granted to inmates who showed severe malice and defiance towards conventional correctional settings/staff over a considerable period of time; a similar admissions criteria is applied presently. The rationale behind DT was to help these violent and mentally disordered offenders adapt to a less distressing correctional environment, which would in turn set a foundation for their successful return to traditional correctional settings/programs with less subsequent incidents and altercations.

More recently, researchers have adapted and expanded the model to target youths manifesting psychopathic traits – where some success has been achieved. For instance, Caldwell and Van Rybroek (2001) found a criminal recidivism rate of only 10% for those youths who received DT compared to those youths who received treatment as usual (20%) and those youths who received assessment-only treatment (70%). Moreover, Caldwell, Skeem, Salekin, and Van Rybroek (2006) reported significantly lower and slower rates of violent recidivism for those youths who received experimental treatment compared to those who received treatment as usual, with the latter group being twice as likely to violently recidivate in the two-year study period. Together, these results suggest that DT can effectively accommodate adolescents showing psychopathy signs.

However, without any available research, it is unclear whether the same results will generalize to the adult psychopath population. Hence, the present discussion seeks to explore and analyze this issue. Correspondingly, a brief overview of DT is outlined below.

DT has been limited to the Mendota Forensic Center in Madison, Wisconsin, where treatment occurs in a designated correctional facility. Accordingly, using their research knowledge and expertise, Mendota forensic psychologists train correctional staff to rehabilitate offenders using three core techniques: (1) minimize threatening stimuli; (2) incorporate reward systems; and (3) foster positive relationships (Caldwell & Van Rybroek, 2001). To ensure safety, offenders only interact with staff (not other inmates), and staff reconvene daily to assess each others well-being. Also, given the nature of clients that staff work with, Preventive Aggression Devices (PADs) can be deployed; PADs are wrist or ankle cuffs that get attached to belts by adjustable straps (Monroe et al., 1988). These devices allow for both safe and fruitful social interactions. Furthermore, more recent DT variations provide every offender with access to a psychologist, psychiatrist, and social worker, in addition to substance abuse or anger management training, for example – depending on their needs (Caldwell et al., 2007). Thus, offenders spend their time either interacting with staff in comfortable common areas or privately in their cell. The length of treatment is at the discretion of staff. If satisfied, and depending on the length of a given sentence, staff will (1) release the offender into society or (2) transfer the offender to a regular correctional facility. However, after being released from the program, offenders can be readmitted to DT if they commit a new offense in a community or correctional setting (Monroe et al., 1988). Notably, although a promising framework, DT has yet to become widely adopted. It remains a short-term, transient treatment rather than a long-term, independent correctional process on its own. Thus, in order to obtain optimal results, this transformation should be the top priority of researchers.

Considering the above, the remaining discussion highlights the theory behind DT as it relates to primary and secondary psychopathy – and the reasons why positive outcomes can be anticipated for the latter population. Note that the anticipated benefits of DT do not apply equally to both populations, thereby underscoring the need to consider the context of offenders being treated. Therefore, primary psychopathy is used as a point of reference throughout the discussion to show how DT mechanisms operate differently for unique offender populations. Thus, compared to their primary counterparts, secondary psychopaths from a Caucasian adult male demographic will show better treatment outcomes via DT, due to their distinct, environmentally determined etiology; specifically, this includes emotional processing, reward sensitivity, and attachment style factors which vary between primary and secondary psychopaths – detailed below, respectively.

