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Are Narcissism and Entitlement Associated with Higher Rates of Violence and Unsuccessful Treatment Completion?

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ARE NARCISSISM AND ENTITLEMENT ASSOCIATED WITH HIGHER RATES OF VIOLENCE AND UNSUCCESSFUL TREATMENT COMPLETION?

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DISSERTATION APPROVAL

This is to certify that the thesis presented to us by ____Melissa Chipollini_____

on the ___12_____ day of ___October_____, 20_21_, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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ABSTRACT

Following the dimensional-categorical model of personality functioning, this study used archival data to examine the degree to which narcissism and entitlement determined engagement in violent acts and treatment completion. The study reviewed MCMI-III/IV scores, discharge summaries, and violence histories for a sample of 105 individuals who were referred for forensic outpatient services by the court. One-way ANOVAs were used to assess all four of the hypotheses (a) individuals with more than one violent act (vs. one violent act) would have significantly higher mean scores on the MCMI-III/IV entitlement subscale, (b) individuals with more than one violent act would have significantly higher mean scores on the MCMI-III/IV narcissism scale, (c) individuals who had unsuccessful (vs. successful) treatment completion would have higher mean scores on the MCMI-III/IV entitlement subscale; and (d) individuals who had unsuccessful treatment completion would have higher mean scores on the MCMI-III/IV narcissism scale. Findings did not support these hypotheses. However, results supported literature highlighting discrepancies between conviction rates and offenders' and victims' self-reports of violent offending. Further, exploratory analyses were conducted to examine the relationship among Central Eight risk factors, narcissism, entitlement, violent acts, and treatment completion. Findings supported the Central Eight risk factors being predictors of violent engagement and correlated with treatment success and severity of narcissism and entitlement. Antisociality, as a Central Eight risk factor, was especially correlated with violent acts and treatment success. Overall, this study supported the dimensional conceptualization of personality disorders and expanded use of the risk-needs-responsivity model for treatment of violent offenders.

CHAPTER 1: INTRODUCTION

Statement of the Problem

Crime in the United States is categorized as either property (i.e., burglary, larceny-theft, motor vehicle theft, arson) or violent (i.e., rape, assault, homicide, robbery) offenses. In 2017, an estimated 2,362 property crimes and 383 violent crimes occurred per 100,000 U.S. residents (Federal Bureau of Investigation [FBI], n.d.). Drug-related charges are the leading cause of incarceration, followed by possession of weapons and sex offenses (Federal Bureau of Prisons, 2021). Upon release from custody, five in six individuals are likely to recidivate, or reoffend, within 9 years of release. Re-offenses typically include property, drug-related, and violent charges. However, violent offenders specifically tend to recidivate with violent charges (Bureau of Justice Statistics [BJS], 2018).

Violent offenses are of most concern to the general public, as they have enduring effects on offenders, victims, and the community. Victims of sexual violence (i.e., sexual activity without consent) are likely to have behavioral challenges, including substance abuse and risky sexual practices. They are also likely to have physical concerns, such as cardiovascular or gynecological complications, and emotional distress, including depression and posttraumatic stress (Centers for Disease Control and Prevention [CDC], 2021). Victims of childhood trauma (i.e., neglect, physical/sexual abuse) are also likely to engage in delinquent, violent offenses; have higher levels of psychological distress; and enter the criminal justice system at young ages (Mersky et al., 2012; Messina et al., 2007).

Offending populations typically have high prevalence of personality disorders (Johnson et al., 2000). Psychopathy and Cluster B disorders, such as antisocial personality disorder and narcissistic personality disorder, are strongly associated with criminal behavior (Barry et al., 2007; Fazel & Dannsh, 2002; Hare, 2003). Approximately 80% of inmates are diagnosed with antisocial personality disorder, while 25% of the correctional population (i.e., inmates, forensic psychiatric patients) are considered psychopathic, and 3% of all offenders have narcissistic personality disorder (American Psychiatric Association [APA], 2013; Hare, 2003; Johnson et al., 2000; Torgersen, 2005). However, neither a diagnosis of antisocial personality disorder nor high scores on psychopathy scales (e.g., Psychopathy Checklist –Revised [PCL-R]) are always predictive of general or violent recidivism (Shepherd et al., 2018). For example, although individuals with antisocial personality disorder are likely to reoffend, they do not commit violent re-offenses at higher rates than individuals without antisocial personality disorder (Nilsson et al., 2011).

Disordered personality characteristics are more predictive of violent behavior than are diagnoses (Dune et al., 2018). Specific Cluster B personality disordered traits, such as low conscientiousness; low empathy; and narcissistic traits like grandiosity, entitlement, exploitativeness, and exhibitionism, are associated with violent behavior (Barry et al., 2007; Hepper et al., 2014; Johnson et al., 2000; Thornton et al., 2010; Torgersen, 2005). Narcissistic traits are specifically predictive of repeated engagement in violent acts (Barry et al., 2007; Hepper et al., 2014; Johnson et al., 2000; Torgersen, 2005). Longitudinal studies show that individuals presenting with facets of narcissism (e.g., entitlement, exhibitionism, exploitiveness) recidivate within 2 to 3 years (Barry et al.,

2007). Further, having a sense of entitlement is a specific psychologically meaningful risk factor among sex offenders (Mann et al., 2010). However, whether a sense of entitlement is predictive of repeated violence among all types of violent offenders (e.g., child abuse, domestic violence) is unclear in the literature.

Risk factors for criminal engagement are both static and dynamic. Static risk factors are permanent, whereas dynamic risk factors are amenable to change. A combination of Central Eight static and dynamic risk factors are considered strong predictors of general and violent recidivism. These factors include criminal history, substance abuse, and antisocial personality traits (Andrews & Bonta, 2010; Bonta & Andrews, 2017; Bonta et al., 2014; Eisenberg et al., 2019). Psychological treatment can alter dynamic factors and reduce overall risk for reoffending (Andrews & Bonta, 2010; Bonta et al., 2014; Wooditch et al., 2014).

Treatment addressing psychological risk factors has been found successful in reducing violent reoffending (Manguno-Mire et al., 2014; Mann et al., 2010). However, this success tends to be specific to treatment that addresses cognitive aspects of criminality (Banse et al., 2013; Eisenberg, 2019). For example, literature on domestic-violence treatment shows offenders who continued to have entitled beliefs about their crimes did not successfully complete treatment (Catlett et al., 2010). Motivation for treatment also appears to impact treatment completion (Wooditch et al., 2014). As Zemojtel-Piotrowska (2016) argued, a high sense of entitlement may prevent offenders from becoming highly motivated to complete treatment. Thus, the impact of entitlement on treatment completion and reoffending needs to be further researched.

Purpose of the Study

The purpose of this study was to examine the degree to which narcissism and entitlement, as measured by the The Millon Clinical Multiaxial Inventory, 3rd or 4th edition (MCMI-III/IV), were significantly distinguished among individuals who engaged in one violent act versus individuals who engaged in multiple (> 1) violent acts. In addition, the proposed study examined the association between narcissism, entitlement, and successful treatment completion. Finally, the study examined the degree to which risk factors identified in the literature (i.e., Central Eight risk factors) and narcissism and entitlement were correlated with number of violent acts.

Research Questions and Hypotheses

This study explored the following questions: Is narcissism associated with engagement in violent acts among violent offenders? Are violent offenders who endorse entitlement most likely to commit violent acts? Are entitled violent offenders least likely to successfully complete forensic outpatient treatment?

