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Review Paper

Preparatory Phase in the Institutional Treatment of Delinquents with Pronounced Psychopathic Traits According to the Caldwell's Decompression Model*

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Despite widespread view among experts that "nothing works" in the treatment of individuals with psychopathic profiles, long-term, intensive treatment based on the Decompression Model by Caldwell and colleagues has shown positive outcomes even in delinquents with pronounced psychopathic traits. The Decompression Model is a cognitive-behavioural programme targeting the socio-behavioural aspects of psychopathy. This paper presents an overview of the preparatory phase of this programme, as well as an analysis of its contribution to the overall treatment effectiveness. The preparatory phase of decompression focuses on reducing antagonistic exchanges between adolescents and staff, paving the way for more constructive interactions. During this process, professionals attempt to improve role dynamics within the collective and break the pattern of defiant behaviour, which is sometimes a consequence of persistent punitive experiences within this population. There are indications that the preparatory phase significantly contributes to the effectiveness of the Decompression Model, and that it seems reasonable to implement it in working with especially aggressive and disruptive delinquents who have shown resistance to standard treatment forms. Although there are systematic barriers to the full implementation of the preparatory phase in local institutions, one of the elements that can be used is orienting the initial intervention programme towards reducing resistance to treatment and fostering a collaborative relationship with the offenders.

KEYWORDS: Decompression Model / institutional treatment / delinquency / psychopathy / adolescents

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Introduction

Delinquents who score highly on instruments assessing psychopathic traits typically exhibit an elevated level and frequency of delinquent behaviour, an earlier onset of such behaviour, and greater stability into adulthood (Allen et al., 2024; Farrington & West, 1993; Radulović, 2006; Vitacco et al., 2010). Evaluative studies show the ineffectiveness of standard resocialisation practices, with even counterproductive outcomes to the set goals of the treatment. In other words, after undergoing standard forms of treatment, recidivism rates may actually increase (Chakhssi et al., 2010; Radulović, 2012; Salekin et al., 2004). However, this is the case when the treatment programme is insufficiently adapted to the adolescent age group or the specific socio-psychological characteristics of delinquents with pronounced psychopathic traits (Caldwell, Skeem et al., 2006). In any case, the results of numerous studies consistently indicate that this category of offenders exhibits above-average aggression and disruptive behaviour within institutions, as well as low level of cooperation during institutional treatment. This results in slower progress in treatment and higher rates of dropout or expulsion from treatment programmes (Caldwell et al., 2007; O'Neill, 2003; Spain et al., 2004; Wilkinson et al., 2016). Nevertheless, there are indications that specialised treatment programmes targeting the behavioural aspects of psychopathy can yield positive outcomes in adolescent populations (Caldwell & Van Rybroek, 2001; Rogers et al., 2004; Spain et al., 2004), and there is some evidence suggesting that even interventions focused on affective-interpersonal functioning (Ribeiro da Silva et al., 2021; Salekin et al., 2012) can reduce the risk of recidivism. A systematic review encompassing 30 studies on the outcomes of institutional treatment for violent delinquents (Genovés et al., 2006) found an average reduction of 7% in recidivism rates, with a small effect size. The most successful results were achieved by cognitive-behavioural programmes, with Caldwell and colleagues' programme singled out as the most effective (Caldwell & Van Rybroek, 2001). These authors developed a high-intensity, relatively long-term institutional treatment programme (averaging 50 weeks) designed to reduce aggressive and disruptive behaviour in the institution, increase cooperation, and decrease recidivism upon release. The programme was developed for adolescents who demonstrated resistance to standard forms of treatment (Caldwell, Skeem et al., 2006).

Decompression Model

The Decompression Model is a comprehensive approach to the treatment of the most serious categories of juvenile offenders, which has demonstrated considerable effectiveness in reducing disruptive behaviour within institutions (Caldwell et al., 2007; 2012) and recidivism upon release (Caldwell, 2011;

Caldwell & Van Rybroek, 2001, 2005; Caldwell, Skeem et al., 2006; Caldwell et al., 2007), as well as in reducing levels of psychopathy (Caldwell et al., 2012). Although this intensive treatment programme requires significant financial and personnel resources, its benefits have been shown to outweigh the costs (Caldwell, Vitacco et al., 2006). The programme includes several components: 1) Preparatory Phase of Decompression; 2) Behavioural Assessment System; 3) "Today-Tomorrow" Behavioural Reward System; 4) Group Work; 5) Individual Work; and 6) Pedagogical and Educational Work. The programme's implementation is flexible and involves an individualised approach for each offender. In addition to its high intensity and duration, this programme is particularly characteristic by the Preparatory Phase of Decompression.

Preparatory Phase of Decompression

The *Decompression Phase* was developed to address the problem of the excessive use of safety confinement measures within correctional institutions for youths who already exhibit a markedly high level of behavioural problems (Caldwell & Van Rybroek, 2001). More specifically, the aim of this phase is to avoid prolonged exposure of delinquents to retaliatory measures, as this can be linked to the escalation of behaviour and premature dropout from treatment (Aranda-Hughes et al., 2021; Luigi et al., 2020).

