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Reflections at Five Years and Post COVID-19

Gary Chaimowitz1,2

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Almost five years ago, the first issue of the International Journal of Risk and Recovery (IJRR) arrived in an already crowded medical journal market (Chaimowitz, 2018). It strove to both address key forensic psychiatry issues and to make the articles readily accessible for forensic psychiatry clinicians. The IJRR aimed to focus not only on the myriad of risk issues but also on the rehabilitation of forensic psychiatry patients and especially the application of recovery principles to this patient population (Simpson & Penney, 2011). Finding and maintaining the balance between risk and recovery was key.

And over the last five years, much—and in part little—has changed. One could argue that little really changes in psychiatry and very little in forensic psychiatry. Patients are the same, risk factors don’t really change, and human behaviour hasn’t changed for time immemorial. We continue to assess, predict, then manage risk under whatever legal or quasi-legal system operates in the jurisdiction we work in.

But who would have predicted COVID-19 and its impact on society, our patients, staff, and healthcare (Chaimowitz et al., 2021). Apart from the fear, losses, and isolation felt by many was the fracturing of society, with hardened positions, and science questioned at multiple levels. Delusional-like beliefs entered mainstream, and the boundary between psychosis or illness and widely held beliefs blurred to an extent not seen before.

As in times of war, innovation accelerated. Virtual meetings, virtual court hearings, virtual connections, and virtual assessments rapidly became the norm. Working from home and not connecting with (or even assessing) patients in real life is the way many now practise. Psychiatry, and to a lesser extent forensic psychiatry, may never go back to fully in-person practice. The rapid availability of virtual clinics, the use of big data and artificial intelligence, measurement-based care, electronic databases and health records, genetic testing, and speech language tools was stunning. To some extent, not being able to use patient inputs in research for several years meant a push to different approaches. This is all reflected in the type of articles published. Political events also drove a substantial movement to address longstanding gaps in addressing equity, diversity, indigeneity, inclusiveness, and accessibility (Candilis & Griffith, 2021).

Many journals were already moving to a digital format when we launched the IJRR. We published a few print issues in addition to a digital version, but COVID-19 was the death knell for print journals. Adoption of online journals, which was slow pre-COVID-19, rapidly accelerated. We are proud to say we continued to publish regularly through the pandemic and continue to maintain an open-access format. We also pivoted to using Scholastica, which has made for an easier submission and review process. The IJRR also moved to the Forensic Psychiatry Institute website, which allows us to provide articles in a mobile-friendly format and easier to find through search engines.

We readily acknowledge that the field of forensic psychiatry has much more to do. As suggested by the title of our journal, we need to keep our eyes on finding the balance between risk and recovery, as recovery is the ultimate risk mitigation destination (Shepherd et al., 2016). But there is now much more we can think about, issues of structural racism as it impacts our patients and our practices, doing what we can to protect the environment, introducing innovation into forensic psychiatry, and being much stronger advocates for the social issues that drive people into the forensic system (Chaimowitz & Simpson, 2021). Stigma continues to loom large and may in fact increase given the stresses on our system.
We are proud of what we have accomplished over the past five years. This journal will continue to provide a forum for healthy discussion, debate, and innovation in forensic mental health services by focusing on the delicate balance of risk management and recovery promotion. But more than that, our forum will include advocacy and the other socio-political key issues impacting forensic mental health.

References

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The introduction of a recovery approach to forensic psychiatry services has been embraced in recent years. The recovery approach moves patient care beyond the domains of symptom reduction and aggression management. It places the importance on the patient’s personal experiences and values, and instills hope for a future with meaningful activities and supportive social relationships. As an initial step to integrating a recovery approach, we sought to better understand patients’ and family members’ perspectives and experiences of recovery in a forensic psychiatry program (FPP). This project involved one family member and two patient focus groups. All groups were asked what recovery meant to them and what we could do to support their recovery in the FPP. The focus groups were audio recorded and transcribed. A thematic analysis approach identified themes from the transcripts. Family themes included the patient returning to their original identity, opportunities to address the past, developing positive connections with others, balancing rehabilitation in the forensic environment, and maintaining communication with staff. Patient themes included developing positive connections, developing better communication about the forensic system, balancing rehabilitation in the forensic environment, and progressing with their lives. Patients and family members described their experiences of recovery in our FPP. Some areas for improvements were identified, which can form the groundwork for future improvement initiatives in our FPP.

Key words: recovery, forensic psychiatry, forensic patient, forensic family, focus groups

While conventional mental health practices and research have focused on clinician perspectives, recent trends have highlighted the importance of the patients’ perspectives regarding care (Livingston et al., 2012; Marklund et al., 2020). Crucial to recovery is a relationship between patients and staff that recognizes and incorporates the perspectives of patients as they begin the process of accepting and overcoming their individual challenges. Similarly, patient perspectives may pinpoint effective interventions that clinicians may not identify (Tapp et al., 2013).

Recovery-oriented guidelines have been developed to help mental health services implement a recovery approach (Mental Health Commission...
of Canada, 2015). A core idea of recovery is that patients are active participants, rather than passive recipients of care. Trends in health services recognize patient contributions and perspectives as key pieces to maximize the therapeutic value of care (DeBronkart, 2015). Best practices from general mental health services have been used to inform forensic mental health practice and the development of interventions for forensic patients (Simpson & Penney, 2011). However, some of the challenges patients and families experience in the forensic system remain unique compared with other mental health services (Davidson et al., 2006; Mann et al., 2014; Tomlin et al., 2020).

Forensic mental health services differ from general mental health services in a few ways. Forensic services are for patients with mental illnesses who have been found not criminally responsible or unfit to stand trial and touch both legal and health-care systems. Forensic psychiatric facilities have high levels of environmental and procedural security, where visits are regulated and restrictive orders may not allow patients to leave the hospital. Access to personal belongings may be restricted, as is intimacy and contact with the outside world. These restrictions can last many years and can have an effect on social, occupational, and vocational domains, as well as decrease motivation and hope because patients often lack an understanding of their lengthy course in the forensic system (Ghaemi & Pope, 1994; Tomlin et al., 2020).

Creating a supportive and rehabilitative environment for forensic patients can be a challenge. Forensic patients are unwillingly detained in hospital, and this would impose threats to autonomy and choice, especially where feelings of oppression are often unavoidable (Livingston et al., 2012; Mann et al., 2014). Also, the risk for violence in forensic psychiatric services poses another barrier to a recovery approach, where the focus on safety may confine the limits of a patient-centred approach (Hörberg & Dahlberg, 2015; Morrissey et al., 2018). This type of milieu can also lead to authoritarian and restrictive attitudes by staff (Asksøla et al., 2020).

In the past decade, there has been an increase in literature looking at understanding patients’ experiences with recovery in forensic psychiatric services. More specifically, qualitative research looking at patients’ perspectives of recovery are beginning to yield some common themes. Systematic reviews of the recovery approach have identified concepts such as connections, hope, identity, meaningful life, and empowerment (Clarke et al. 2016; Leamy et al., 2011). Although the literature suggests that forensic patients endorse the importance of these mainstream concepts of recovery, forensic patients also have unique needs compared with other mental health populations that must be recognized (Aga et al., 2017; Mann et al., 2014; Mezey et al., 2010; Shepherd et al., 2016; Turton et al., 2011).

In recent years, qualitative studies involving forensic patients have identified important themes for recovery in forensic settings. However, some of the themes emerging from qualitative studies may be affected by contextual factors, such as policies, local practices, relationships with staff, and availability of services. As an initial step to integrating a recovery approach into our forensic psychiatry program, we sought to obtain the perspectives of patients and their family members. Our paper describes a qualitative study we conducted to gain a better understanding of patients’ and family members’ perspectives and experiences of recovery in a forensic psychiatry program (FPP).

Methods

Design

We used focus groups with an evaluative, descriptive focus to gain participants’ perspectives about their recovery in an FPP. To promote more open and honest responses from participants, the facilitator was a staff member from outside the FPP. The facilitator was skilled in conducting focus groups and creating an environment where participants were encouraged to share their perspectives of recovery.

Each focus group followed a general interview guide with the following open-ended questions:

1. What does recovery mean to you?
2. What could we do to support your recovery in the FPP?

Each of the three focus groups were audio-taped. Transcription of the audiotapes was done by a transcriptionist outside the FPP.

Participants and Recruitment

Patients were recruited through community meetings on the forensic in-patient units. As well, outpatients responded to a flyer that was posted in the forensic outpatient waiting room. Patients had to speak English and be willing to talk about their experience of recovery in the FPP to be eligible to participate. Patients contacted the project lead if they were interested in participating in the project.

Family members or a person the patient considered a significant other were invited to participate in this project. Case managers and social workers typically had more established relationships with
family members and contacted them by email or phone to provide an explanation of the project. Interested individuals were contacted by the project lead to provide more information about the study.

All participants signed a consent form to participate and be audiotaped. Upon completion of the focus group, each participant was given an honorarium for participating in the focus group.

**Ethics**

This project was recognized as a quality improvement initiative by the research ethics board. All participants in the focus groups provided written informed consent to participate in the project.

**Analysis**

A thematic analysis approach was taken following the framework described by Rabiee (2004) in analyzing the focus group transcripts. The framework provides steps to sift through a substantial amount of data while maintaining the integrity of social interaction and addressing lived experiences.

In this study, analysis began with two of the authors (I.F. and M.C.) familiarizing themselves with the focus group audiotapes and transcripts. Memos and notes were taken with the transcripts to help code the data and link different segments in the data. The coded data were then categorized to generate concepts and subthemes. At times, the two authors may have placed quotations from the transcripts under different themes. When a discrepancy was identified, both authors re-read the transcripts to obtain a better understanding of the context of where the quotation originated. Once a context was identified, the authors identified the theme under which the quotation best fit. Each quotation in the manuscript has a coinciding number [in square brackets], which represents the line number in the transcript where the quotation is found.

The themes arising from the focus group transcripts were linked to the purpose of the project, which was to gain a better understanding of patients’ and family members’ perspectives and experiences of recovery within our FPP. Quotations representative of emergent themes were identified. The themes were compared between the patient and family focus groups for similarities and differences.

The results of the thematic analysis along with supporting quotations were presented to a recovery group to raise awareness of our patients’ current experiences with recovery in the FPP. Many front-line staff confirmed an awareness of these themes from discussions with patients. Patients in the group confirmed the accuracy of the themes either through their own experiences or from speaking with other patients. The results were also presented to the recovery project team and compared with the peer-reviewed literature to identify similarities and differences.

**Results**

Twelve patients, including 11 males, participated in the focus groups. Patient participants’ length of stay ranged from three to 52 months. Two patients were outpatients at the time.

Five family members of patients in the FPP also participated in the focus groups. At the time of the project, they had been connected with the FPP for 14 to 52 months. Participants were three mothers and two fathers of three patients.

**Family Focus Group**

The family focus group identified five themes and related subthemes as important to recovery (Table 1). Direct quotations from the family focus group transcripts are used to support each main theme.