It was hypothesized that individuals with more than one violent act would have significantly higher mean entitlement scores on the MCMI-III/IV entitlement subscale than individuals with one violent act.

It was hypothesized that individuals with more than one violent act would have significantly higher mean narcissism scores on the MCMI-III/IV narcissism subscale than individuals with one violent act.

It was hypothesized that individuals who had unsuccessful treatment completion would have significantly higher mean scores on the MCMI-III/IV entitlement subscale than individuals who had successful treatment completion.

It was hypothesized that individuals who had unsuccessful treatment completion would have significantly higher mean scores on the MCMI-III/IV narcissism scale than individuals who had successful treatment completion.

Lastly, exploratory analysis examined which Central Eight risk factors, along with entitlement and narcissism, were correlated with violent acts.

CHAPTER 2: REVIEW OF THE LITERATURE

Prevalence of Violent Offending

The World Health Organization (WHO) defines interpersonal violence as the intentional use (threatened or actual) of physical force against another person or community that is highly likely to result in injury, death, psychological harm, maldevelopment, and/or deprivation (Krugg et al., 2002). A violent crime in the United States includes acts of murder, rape/sexual assault, robbery, and/or assault (Bureau of Justice Statistics [BJS], 2021). Since 2012, the United States' homicide rate of 5.4 per 100,000 persons exceeds that of other high-income nations (i.e., Canada: 1.8; United Kingdom: 1.5; Australia: 1.1 per 100,000 persons; WHO, United Nations Office on Drugs and Crime, & United Nations Development Program, 2014).

Although fatal acts of interpersonal violence are well documented, nonfatal acts tend to be unreported, underreported, or undetected (Sumner et al., 2015). Nonfatal acts include child and/or elder abuse, domestic abuse, youth violence, and sexual assault (U.S. Department of Health & Human Services, Administration for Children and Families, Administration of Children, Youth and Families, & Children's Bureau, 2020). For example, although approximately 10 million children reported experiencing caregiver abuse through national survey data, police receive only about 480,000 annual reports of injuries related to domestic abuse (Finkelhor et al., 2013; Sumner et al., 2015). Further, only approximately 150,000 of these injuries receive medical treatment (Finkelhor et al., 2013).

Although violent crime in the United States has decreased overall since the 1960s, the trend since 2014 has moved upward (James, 2018). The total rate of violent incidents

(i.e., criminal acts against a victim) has increased from 5.2 million in 2017 to 6 million in 2018. Of these, the rate of completed violent incidents (vs. attempted/threatened) has risen from 5.6. to 6.9 per 1,000 individuals (aged 12years and older). Completed incidents of rape/sexual assault also increased from 1.4. to 2.7 per 1,000 individuals from 2017 to 2018 (BJS, 2018).

The number of victims of violent crime has also grown. In 2018, 3.3 million victims of violent crimes were reported nationwide, compared to 2.7 million in 2015 (BJS, 2018). Approximately 1 in 5 U.S. women (19.3%) reported experiencing completed or attempted rape throughout her lifetime (Breiding et al., 2014; Planty et al**.,** 2013). National data also suggest approximately 12 million individuals experience some form of domestic abuse (e.g., physical/sexual assault, stalking.) annually (Sumner et al., 2015). As such, in 2018, 1,770 U.S. children died from child abuse (U.S. Department of Health & Human Services, Administration for Children & Families, Administration on Children, Youth and Families, & Children's Bureau, 2020).

Recidivism Among Violent Offenders

Violent offenders (i.e., individuals with minimally one violent offense on their criminal record) tend to have more extensive criminal records and recidivate at a quicker and higher rate than nonviolent offenders (Hunt et al., 2019; Kyckelhahnn & Cooper, 2017). According to national longitudinal data, 80% of violent offenders (vs. 44% of nonviolent offenders) have a previous criminal offense. They also tend to be placed in higher criminal history categories (vs. nonviolent offenders; see Kyckelhahn & Herbst, 2018) that reflect longer sentences and more serious convictions (Hunt et al., 2019; Kyckelhahnn & Cooper, 2017). As many as 28% of violent offenders (vs. 2% of

nonviolent offenders) tend to recidivate with a violent offense, especially assault (BJS, 2018; Hunt et al., 2019). Rearrest typically occurs within 18 months of release (vs. 24 months for nonviolent offenders). However, 63.8% of federal violent offenders (vs. 39% of nonviolent offenders) released in 2005, were rearrested within 8 years of release (Hunt et al., 2019).

The rate of violent offending varies by age, race, and gender. Rearrests are more likely to occur within offenders' first year of release, especially for male offenders aged 24 years or younger (Fahlgren et al., 2017; Federal Bureau of Investigation [FBI], 2021). Further, review of Pennsylvania's Prior Record Score (i.e., classification system serving as sentencing guidelines; 204 Pa. Code §303.4) showed risk for recidivism to steadily decrease as age increased. Offenders in their fifties are 73% less likely to recidivate than younger offenders. Offenders in their twenties only had a 30% likelihood of being crime free (Hester, 2019). White offenders form the largest demographic of violent offenders (Hunt et al, 2019). However, Black offenders tend to have lengthier criminal records with more punitive sentences (Frase et al., 2015; Ulmer et al., 2016). They are 20% more likely to recidivate than White offenders (Hester, 2018). Men also have significantly greater involvement in violent offenses than women (Fahlgren et al., 2017; FBI, 2021). National longitudinal data show women comprise fewer than 10% of all violent offenders (Hunt et al., 2019).

Inconsistency Among Recidivism Rates

Discrepancy among recidivism rates and self-reported offenses is high (Farrington, 1989; Farrington et al., 2014; Theobald et al., 2014). Recidivism is typically defined as an arrest, conviction resulting from arrest, and/or commitment following arrest

after an individual was previously released from state/federal custody, completed a court-appointed program, or was placed on probation/parole (BJS, n.d.). However, recidivism rates under this definition typically captures only a small percentage of perpetuated offenses, as most offenses do not result in legal prosecution (Farrington et al., 2014; Prentky et al., 1997; Rice et al., 2006; Theobald et al., 2014). For example, in a longitudinal study of male offenders, 112 offenses were self-reported, yet only 3.3 resulted in conviction (Farrington et al., 2014).

Differences are also shown among recidivism rates and perpetration of violent/sexual offenses (Scurich & John, 2019). Some of this inconsistency is attributed to low rates of victim reporting. Research shows only approximately 14% of international sexual assault victims and 35% of U.S. victims report their attacks (Daly & Bouhours, 2010; Planty et al., 2013). Discrepancy is also attributed to differences in definitions and criteria met for violent charges (Prentky et al., 1997; Rice et al., 2006). For example, as Marshall and Barbaree (1988) found in their seminal work, the difference between offenders who were “re-convicted” (15%) and those “charged” with an offense (26%) was almost doubled. They also found that combined offense reports from child protective services and police precincts were about 250% more than those reported on official crime statistics. As such, recidivism literature often does not accurately capture all violent reoffending (Scurich & John, 2019).

Further, inaccuracy of violent reoffending rates is the result of discrepancies among offender self-reports. In some instances, offenders are convicted for fewer crimes than they commit. For example, Langevin et al. (2004) found the recidivism rate to increase from about 61% to 88% when combining sex offender self-report data with

crime statistics. However, offenders also often underreport their offenses. As such, presence of a polygraph when questioning offenders has been found to increase their reported number of victims and offenses (Bourke et al., 2015; Bourke & Hernandez, 2009).