Caldwell and his colleagues noted that a significant portion of this population has a well-established system of opposition (Caldwell, Skeem et al., 2006). Drawing on observations of theorists in this field (Sherman, 1993), as well as authors who laid the foundation for the concept of decompression and tested it in another population (Monroe et al., 1988), they concluded that the application of a standard, punitive treatment model can be counterproductive. Therefore, in this phase, the focus is first placed on the dynamics of the roles between the delinquent and the professionals, as well as on their predominantly hostile interactions, which are considered a product of the failure of previous treatment (Caldwell, 1994). The "decompressive withdrawal" of the individual from the cyclical pattern of disruptive behaviour—punishment—disruptive behaviour can reduce the antagonism between the offender and the staff, providing a certain level of behavioural control and cooperativeness, thus paving the way for the main part of the treatment. It is expected that this phase will minimise security concerns, which otherwise dominate interactions in high-security facilities (Caldwell & Van Rybroek, 2001). The other side of this process is the management of countertransference content by professionals, enabling them to make decisions that best address the needs of the offender (Caldwell, 1994). Concurrently with the reduction of resistance, this phase also encourages the gradual increase of social contacts and involvement in conventional interpersonal exchanges, until

integration into the collective of peers and staff is achieved (Caldwell & Van Rybroek, 2001).

The content of the Preparatory Phase shares certain similarities with the motivational interviewing paradigm (Burke et al., 2003) and the Precursors Model of Change (Hannah, 2002). The implementation of this phase in practice requires an individualised approach and considerable time, as dismantling an already established system of opposition is a complex process. In other words, the decompression process is not a structured process with clear, unchanging steps, but is tailored to each individual offender (Caldwell & Van Rybroek, 2005). Often, the first step involves the exclusion of all invasive behaviour control techniques and the initiation of frequent informal contact with the professional. In order for the adolescent to shift his focus to prosocial content, they engage in a 30-minute daily activity of their choice with the professional. After some time spent in joint activities, the professional will propose the signing of a behavioural contract, which initially often involves refraining from violence for 48 hours. The contract is aimed at developing a minimum level of cooperation and is not designed to lead to significant changes in behaviour. If the contract is breached, no punishment is applied. In the case of the most disruptive offender, the decompression process begins by singling them out, while simultaneously introducing brief and frequent conversations with the professional at the entrance to the room. This maintains continuity of interaction, which is a prerequisite for engagement in treatment. If the young person expresses dissatisfaction due to the application of punishment, staff make it clear that it is not their responsibility to address such complaints. This technique of redirecting attention is used because it has been shown that young people with a particularly negative relationship with staff do not benefit from additional lessons about the necessity of taking responsibility for their actions. In such cases, it is essential to continue the intervention as soon as possible (Caldwell & Van Rybroek, 2001).

Decompression triggers general changes in interpersonal functioning, towards more pragmatic behaviour (Caldwell et al., 2007), with staff using various techniques to encourage the shift from an antagonistic relationship to one of better exchange and cooperation, without attempting to form a therapeutic relationship (Caldwell & Van Rybroek, 2001).

Although the authors have not yet assessed the contribution of individual programme elements in reducing disruptive behaviour, they note that, alongside the monitoring and scoring system, the decompression process during the preparatory phase is the most significant component of the treatment (Caldwell et al., 2012).

Possibilities for Implementing the Decompression Element in Institutional Treatment of Delinquents in the Republic of Serbia

Data on the success of the Decompression Model in reducing disruptive behaviour, recidivism, and psychopathic traits suggest the implementation of this programme in institutional treatment of juvenile offenders in our country. However, there are several potential obstacles to the implementation of the initial phase of this programme. Given that the model was developed and evaluated in a clinical setting, and is carried out by clinical rather than correctional staff (Caldwell & Van Rybroek, 2001), the absence of institutions suitable for implementing such a treatment model is evident. Within the existing correctional facilities in Serbia, the removal of retaliatory measures from the repertoire of treatment interventions would significantly disrupt the practice of resocialisation, and the institution's collective would be exposed to increased security risks. Additionally, the delinquent population is heterogeneous, and the implementation of the Decompression Model is indicated only for the most severe categories of offenders, for whom the programme requires separation from other offenders. This also raises the issue of financial support for conducting comprehensive assessments of potential beneficiaries, providing new spaces and materials, or adapting infrastructure, as well as staff training.

Despite the above obstacles, it makes sense to attempt to implement some aspects of the decompression process. Reducing the frequency of punishment and avoiding unjustified punishment, as well as focusing on positive, structured activities tailored to the interests of the offenders, with continuous progress evaluation, appears to be a useful and feasible procedure. Additionally, focus of the professional staff on creating a safe, non-violent environment while practising open communication, and working on their own inadequate perceptions of offenders, could be beneficial. Perhaps the most important element that could be applied in our institutions is the adaptation of the treatment programme so that it is focused from the very beginning on reducing resistance to treatment and encouraging a cooperative, practical relationship between the offender and the professional, before proceeding to the treatment itself.

Conclusion

The Preparatory Phase of decompression stands out as a significant element in the intensive treatment programme for serious juvenile offenders with pronounced psychopathic traits. This concept has introduced into the practice of resocialisation the idea that it is essential to establish internal preconditions before starting the treatment and rehabilitation process, and that the absence of this element in institutional treatment can be linked to the failure of such treatment. Mitigating

the antagonistic attitude towards staff and treatment, as well as fostering internal motivation to redirect towards normative activities, are prerequisites for the quality participation of adolescents in institutional treatment, and components that increase the likelihood of positive outcomes.

Although there are practical limitations to the full implementation of all aspects of the decompression phase in institutions in our country, certain elements of this process can be adapted to the resocialisation practice within the current conditions. A key element is the initiation of structured activities by professional staff aimed at reducing resistance to treatment and building a cooperative relationship with the offender. It is reasonable to expect that this approach will increase the participation rate in treatment and the likelihood of recidivism prevention among juvenile offenders with a long and complex history of antisocial behaviour.

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