**Family Theme 1: Returning Patients to Their Original Identity**

Family members noted that patients became increasingly productive and independent during their time in the hospital. In particular, this change in attitude shifted away from the characteristics that emerged with the onset of mental illness and was viewed as a return to the patient’s regular way of being. Some family members also acknowledged that it took time for the patient to start returning to how they used to be, while other family members were still waiting.

*We’re so fortunate to come in here because now he’s changed back to like he was … He went back to like he was … I really think he didn’t know what he was doing, and now it’s amazing how we’ve got our son back.* [23–24], [27], [28–29]

*Yeah, I have seen a lot of improvement in him, and I’m waiting until he is just actually normal. I wouldn’t say he’s perfect right now, and he’s working on his dressing.* [101–103]

**Family Theme 2: Addressing the Past**

Family members took the opportunity to talk about the experience of having the patient enter the forensic psychiatric system. Although this wasn’t the focus of the group, the supportive environment of having others in similar circumstances encouraged a supportive discussion. These shared experiences
decreased feelings of social isolation and anxieties about present circumstances.

*The blame was always put on me because I was the one always calling the police.* [366]

Family members said they felt that patients acknowledging their past actions promoted self-awareness, responsibility, and remorse. Family members gave examples of conversations where patients showed remorse. Verbalizing remorse helped decrease family members’ feelings of blame and guilt.

*He never referred to us as mom and dad. It was [Name-X] and [Name-Y], and now, it’s hard for him to come to terms with the way that he was because I know we mean a lot to him, and he tells us that often.* [197–199]

A family member provided another example of a patient acknowledging their past actions and the resulting consequences. The family member described a conversation they overheard between the patient and another family member:

*They’re about the same age and he’s telling him all kinds of things that he went through. He even told him about being put in the jail, and he hopes in his life he never sees the inside of that place again.* [256–257]

**Family Theme 3: Developing Positive Connections**

Family members said they found that positive connections with staff fostered feelings of confidence in care. Staff support outside the hospital strengthened independence, encouraging positive feelings about discharge, and hope for the future.

*I know that we can still phone, and I can get help. I have a whole list of numbers. They left us very well-equipped that we can get help. [My child] comes and sees case workers.* [1304–1305]

Family experiences in the forensic system presented unique circumstances. It was important for family to feel supported, especially when preparing for discharge from the hospital. Family members felt that having positive peer relationships on the unit would decrease loneliness and stigma for the patient.

*This may be with the patients and maybe with psychiatrists just to kind of referee the whole thing because everybody thinks when you’re sick, they’re just a little island, but if they see other people with maybe not the same illness but similar, they don’t feel so alone.* [789–792]

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**Table 1**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
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<tbody>
<tr>
<td>Returning patients to their original</td>
<td>Recovery is a return to identity before the illness*</td>
</tr>
<tr>
<td>identity</td>
<td>Recovery is seeing their children set goals and being productive and</td>
</tr>
<tr>
<td></td>
<td>independent*</td>
</tr>
<tr>
<td>Address the past</td>
<td>Recovery is their children acknowledging their past and current circumstances</td>
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<td></td>
<td>Recovery is the family having the opportunity to discuss and acknowledge</td>
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<td></td>
<td>the past with the onset of illness</td>
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<tr>
<td>Developing positive connections</td>
<td>Recovery is having the support of the staff and facility</td>
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<td></td>
<td>There is a need to develop a peer support system to address loneliness and</td>
</tr>
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<td></td>
<td>isolation on the unit</td>
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<tr>
<td></td>
<td>There is a need to address stigma and discrimination*</td>
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<tr>
<td>Balancing rehabilitation in the</td>
<td>The patients feeling safe is crucial to the recovery environment*</td>
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<tr>
<td>forensic environment</td>
<td>There is a need to find a balance between freedom and purposeful limitation</td>
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<td></td>
<td>because recovery is a process that requires patience and hard work*</td>
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<td></td>
<td>There is a need for more stimulating, therapeutic activities on the unit</td>
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<td></td>
<td>to develop new skills for re-integration and deterring bad habits*</td>
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<tr>
<td></td>
<td>There needs to be a distribution of roles and tasks on the unit to promote</td>
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<tr>
<td></td>
<td>feelings of responsibility and independence*</td>
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<tr>
<td>Maintaining communication with</td>
<td>The hospital needs to be transparent and accommodating, and to establish</td>
</tr>
<tr>
<td>staff</td>
<td>a clear line of communication with the family*</td>
</tr>
</tbody>
</table>

* Significant agreements (> 50%) made by the participants
There is a stigma. Yeah, and I think a lot of people that haven’t actually personally dealt with it like we have, they don’t understand it. [219–220]

**Family Theme 4: Balancing Rehabilitation in the Forensic Psychiatric Environment**

Family members said they felt that being on a forensic in-patient unit was very different than living in the community. However, they said they felt that the forensic psychiatry system was necessary to limit risks and contributed to a greater understanding of patients’ circumstances. Some family members said they felt the patients were bored and didn’t have many responsibilities on the unit. They suggested that asking patients what they wanted to do and finding activities to keep patients occupied and happy would help with their recovery.

*Something he did say is that they should be doing more physical things and jobs. That’s something he wanted to do when he first got in here. He said oh, if I even at least could just even sweep the floor or work in the kitchen doing the dishes.* [823–825]

*Yeah, I think we should see if it’s their interest. It should be about their interest because, if you offer things that they’re not exactly into, they might not join the group, so we have to find out what their interests are first. But just find things to keep them occupied and happy, and even if they’re happy, they will recover even faster. They can develop those skills at the same time that would enable them to get back into society, find a job, and just go to find a purpose.* [495–500]

**Family Theme 5: Maintaining Good Communication with Staff**

Good communication with the hospital staff increased confidence in care and feelings that the patient was safe. Availability of staff was essential to make the family feel cared for, easing tensions, and increasing feelings of respect and trust toward staff. The staff provided information about available resources that could help with the patient’s recovery. Staff were also instrumental in facilitating visits with patients and provided support during interactions with the patient.

*I think that you do a great job in supporting the family, and I always knew when our [child] was in the hospital. We came often, three times a week, to see them, and we got to know who they were seeing, a lot of people, and I found that [staff] were always available if we needed help. If we had a question that we didn’t know the answer to, we would get an answer.* [1295–1299]

**Patient Focus Groups**

The patient focus groups identified four main themes and related subthemes that were important to their recovery (Table 2). Direct quotations from the patient focus group transcripts are used to support each main theme.

**Patient Theme 1: Developing Positive Connections**

Patients talked about developing and maintaining positive connections with patient peers, family, and staff. Existing interactions with staff highlighted issues with unequal power distribution on the unit. Patients indicated a power imbalance and the lack of a relationship between staff and patients created a disengaging environment.

*An activity that I always enjoy doing is going for a walk with staff around the hospital on (inaudible). I would get to know the staff a lot better, get to know what they do and stuff like that, what they like doing. It’s just an experience which boosts recovery, because when you get to know the staff, the staff like you a lot better. When staff have a general outlook on your behaviour and they can benchmark it and create windows so that they will know that no matter what, that you’re not going to mess up.* [441–446]

Patients valued maintaining connections with their family while they were on the unit even through virtual connections.

*I’d say having more access to our family on the unit. A big thing for me is me and my family text, and we Facebook a lot … I just don’t have access to my family when I think it would beneficial over time.* [358–359, 360–361]

Patients also identified that some of the policies and rules prevent patients from showing compassion and interacting in meaningful ways.

*Right now, the hospital trains us not to help anyone, because we can get in trouble for it, when that’s not [being] a human being … We’re all in the same boat, and sometimes
it’s sinking, and we’ve got to bail it out. We can’t because we’re not allowed to hand things or donate things [to each other]. [566–567, 569-570]

Patient Theme 2: Developing Better Communication About the Forensic System

Lack of information about the patient’s course of treatment in the hospital served as a barrier to motivation and hope. As a result, frustration increased about wasting time in the system and not knowing what to do to progress through the system.

They have the team meeting about you behind closed doors, and you’re not there to hear what the nurse, or the psychiatrist, or anyone has to say about you. So, you’re in the dark, and they don’t tell you how you can improve. They simply give you a green sheet eventually, and you wait for it, and say, this is what your privileges are. They don’t say how you can improve and what they’ve noticed from you being in the in-patient unit. [399–404]

At times, the difference in opinion between the staff and patients of where the patients were in their recovery created a reluctance to engage with the system.

And my disposition has been direct community. And I would like to go to school, to [college], in September. But I’m not going to be at that stage of my choice with my privileges. But I feel like I’m ready. So, I don’t have the choice to go to [college] yet. I have to wait until another full year is wasted, so I can go to [college]. So, I don’t have the choice to go myself. I have to wait until the doctors and the nurses say that I’m ready and I’m a low risk and stuff like that. [655–660]

Psychoeducation allowed patients to understand their illnesses, creating a sense of acceptance and responsibility. This promoted self-management and increased feelings of independence.

I think what would help me recover was a psychoeducation. Psychoeducation based on what would help me homogenate and control my symptoms, what I’m experiencing, right, so that I can tackle day-to-day living. When you can tackle day-to-day living, that’s the first step towards recovery. [346–349]
Patient Theme 3: Balancing Rehabilitation in the Forensic Environment

The restrictions placed on a forensic in-patient unit made for an inflexible structure, which resulted in the temporary suspension of responsibilities, risk management priorities, and lack of personal autonomy. Patients recognized that increased security and rules were necessary for some patients, however, at the same time, limited choices and activities for others. As patients progressed closer to moving into the community, they said they found the unit did not simulate living in the community.

*If it’s worth doing well, it’s worth focusing [on] all things together. So, trust me when I say, I need this, or I don’t need that. Because when I say, I don’t need this, or I don’t need that, that’s my honest [opinion]. And if you’re going to say you have no choice, you have to do it, well then you’re making me do something that I think is pointless, and you’re wasting my energy. [593–597]*

Well, that’s a pretty strict rule that we don’t follow in general society. If I can’t share, what can we do? I’m supposed to be selfish or do it underhanded behind your back? [730–732]

Conversely, security and risk assessment were regarded as necessary, suggesting the importance of balancing structure and autonomy.

*Maybe not so much open the doors, because there are some patients, and we are criminals. Let’s get down to the facts. There are some patients that would escape and probably would do something terrible. So, we can’t just leave the doors open, I mean. But we can get certain passes for the security, and they could open them for us. [337–340]*

The emphasis on security impeded on autonomy, which resulted in limited choices for activities. Rather than wasting time, participation in therapeutic activities was preferred to build self-confidence and acquire new skills for re-integration into the community.