Risk Factors for Reoffending

Static and Dynamic Factors

Factors that typically predict reoffending for violent offenders are conceptualized in the literature as static or dynamic. Static risk factors (e.g., age, race, gender) are features of an offender that are not typically altered. Contrarily, dynamic risk factors (e.g., substance use, antisocial social peer engagement) can change over time (Bonta & Andrews, 2017; Eisenberg et al., 2019; Mann et al., 2010). Static and dynamic factors can be interchangeable. For example, a history of substance use is considered static, yet becomes dynamic if an offender is actively using. Static factors tend to be most predictive of both general and violent recidivism (Bonta et al., 2014; Collins, 2010; Olver et al., 2014). Eisenberg et al. (2019) specifically found such static factors as criminal history and antisocial pattern of behavior to be the strongest predictors of both general and violent recidivism.

Central Eight Risk Factors

Research has found a compilation of Central Eight static and dynamic risk factors (mainly dynamic; Andrews & Bonta, 2010) that are predictive of recidivism (Bonta & Andrews, 2017; Bonta et al., 2014). Risk factors include criminal history, antisocial personality traits (e.g., impulsivity, lack of empathy, aggressiveness), antisocial cognitions, level of involvement with pro-criminal friends, family/relationships, quality

of performance in school/work and leisure (i.e., involvement in prosocial activity), and substance abuse (Andrews & Bonta, 2010; Bonta & Andrews, 2017). Increased presence of these factors reinforces offending, thus also increasing the likelihood of reoffending (Bonta & Andrews, 2017). Dynamic factors have been found to reduce the probability of reoffending when altered with psychological treatment (Andrews & Bonta, 2010; Bonta et al., 2014). Further, when compared to static factors within the same domain (e.g., history of substance use vs. active substance use), dynamic factors were more predictive of reoffending (Eisenberg et al., 2019).

Risk-Need-Responsivity Model

Treatment addressing risk factors for reoffending typically adheres to the risk-need-responsivity model (RNR; Bonta & Andrews, 2017). The model is based on three principles: *risk,* which specifies treatment intensity to match recidivism (i.e., offenders with higher risk have more intensive treatment); *need,* requiring treatment to focus on criminogenic needs (i.e., dynamic risk factors) instead of less correlated factors of recidivism (e.g., mood); and *responsivity*, ensuring treatment fits with offenders' characteristics and learning abilities (Andrews & Bonta, 2010). This model informs current correctional treatment and policies. For example, it has prompted the use of actuarial risk assessments (e.g., Static-99; Historical Clinical Risk Management-20 [HCR-20]), structured tools measuring the presence of static/dynamic risk factors and likelihood of reoffending (Beech et al., 2016; Heffernan et al., 2019; Helmus, 2018).

Implementation of the RNR model is empirically supported to reduce recidivism rates (e.g., Andrews & Bonta, 2010; Klepfisz et al., 2016; Wormith & Zidenberg, 2018). However, effect sizes appear to be low to moderate (Heffernan et al., 2019). In their

meta-analytic research, Lipsey and Cullen (2007) found an average of 20% reduction in recidivism post treatment. Although this finding is still indicative of the effectiveness of RNR as a treatment model, it also underlines the lack of causality among dynamic factors and recidivism. As such, dynamic factors are not causal for offending, or at least are not the main cause of reoffending (Heffernan et al., 2019).

Recent literature conceptualizes dynamic factors as symptoms of underlying causal processes for reoffending (Klepfisz et al., 2016; van den Berg et al., 2018). Although the RNR model of treatment emphasizes focus on dynamic risk factors, static and dynamic risk factors overlap. Studies comparing static and dynamic risk assessments demonstrate small effect sizes and, thus, similar predicative value (van den Berg et al., 2018). Further, static and dynamic risk factors and protective factors are considered to measure different aspects of the same construct (Bonta & Andrews, 2017; Casey, 2016; Heffernan et al., 2019; Helmus, 2018). This finding fits accordingly with the propensities model of risk (Hanson & Harris, 2001), which divides dynamic factors into acute/imminent risk and stable/enduring vulnerabilities (e.g., personality traits), thereby depending on context to result in reoffending (Ward & Beech, 2004).

The application of static and dynamic risk factors within treatment does not match the original intent of its research base (Gannon & Ward, 2014). Andrews and Bonta's (2010) original research studied static and dynamic factors at a group level with intention of informing correctional policy (Gannon & Ward, 2014). However, the RNR model has taken over psychological treatment at an individual level. Treatment focuses on altering dynamic risk factors yet does not determine the relevance of risk factors at the level of the individual (Heffernan et al., 2019). Literature on dynamic risk factors and recidivism

reduction at an individual level has mixed results. Some studies (e.g., Olver, Mundt, et al., 2018) are supportive of this link, while others (e.g., Olver, Kingston, et al., 2014) show weak/limited support (Heffernan et al., 2019). As such, factors aside from the Central Eight factors have an influence on an offender's risk of recidivism (Beggs, 2010; Gannon & Ward, 2014; Heffner et al., 2019).

Personality Disorders

Personality disorders are prevalent among offending populations. They are diagnosed among 42%-78% of violent offenders and 30% of sex offenders (vs. 4%-13% of the general population; Coid et al., 2006; Craissati et al., 2008; Fazel & Danesh, 2002; Singleton et al., 1998). Further, offenders who are diagnosed with personality disorders are more likely to recidivate violently (Jaimeson & Taylor, 2004). Community studies also show individuals who report engagement in violent activities (vs. nonviolent individuals) meet higher rates of diagnostic criteria for personality disorders (Craissati & Blundell, 2013; Johnson et al., 2000; Thornton et al., 2010; Yang & Coid, 2007).

The *Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5;* American Psychiatric Association [APA], 2013) defines a personality disorder as an enduring pattern of cognition, affect, interpersonal functioning, and/or impulse control. This pattern deviates from the cultural norm and impairs daily functioning in a manner that is stable across time and context. To be diagnosed with a personality disorder, one must meet criteria for possessing a minimal number of listed traits and/or cognitive, affective, and/or behavioral displays. Personality disorders are divided into three clusters. Cluster A is identified as "odd and eccentric"; it includes paranoid, schizoid, and schizotypal personality disorders. Cluster B is conceptualized as "dramatic, emotional,

and erratic," including antisocial, borderline, histrionic, and narcissistic personality disorders. Cluster C encompasses the "anxious and fearful" disorders, such as avoidant, dependent, and obsessive-compulsive (APA, 2013).