Primary Versus Secondary Psychopathy: Emotional Processing

Unlike primary psychopathy, secondary psychopathy customarily originates from learned, environmental experiences, which take place early on in life. That is, secondary psychopaths are frequently subjected to harsh parental rejection and physical/sexual abuse during their childhood (Yildirim & Derksen, 2015). This also encompasses parents who act violently towards one another or inanimate objects. Therefore, compared to primary psychopaths, secondary psychopaths would respond better to DT due to their hyperactive (rather than hypoactive) emotional processing mechanisms. Hyperactive mechanisms lead an individual to overvalue potentially harmful stimuli in an environment whereas hypoactive mechanisms lead an individual to undervalue potentially harmful stimuli in an environment. To expand, research demonstrates that maltreated children are particularly sensitive to threat-related cues in their surroundings (Kimonis, Frick, Cauffman, Goldweber, & Skeem, 2012). Such children seek out angry faces/gestures, and have great difficulty disengaging from these cues. Additionally, these children learn to act aggressively towards these cues as a means to alleviate their distress. Ultimately, this maladaptive coping mechanism starts early in life and then carries on throughout the life course, thus promoting secondary psychopathic traits (Yildirim & Derksen, 2015).

One reaction time study involving primary/secondary psychopaths captured this phenomenon by cycling through positive, negative, and neutral stimuli images (Kimonis et al., 2012). Specifically, the researchers hypothesized that secondary psychopaths would have quicker reaction time scores when negative images were present, as their attentional focus would already be directed towards such stimuli.

Indeed, this was the case, in turn supporting the notion that secondary psychopaths are unusually sensitive to harmful stimuli; further, primary psychopaths did not demonstrate this response pattern.

Regarding DT, this model is suitable because it avoids displaying potentially harmful or threatening stimuli (Caldwell & Van Rybroek, 2001). The correctional facility is designed to mitigate feelings of entrapment, isolation, and abandonment. Rather than employing punitive measures which resemble a secondary psychopaths upbringing, rehabilitative measures are employed instead. This, in turn, reduces the likelihood of an unwanted altercation occurring between a patient and other staff or inmates. To illustrate, offenders are allowed out of their cells into open common areas with furniture where they can interact with staff who are trained to act friendly. The staff may attempt to make warm gestures, such as by offering a smoke or a refreshment. In addition, the regimes are not harsh and rigid, thereby eradicating any sense of coercion or control possibly held by the offender. Ultimately, the decompression model reduces the amount of potentially threatening stimuli for secondary psychopaths to react over, be it interpersonally, structurally (i.e., building design), or timetable wise (Monroe et al., 1988). One exception to this rule involves the prioritization of staff safety. A prime example of this notion is the use of PADs, as defined above. Offenders may view leather shackles and cuffs as being a threat to their personal freedom. However, such devices prevent staff from being assaulted, thus empowering staff to carry out their duties, which in turn benefits offenders. If the staff perceive their environment as unsafe, their service quality will decline and their attrition rates will increase. Not to mention, PADs are only used in the most serious cases, and can be removed indefinitely after an offender exhibits sustained, socialized behaviour.

At this point, it may be argued that secondary psychopaths possess hypoactive emotional processing mechanisms as opposed to the suggested hyperactive variant (Porter, 1996). This hypoactive mechanism essentially indicates the reverse. That is, it involves a dissociation of emotion where, after repeated traumatization, one learns to “turn off” their emotions in an effort to cope (Porter, 1996). These episodes generally occur earlier on in life but then endure throughout adulthood – such that, the victim is unable to emotionally connect with other individuals. Nevertheless, in the realm of psychopathy, this link has yet to be established; primary psychopaths exhibit hypoactive emotional processing mechanisms, but this is due to genetic dispositions rather than environmental influences (Kimonis et al., 2012). Hence, given that secondary psychopaths respond negatively to threatening stimuli as a result of their hyperactive emotional processing mechanisms, it is imperative that DT initiatives maximize the amount of innocuous components to ensure the successful rehabilitation of this population.