*I’d say more hobbies. People want to get good at something that builds their confidence up. So, if I could learn guitar or to play it better, maybe professionals come in and help guide us or teach us more often. We do rec therapy, which is once a day, an hour, we get volleyball every Wednesday or something, but that’s not enough. You start feeling good about yourself and get better at something. Once you get better at something, that builds the self-confidence. [542–547]*

Patient Theme 4: Moving Ahead with Their Lives

Patients said that refocusing and goal setting were important to build self-confidence. Patients recognized their circumstances and their past actions, but they said they did not want their past circumstances to define who they are. Regaining motivation allowed patients to move forward with their lives, make changes, and want to help others. Regaining motivation and building self-confidence were seen as significant aspects of rehabilitation.

*We might be criminals or done something stupid because we were sick, but it doesn’t make us bad people. Like, we want to help each other. [567–568]*

Patients indicated that there is encouragement from staff to participate in treatment, education, and skill building offered by the program. However, the programs offered may not necessarily have been in areas in which the patient had an interest or felt would help create hope and recovery. The patients said they knew what would create hope and help them recover, hence their time could be better spent on personal goals they valued and enjoyed.

*I think it should be individual goal setting. I mean, there’s not a lot of that. As much as the system will say, well, what do you want to do, what do you want to do, it doesn’t really say goals. The first goal is [to] get out of here, etcetera, but I mean more profound goals. [144–147]*

So, that’s something for me was don’t doubt or limit my self-confidence because I do that enough. And that would give me hope in myself. You don’t have to supply hope for me. I’d like to supply my own hope. [589–592]
Discussion

This project attempted to gain an understanding of the perspectives and experiences of recovery from patients and family members receiving services in an FPP. It sought to understand what recovery meant to patients and family, as well as how an FPP could support their recovery.

Recovery is not done alone, and most patients will be discharged into the community and continue their recovery there. Both family and patients identified the importance of having positive relationships with others throughout their recovery. The importance of connecting with others who can provide support and encouragement, and be positive role models were identified in the literature (Davidson et al., 2006; Leamy et al., 2011; Marshall et al., 2018; Tomlin et al., 2020). Fundamentally, the recovery process focuses on the individual through the support of the family and staff (Topor et al., 2018).

Developing Positive Connections

Developing positive relationships among patients was identified in helping with recovery. This theme emerged in both patient and family focus groups. Family members indicated that relationships with other patients on the unit was important in preventing social isolation and idleness. Patients viewed other patients as potential support systems on the unit who provided avenues to share experiences, practice compassion, help each other, and develop meaningful relationships. However, patients indicated that peer relationships were difficult to develop on the unit because some of the policies precluded patients from developing meaningful relationships with others. The theme that policies in the forensic mental health system precluded the development of meaningful relationships was also reported in other studies (Aga et al., 201; Livingston et al., 2013; Marklund et al., 2020; Tomlin et al., 2020).

Developing positive relationships with staff was also identified as helping with recovery. Family members indicated that having a positive relationship and good communication with staff increased confidence, encouraged independence, and decreased anxiety as patients approached discharge. The literature indicates that a trusting relationship with staff considerably influences recovery, and family members may feel overwhelmed and not equipped to support the patient without this support (Gómez-de-Regil et al., 2014; Priebe et al., 2018).

Patients also indicated that positive relationships with staff was important to their recovery. However, patients in this study reported there was a lack of collaboration and communication between the staff and patients. This led to a lack of understanding of processes and protocols in the forensic system, which increased feelings of uncertainty and feeling like they were wasting their time. Patients identified procedural aspects that precluded them from participating in meetings where decisions were being made about their trajectory in the forensic system. The literature suggests that good care involves positive staff interactions that allow patient perspectives to be understood, and patients are invited and heard rather than act solely as recipients of information (Askola et al., 2018, Hörberg et al., 2012; Livingston et al., 2013; Olsson et al., 2015; Selvin et al., 2016).

Providing Family Support

The dynamics of the family focus group highlighted the idea that family members require support and education throughout the patient's stay in the forensic system. At times, the discussion kept circling back to what the family had to do to get the patient help. Frequently, family members asked questions about how others handled particular situations. Family members of forensic psychiatric patients hold a crucial role in rehabilitation and are an essential resource, yet they are often under considerable stress themselves (Absalom-Hornby et al., 2011; Laithwaite & Gumley, 2007).

Initial feelings of disbelief, devastation, anger, fear, and guilt over time may establish heavy emotional burdening if left unaddressed (MacInnes & Watson, 2002). Having a forum to share experiences can be used to form social alliances, which can alleviate feelings of social isolation and stigma that are frequently reported in psychiatric patients' family members (Absalom-Hornby et al., 2011; Chang & Horrocks, 2006; Tsang et al., 2002).

Where possible, patient experiences are fundamentally intertwined with family involvement. Family perspectives and experiences are critical when assessing repeated crime because family members usually hold knowledge of occurrences outside of the hospital (Askola et al., 2017).

Family members play an important role in the recovery of forensic patients. Patients described wanting to maintain contact with family, and family members described needing information and access to resources on how to help the patient and themselves. Forensic programs need to focus on developing services aimed at keeping families engaged in the recovery of forensic patients, while providing families with the necessary support.
Facing Stigma

Patients and family members in the forensic psychiatry system face stigma. Triple stigma has been identified when patients have a mental illness, addiction, and offending history (Livingston et al., 2011). Family members recognized the impact of stigma toward themselves and the patient, which can lead to being ostracized by the community and causing social isolation.

Interestingly, stigma was not a concern raised in the patient focus groups. It is not clear whether patients were unwilling to discuss it because it was a sensitive issue or if forensic patients, who have been in hospital for long periods and not engaged in the community, have yet to experience the full impact of stigma. However, qualitative studies have indicated that stigma is experienced by forensic patients and can hold back recovery (Aga et al., 2019; Livingston et al., 2011; Mezey et al., 2010; Tomlin et al., 2020).

Addressing the Offending Behaviour

Family members and patients saw addressing the past offending behaviour and what led up to it as important for patients. Family members noticed that patients who acknowledged their past actions expressed remorse and recognized the consequences of their actions. Patients said they felt that talking about what happened and how to avoid it in the future gave them hope and confidence. These feelings align with what is found in the literature, where accepting the social and personal consequences of their actions may lead to guilt, remorse, or even shame. The literature indicates that accepting the offender identity is a crucial component in preventing future crime and developing insight (Askola et al., 2017; Askola et al., 2020).

Balancing the Forensic and Recovery Environment

Both the family and patient focus groups indicated that there should be more opportunities for patients to participate in activities to promote daily living skills. Patients indicated that being on the unit caused boredom and did not prepare them for living in the community. They viewed the lack of activity as restrictive and impeding their recovery. The restrictions of the unit created a disconnect between security and therapy, limiting their motivation to live independently. The literature suggests that care based on protocol has been reported to risk patient–staff relationships, hinder recovery, and destroy individuality (Aga et al., 2019; Askola et al., 2020; Higgins et al., 2016; Looi et al., 2014; Marklund et al, 2020; Morrissey et al., 2018; Slemon et al., 2017; Tomlin et al., 2020).

The literature suggests balancing agency and rehabilitative practices to incorporate a broader set of practices that enact life on the unit (Tucker et al., 2019). This aligns with themes from our study in which family members spoke of the need to allow patients control over domestic activities on the unit to increase feelings of responsibility and mitigate the potentially negative impact of idleness and boredom. Additionally, family members valued experiences of success in patient progress, which increased confidence, proactivity, and motivation, and encouraged patients to look toward the future (Pearson & Tsang, 2004).

Conclusion

The aim of this project was to obtain patient and family perspectives of recovery as experienced in our FPP. Since patients’ and family members’ perspectives are influenced by many context-specific variables, the results found in our project can not necessarily be generalized to other FPPs. However, the perspectives and experiences identified by our patients and family members provide a valuable foundation for future quality improvement initiatives in our program.

The small sample sizes of both the patient and participants can be a limitation. However, the information gained from the participants has provided valuable insights into the recovery of patients in our program. This information can be confirmed through further study with a larger group of patients and family members from the program to gain a broader perspective.

With a growing body of literature about forensic patient and family members’ experiences in forensic psychiatric services, there appear to be themes emerging that are unique to the forensic environment. Further exploration of this body of literature may develop a more solid evidence base to identify the unique needs of patients who are recovering in a forensic psychiatry environment.

Conflict of interest: none

References


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Impacts of Implementing a Forensic Treatment Mall: A Program Evaluation

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Psychiatric in-patients need programming and clinical interventions to support recovery and gradual re-integration into the community. Treatment malls are designed to meet these needs by offering psychosocial, person-centred rehabilitation groups in a centralized setting. Evidence suggests this treatment model increases patient engagement, broadens social networks, and improves functioning. Given this, our hospital implemented a treatment mall in our forensic services department in 2018. Because this was a new initiative at our hospital and the lack of outcome data on treatment malls in Canada, we conducted a program evaluation to explore the effects of the treatment mall and identify possible areas of improvement. Guided by a logic model, this evaluation used a retrospective chart review. Variables of interest included patient engagement, psychotropic pro re nata (PRN) administration, recovery scores, time spent off unit, elopement, use of restraints and seclusion, and patient activity levels. We assessed whether these changed post-implementation of the treatment mall. The results provide preliminary evidence of the positive effects of the treatment mall. Patient engagement and time spent off unit increased. Maintenance of changes and long-term outcomes remain to be seen; however, this evaluation provides support for the continued use and investigation of the treatment mall for our forensic services department.

Key words: treatment mall, psychosocial rehabilitation, in-patients, treatment, forensic services

The treatment mall is an integrative model of in-patient psychiatric care involving psychosocial treatments delivered in a centralized physical space (Matthews et al., 2015). It provides comprehensive and evidence-based treatment to psychiatric in-patients off-ward, allowing for occupational engagement, improved preparation for community living, and broadened social networks and opportunities to engage with others. These services are often provided in a classroom setting by a multidisciplinary team (Matthews et al, 2015). This set-up allows for greater use of staffing resources (Dhillon & Dollieslager, 2000), increased programming and treatment offerings (Holland et al., 2005), and greater patient engagement (Bopp et al., 1996). Indeed, treatment malls allow patients access to the hospital’s full complement of treatment and rehabilitation services rather than only those provided on their own units. This increased engagement is noteworthy as prior research has found that involvement in treatment is positively correlated with functioning (Brekke et al., 1999). Treatment malls implemented in forensic psychiatric facilities can use the Risk-Need-Responsivity (RNR) model, which posits that services should directly address criminogenic needs and be tailored to match a patient’s level of risk and their ability to respond to an intervention (Bonta & Andrews, 2007). Accordingly, programming should include interventions focused on reducing pro-criminal attitudes, self-management skills, and substance misuse (Bonta & Andrews, 2007). Initial investigations on treatment malls have largely been positive. Participants report increased confidence, improvements in emotion regulation, and a better
understanding of their mental illness (e.g., Estrella et al., 2019). However, despite the growing positive feedback, there remains a lack of literature evaluating the effectiveness of treatment malls.