Personality disorders within Clusters A and B are most associated with violent and nonviolent offending (Dunsieth et al., 2004; Johnson et al., 2000; Thornton et al., 2010). Borderline personality disorder (i.e., characterized by instability in interpersonal relationships, self-image and affect, and impulsivity), and antisocial personality disorder (i.e., characterized by disregarding the rights of others/social norms, deceitfulness, impulsivity, and aggression) are the most common diagnoses among offenders (APA, 2013; Blackburn & Coid, 1999; Coid, 2002; Fazel & Danesh, 2002; Hare, 2003). For example, approximately 56% of sex offenders were found to be diagnosed with antisocial personality disorder, and 28% were diagnosed with borderline personality disorder (Dunsieth et al., 2004). Emmelkamp and Kamphuis (2007) also found antisocial personality disorder and borderline personality disorder to be specifically associated with violence perpetration both in and out of the home. Of the Cluster A personality disorders, schizoid (i.e., characterized by interpersonal detachment, restricted range of emotional expression, and exaggerated engagement in solitary activity) and schizotypal (i.e., characterized by reduced capacity for social relationships, cognitive/perceptual distortions, and eccentric behavior) have been most associated with violence for both men and women (APA, 2013; Craissati & Blundell, 2013; Ehrensaft et al., 2006). However, narcissistic personality disorder (i.e., characterized by grandiosity, lack of empathy, entitlement) and paranoid personality disorder (i.e., characterized by suspicion and distrust of others) have also shown moderate-to-high prevalence among violent

offenders in forensic settings (Blackburn & Coid, 1999; Coid, 2002; Timmerman & Emmelkamp, 2001).

Cluster C disorders are also beginning to be associated with violent offending (Emmelkamp & Kamphuis, 2007). Sex offenders against children were found to have high rates of Cluster C diagnoses. Additionally, sex offenders in general also show high prevalence of avoidant personality disorder (i.e., characterized by social inhibition, sense of inadequacy, and hypersensitivity to negative evaluation), and obsessive-compulsive personality disorder (i.e., characterized by preoccupation with orderliness, perfectionism, and mental/interpersonal control), followed by schizoid, paranoid, and borderline personality disorders (APA, 2013; Francia et al., 2010). Cluster C disorders are also associated with intimate partner violence (Dutton 2002; Henning et al., 2003).

Psychopathy

Psychopathy is a clinical construct that has been well linked to criminality during the past 30 years (DeLisi, 2009; Dhingra & Boduszek, 2013; Hare, 1991; Olver, Neumann, et al., 2018; Reidy et al., 2015). High scores on the Psychopathy Checklist-Revised (PCL-R; Hare, 2003), the gold standard measurement, are predictive of violent offending and poor treatment outcomes among adolescents and adults (Asscher et al., 2011; Edens et al., 2007; Leistico et al., 2008; Wilson & Yardley, 2013). Psychopathic offenders (vs. nonpsychopathic offenders) are likely to recidivate within 5 years as the result of a new violent crime (Harris et al., 1991; Hemphill et al., 1998; Serin & Amos, 1995). They also tend to particularly engage in instrumental violence (i.e., controlled, purposeful, and used to achieve a goal), as opposed to reactive violence (i.e., impulsive, emotion-driven, and in reaction to a perceived threat; Cleckly, 1941,1976; Cornell et al.,

1996; Dhingra & Boduszek, 2013; Meloy, 1997; Williamson et al., 1987). Sex and violent offenses perpetrated by psychopathic offenders are particularly violent and opportunistic (i.e., victims are not chosen by type but rather opportunity to offend; Knight & Guay, 2006; Knight & Sims-Knight, 2003; Porter et al., 2000).

Psychopathy as a construct consists of four dimensions encompassing personality traits and deviant behaviors. It differs from antisocial personality disorder, which primarily measures socially deviant behaviors (APA, 2013; Widiger et al., 1996). Measurements of these dimensions include interpersonal (i.e., superficial charm, grandiose sense of self-worth, pathological lying); affective (i.e., lack of remorse/guilt, shallow affect, callous/lack of empathy, failure to take responsibility for own actions); lifestyle (i.e., need for stimulation/proneness to boredom, lack of realistic long-term goals, impulsivity); and antisocial (i.e., poor behavioral control, juvenile delinquency, criminal versatility; Hare, 2003). Manifestations of these traits are stable over time (beginning in childhood) and said to have a genetic link (Hare, 1996; Larsson et al., 2006; Lynam et al., 2007).

More recently, the field has shifted to identify psychopathy dimensionally, rather than categorically (Edens et al., 2006; Guay et al., 2007). For example, interpersonal/affective dimensions are particularly correlated with perpetration of instrumental violence, whereas the lifestyle/antisocial dimensions are related to reactive violence (Declercq et al., 2012). This shift fits Hart and Hare's (1997) original explanation that endorsement of specific psychopathic traits (i.e., impulsivity, lack of empathy, grandiosity) are responsible for both decreasing behavioral inhibition and increasing the likelihood of criminal engagement. As Hare and Newman (2008)

explained, although psychopathy is common among offenders, it can be understood as a spectrum that indicates violence across the entire population (i.e., offenders and nonoffenders).

Dimensional Conceptualization of Personality

Although diagnosis of personality disorders remains based on categorical classification, there is a push in the field to understand them dimensionally. Under the dimensional-categorical model within Section III of the *DSM-5* (2013), personality disorders are conceptualized by specific impairments in functioning related to self/others (Criterion A) and level of adherence to specific personality traits (Criterion B; APA, 2013; Krueger & Markon, 2014). The dimensional-categorical model resembles models of normal personality (i.e., five-factor model; Costa & McCrae, 1990) by having variations among the domains of maladaptive personality traits (i.e., antagonism, negative affect, disinhibition, detachment, and psychoticism; APA, 2013). This model also drives an explanation for issues previously raised within the traditional categorical classification, such as overlap among diagnoses and differences in diagnostic presentation (e.g., irritability and impulsivity being features for both antisocial personality disorder and borderline personality disorder; Dunne et al., 2018). This model thus also allows personality disorders to be identified on a spectrum of personality functioning and for endorsement of personality traits to be emphasized.

Dimensions of adaptive and nonadaptive personality traits have been found predictive of violent offending. For example, dimensions within the five-factor model (i.e., extraversion, agreeableness, conscientiousness, neuroticism, openness/intellect; Costa & McCrae, 1990), such as low agreeableness and conscientiousness, and high

neuroticism, are correlated with aggression and violence (Gleason et al., 2004; Thornton et al., 2010; Tremblay & Ewart, 2005). Individuals endorsing Cluster A and B traits also present with high dimensions of neuroticism and low dimensions of agreeableness and conscientiousness, respectively. They both have greater likelihood of violent offending (Thornton et al., 2010). Violence is also associated with variations in dimensions of the Personality Psychopathology Five (Harkness & McNulty, 1994). High levels of aggressiveness, negative emotionality, and psychoticism, as well as low levels of constraint and positive emotionality, are predictive of violent behavior (Gleason et al., 2004; Sharpe & Desai, 2001).

The *DSM-5* (2013) dimensional categorical model further divides its five domains into 25 facets. For example, the antagonism domain is composed of grandiosity, attention seeking, callousness, deceitfulness, and manipulativeness. Facets (vs. dimensions) tend to have greater predictability of behavior, such as aggression and violence (Dunne et al., 2018; Jones et al., 2011). As such, within the domain of antagonism, facets of grandiosity, attention-seeking, and callousness have moderate-to-strong associations with aggression/violent behavior (Bettencourt et al., 2006; Dunne et al., 2018; Enebrink et al., 2005). Contrarily, deceitfulness and manipulativeness have low-to-moderate effect sizes (Dunne et al., 2018; Jones et al., 2011). However, as Dunne et al. (2018) determined, the field must further distinguish which facets of personality characteristics best explain associations with violence.