Primary Versus Secondary Psychopathy: Reward Seeking

As mentioned above, secondary psychopathy is largely the product of neglect and abuse experienced in early childhood. Yet, as a consequence, this produces substantial changes to their nervous system functioning – particularity as it relates to reward sensitivity (Yildirim & Derksen, 2015). Thus, relative to primary psychopaths, secondary psychopaths would respond better to DT due to their strong (rather than weak) physiological propensity towards reward gratification. Unlike primary psychopaths, secondary psychopaths display strong neurotic symptoms – namely anxiety, but also depression. In fact, researchers frequently distinguish between the two groups on the basis of high/low Welsh Anxiety Scale (WAS) scores (Newman, MacCoon, Vaughn, & Sadeh, 2005). Furthermore, the anxiety which is inherent to secondary psychopathy corresponds to a distinct pathway of nervous system functioning. Specifically, Gray’s model of the nervous system postulates two primary motivational systems: the behavioural activation system (BAS) and the behavioural inhibition system (BIS) (Gray, 1987, as cited in Newman et al., 2005). The former is receptive to reward cues and thus initiates behavioural approach, while the latter is receptive to punishment cues and thus initiates behavioural avoidance. Importantly, secondary psychopathy is associated with a strong BAS and a normal BIS while primary psychopathy is associated with a strong BIS and a normal BAS (Newman et al., 2005). In other words, secondary psychopaths value reward over risk-aversion whereas primary psychopaths value risk-aversion over reward.

Accordingly, DT takes advantage of secondary psychopaths extreme need for reward satisfaction. The model is premised on operant conditioning principles, particularly those of positive reinforcement (Monroe et al., 1988).

Initially, stringent disciplinary measures and protocols are imposed on offenders. However, for every prosocial action that an offender makes – small or large – the more these measures and protocols are gradually lifted. For example, if a violent offender does not utter threats or misbehave for a considerable duration of time, then their PADs can be removed. Further, prosocial behaviours are reinforced through various levels of rewards; the more an offender complies, the more an offender is rewarded. Therefore, these rewards progressively increase in quality (e.g., chocolate bar to television privileges) and quantity (e.g., 10 minutes of television time to 30 minutes of television time). This technique is known as shaping, which involves the continued reinforcement of behaviours that increasingly approach a desired response outcome – in this case, prosocial attitudes and behaviour (Caldwell & Van Rybroek, 2001).

Notably, a glaring issue now arises: since the decompression model is practiced in correctional settings, the rewards will no longer continue upon release, and hence, secondary psychopaths will return to being antisocial. However, neuroscientific brain scans conducted on secondary psychopaths have produced telling results. Namely, secondary psychopathy is associated with decreased grey matter in brain areas like the amygdala, orbitofrontal cortex, posterior cingulate, para-hippocampal region, and the temporal pole – all parts of the paralimbic system (Anderson & Kiehl, 2012). This system is associated with functions such as self-control, higher reasoning, and most importantly here, pleasure thresholds. Consequently, given this reduced grey matter, secondary psychopaths do not derive the same level of satisfaction from rewards, nor are they able to exercise proper self-control, which in turn, causes them to seek rewards impulsively (Yildirim & Derksen, 2015). However, researchers contend that, with enough reward gratification over time, new grey matter is formed in areas of the paralimbic system – thereby signalling permanent changes in the brain (Anderson & Kiehl, 2012). As a result, secondary psychopaths would derive more pleasure from each individual reward they receive while concurrently reducing their inappropriate reward seeking habits. In sum, given that secondary psychopaths are especially receptive to rewards due to strong abnormalities in their BAS, DT must sufficiently reward these individuals in order to regulate their reward seeking tendencies upon release.