Because the treatment mall was a new initiative at our hospital and the lack of outcome data of treatment malls—especially in Canada—we determined it crucial to explore both its effects and possible areas of improvement. This paper reports on the initial outcomes as guided by our logic model (see Figure 1). Based on the literature and our clinical expertise, we hypothesized that post-implementation of the treatment mall, forensic patients would (relative to pre-implementation):

1. be off the units more often;
2. have lower Level of Care Utilization System (LOCUS) scores;
3. have higher Recovery Assessment Scale (RAS) scores;
4. have less psychotropic pro re nata (PRN) medication administrations; and
5. have less aggression incidents.

The links in the model indicate only associations. Claims of causality are beyond the scope of the our evaluation as this was a small program evaluation without a control group. Our logic model hypothesizes that implementation of the treatment mall would be associated with a variety of outcomes, ranging from short to long term. Our evaluation serves as an initial look at the early effects and, as such, only short-term measures were evaluated. Of the limited literature available, most studies report on the design (Dvoskin et al., 2002), implementation process (Holland et al., 2005), or satisfaction with treatment malls (Ballard, 2008) rather than effect, which prompted us to publish our evaluation.

**Method**

**Design**

We used a retrospective chart review. Variables of interest were collected from patients’ electronic health records at three specified times. As this was not a research study, it was exempted from an ethics review.

Pre-implementation variables were collected for the period running January 2018 to March 2018 (Time 1). Post-implementation variables were collected for two times: January 2019 to March 2019 (Time 2) and December 2019 to February 2020 (Time 3). Time 3 was shifted a month earlier than originally planned due to unanticipated changes implemented in March 2020 in response to the COVID-19 pandemic. We believed that the data from March were compromised and confounded by external factors, and thus shifted the measured time to reduce this potential confound.

We have included two follow-up times for several reasons. First, with any new initiative, growing pains during initial stages of implementation often inform adjustments that are later incorporated and, as such, the full effects of the initiative may take
time to become evident. In addition, collection of more data allowed an opportunity to assess the process of change. We reasoned that the paradigm would allow an opportunity to assess whether changes were linear (i.e., steady increases from Time 1 through to Time 3) or whether some changes took time to manifest (i.e., becoming evident only after two years).

Treatment Mall

Our facility is a public psychiatric hospital located in Ontario, Canada. This project involved the forensic in-patient program, which provides assessment, treatment, rehabilitation, and community re-integration services to patients deemed unfit to stand trial or not criminally responsible on account of mental disorder (NCR).

Traditionally, rehabilitative programming for forensic patients at our hospital was decentralized and unit specific. This meant that patients only had access to certain groups. Before implementing the treatment mall, a program-wide survey was conducted to determine current and previous group offerings, and what patients were interested in participating in. The RNR model was adopted as a guiding framework. For example, care was taken to include groups addressing criminogenic needs. Staff applied RNR principles when referring patients to groups to ensure the group matched their learning needs or risk level. The Good Lives Model (GLM), which capitalizes on patient strengths and goals (Ward & Gannon, 2006), guided programming decisions to help adopt a strengths-based and personalized approach to care. Groups for the initial cycle were determined by considering the priority needs of patients from the perspective of risk management and recovery, which programming would likely maximize patient attendance, and clinicians’ ability to facilitate them.

The groups offered through the treatment mall fall under four categories and include:

- **Risk Reduction**
  - Anger and Conflict Resolution
  - Wellness Recovery Action Plans (WRAP)
- **Education**
  - Navigating the Forensic System
  - Discharge 101
- **Psychotherapy**
  - Cognitive Behavioural Therapy for Psychosis
  - Cognitive Restructuring Therapy
- **Therapeutic Recreation**
  - Explore Your Senses
  - Expressive Art Therapy

Groups were facilitated by the interdisciplinary team, including psychologists, behavioural therapists, occupational therapists, social workers, and recreational therapists. Facilitators were chosen based on credentials and areas of interest. Two facilitators led each group. Each group typically included eight participants.

Participants

The sample includes data from 244 adult forensic in-patients, most of whom were male with a primary diagnosis of a psychotic disorder. All patients had been found NCR for illegal, violent behaviour and given a detention order, which resulted in their admission to our facility.

We did not distinguish between patients who had participated in the treatment mall and those who had not, but rather included everyone to examine the overall effect of this initiative on the forensic program. This was due in part to sample size. If we included only those who had participated, the small sample size would contraindicate subsequent statistical analyses. Moreover, our logic model—which serves as the basis of this evaluation—predicts program-wide outcomes rather than outcomes specific only to treatment mall participants. In the first year of implementation, 105 patients (43%) participated (i.e., completed at least one group). We do not have participation rates for the subsequent (i.e., second) year of implementation but believe rates were similar.

Data Collection

Data were collected from electronic health records for each specified period. Extracted variables are described below.

**Defined Variables**

**Incidents of Aggression.** This variable was the number of staff-documented aggressive incidents for a given patient. Aggressive incidents were defined as behaviours carried out with the intent to harm and could have or did result in harm to a person or property (e.g., violence, threats of violence, use of weapons).

**Absent Without Leave (AWOL) Incidents.** This variable was the number of times a patient eloped from their designated unit without off-unit privileges. These privileges are determined by the patient’s Ontario Review Board (ORB) disposition and used at the discretion of the care team.

**Level of Care Utilization System (LOCUS).** The LOCUS (American Association of Community Psychiatrists, 2009) is designed to help staff working with patients in psychiatric facilities determine
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An individual is scored on six parameters from 1 to 5, with higher scores indicative of more difficulties. Research has found this tool to be reliable and effective (Sowers et al., 1999). At our hospital, patients are scored monthly by care teams. The following two parameters were collected for this evaluation:

- **Engagement and Recovery**: An individual's understanding of their illness and the treatment plan to manage their illness, as well as willingness and ability to engage in the recovery process. This was assessed on a scale from 1 (optimal Engagement and Recovery) to 5 (unengaged and stuck).

- **Functional Status**: Degree to which an individual can fulfill social responsibilities, interact with others, and maintain capacity for self-care. This was assessed on a scale from 1 (minimal impairment) to 5 (severe impairment).

**Psychotropic PRN Medication Administrations.** PRNs are medications administered as needed, meaning that they can be requested by the patient or recommended by their care team provided the patient consents. For this evaluation, we examined PRNs administered for psychotropic reasons (i.e., supporting mental state), rather than other indications (e.g., physical pain, allergies). The variable we used in our evaluation was the number of PRN administrations throughout the specified period.

**Recovery Assessment Scale (RAS).** The RAS is used to assess patient recovery and improvements. Patients describe themselves using a five-point agreement scale (1 = strongly disagree; 5 = strongly agree) on 41 items. Example items include "I have a desire to succeed" and "Coping with my mental illness is no longer the main focus of my life." A review of psychometric properties supports use of the RAS (Salzer & Brusilovskiy, 2014). At our hospital, patients completed the RAS about monthly.

**Restraint and Time Spent in Seclusion.** This variable was coded as the total minutes of mechanical restraints and seclusion used for a patient in each period. Seclusion refers to confinement to a designated room or area to manage unsafe behaviours. Mechanical restraint refers to an appliance restricting free movement and is attached to or worn by the patient to prevent harm to themselves, others, or both. Restraints and seclusion are used as a last resort and for the shortest possible duration.

**Time Off Unit.** The number of times a patient left their unit was used as a proxy for time spent off the unit. This measure only applies to those in minimum security who were deemed clinically able to leave the unit and have the condition in their disposition order. This time also included time they may have spent in a treatment mall group.

### Data Analysis

We wanted to assess whether variables of interest changed across the three timepoints. However, there was substantial missing data as
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only a small proportion of patients engaged in the treatment mall during all three timepoints. This was managed through pairwise deletion, precluding certain statistical analyses (i.e., analysis of variance [ANOVAs]) for several variables, namely Engagement and Recovery (LOCUS), Functional Status (LOCUS), RAS, and time off unit. For these variables, we conducted paired t-tests to assess differences pre- and post-program implementation. Specifically, pre-program data (Time 1) were compared with Time 2 (January to March 2019) and Time 3 (December 2019 to February 2020) post-program data. An alpha of .05 was used for all analyses. Cohen’s d effect sizes are reported for t-tests, with .2, .5, and .8 reflecting small, medium and large effect sizes, respectively (Cohen, 1988). The means and standard deviations presented in Table 1 reflect the entire sample, whereas results discussing the t-tests include only those for which there were sufficient data for inclusion in these analyses. As such, some differences in descriptive data are to be expected.

To standardize results and facilitate future comparisons, variables were transformed into scores that represented rates per 1,000 occupied beds. This was done for each of the following variables: time off unit, minutes in restraint or seclusion, aggression incidents, AWOLs, and PRN administrations. We compared data from pre-implementation to two post-implementation periods to assess whether changes occurred.

Paired t-tests were used to assess changes from year to year. Time 1 measurements were compared to Time 2 measurements, Time 1 to Time 3, and finally, Time 2 to Time 3.

**Results**

Descriptive statistics are presented in Table 1. Table 2 summarizes the results of the paired t-tests.

The results of the paired t-tests between Time 1 and Time 2 revealed that only LOCUS scores differed between timepoints. Specifically, Engagement and Recovery Status score at Time 1 (M = 4.03, SD = .85) decreased by Time 2 (M = 3.35, SD = 1.03, t(46) = 3.98, p < .01, d = .58). Similarly, the Functional Status score at Time 1 (M = 3.43, SD = .61) decreased by Time 2 (M = 2.96, SD = .75, t(46) = 3.73, p < .01, d = .54). In contrast, neither RAS score nor time off unit differed between timepoints.

For analyses comparing Time 1 with Time 3, several noteworthy results emerged. Unlike at the one-year mark (i.e., Time 1 vs. Time 2), after two years (i.e., Time 1 vs. Time 3), time off the unit significantly increased (M = 143.65, SD = 132.00 to M = 282.87, SD = 213.77, t(30) = -3.75, p = .001, d = -.67). LOCUS scores for the Engagement and Recovery Status parameter continued to stay lower.