Narcissism

Definition and Prevalence

Narcissism has been heavily linked with aggression and violent/sexual offending (Baumeister et al., 2002; Baumeister et al., 1996**;** Bushman & Baumeister, 1998; Barry et al., 2007; Hanson et al., 2018; Kosson et al., 1997; Lawrence, 2006; Papps & O'Carroll, 1998; Washburn et al., 2004). Approximately 3% of all offenders (vs. 0.5% of the general population) are diagnosed with narcissistic personality disorder (Johnson et al., 2000; Torgersen, 2005). Several studies conclude offenders with narcissistic personality disorder (i.e., previously labeled antisocial-narcissistic cluster) to have extensive criminal careers that are likely the result of both sexual and violent recidivism (Blackburn & Coid, 1999; Eher et al., 2010; Hepper et al., 2014; Kosson et al., 1997; Pettersen et al., 2020). More specifically, narcissistic offenders are likely to have repeated criminal behavior and contact with police/arrests; to have sexually assaulted children and adults; and to have violently assaulted others while using a weapon (Barry et al., 2007; Eher et al., 2010; Kosson et al., 1997; Pettersen et al., 2020; Vaughn et al., 2008). Further, narcissism has been found prevalent across the lifespan, particularly during adolescence and early adulthood (Barry et al., 2007; Hepper et al., 2014; Johnson et al., 2000; Vaughn et al., 2008).

Narcissism is a multidimensional clinical construct, ranging from normal/healthy to pathological/disordered (Aslinger et al., 2018). The construct was originally identified as a grandiose/exaggerated sense of self (Raskin & Terry, 1988). It is now known to include areas of self-esteem, interpersonal relationships, empathy, acknowledgement of abilities, and accountability (Hartwell-Walker, 2016). Most individuals possess a healthy

level of narcissism which allows them to develop a positive self-concept, set appropriate boundaries with others, and take responsibility for their actions. The severity of narcissism depends on the appropriateness in which developmental tasks are met. When these tasks are not met, a pathological level of narcissism is developed, arguably as a coping mechanism (Miller et al., 2017; Pincus & Lukowitsky, 2010; Schmidt, 2019). Narcissistic personality disorder makes up the most severe end of the narcissism spectrum. It is characterized by a grandiose sense of self, exaggerated need for admiration from others, arrogance, sense of uniqueness and entitlement, lack of empathy, and tendency to exploit others (APA, 2013).

Facets and Violence

Pathological narcissism is further expanded into two prototypical presentations: grandiosity and vulnerability (Pincus & Roche, 2011). It is associated with problems in areas of functioning, however not in a pervasive manner as in narcissistic personality disorder (Dashineau et al., 2019; Roche et al., 2013). Narcissistic grandiosity, which is the most studied and common manifestation, is characterized by arrogance, manipulation of others, and a sense of entitlement. Narcissistic vulnerability is characterized by social withdrawal and emotional dysregulation, as a result of self-enhancement and entitled expectations not being met (Miller et al., 2011). Both presentations are found to share facets of antagonism (i.e., grandiosity, attention-seeking, callousness, deceitfulness, and manipulativeness) and entitlement that allow individuals to use self-enhancement, validation, and defensiveness to maintain their positive self-image (Krizan & Herlache, 2018; Miller et al., 2017).

Specific facets of narcissism are associated with violent offending (Barry et al., 2007; Hepper et al., 2014). Narcissistic individuals are specifically likely to react aggressively in situations they perceive to be humiliating, socially rejecting, or challenging of their self-esteem (Emmelkamp & Kamphuis, 2007). Most individuals on the pathological side of the spectrum tend to maintain psychological health and emotional stability (Miller & Campbell, 2008). However, their violent tendency aligns well with Bauemeister et al.'s (1996) original explanation of physical violence among narcissists, explaining it to be a result of a threatened ego and use of favorable self-appraisals.

Empathy

A lack of empathy, or inability to understand others' perspectives/emotional experiences (Hastings et al., 2006**),** has been most established to correlate with antisocial behavior and violent offending (Day et al., 2010; Hepper et al., 2014; Jolliffe & Farrington, 2007; Miller & Eisenberg, 1988). For example, Hepper et al. (2014) found offenders with pathological narcissism to also have low cognitive and affective empathy. Observed level of empathy was also found to be more indicative of offender status than was self-reported aggressive attitudes among a sample of offenders and nonoffenders (Robinson et al., 2007). It is hypothesized that a lack of empathy for others allows narcissistic individuals to follow through with violent acts as a means of obtaining personal gratification/validation (Gurtman, 1992; Hepper et al., 2014).

Antagonism

Grandiosity and attention seeking have classically described narcissism (Kernberg, 1995). As such, the extent of the literature linking narcissism with violence revolves around these facets (Bettencourt et al, 2006; Bushman & Baumeister, 1998;

Bushman et al., 2003; Thomaes et al., 2008; Wink, 1991). Grandiosity and attention seeking are especially predictive and considered risk factors for violence in situations where individuals feel provoked (Dunne et al., 2018). Narcissistic individuals are thought to have an unstable self-esteem and to be hypersensitive to criticism from others. They thus use grandiosity and peer attention to validate/stabilize their self-esteem, and often use violence if they perceive their self-concept to continue being attacked (Baumeister et al., 1996; Bushman & Baumeister, 1998).

Callousness (i.e., lack of concern for others and sole engagement of instrumental relationships) is also predictive of violent/sexual recidivism (Hanson et al., 2018; Mann et al., 2010). Literature on callousness as a lone facet (or "callous/unemotional traits") explains that callousness develops during adolescence and remains stable into adulthood (Blonigen et al., 2005; Dadds et al., 2005). It also begins to be associated with violent/criminal behavior during childhood/adolescence (Enebrink et al., 2005; Frick et al., 2003). Callousness is also closely tied with psychopathy and its link to repeated violent offending (Asscher et al., 2011; DeLisi, 2009; Dhingra & Boduszek, 2013; Edens et al., 2007; Hare, 1991; Leistico et al., 2008; Olver, Neumann, et al., 2018; Reidy et al., 2015; Wilson & Yardley, 2013). Therefore, this facet could be a driving force for the prevalence of instrumental and opportunistic violence among psychopathic offenders (Dhingra & Boduszek, 2013; Knight & Guay, 2006; Knight & Sims-Knight, 2003; Porter et al., 2000).

Deceitfulness and Manipulativeness

Literature on deceitfulness and manipulativeness as facets of narcissism defined under these terms is scarce (Dunne et al., 2018). As such, empirical support for these

facets comes from proxy literature that associates low levels of straightforwardness (i.e., not being honest in expression) with violent behavior (Dunne et al., 2018; Miller et al., 2012; O'Boyle et al., 2015). Straightforwardness has also been linked to psychopathy and its relation to violence (Hare & Neumann, 2008).

Exploitiveness and Exhibition

Studies using the Narcissism Personality Inventory (NPI; Raskin & Terry, 1988) consider exploitiveness and exhibition (i.e., self-enhancement among others), as well as entitlement, to be the most maladaptive facets of narcissism **(**Barry et al., 2007; Raskin & Terry, 1988). For example, exploitiveness is highly related to bullying (e.g., perpetration of physical violence; Ang et al., 2010). High NPI scores on these facets are also predictive of criminal activity and recidivism within 2 years (Barry et al., 2007).

As seen, literature on facets of narcissism and their relation to violent offending remains scarce. Most facet-level empirical support combines facets of narcissism with other constructs, primarily psychopathy (Dunne et al., 2018). However, this mixing of constructs can be confusing and misleading. For example, individuals could endorse facets of narcissism (i.e., deceitfulness, callousness) that are empirically linked with psychopathy, yet without meeting full criteria for psychopathy. These individuals also can be engaging in as much violent offending as would psychopathic individuals, yet as the result of different internal/external motives (Baumeister et al., 1996; Bushman & Baumeister, 1998; Emmelkamp & Kamphuis, 2007). As such, further research is needed on the relation among facets of narcissism and violent offending to help the field better understand causes of violence and differences among personalities.