Primary Versus Secondary Psychopathy: Attachment Styles

Problems between infants and caregivers are known to result in several possible troublesome attachment styles, of various forms (Unrau & Morry, 2019). As a result, these attachment styles differentially impact an individuals interpersonal abilities and skills, typically in a negative manner. Accordingly, secondary psychopaths would respond better to DT due to their environmentally determined anxious attachment style, in comparison to primary psychopath's evolutionarily associated avoidant attachment style. To start, attachment theory proposes that infants have an innate need to bond with and maintain close proximity to their caregivers (Unrau & Morry, 2019). If these needs are satisfied, the child develops a secure attachment style. However, if these needs are not satisfied, the child develops an insecure attachment style – which can be further divided into avoidant and anxious variants. The former is characterized by items like avoidance of intimacy and cynicism regarding relationships, engendered through nonresponsive caregiving (Christian, Sellbom, & Wilkinson, 2017). The latter is characterized by items like fear of abandonment and excessive reassurance seeking, engendered through inconsistent caregiving (Christian et al., 2017). Infant attachment styles also correspond to adult attachment styles in terms of the behaviours, cognitions, and emotions that a given individual displays (Unrau & Morry, 2019). So, an anxious infant-parent relationship would later translate to an anxious adult-partner relationship, for example.

Evidently, researchers discovered that secondary psychopathic traits related to anxious attachment styles while primary psychopathic traits related to avoidant attachment styles (Blanchard & Lyons, 2016). That said, the life history theory paradigm posits that primary psychopathy is an evolutionary consequence; these individuals have adapted to exploit and manipulate others in order to ensure their own survival and reproductive success. Therefore, their avoidant attachment style is postulated to derive not from the environment, but from genetic mutations (Blanchard & Lyons, 2016). On the other hand, secondary psychopathy is regarded as an environmentally derived phenocopy of primary psychopathy – albeit its manifestation as anxious attachment (Blanchard & Lyons, 2016).

Essentially, the attachment style of primary psychopaths is firmly established while the attachment style of secondary psychopaths is not.

Accordingly, the interpersonal aspect of DT addresses the attachment style held by secondary psychopaths. In particular, healthy relationships are fostered between staff and offenders. Although these interactions are not as structured or intricate as more established interpersonal therapies, they do abide by important principles (Monroe et al., 1988). DT emphasizes rapport building between offender and staff; the staff are trained to take an interest in offenders, mostly at a casual level. This includes any necessary education to ensure successful interaction with offenders. For instance, this comradery could simply take the form of a conversation where an offender is free to discuss a host of different topics (e.g., future goals), as long as the conversation stays appropriate. Furthermore, DT staff avoid portraying offenders in a suspicious manner, while coming across as humble and reliable. Elsewhere, psychopaths are often disrespected, humiliated, or met with pre-existing pessimism on behalf of therapists (Martens, 2004). Moreover, DT is small-scaled so offenders can be regularly attended to, and protocols can be tailored to fit their needs. Not to mention, newer adaptations of DT incorporate external specialists like psychiatrists and social workers into the model. Thus, these individuals further aid in developing an offenders social skills, communication abilities, problem solving capacity, and social receptivity. Essentially, DT helps secondary psychopaths develop secure relationships with program staff, which contradict and thus weaken their normally unstable, anxious relationships (Monroe et al., 1988).

That said, evidently, the majority of individuals who develop an anxious attachment style do not proceed to develop secondary psychopathy. Nonetheless, researchers note that attachment styles are not entirely fixed in nature (Christian et al., 2017). Alternatively, they propose an accumulation or cascading effect – in which, an attachment style is strengthened or weakened based on experiences throughout the life span. Not only do secondary psychopaths experience an extreme degree of adversity in childhood, they also have difficulty in school, work, and other related organizations, which all involve interpersonal transactions (Yildirim & Derksen, 2015). These transactions are characterized by distrust, discourse, and instability. Therefore, this accumulation of negative experiences strengthens their anxious attachment style, which consequently fosters destructive relationships (Christian et al., 2017). Meanwhile, researchers contend that the evolutionary based avoidant attachment style of primary psychopaths is more immune to accumulation effects, and thus steadily fixed (Blanchard & Lyons, 2016). Accordingly, given that secondary psychopaths present anxious attachment styles that are, overall, amendable to change, it is paramount that DT emphasizes the development of secure attachments between secondary psychopaths and staff.