**Table 2**

*Paired t-tests of Specific Measures in a Forensic Inpatient Program Before and After Implementation of a Forensic Treatment Mall*

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<tbody>
<tr>
<td></td>
<td>Pair 1: Time 1 and Time 2</td>
<td></td>
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<tr>
<td>Engagement &amp; Recovery</td>
<td>3.98</td>
<td>46</td>
<td>&lt;.01</td>
<td>.58</td>
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<tr>
<td>Functional Status</td>
<td>3.73</td>
<td>46</td>
<td>.001</td>
<td>.54</td>
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<td>RAS total score</td>
<td>.291</td>
<td>17</td>
<td>.78</td>
<td>.07</td>
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<tr>
<td>Time off unit</td>
<td>-1.16</td>
<td>57</td>
<td>.25</td>
<td>.15</td>
</tr>
<tr>
<td></td>
<td>Pair 2: Time 1 and Time 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Engagement &amp; Recovery</td>
<td>2.84</td>
<td>35</td>
<td>.01</td>
<td>.47</td>
</tr>
<tr>
<td>Functional Status</td>
<td>2.35</td>
<td>35</td>
<td>.03</td>
<td>.39</td>
</tr>
<tr>
<td>RAS total score</td>
<td>-1.17</td>
<td>8</td>
<td>.28</td>
<td>-3.9</td>
</tr>
<tr>
<td>Time off unit</td>
<td>-3.75</td>
<td>30</td>
<td>.001</td>
<td>-67</td>
</tr>
<tr>
<td></td>
<td>Pair 3: Time 2 and Time 3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Engagement &amp; Recovery</td>
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<td>60</td>
<td>.73</td>
<td>.04</td>
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<tr>
<td>Functional Status</td>
<td>.39</td>
<td>60</td>
<td>.70</td>
<td>.05</td>
</tr>
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<td>RAS total score</td>
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<td>19</td>
<td>.17</td>
<td>.32</td>
</tr>
<tr>
<td>Time off unit</td>
<td>-2.20</td>
<td>50</td>
<td>.03</td>
<td>-.31</td>
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than at Time 1 (from $M = 4.09, SD = .88$ to $M = 3.57, SD = 1.10, t(35) = 2.84, p = .01, d = .47$). Similarly, LOCUS scores for Functional Status were lower at Time 1 than Time 3 (from $M = 3.45, SD = .65$ to $M = 3.09, SD = .77, t(35) = 2.35, p = .03, d = .39$).

Finally, when Time 2 was compared to Time 3, no differences emerged for LOCUS or RAS scores. However, there was an increase in time off unit from Time 2 to Time 3 (from $M = 202.59, SD = 155.43$ to $M = 261.14, SD = 190.51; t(50) = -2.20, p = .03, d = -.31$).

A repeated measures ANOVA involving participants who engaged in the treatment mall at all three timepoints was conducted. Given the small number of such participants, analyses were limited to the following variables: PRN administration, AWOLs, minutes of restraints or seclusions, and aggressive incidents. Results did not reveal any significant changes; however, given the limited data available, this needs cautious interpretation. Table 3 summarizes these results.

**Discussion**

Overall, our program evaluation examined preliminary outcomes of shifting the existing treatment model in our forensic program to a treatment mall structure. One year after implementation, we found that patient engagement and function (i.e., LOCUS scores) improved. That is, patients were rated to have an improved understanding of their illness, ability to engage in recovery (Engagement and Recovery Status), or both and exemplified improved social, physical, and adaptive functioning (Functional Status). Although the improvement was maintained after the second year (i.e., Time 3), no further improvements were observed. To some degree, these findings are consistent with hypotheses stemming from the logic model: that the introduction of a new treatment model would support progress through the program and result in a decreased need for support over time. However, it is unexpected that improvements—while maintained after the second iteration—did not further improve. Possible explanations for this may be that the positive benefit of treatment mall on LOCUS scores may have an upper limit, or there was human error with staff using this tool—although the demonstrated reliability of this tool (i.e., Sowers et al, 1999) and administration by trained members of the treatment team admittedly limits the possibility of the latter. Regardless, given that this finding was unexpected, re-evaluation at a later juncture is prudent.

Similar to prior observations (Webster & Harmon, 2006), there were no changes in aggressive incidents over time. This runs contrary to hypotheses, but the lack of increase bears consideration. Indeed, aggressive incidents did not increase despite changing the location and structure of group delivery despite patients attending a central area and interacting with those from other units. This is important as it dispels the notion that patients’ risk for violence is best managed by restricting them to their units and not permitting off-unit programming attendance.

Finally, the number of times patients were off unit did not change between Time 1 and Time 2 but did increase from Time 2 to Time 3. This suggests that the treatment mall may have helped patients better use privilege levels. It appears that this change required time (i.e., two years) to manifest. In offering a potential reason as to why this may be, consider that changes in privileges also take time. A patient must first demonstrate improvements to sufficiently convince the care team that increased access to privileges would not cause additional risk. Moreover, if the ORB has not yet granted a patient off-unit privileges, it may take at least one year for this to be added to one’s disposition, which may also account for the observed lag. Nonetheless, that a change over time has been found (despite the delay in its emergence) is promising. It stands to reason that clients who are permitted to leave their unit and do so without issue are more likely to be behaviourally activated and engage in healthy behaviours (e.g., socializing, physical activity).
Limitations

Our evaluation presents with limitations that should be acknowledged. Firstly, given organizational constraints, the treatment mall was implemented across the entire forensic program without a control group. Our ability to draw strong, generalizable conclusions is thus weakened. It is possible that simply placement in a psychiatric facility with access to medical care and attention may lead to positive change over time. However, a pre–post evaluation design is nonetheless common in research conducted in real-world environments. Moreover, our evaluation is meant to be preliminary. Its purpose was to provide initial data to support continued exploration in this area. To this end, the current results—albeit not widely generalizable at the present time—nonetheless support the idea that treatment malls merit continued investigation. We certainly hope that future investigations employ a more controlled evaluation paradigm.

In addition, our results are subject to real-world factors (e.g., limited quality control for data collection, staffing), which limit data accuracy. For example, we were unable to measure the exact number of minutes each patient was off unit but rather constructed a proxy by using the number of times a patient signed out of their units.

Furthermore, the recorded amount of time a patient was kept in restraints, seclusion, or both may be skewed by documentation practices (e.g., documenting discontinuation of seclusion several minutes after it happens) or clinical practices (e.g., a patient in seclusion being permitted a short walk accompanied by staff). The reduced accuracy of data limits our ability to accurately assess changes over time. The incidence of restraints and seclusion was also subject to an organizational effort to reduce this practice, so changes to this variable cannot be fully credited to the treatment mall.

Additionally, some variables had very low occurrences (e.g., AWOLs). The statistical analyses employed are not well-equipped to assess incidents occurring at such low base rates.

Future investigation would benefit from minimization of the effect of the real-world factors described above. For example, offering refresher training for staff about documentation practices may be effective. Moreover, to the extent that future evaluation iterations will have access to more data (by virtue of having more time to accumulate the same), analyses may be better able to speak to low-frequency events (i.e., AWOLs), and a larger dataset will minimize the undue influence of any anomalous scoring.

Another limitation relates to our sample. We included all in-patients in the forensic program, even though only a subset participated in the treatment mall. Indeed, most patients did not participate due to a variety of reasons, including mental health status, risk, and apathy. On the one hand, that we were able to detect significant changes despite inclusion of nonparticipants is promising. It appears possible that such individuals may have indirectly benefited from the active behaviour of others (patients and staff). Stated differently, it may be that there was a spillover effect that positive changes in some had a positive effect on others. However, an alternative explanation is that inclusion of nonparticipating in-patients may have attenuated observed results. That is, it may well be that participants experienced greater improvements than demonstrated in our evaluation, as inclusion of nonparticipants weakened the strength of observed changes. It is unfortunate that our sample size was insufficient to assess changes among only those who participated in treatment mall programming. However, that we did nonetheless find changes despite this potential attenuation supports continued investigation of treatment malls as a viable treatment model. We hope that future investigations will be able to evaluate patterns both across and between participants and nonparticipants. In addition, to obtain novel insights on participants, benefit may come from exploration of their self-reported gains and overall functioning following completion of treatment mall participation, along with a qualitative analysis of their overall experiences with treatment mall.

Finally, there were substantial missing data. While we used pairwise deletion to manage missing data, the small sample size limited statistical analyses. While it would have been ideal to conduct ANOVAs for all variables, there were insufficient patients for whom data was recorded at all three timepoints. As such, only paired t-tests could be conducted for several important variables. This was not ideal for various reasons, primary among which are increased probability of Type 1 error and preclusion of trajectory analyses. Moreover, it hampers the generalizability of our evaluation. Despite this, we contend that given the unavoidable limitations of our dataset and the lack of Canadian outcome data, our evaluation remains informative. However, we will certainly strive to reduce the frequency of missing data for future evaluations.

Clinical Implications

The results of our investigation provide preliminary data suggesting that treatment malls may increase patient engagement and activity. To
be sure, observed improvements were limited to certain domains (i.e., Engagement and Recovery Status, Functional Status, time off unit); however, such changes are nonetheless promising. Previous research on behaviour change found that changes in one domain may inadvertently promote change in others, due in part to improved motivation (Truelove et al., 2014). We believe that the positive experiences of patients who participated in the treatment mall programming may affect how they subsequently interacted with other patients and staff members, how they managed their symptoms on the units, how they influenced the perspectives of staff, or any combination of these.

We did not see hypothesized changes in PRN medication. This has influenced our team to review the existing programming and offer additional groups that target distress tolerance and emotional regulation skills for subsequent iterations.

Overall, the results of our evaluation, albeit preliminary in nature, provide initial support for the continued investigation of the treatment mall as a viable treatment model in in-patient forensic psychiatric programs. However, despite this initial positive prognosis, we caution that continued evaluative work is prudent. The scope of our evaluation was to assess the short-term effects. Per our logic model, however, we also anticipated there to be medium-term and longer-term effects associated with this treatment model structure. Specifically, we hypothesize that patients will have shorter lengths of stay, reduced re-admission rates, and longer tenure in the community once discharged, and that these will in the longer-term promote safer communities. We plan to investigate the identified medium-term variables beginning in the fifth year post-implementation, and in doing so, heed the call of others to evaluate and report on the long-term outcomes associated with treatment malls (Matthews et al., 2015).

Conflict of interest: none

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Alexithymia, Cognitive Distortions and Child Sexual Offending: An Exploratory Study

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Mots-clés : violence sexuelle, traitement de l’information, alexithymie, distorsions cognitives

Current research on sexual violence is interested in social information processing among those who engage in this behaviour, particularly cognitive distortions and emotional deficits like alexithymia. The sample included 20 individuals who had sexually offended against children who took part in this cross-sectional research. We examined self-report scales to measure alexithymic deficits and cognitive distortions. Descriptive statistics of the whole sample showed a high average level of alexithymia and cognitive distortions. Mean comparisons showed some differences about range of alexithymia level between the offending sample and outpatient participants, particularly on the emotional factor. In line with the literature, our study findings suggest high levels of alexithymia and cognitive distortions among those who sexually offended against children. Our study has implications for understanding emotional information processing deficits in this group, the role of context on these deficits, and thus the allocation of treatment modules to reduce offending behaviour.

Keywords: sexual violence, information processing, alexithymia, cognitive distortions
La volonté d’appréhender les facteurs participant à l’agression sexuelle a amené les chercheurs à s’intéresser au traitement de l’information sociale chez les auteurs de violence sexuelle (AVS), classiquement par l’entremise des distorsions cognitives, mais également par l’étude des compétences émotionnelles. Les AVS tendent à présenter des difficultés dans la gestion de leurs vécus émotionnels (Gillespie et al., 2015), et notamment par l’expérience d’émotions négatives telles que la colère (Velotti et al., 2017). Dans cette perspective, le concept d’alexithymie fait l’objet d’un certain intérêt en ce sens qu’il traduit un traitement cognitif déficitaire de l’information émotionnelle (Luminet et al., 2003) et pourrait être associé à la dynamique des violences sexuelles.