Entitlement

Definition and Prevalence

Entitlement is considered a facet of narcissism. Like narcissism, entitlement has a spectrum of healthy to unhealthy. Healthy entitlement is associated with assertiveness, self-worth, and awareness of unjust situations. However, unhealthy entitlement reflects a willingness to disrespect and exploit the rights of others (Nadkarni et al., 2009). Unhealthy entitlement is further divided into three variations: active, passive, and revenge entitlement. Active entitlement describes individuals who have expectations for how others should treat them, yet they do not have a sense of being special or unique. Passive entitlement refers to expectations of others following social norms and having an obligation to assist those in need. Revenge entitlement focuses on individuals who expect retribution from those who have hurt them without forgiving them (Żemojtel-Piotrowska, 2016).

High levels of unhealthy entitlement are common among male violent and sex offenders (Beech & Mann, 2002; Cairns, 1993; Parkinson, 2017; & Pemberton & Wakeling, 2009). Prison studies show inmates have mixed levels of active, passive, and revenge entitlement (Piotrowska, 2019; Żemojtel-Piotrowska, 2016). Men with unhealthy levels of entitlement are also prone to enacting gender roles in a dysfunctional manner (Hill & Fischer, 2001; Schwartz & Tylka, 2008). They tend to perceive sexual harassment of women and heterosexual rape more favorably than other men, and have a higher tendency to react aggressively or violently when their entitled expectations are not met (Monick, 2006). They appear to have reduced awareness of physiological/psychological changes (e.g., becoming angry) in situations when these

expectations are violated (McDermott et al., 2012). Although women can also hold entitled beliefs, they tend to perpetrate less violence than men (Alvarez & Bachman, 2008; Madfis, 2014).

Sex Offending

Most of the literature on entitlement and criminality revolves around sex offending (Beech & Mann, 2002; Cairns, 1993; Hepper et al., 2014; Mann et al., 2010; Pemberton & Wakeling, 2009; Walters et al., 2015; Ward et al., 1997). Sex offenders commonly hold beliefs of sexual and masculine entitlement, such as the expectations that they are deserving of sex with any desired individual (Hanson & Harris, 2001; Hill & Fisher, 2001; Pemberton & Wakeling, 2009). These beliefs have been identified as a criminogenic need for sexual offending as they are often associated with sexual assaults against women and children (Beech & Mann, 2002; Cairns, 1993; Mann et al., 2010; Parkinson, 2017; Pemberton & Wakeling, 2009). According to the narcissistic reactance model (Baumeister et al., 2002; Bushman et al., 2003), sexual offending may occur as the result of entitled individuals having a grandiose self-worth and, thus, a belief that they (vs. others) have a superior right to have sexual relations with whomever they choose. When their egotistic self-view is threatened, they are then likely to react in a sexually aggressive manner (e.g., rape/assault; Baumeister et al., 2002; Bushman et al., 2003; Pemberton & Wakeling, 2009).

However, sex offenders also have a general sense of entitlement that is predictive of their repeated offending (Mills et al., 2004; Walters et al., 2015; Ward et al., 1997). For example, Mills et al. (2004) found incarcerated sex offenders with a similar level of general or antisocial entitlement as non-sex offenders to have a greater history of

previous sentences. Overall, entitled sex offenders (vs. non-entitled sex offenders) were also highly associated with having other criminal thinking patterns and to be more likely to reoffend (Walters et al., 2015).

Violent Offending

Entitled men tend to perpetrate the majority of violent offenses (Alvarez & Bachman, 2008; Bouffard, 2010; Jewkes et al., 2011; Madfis, 2014; Parkinson, 2017; Richardson et al., 2017). Although women can also hold entitled beliefs, such as those related to race, they do not react violently at the same rate as that of men (Madfis, 2014). An example of this discrepancy is mass murder, which is disproportionately committed by white men holding beliefs of white entitlement (Fox & Levin, 1998; Humes et al., 2011; Madfis, 2014). As Wise (2005) explained, white entitlement is the expectation of constant progression resulting from having a privileged status. It becomes threatened when chances of success are perceived to diminish because of others, such as through affirmative action laws (McKinney, 2005). Violence at the level of mass murder is then an attempt to regain a lost sense of masculinity, superiority, and power (Madfis, 2014).

Entitlement also influences the perpetration of domestic violence (Eisler et al., 2000; Monick, 2006; Vass & Gold, 1995). Similar to Wise (2005), Kimmel (2013) coined the term *aggrieved entitlement,* which references the anger some men feel when their expected patriarchal or culturally superior privileges are denied or threatened. In instances of domestic violence, women are perceived as threatening their perpetrators' power and egotistic views of themselves (Baumeister et al., 1996; Eisler et al., 2000; Vass & Gold, 1995). This threat elicits anger and violence, again as a means of restoring power (McDermott et al., 2012).

Prison studies also show violent offenders to have high levels of entitlement (Baumeister et al., 2000; Fisher & Hall, 2011; Hepper et al., 2014). Level of entitlement is often predictive of an individual's adjustment to prison life and future recidivism (Walters, 2002). An inmate's level of entitlement is evident with complaint filing in prison, where select inmates make up the majority of complaints without grounds (Piotrowski & Jurek, 2019). Prisoners' high levels of active and passive entitlement are believed to allow them to demand their rights from others (e.g., guards), while often violating social justice norms (Piotrowska, 2019; Żemojtel-Piotrowska, 2016). Incarcerated violent offenders with entitled beliefs are also more likely to engage in violence when their entitled beliefs are violated (Fisher & Hall, 2011). Violence is said to be used to compensate for feelings of anger that arise from perceived violation of rights (Fisher & Hall, 2011; Keulen et al., 2016).

Of the facets of narcissism, entitlement is one of the most predictive of violent offending. Whereas other facets like manipulativeness may be socially maladaptive, entitlement appears to be the driving force that allows individuals to break the law to get ahead and achieve their goals (Hepper et al., 2014). Some literature describes it as the most antisocial component of pathological narcissism and associates it with having a lack of empathy (Hepper et al., 2014; Miller & Campbell, 2008).

Treatment Completion

Although entitlement is predictive of violent offending, literature on its predictiveness for repeated offending remains inconclusive (Mann et al., 2010). Most of the literature involves prison studies (e.g., Baumeister et al., 2000; Fisher & Hall, 2011; Mills et al., 2004) or sex offenders (e.g., Hill & Fisher, 2001; Pemberton & Wakeling,

2009; Walter et al., 2015). Although some studies show high levels of entitlement to be predictive of reoffending, a stronger literature base on offenders' continued engagement in violent acts while in the community and in forensic treatment is needed (Walter et al., 2015).

High level of entitlement may also be a barrier for forensic treatment success that focuses on reducing risk of reoffending if the offender has no desire to change and is motivated to continue offending. As Żemojtel-Piotrowska (2016) found, offenders tend to have a high sense of active entitlement which reflects a readiness for self-improvement, yet only for desired areas that forensic treatment may not include. For example, men with domestic-violence offenses who unsuccessfully terminated forensic treatment continued to have entitled beliefs. These beliefs included having a higher status than their partners that should be respected and their violence being a reasonable response to their partners' actions. In comparison, those who successfully completed treatment had beliefs that their violence was their responsibility (Catlett et al., 2010).