Conclusion: Strengths, Limitations, and Implications of Decompression Treatment

Overall, it has been argued that the DT model should be applied to the secondary psychopath population. Importantly, the argument is premised on the fact that primary and secondary psychopathy is distinguishable based on its predominantly genetic and environmental etiology, respectively. Correspondingly, the first variable etiological characteristic pertains to emotional processing; primary psychopaths possess hypoactive mechanisms while secondary psychopaths possess hyperactive mechanisms. Therefore, given that DT operates by reducing the amount of harmful stimuli in the environment, it follows that secondary psychopaths would respond well. The second variable etiological characteristic pertains to reward sensitivity; primary psychopaths rate risk-aversion over reward while secondary psychopaths rate reward over risk-aversion. Thus, given that DT provides increasing reward incentives for prosocial behaviour, it follows that secondary psychopaths would respond well. Finally, the last variable etiological characteristic pertains to attachment style. Primary psychopaths have an evolutionarily associated avoidant attachment style while secondary psychopaths have an environmentally determined anxious attachment style – which implies that the former is more resistant to change. Thus, given that DT fosters secure relationships between staff and offenders, it follows that secondary psychopaths would respond well. All together, secondary psychopaths from a Caucasian adult male demographic will show better treatment outcomes via DT due to their environmentally unique, etiological variations in emotional

processing, reward sensitivity, and attachment style – relative to their primary counterparts.

Notably, several potential variables may moderate or mediate the link between secondary psychopathy and the treatment outcomes anticipated above. For instance, even if two individuals share a diagnosis of secondary psychopathy, odds are they would differ on at least one sociodemographic parameter such as age, ethnicity, gender, or comorbid mental disorder. For example, compared to male psychopaths, female psychopaths are more likely to be emotionally unstable, relationally manipulative, and embody an unstable self-concept – in addition to being less aggressive, disruptive, domineering, and self-aggrandizing (Douglas et al., 2015). Touching on ethnicity, some researchers believe that only the affect-based deficits of psychopathy are cross-culturally stable (Cooke, Michie, Hart, & Clark, 2005). Meanwhile, other researchers contend that psychopathy measures (e.g. PCL-R) show overall cultural equivalence despite item level differences (Douglas et al., 2015). Unfortunately, provided the current state of the DT literature, it is too premature to make definitive claims as to how exactly these types of variables may impact the treatment process, both theoretically and empirically. This is a large area for future research, and the results of such query will inform additional treatment considerations beyond that of the primary-secondary distinction. Even at that, there have been poor efforts to distinguish between primary and secondary variants to date, despite the fact that this distinction is paramount with respect to treatability (Yildirim & Derksen, 2015). Criminal attitudes and actions can seemingly be reduced in secondary psychopaths through models like DT, which exemplifies a customizable, flexible framework. That said, DT currently has three major limitations.

First, the model has been limited to correctional settings. Thus, there is a premise that secondary psychopaths must be apprehended before they receive this treatment. By extension, this means that DT falls into the category of tertiary prevention. Unlike primary/secondary prevention, tertiary prevention deals with preventing future criminal transgressions once an offender has already offended at least once (Simeonsson, 1991). In other words, tertiary prevention is primarily focused on curtailing criminal recidivism. Tertiary prevention is not the ideal form of crime prevention as a certain level of harm has already been imposed on society. However, tertiary prevention constitutes a major portion of criminal justice system activities, and to assume in modern society that all crime can be entirely prevented before it occurs is a fictitious statement. Moreover, given that psychopaths have egocentric and self-absorbed personality traits, it is highly unlikely that these individuals would seek treatment on their own. Not to mention, detecting psychopathy among lay persons is not an easy undertaking (Skeem, Johansson, Andershed, Kerr, & Louden, 2007). In theory, since secondary psychopaths display more Cluster B personality features (e.g., irritability, attention-seeking, reactive anger, intense mood swings, poor impulse control) and overt behavioural reactions, it seems like this population would be slightly easier to identify (Skeem et al., 2007). However, even if early identification was possible, the amount of proper treatment resources and time they would receive is questionable. Therefore, although DT is considered tertiary prevention, it still has a place in contemporary correctional programming.