**Alexithymie**

Le terme d’alexithymie a été proposé (Sifneos, 1973) afin de rendre compte d’un dysfonctionnement dans le traitement cognitif des émotions. La littérature définit quatre dimensions de l’alexithymie :

1. une difficulté à identifier et à distinguer les états émotionnels;
2. une difficulté à verbaliser les états émotionnels à autrui;
3. une vie fantasmatique réduite;
4. un mode de pensée opératoire (Taylor et al., 1997).

Bermond et al. (2007) considèrent une cinquième dimension relative aux difficultés à réagir face à une situation émotionnelle.

L’alexithymie est un construit dimensionnel qui se manifeste tant au sein de populations cliniques qu’au sein de la population générale (Deborde et al., 2004). Plusieurs recherches ont étudié l’alexithymie auprès de populations incarcérées, et les résultats y montrent une prévalence plus importante que dans la population générale (Gillespie et al., 2018), notamment en ce qui concerne l’identification des états émotionnels (Garofalo et al., 2017). Dans le champ de la violence sexuelle, l’alexithymie reste peu examinée, même si une étude récente tend à montrer une prévalence plus élevée de ces déficits parmi des AVS comparativement à la population générale (Gillespie et al., 2018).

**Distorsions cognitives**

Le terme de distorsion cognitive, introduit par les travaux de Beck, a été défini comme des contenus de pensées irréalistes et dysfonctionnelles (Cottraux, 2011). Dans le champ de la violence sexuelle, les distorsions cognitives font référence aux croyances sur les comportements sexuels, notamment dans une perspective de rationalisation et de justification (Benbouriche et al., 2013). La littérature mobilise ce construit comme étant un élément central de l’étiologie des violences sexuelles (Vanderstukken et al., 2015), notamment, l’idée que les AVS sur mineurs partageraient un ensemble de croyances spécifiques quant aux comportements sexuels. Dans ce sens, Marshall et al., (2001) soulignent que ces distorsions cognitives pourraient être associées à des déficits dans l’identification des émotions et ainsi altérer le traitement de l’information pouvant conduire à des comportements dysfonctionnels tels que la violence sexuelle.

Bien que le rôle des distorsions cognitives dans la violence sexuelle soit sujet à débat (Benbouriche et al., 2013), leur mesure reste essentielle tant pour préciser le rôle de ces distorsions dans le traitement de l’information par les AVS que pour adapter la prise en charge de ces personnes (Gannon & Polaschek, 2006).

**Objectifs de l’étude**

Plusieurs objectifs ont été poursuivis :
1. évaluer le niveau d’alexithymie et de distorsions cognitives chez des AVS sur mineurs;
2. étudier les liens entre ces deux construits;
3. comparer si les niveaux de distorsions cognitives et d’alexithymie varient en fonction du lieu de prise en charge (milieu ouvert ou milieu fermé), de l’état de récidive et des antécédents de victimisation sexuelle.

Bien qu’exploratoire, en raison de l’échantillon, ce troisième objectif repose sur des données tirées de la littérature quant aux liens entre ces facteurs et les violences sexuelles.

**Méthode**

**Participants**

L’échantillon était composé de 20 hommes AVS sur mineurs (M = 50 ans; Min = 30 ans; Max = 72 ans; E.T. = 13,11) recrutés en milieu fermé, au sein d’une Maison d’arrêt (n = 11), et en milieu ouvert, au sein d’un Centre ressources pour intervenants auprès d’auteurs de violence sexuelle (CRIAVS) (n = 9).

**Mesure**

L’alexithymie a été mesurée à partir du *Bermond and Vorst Alexithymia Questionnaire* (BVAQ) (Bermond et al., 2007), traduit et validé en français (Zech et al., 1999). Le BVAQ (α = 0,73) est composé de 40 items répartis en cinq dimensions. Les items sont cotés au moyen d’une échelle de type Likert en cinq points (1 = tout à fait d’accord;
5 = pas du tout d’accord). Plus le score est élevé et plus l’alexithymie est importante. La littérature (Bermond et al., 2007) montre une structure à deux facteurs de l’alexithymie, ce qui permet de calculer deux scores respectifs.

L’évaluation des distorsions cognitives a été réalisée à partir de l’échelle Molest Scale (Bumby, 1996) et de sa traduction française (Vanderstukken et al., 2005). Cette échelle (α = 0,90) est composée de 38 énoncés affirmatifs. Les participants ont pour consigne de répondre selon le sentiment que l’énoncé suscite en eux sur la base d’une échelle de type Likert en quatre points (1 = fortement en désaccord; 4 = fortement en accord). Un score élevé correspond à une forte présence de distorsions cognitives.

### Procédure

L’étude a été menée individuellement auprès de tous les participants et selon la même procédure, en milieu ouvert et en milieu fermé. Dans un bureau spécifique, et après avoir pris connaissance du formulaire d’information et de consentement, les participants ont rempli le questionnaire autorapporté.

### Analyses statistiques

En raison de la taille de l’échantillon, toutes les analyses ont été réalisées en non paramétrique.

### Résultats

#### Analyse descriptive

La description de l’échantillon (voir Tableau 1) souligne que pour la qualification de viol (n = 6), cinq des six participants étaient en milieu fermé. Pour l’infraction d’agression sexuelle (n = 14), la répartition est plus homogène, avec six participants en milieu fermé, et huit en milieu ouvert. Concernant les antécédents de victimisation sexuelle (n = 7), cinq des participants qui ont déclaré ce type d’antécédent étaient en milieu fermé. Enfin, tous les participants en état de récidive d’infraction à caractère sexuel (n = 4) étaient en détention au moment de l’étude.

Les analyses descriptives (voir Tableau 2) montrent un score global médian d’alexithymie de 104 (Med = 104; Mode = 99; Min = 73; Max = 132). En ce qui a trait aux cinq sous-dimensions (voir Tableau 1), le score médian le plus faible est de 18 pour la dimension relative à la « Pensée opératoire » (Med = 18; Mode = 11; Min = 11; Max = 29), tandis que le score médian le plus élevé concerne la dimension « Difficulté à décrire ses émotions » (Med = 24; Mode = 24; Min = 12; Max = 35). En ce qui concerne les distorsions cognitives, le score médian est de 78, avec une grande variabilité allant presque du simple au double selon les participants (Med = 78; Mode = 82; Min = 52; Max = 101) (voir Tableau 2).

#### Analyse corrélationnelle

Une analyse corrélationnelle a été réalisée, avec le coefficient Rho de Spearman, afin d’étudier les liens entre le BVAQ et la Molest Scale (voir Tableau 3). Les résultats soulignent une absence de corrélation significative entre les deux échelles (Rho = 0,291; p = 0,212). Cependant, une corrélation positive significative existe entre le facteur cognitif du BVAQ et de la Molest Scale (Rho = 0,447; p = 0,048) et plus particulièrement avec la dimension I, relative à la difficulté d’identifier ses émotions (Rho = 0,536; p = 0,015).

### Comparaison de moyennes

Les auteurs de viol et les auteurs d’agression sexuelle ne diffèrent pas significativement quant à leurs scores pour l’alexithymie (U = 53,00;
Tableau 2

Données descriptives pour le score moyen au Bermond and Vorst Alexithymia Questionnaire (BVAQ) et ses sous-dimensions, et à la Molest Scale

<table>
<thead>
<tr>
<th>Variables</th>
<th>Médiane</th>
<th>Mode</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>BVAQ</td>
<td>104,0</td>
<td>99,0</td>
<td>73,0</td>
<td>132,0</td>
</tr>
<tr>
<td>V</td>
<td>24,0</td>
<td>24,0</td>
<td>12,0</td>
<td>35,0</td>
</tr>
<tr>
<td>F</td>
<td>22,5</td>
<td>18,0</td>
<td>13,0</td>
<td>36,0</td>
</tr>
<tr>
<td>I</td>
<td>20,2</td>
<td>21,0</td>
<td>9,0</td>
<td>26,0</td>
</tr>
<tr>
<td>E</td>
<td>19,0</td>
<td>19,0</td>
<td>13,0</td>
<td>34,0</td>
</tr>
<tr>
<td>A</td>
<td>18,0</td>
<td>11,0</td>
<td>11,0</td>
<td>29,0</td>
</tr>
<tr>
<td>Cognitif</td>
<td>63,0</td>
<td>68,0</td>
<td>37,0</td>
<td>80,0</td>
</tr>
<tr>
<td>Émotionnel</td>
<td>41,5</td>
<td>35,0</td>
<td>28,0</td>
<td>62,0</td>
</tr>
<tr>
<td>Molest Scale</td>
<td>78,0</td>
<td>82,0</td>
<td>52,0</td>
<td>101,0</td>
</tr>
</tbody>
</table>

Note : V = Difficulté à décrire ses émotions; F = Pauvreté de la vie imaginaire; I = Difficulté à identifier ses émotions; E = Difficulté à réagir aux situations émotionnelles; A = Pensée opératoire; Cognitif = Facteur cognitif du BVAQ; Émotionnel = Facteur émotionnel du BVAQ.

Tableau 3

Détail des corrélations (Rho) entre le Bermond and Vorst Alexithymia Questionnaire (BVAQ) et ses sous-dimensions, et la Molest Scale

<table>
<thead>
<tr>
<th>Variables</th>
<th>BVAQ</th>
<th>V</th>
<th>F</th>
<th>I</th>
<th>E</th>
<th>A</th>
<th>Cognitif</th>
<th>Émotionnel</th>
<th>Molest Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>BVAQ</td>
<td>1,000</td>
<td>0,607**</td>
<td>0,373</td>
<td>0,304</td>
<td>0,353</td>
<td>0,648**</td>
<td>0,815**</td>
<td>0,443</td>
<td>0,291</td>
</tr>
<tr>
<td>V</td>
<td>—</td>
<td>—</td>
<td>-0,061</td>
<td>0,448*</td>
<td>-0,300</td>
<td>0,147</td>
<td>0,811**</td>
<td>-0,239</td>
<td>0,186</td>
</tr>
<tr>
<td>F</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-0,473*</td>
<td>0,299</td>
<td>0,168</td>
<td>-0,100</td>
<td>0,86**</td>
<td>-0,329</td>
</tr>
<tr>
<td>I</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>0,090</td>
<td>0,034</td>
<td>0,562**</td>
<td>-0,338</td>
<td>0,536*</td>
</tr>
<tr>
<td>E</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>0,272</td>
<td>-0,021</td>
<td>0,686**</td>
<td>0,012</td>
</tr>
<tr>
<td>A</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>0,603**</td>
<td>0,237</td>
<td>0,356</td>
</tr>
<tr>
<td>Cognitif</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-0,115</td>
<td>0,447*</td>
</tr>
<tr>
<td>Émotionnel</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>-0,249</td>
</tr>
<tr>
<td>Molest Scale</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Notes : V = Difficulté à décrire ses émotions; F = Pauvreté de la vie imaginaire; I = Difficulté à identifier ses émotions; E = Difficulté à réagir aux situations émotionnelles; A = Pensée opératoire; Cognitif = Facteur cognitif du BVAQ; Émotionnel = Facteur émotionnel du BVAQ.