Literature is mixed regarding the efficacy of forensic treatment (Babcock et al., 2004; Jackson et al., 2003). However, meta-analytic evidence shows that treatment based in cognitive-behavioral therapy that focuses on altering criminal beliefs, such as entitlement, effectively reduces risk of reoffending (Banse et al., 2013). On the contrary, prison programs that tend to focus solely on reducing reactive criminal thinking (i.e., violence as a reaction to another's actions) rather than on proactive criminal thinking (i.e., entitlement) is ineffective in reducing reoffending (Walters, 2009). As such, entitlement was proposed as a criminogenic need. Reduction of entitled beliefs appears to be an effective strategy for forensic therapy (Fisher et al., 2008).

Further research is needed to identify the influence of forensic outpatient treatment on repeated violent activity. Although the literature highlights a strong relationship between holding entitled beliefs and perpetration of violence (e.g., domestic violence, sexual assault, mass murder), it is unclear whether entitlement is predictive of continuous violent offending or general offending (i.e., parole violations; Baumeister et al., 2009; Fisher & Hall, 2011; Hepper et al., 2014). The effects of pathological levels of narcissism and entitlement on completion of treatment also need to be further explored to distinguish whether successful treatment completion from forensic therapy that alters criminal beliefs, such as entitled beliefs, is successful in reducing offenders' engagement in repeated violent acts (Banse et al., 2013). Altering entitled beliefs may reduce perceptions of the ego being threatened that, as explained in the narcissistic reactance model, leads narcissistic offenders to feel violated and enact violence to restore their power and positive self-image (Baumeister et al., 1996; Bushman et al., 2003).

CHAPTER 3: METHOD

This quantitative study used archival data to examine the degree to which narcissism and entitlement determine treatment completion and engagement in violent activity among individuals who were referred for forensic outpatient services upon being indicated of, convicted of, and/or referred for an assessment of their violence by the court. Participants' narcissism and entitlement scores were obtained from baseline Millon Clinical Multiaxial Inventory, 3rd or 4th editions (MCMI-III/IV) assessments. Treatment success was obtained from forensic treatment program clinical records. Engagement in violent activity was also obtained from clinical records outlining violence history prior to initial date of service.

Participants

Participants included adults who were referred to attend an outpatient forensic treatment services center in an urban area within the northeastern United States. This treatment center provides forensic evaluation and treatment to violent and sexual offenders. Treatment focused on altering criminal thinking (e.g., entitled beliefs), attitudes, and behaviors, as well as understanding and managing disordered personality traits (e.g., lack of empathy) related to violent offending. Participants included individuals from the treatment center who were referred to forensic outpatient services upon being indicated or convicted of a violent offense, and/or referred by the court for an assessment of their violence.

Inclusion Criteria

To be included in the study, participants had to be older than the age of 18 years, have completed an MCMI-III or MCMI-IV during their initial evaluation, and been

enrolled at the forensic treatment services center between 2012 to 2020. The offense for which participants were referred to forensic services had to be violent in nature, including rape, aggravated indecent assault, child sexual assault, simple or aggravated assault. There were no exclusion criteria if inclusion criteria were met.

Screening

Archived data from clinical records at the forensic treatment services center were reviewed to identify those who met inclusion criteria. Data were reviewed for type of violent offense, initial and end dates of service, and provision of MCMI-III or -IV scores.

Measure

The Millon Clinical Multiaxial Inventory-III/IV (MCMI-III/IV; Millon et al., 2009, 2015)

The MCMI-III and -IV are designed to capture the presence of symptoms of personality disorders and other clinical syndromes within the 4th and 5th editions of the *DSM*. The MCMI-III has 175 items containing 14 personality scales, 10 clinical syndrome scales, and 42 Grossman Facet scales. The Grossman Facet scales are subscales of the personality scales that identify the most salient domains of each personality scale and account for differences in overall personality presentation (Millon, et al., 2009). The MCMI-IV contains 195 items measuring 15 personality scales, 10 clinical syndrome scales, and 45 Grossman Facet scales (Millon et al., 2015). Validity scales for both editions account for under/overreporting of symptoms, social desirability, and inconsistency in responding. Base rate (BR) scores greater than 60 indicate a presence of a personality style that may typically be adaptive. BR scores between 75 and84 indicate the presence of a personality type that may be problematic. BR scores

greater than 85 indicate presence of a personality disorder that is impairing functioning. For the Grossman Facet scales, BR scores above 65 are implicated for clinical use (Millon et al., 2009, 2015).

MCMI-III/IV are normed among a clinical and nonclinical population. Internal consistency for the MCMI-III ranges for the personality scales (Cronbach's alpha = .66 - .89) and clinical syndrome scales (Cronbach's alpha = .71-.89; Millon et al., 2009). For the MCMI-IV, internal consistency is captured for the personality scales (Cronbach's alpha = .84), clinical syndrome scales (Cronbach's alpha = .83), and Grossman Facet scales (Cronbach's alpha = .80; Millon et al., 2015). Both MCMI-III/IV have been deemed valid and reliable among forensic populations (McCann, 2002; Millon et al., 2009, 2015).

This study measured narcissism through elevated scores (i.e., BR 75+) on the narcissistic personality scale (Cronbach's alpha = .67 -.75). Entitlement was measured through elevation (i.e., BR 65+) on the "Interpersonally Exploitive" Grossman Facet subscale (Cronbach's alpha = .74; Millon et al., 2009, 2015).

Constructs of Interest

Violent Offending

A violent offense included sexual or physical assault on a child or adult. To be indicated for a violent offense referred to individuals who were accused of committing said offense, such as by Children and Youth Services, yet were not convicted of it by a court of law. Individuals under investigation for an offense were indicated for their offenses. To be convicted of a violent offense referred to individuals who were found guilty of their offenses by a court of law. For the purposes of this study, all participants

had at least one violent offense, for which they were indicated for, convicted of, and/or referred for an assessment of their violence by the court. This information was reflected in the data acquired from the forensic treatment services center that originated from referral information sent to them from the Department of Corrections and/or Children and Youth Services. Data were used to screen participants for eligibility into the study.

Treatment Completion

Successful treatment completion was defined as the termination of treatment as a result of adequate acquisition of treatment concepts and minimal risk of reoffending, as determined by the treatment provider.

Unsuccessful treatment completion was defined as premature treatment termination, as determined by the treatment provider. Reasons for premature termination included treatment refusal, lack of attendance, incarceration, treatment noncompliance, and voluntary premature leave. Termination because of treatment refusal referred to patients who attended only their initial evaluation session and refused to continue the forensic treatment they were referred to complete, per assessment of their violence. A lack of attendance referred to two or more consecutive, non-excused absences, per agency attendance policy. Treatment noncompliance referred to failure to follow agency rules. Voluntary premature leave referred to patients who announced they were terminating treatment before meeting grounds for successful treatment completion. Discharge reasons were determined by the treatment provider in discharge paperwork. Reasons for discharge were reflected in data obtained from the forensic treatment services center.