Second, the DT model has one major shortcoming that the available literature fails to explicitly address. Namely, does the displacement of an offender from DT into conventional prison programming reduce or even eliminate the benefits that an offender acquired while in DT? Given that DT is designed for serious offenders, it follows that their criminal sentence is likely to be of a lengthy duration. Consequently, a bountiful amount of time, resources, and monetary means are going to be allocated to a single offender. Further, the problem becomes exacerbated when one considers the total amount of offenders placed in DT programming. Nevertheless, a few possible solutions exist.

First, an indirect solution involves an increase in the amount of DT patients who are either granted parole or statutory release. This would allow certain individuals access back into their communities while simultaneously reducing the resource burden faced by DT. Yet, the odds of this indirect consequence are variable, and hence, not a great solution to the problem. Another, more pragmatic solution is to transfer DT patients to the regular corrections facility of their given jurisdiction with regular follow-up evaluations taking place thereafter. Forensic psychologists associated with DT could open a case file that contains information about a particular client while that client is undergoing DT. Thereafter, once transferred to regular corrections, the same psychologist could conduct

direct interviews with their assigned client, interview other correctional staff or inmates, monitor any available records or security footage, administer self-report measures or other psychological tests, and so forth. Then, the psychologist would rule whether their client should remain in their current corrections environment or return to DT, based on how well their client has adjusted to regular corrections. Finally, a third proposed solution is to restrict DT to small-scale operations. Although the total amount of offenders assigned to DT would be limited, those who are involved in the programming could be thoroughly treated from the beginning to the end of their sentence.

Fittingly, this leads to the third major limitation of the model: the DT literature is largely restricted to small sample sizes. This issue presents a paradox. On the one hand, future research should aim to expand the model and its services without compromising its effectiveness. Yet, on the other hand, given the limited amount of resources that the model has available and the nature of the individuals being treated, it appears as if the expansion of DT is not entirely feasible.

Despite these limitations, DT seemingly presents numerous benefits, with the two most prominent being cost and harm reductions. Secondary psychopaths incur expensive costs in three general, broad domains. The first domain is offender related. Items in this category include criminal justice system costs, incarceration costs, rehabilitation costs, and so forth. The second domain is offence related. Items in this category include residential/commercial/business property damage costs, incivility costs, insurance costs, and so forth. The last domain is victim related. Items in this category include victim service costs, lost time from work costs, physical injury costs, and so forth. Furthermore, particularly in the last domain, it is important to not only consider tangible costs, but also intangible costs (McCollister, French, & Fang, 2010). Attempting to place a monetary value on pain, suffering, shame, guilt, fear, and so on, can drive costs even higher. Although it seems that these collective costs override those of DT initiatives, future research must verify this.

Additionally, a related issue is that of harm reduction. Secondary psychopaths cause many interpersonal troubles among family, friends, and strangers (Yildirim & Derksen, 2015). Such conduct in turn impacts the recipient in a variety of negative ways. Some recipients may become irritated or frustrated, and try to retaliate against or provoke a secondary psychopath; other recipients may become withdrawn or get taken advantage of by a secondary psychopath; other recipients may become fearful of crime and victimization by a secondary psychopath even if their actual risk of being a victim is low. Regardless, without any intervention, secondary psychopaths have the potential to harm both individuals and society as a whole. Thus, DT provides a starting point to mitigate the extent of these damages. Yet, above all, DT offers a robust template to eradicate the notion that psychopathy is completely untreatable. At its core, the model relies on sound principles in order to ameliorate the behaviours, cognitions, and attitudes of the most problematic of offenders. Ultimately, the intervention efficacy of DT for secondary psychopathy appears promising, and hopefully one day, with some modifications, primary psychopaths will similarly benefit.

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