* = La corrélation est significative au niveau 0,05; ** = La corrélation est significative au niveau 0,01; — vierge intentionnellement
Discussion

Cette recherche avait pour principaux objectifs d’étudier le niveau d’alexithymie et de distorsions cognitives chez des AVS sur mineurs, ainsi que les relations entre ces deux variables. Enfin, nous nous sommes intéressés aux différences que pourraient présenter ces variables en fonction du lieu de prise en charge, des antécédents de récidive et de victimisation sexuelle.

Bien que peu d’études aient examiné l’alexithymie d’AVS sur mineurs, notre recherche permet de mettre en évidence un niveau élevé d’alexithymie. En effet, les données issues de la population générale montrent en moyenne un score au BVAQ inférieur à 70 (Preece et al., 2020), tandis que le score moyen pour une population d’AVS est généralement supérieur à 100 (Hornsved & de Kruyk, 2005). Ces données concordent avec la littérature, qui souligne les liens entre alexithymie et violence sexuelle (Gillespie et al., 2018) et particulièrement en ce qui concerne la dimension relative à la compréhension et à la verbalisation de ses états émotionnels. En ce qui a trait aux distorsions cognitives, le score médian obtenu dans notre recherche concorde avec les données de la littérature quant à la prévalence élevée au sein d’une même population et mesurée par le même outil. Ces études (Arkowitz & Vess, 2003; Daspe et al., 2017) tendent à montrer un score moyen de distorsions cognitives des AVS supérieur à 65 sur la Molest Scale, ce qui est conforme à nos résultats, qui soulignent une adhésion médiane supérieure à ce seuil. De plus, les études montrent que le niveau de distorsions cognitives spécifiques aux enfants diffère en fonction du type de passage à l’acte. Ainsi, les AVS sur mineurs se caractérisent par une adhésion plus importante à ce type de croyances comparativement à des AVS sur adultes ou à des auteurs de violence non sexuelle (Feelgood et al., 2005). Ces résultats confirment donc la présence de déficits du traitement de l’information chez les AVS, tant d’un point de vue cognitif, avec la présence de croyances erronées, que du point de vue émotionnel, avec une forte alexithymie.

Par ailleurs, les résultats mettent en évidence que les distorsions cognitives sont associées positivement au facteur cognitif de l’alexithymie. L’alexithymie représente un mode spécifique de traitement cognitif de l’information émotionnelle (Luminet et al., 2003) qui privilégie les aspects concrets de la vie et qui se caractérise par des déficits dans le traitement interne des informations émotionnelles. Ainsi, le facteur cognitif de l’alexithymie traduirait plus particulièrement une orientation du traitement des informations vers celles de nature cognitive au détriment de celles de nature émotionnelle. L’alexithymie représenterait de fait un biais dans le traitement et la perception des expériences émotionnelles (Frawley & Smith, 2001).

La comparaison en fonction du lieu de prise en charge a souligné des différences quant aux scores d’alexithymie uniquement sur le facteur émotionnel. Les AVS en milieu fermé ont montré des déficits plus élevés sur le facteur émotionnel que ceux en milieu ouvert. Cette différence pourrait s’expliquer, notamment, par l’effet spécifique du contexte de détention sur des processus psychologiques. Un rapport d’Archer et al. (2008) a mis en évidence les conséquences de l’incarcération sur la santé physique et mentale des détenus. De plus, une étude a souligné les effets délétères de l’incarcération sur la santé mentale, notamment en ce qui concerne le vécu émotionnel (Van Harreveld et al., 2007). Ainsi, nous supposons que l’état d’incarcération peut influencer la capacité de l’individu à accéder à son vécu émotionnel et, notamment, à mobiliser l’imagination et la rêverie. Le contexte de vie d’une personne pourrait avoir un effet plus ou moins facilitateur...
dans l’apparition de déficits émotionnels associés à l’alexithymie. Bien que l’alexithymie soit conceptualisée comme un trait de personnalité stable (de Bruin, et al., 2019), notre recherche porte à croire qu’elle peut également être un état transitoire influencé par les conditions psychologiques ou physiques de l’individu et représenter un moyen pour celui-ci de faire face à un contexte de vulnérabilité (Kojima, 2012).

Les données ne montrent aucune différence en termes d’alexithymie selon la présence ou non d’antécédent de victimisation sexuelle. La littérature souligne pourtant une association entre les expériences traumatiques (négligences physiques ou émotionnelles, abus sexuels) et l’alexithymie (Brown et al., 2016). Ces expériences pouvant contribuer à différents déficits dans le traitement émotionnel tels que l’alexithymie (Hawkins et al., 2021). Au regard des données sur la prévalence élevée des abus durant l’enfance chez les AVS (Levenson et al., 2016), nous pouvons supposer que la part des sujets de notre échantillon présentant des expériences traumatiques antérieures était plus grande que la part présentant la seule victimisation sexuelle mesurée, ce qui pourrait expliquer qu’aucune différence n’ait été trouvée sur le plan de l’alexithymie.

Enfin, les résultats montrent que les participants en état de récidive sexuelle présentent un niveau de distorsions cognitives inférieur aux primodélinquants. Bien que la littérature souligne l’absence de caractère prédicif des distorsions cognitives sur la récidive d’infraction à caractère sexuel sur mineurs (Marshall et al., 2001), une plus faible présence de distorsions chez les auteurs récidivistes interroge. Une hypothèse tiendrait à la capacité de certains AVS à adopter des stratégies adaptatives pour leurs réponses à ce type de mesure. Ainsi, les AVS récidivistes pourraient bénéficier d’un effet d’apprentissage à mesure qu’ils sont soumis à ce type d’étude, et ainsi percevoir et identifier les attentes sociales et les normes en la matière. Ce phénomène dit de clairvoyance normative est défini comme la connaissance du cadre normatif, et par conséquent du cadre contre-normatif, d’un type de comportement ou de jugement (Jouffre et al., 2001). Cette clairvoyance permettrait aux auteurs de favoriser un discours prosocial dans une perspective instrumentale (par exemple, pour éviter une peine plus lourde), mais également comme mesure de protection psychique visant à préserver leur estime de soi d’un effet de stigmatisation, particulièrement important en raison de la nature de leur acte.

Cette étude comporte plusieurs limites : la taille réduite de l’échantillon et son hétérogénéité. En effet, le temps passé en détention ou encore le fait d’avoir été victime de violence, pas uniquement sexuelle, sont autant de facteurs susceptibles d’être associés à des déficits dans le traitement de l’information. L’absence d’un groupe contrôle issu de la population générale limite la possibilité de comparer les scores d’alexithymie et de distorsions cognitives, même si les résultats obtenus vont dans le sens de ceux retrouvés dans la littérature pour une population d’AVS sur mineurs. Enfin, l’utilisation de questionnaires autorapportés apparaît comme une mesure intéressante mais insuffisante de processus cognitifs qui sont particulièrement sensibles à la désirabilité sociale en raison de la thématique étudiée.

De futures recherches pourraient approfondir le rôle de la dimension émotionnelle dans la violence sexuelle. La littérature tend à montrer que le rôle de l’alexithymie sur les comportements violents serait médiatisé par la régulation émotionnelle (Garofalo et al., 2017). De plus, des auteurs précisent l’existence de différents types d’alexithymie en fonction des dimensions déficitaires selon qu’elles portent sur le facteur cognitif ou émotionnel (Bermond et al., 2007), mais également en fonction de l’origine de ces déficits (Messina et al., 2014). Cette perspective favoriserait l’adaptabilité de la prise en charge en fonction des ressources et du contexte des AVS. Enfin, l’orientation des recherches dans le champ de la coercition sexuelle permettrait d’appréhender à la fois un ensemble de comportements plus large et non nécessairement de nature infracriminelle (Benbouriche, 2016).

**Conclusion**


**Conflit d’intérêts** : aucun
Références


Alexithymie, distortions cognitives et violence sexuelle sur mineurs 29


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The Psychiatric Aspects of Terrorism: Prevention and Rehabilitation

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Preventing terrorism has thus far been in the domain of national security and law enforcement agencies. The expectation that psychiatry has a primary role to play in the rehabilitation of those involved in terrorism remains controversial, although the significance of certain mental disorders has been highlighted among lone-actor terrorists. This paper provides an overview of the motivating factors for radicalization to terrorism at both community and individual levels, as well as preventive and rehabilitative approaches to terrorism. We argue that psychiatry may have a role to play in these approaches with the goal of preventing violence in select cases.

Key words: terrorism, radicalization, extremism, prevention, rehabilitation

In Canada, section 83.01 of the Criminal Code defines terrorism as an act committed “in whole or in part for a political, religious or ideological purpose, objective or cause... with the intention of intimidating the public” (R.S.C. 1985). Despite decades of research, efforts to identify a universal psychological terrorist profile have been unsuccessful (Wright & Hankins 2016). This is hardly surprising given the heterogenous nature of terrorist groups around the globe. As a result, radicalization, a process by which an individual comes to adopt increasingly extreme political, social, or religious ideals, has attracted more attention in the academic literature (Woodhams, 2016; Wright & Hankins, 2016). In theory, while radicalization is not an ideology-specific phenomenon, it has been most thoroughly studied in the context of Islamic extremism, which provides the source material for this paper. Understanding radicalization is essential to defining both preventive and rehabilitative approaches to terrorism, with the goal of reducing political violence.

Radicalization to Terrorism

The process of radicalization is influenced by individual and community factors (Woodhams, 2016). This acknowledges that an individual’s path to terrorism is unique, while some common contributing factors are identifiable. A crucial stage in the radicalization process is when the individual comes to believe that vigilante justice and violence are justified (Woodhams, 2016). At this point, the individual may join a terrorist group that seeks perceived justice through organized violence or engage in acts of lone-actor terrorism. Many studies propose push and pull factors to explain how individuals become radicalized (Striegher, 2013). Examples of push factors include poverty, social or political marginalization, human-rights violations, corruption, and youth frustration (Striegher, 2013). Push influences exist before radicalization and tend to be socio-economic, geopolitical, and historical variables that make the individual feel victimized, marginalized, or filled with a sense of insignificance in life. By contrast, pull factors are attractions that draw a vulnerable individual toward terrorist groups (Striegher, 2013). Examples include a sense of belonging, access to resources and security, religious moralization, leadership, and the means to enact revenge. These attributes are common to many terrorist groups, regardless of their ideological commitment (see Table 1).

More recently, the importance of social networks in the radicalization process has been clarified (Woodhams, 2016). Young people seem particularly vulnerable to online extremist messaging (Neumann, 2013; Pedersen et al., 2018). A parallel trend in mental health is that rising rates of adolescent depression and social isolation have been
linked with spending large amounts of time online (Gross, 2004). Some studies have linked social media use to negative mental health outcomes, including suicide, loneliness, and social anxiety (Berryman et al., 2018). In support of this radicalization pathway, a Norwegian study found that a radical interpretation of Islam may be linked with a high level of political activity on social media among young Muslim men (Pedersen et al., 2018).

A clear radicalization pathway has proven difficult to pin down. In their systematic review of the literature on pathways to radicalization among Muslims living in Western societies, McGilloway and colleagues (2015) identified numerous factors that contribute to radicalization. The authors grouped these factors into predisposing, precipitating, and perpetuating factors, ranging from personality traits, personal experiences, media influences, specific grievances, discontinuity between Islamic and national identity, and many more. The review examined 17 papers that provided empirical data on radicalization. While some vulnerabilities to radicalization could be identified, that systematic review ultimately concluded that no single cause or pathway exists to radicalization. The authors emphasized that a wide range of conditions interact to radicalize a person. The process is highly unique to the context and personal history of the individual. The authors point out that a common characteristic across studies was that terrorists were generally well-integrated into society, rebuking the often-repeated idea that terrorism is fundamentally a cultural integration problem. The authors conclude by calling for terrorism to be treated as a public health issue as opposed to a criminal justice matter, following the trajectory that domestic violence took in Western societies.

**Preventive Strategies**

Counterterrorism efforts have focused on several methods of deterrence. Preventing online radicalization is fraught with difficulties. Solutions that require social media companies to censor users has generated fierce political debate. Most prominent platforms (e.g., Facebook and Twitter) are U.S. based, therefore content that would qualify as extremist is often protected under the First Amendment of the United States Constitution (Neumann, 2013). Companies may de-platform (or refuse to promote) extremist content online; however, this method of prevention has been met with legal challenges in the United States (Neumann, 2013).

While there are many publications detailing the radicalization process, far fewer address prevention. This is partly due to the problem of defining prevention because, by definition, effective prevention produces no measurable outcome. It is also partly due to the lack of empirically driven preventive strategies. As such, interventions tend to be largely driven by expert opinion and evaluated based on societal outcomes, such as the number of terrorist attacks in a year, the number of victims affected, material damage by terrorism over time, or the number of arrests terrorism made (van Dongen, 2011). The U.S. Department of Defense acknowledges both the necessity and difficulty in defining and measuring effective prevention protocols (Perl, 2007). Too often, counterterrorism initiatives are implemented and never evaluated, as highlighted in multiple systematic reviews (Lum et al., 2006).

Prevention efforts have involved psychiatry to identify a psychological profile that might predict proneness to radicalization or terrorism. The work of Jerome Post (1984) is a prime example. He distinguished two major categories of terrorist groups in true psychodynamic fashion: the anarchic-ideologues who are committed to destroying the world built by their fathers, and nationalist secessionists committed to preserving the world of their fathers.

Outside the realm of psychodynamic theory, most efforts to involve psychiatry in the profiling of terrorists have been unsuccessful, not least because of the heterogenous nature of terrorist groups (Wright & Hankins 2016). Counterintuitively,
terrorists tend not to have psychopathy or sociopathy, nor do they suffer from emotional instability (Neumann, 2013; Wright & Hankins, 2016). On the contrary, most terrorists tend to have a clear, albeit distorted, rationale for violence, often stemming from perceived social, political, or religious injustice, which makes prevention difficult from a mental health perspective (i.e., not based in psychopathology; Nizami et al., 2014). This observation is truer of group actor terrorism than it is of lone-actor terrorism (Smith, 2018), a distinction that has become more relevant in recent years and is discussed in more detail in the Rehabilitation section of this paper. However, the psychological profiles of lone actors tend to overlap with individuals who are prone to violence generally (e.g., younger males, low socio-economic status, history of violence, social isolation, etc.; Smith, 2018). This type of risk assessment for violence is already part of a standard psychiatric practice.

Improving socio-economic factors and social supports tend to be a prevention strategy that is universally accepted. The parallel to social determinants of health have prompted some to ask what role medical professionals play in identifying youth at risk of radicalization. Some general practitioners have resisted this responsibility on the grounds that it damages the therapeutic relationship, contributes to marginalization of minority groups (e.g., refugees and migrants), and ought to be the role of law enforcement agencies (Neumann, 2013; Wright & Hankins, 2016). Balancing multiple imperatives has created slightly different emphasis in the approach to preventing terrorism between societies.

For its part, Canada has adapted its own counterterrorism strategy that emphasizes a community collaborative approach (Ahmad, 2017). This soft approach to preventing extremism is sometimes contrasted with more hardline approaches that involve expanding the powers of law enforcement to combat terrorism (Bjørø, 2016). A large Canadian database called the GATE database examined all state counterterrorism interventions between 1985 and 2013, and evaluated these interventions by correlation to quarterly reports of terrorist attacks over time (Chenoweth et al., 2015). This dataset included many motivations toward violence, including radical environmentalist groups, al-Qaeda inspired attacks, and right-wing extremist groups, among others. They found that the effectiveness of specific interventions varied widely according to the target terrorist group (e.g., left-wing extremists tended to respond to policy concessions better than right-wing groups). In general, however, state actions that were indiscriminately repressive were counterproductive, sometimes even increasing terrorist violence in the aftermath. This observation has tended to inform Canada’s approach to preventing terrorism.

The United Kingdom’s Preventing Violent Extremism (PVE) initiative emphasized the promotion and dissemination of counternarratives (Qurashi, 2018). A counternarrative is a moderate alternative interpretation of a religion, ideology, or political philosophy that discourages violence. A strong counternarrative attempts to unite a committed majority against violent outliers by appeal to common values (Bertram, 2015). The PVE initiative also included community engagement targeted at addressing push and pull factors that lead to radicalization and draw young people to terrorism in the first place (Qurashi, 2018).

In Continental Europe, there is less emphasis on challenging doctrine and more attention given to the integration of Muslim immigrants and refugees into society (Korn, 2016). Europe has tended to favour preventative measures that address the root causes of terrorism (e.g., socioeconomic factors and cultural integration).

Initially, legislators in Sweden, Norway, and Denmark were eager to expand police powers to include communication surveillance and criminalizing preparatory terrorism under the mantle of proactive policing (Husabe, 2013). This approach mimicked the American Patriot Act, which empowered intelligence agencies to monitor the communications of ordinary citizens for signs of impending terrorist activity. Nordic countries have since transitioned to a more holistic approach to preventing terrorism (Bjørø, 2016); a trend that is reflected globally in most developed countries struggling to balance privacy rights of individual citizens with national security interests.

Rehabilitation

In tandem with preventive strategies, efforts should also focus on rehabilitation. Most rehabilitation programs have been studied on those convicted of a terrorist act (Striegher, 2013). The goal of terrorist rehabilitation tends to be either disengagement or deradicalization (Bertram, 2015; Striegher, 2013). Disengagement is achieved when the individual leaves a terrorist organization and no longer intends to use violence to achieve ideological goals, despite maintaining their extremist beliefs. Deradicalization involves changing core beliefs and attitudes and is generally more robust at preventing recidivism in the long term (Striegher,
2013). Deradicalization has been the goal of Saudi Arabia’s pioneering rehabilitation program for many years. The Saudi program emphasizes education on the process of indoctrination itself, and the tactics terrorist leaders use to train conformity and isolate followers from alternative worldviews (Lankford & Gillespie, 2011).

Another important tactic is rehumanizing the enemy by having individuals who have been incarcerated continuously interact with other inmates who are demonized by terrorist propaganda (e.g., Jews and Americans; Lankford & Gillespie, 2011). This exposure tactic resembles studies in psychology and sociology that find repeated exposure to outgroups can reduce prejudice overtime (Turner et al., 2007).

Deradicalization programs in Southeast Asia (e.g., Indonesia, Malaysia, Singapore, Thailand) have tended to use counternarratives to challenge the doctrine of extremism, with psychological counselling for those who have been incarcerated for terrorism (Aslam et al., 2016). Deradicalization programs exist to some degree in France, Belgium, Germany, the Netherlands, and the United Kingdom (Feddes, 2015). However, there are no studies comparing the relative effectiveness of these programs, nor is there an agreed-on standard to evaluate their effectiveness at achieving deradicalization.

In most places, rehabilitating those involved in terrorism fall under the purview of the criminal justice system. In academia, clinical approaches to rehabilitation have scarcely been explored. Perhaps this is because terrorism is relatively rare and terrorist subjects are hard to reach. Or perhaps it is because the link between mental disorder and terrorism is controversial (Stoddard et al., 2011).

Here, a distinction can be made between group and lone-actor terrorists (Corner et al., 2016; Smith, 2018). Terrorist groups tend not to recruit individuals with overt signs of mental illness due to the perceived security risk they pose (Wright & Hankins, 2016). However, more recent studies have demonstrated that mental disorder is more common in lone-actor terrorists than group actors (Corner et al., 2016). In particular, three mental disorders appear to be significantly more common among lone-actor terrorists compared to the general population: schizophrenia, delusional disorder, and autism spectrum disorder (Corner et al., 2016). As well, certain features of conduct disorder (e.g., childhood disobedience) and antisocial personality disorder may predict lone-actor terrorism (Dhumad et al., 2020). Such studies are correlational, and many factors that predispose mental illness also predispose terrorism (Smith, 2018). The link between mental disorder and terrorism remains controversial, unaided by misleading terms such as suicide bomber that is not motivated by nihilistic depression but rather an empowering ideological commitment (Nizami et al., 2014; Stoddard et al, 2011).

Perhaps, psychiatry might assist with assessment and treatment of underlying mental disorders and risk assessment in a collaborative framework involving law enforcement and other health and social care agencies. This may help prevent violence from occurring in select cases, but there is no standard of care or established guidelines to treat or modify the risk of extremist violence in hospitals. Even if psychiatry could lend itself to counterterrorism initiatives, some would be reluctant to do so, believing that other principles come into conflict, such as patient confidentiality, or even the Hippocratic Oath.

Conclusion

The clinical literature on preventing violent extremism and rehabilitating those involved in terrorism is limited. Although many governments would like to enlist the help of physicians in counterterrorism initiatives, many have pushed back, citing ethical commitments to patient care and confidentiality (Wright & Hankins, 2016). The link between mental disorder and terrorism remains controversial and more prominent among lone-actor terrorists than group actors. For certain individuals in certain cases, psychiatry may play a collaborative role in prevention and rehabilitation. To date, radicalization and terrorism have been addressed as a criminal justice matter rather than a mental health issue. While many concepts discussed in this paper (e.g., counternarratives, push and pull factors, disengagement, and deradicalization) were studied in the context of Islamic extremism, there is no clear reason why these concepts could not be generalized. In fact, concepts learned from studying Islamic terrorism in the United States are already being applied to political extremism (e.g., far-right and far-left wings) that seem to be on the rise (Chermak & Gruenewald, 2015).

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