Procedures

Archival data were gathered from clinical records from the forensic treatment services center. Data included MCMI-III/IV scores, discharge summaries, violence history, and demographics (i.e., age, race, gender). Data were then entered into a password-protected Microsoft Excel spreadsheet and deidentified by replacing patient names with a code consisting of their first initial and last three letters of their last name. Data were organized in order of participant deidentifiable code, initial and final dates of services, treatment completion status, and violent offense information. Data were then transferred to SPSS, a data analysis software, for statistical analyses.

Statistical Analyses

SPSS was used to analyze all data. Descriptive analyses were conducted on sample demographic variables. These included participants' age, biological sex, race, and court status (i.e., convicted or indicated of a charge), as well as their offending dynamics (e.g., nature of violence, victim type). Means and standard deviations were calculated for continuous variables. Frequencies were calculated for categorical variables. Frequency distributions were also examined to identify the degree to which the dependent variables were normally distributed. Analyses of variance (ANOVA) were used to assess all four hypotheses. An examination of the bivariate correlations between the independent, dependent, and demographic variables was used to identify instances of multicollinearity.

For Hypothesis 1, a one-way ANOVA was used to examine the mean differences on the continuous dependent variable of entitlement, as measured by the MCMI-III or MCMI-IV Interpersonally Exploitive scale, between participants who committed one, two to nine, and 10 or more prior violent acts.

For Hypothesis 2, a one-way ANOVA was used to examine the mean differences on the continuous dependent variable of narcissism, as measured by the MCMI-III or MCMI-IV Narcissism scale, between participants who committed one, two to nine, and 10 or more prior violent acts.

For Hypothesis 3, a one-way ANOVA was used to examine the mean differences on entitlement between participants who were successful or unsuccessful in completing treatment.

For Hypothesis 4, a one-way ANOVA was used to examine the mean differences on narcissism between participants who were successful or unsuccessful in completing treatment.

Additionally, bivariate correlations were used for the exploratory analyses to evaluate the relationship between the Central Eight risk factors (i.e., criminal history; antisocial personality traits; antisocial cognitions; lack of involvement with family/relationships; substance abuse; involvement in prosocial activity; procriminal friends; and lack of involvement with school or work; Andrews & Bonta, 2010) and narcissism, and entitlement.

Power

Assuming a moderate effect size, with an alpha of .05, a sample size of 121 was estimated to be necessary to achieve statistical power of .80 (Cohen, 1988).

CHAPTER 4: RESULTS

Participant Demographics

A total of 105 individuals were identified as eligible for the study. Most participants (69%) identified as male (vs. 32% female). Participants also ranged in age from 19 to 59 years old, with an average age of 34 years (*SD* = 9.47; see Table 1). Fifty-seven percent of the sample identified as White, while 27% identified as Latino/Hispanic, 12% identified as Black, 2% identified as Asian, and 2% identified as biracial. In addition, 56 (53.3%) participants were convicted of violent charges, and 28 (27%) were "indicated," meaning they were under investigation and awaiting a court decision for their crime. Twenty-one (20%) participants were neither convicted nor indicated for their violent acts. Further, 51% did not have additional history of nonviolent charges (e.g., drug-related charges, burglary), while 50% were also previously convicted of nonviolent charges.

Table 1

Sample Demographics

Variable	*M (SD)*	*N* (%)
Age (years)	34.26 (9.47)	
Biological sex		
Male		72 (68.6)
Female		33 (31.4)
Race		
White		60 (57.1)
Latino/Hispanic		28 (26.7)
Black		13 (12.4)
Asian		2 (1.9)
Biracial		2 (1.9)
Violent charges		
Convicted		56 (53.3)
Indicated		28 (26.7)
None		21 (20)
Nonviolent charges		
None		53 (50.5)
Convicted		52 (49.5)

On average, participants had committed 6.31 (*SD* = 3.6; see Table 2) violent acts by the time of their initial evaluation at the forensic treatment services center. Forty-nine percent of participants committed 10 or more violent acts, 42% committed between two to nine acts, and 13% committed only one act. Additionally, most participants (54%) engaged in purely physical violence (e.g., physical abuse, physical assault); 30% committed a mix of physically and sexually violent acts; and 16% solely committed sexual violence (e.g., rape, sexual abuse, voyeuristic acts, creating nonconsensual pornographic content.). Further, most violent acts (70%) were perpetrated on children, while only 31% were against adults. Almost all participants (98%) knew their victims (e.g., spouse, offspring, siblings, peers), and only two (1.9%) participants solely perpetrated on unknown victims. Lastly, most participants (56%) did not admit to perpetrating the violent act for which they were being evaluated for at the forensic

treatment services center. Twenty-four percent admitted to part of their crime (e.g., minimized details, admitted to portions of their offense), and 20% admitted to the entirety of their offense.

Table 2

Sample Violence

Variable	*M (SD)*	*N* (%)
Number of violent acts	6.31 (3.6)	
10+		47 (44.8)
2-9		44 (41.9)
1		14 (13.3)
Nature of violence		
Physical		57 (54.3)
Physical/Sexual		31 (29.5)
Sexual		17 (16.2)
Type of victims		
Child		73 (69.5)
Adult		32 (30.5)
Relation to victims		
Unknown		2 (1.9)
Known		103 (98.1)
Admitting violence		
No		59 (56.2)
Some		25 (23.8)
Yes		21 (20.0)

The sample scored an average of 36.22 (*SD* = 35.68) on the Millon Clinical Multiaxial Inventory, 3rd or 4th edition (MCMI-III/IV) entitlement scale (i.e., Interpersonally Exploitive subscale), and 64.54 (*SD* = 18.28; see Table 3) on the MCMI-III/IV narcissism scale. Seventy-two percent of participants did not endorse entitlement as a clinically relevant trait, meaning their scores fell below clinical threshold (i.e., base rate [BR] score < 65), while 28% had clinically relevant entitlement scores (i.e., BR score 65+). Similarly, 82% of the sample had subclinical narcissism scores (i.e., BR score < 60). Twelve participants (12%) endorsed presence of narcissistic personality disorder

(i.e., BR score of 85+), indicating narcissism to be impairing their daily functioning, and seven (7%) participants endorsed presence of narcissistic traits that may be problematic (i.e., BR score of 75-84).

Further, 75% of participants were unsuccessfully discharged from the forensic treatment services center as a result of refusing treatment, having poor attendance, being noncompliant with program rules, and/or being incarcerated. Treatment refusal included participants who were referred to forensic services for an assessment of their violence and refused to continue with enrollment of forensic therapy, after it was recommended on their evaluation. Three participants (3%) did not complete treatment for "other," nonpenalizing reasons (e.g., referred to higher level of care). Contrastingly, 22% of the sample successfully completed treatment. Successful treatment completion meant participants who successfully completed forensic therapy (i.e., at the discretion of their clinician) and those who were solely court mandated to the forensic treatment services center for an assessment of their violence yet completed all necessary steps. The average time spent in treatment was 4.78 months (SD = 7.95; see Table 3).

On average, participants endorsed 3.89 (SD = 7.95) of the Central Eight risk factors. Ninety-six participants (91%) were described as endorsing antisocial personality traits (e.g., impulsivity, lack of empathy, aggressiveness), and 72 (69%) endorsed antisocial cognitions (e.g., antilaw/law enforcement attitudes, justifications for criminal acts, belief that crime is rewarding; Andrews & Bonta, 2010). Sixty-two participants (59%) were reported to have minimal involvement with family/close relationships, and 17% were involved with pro-criminal friends (e.g., gang involvement). Fifty-two (50%) participants endorsed criminal history (prior to index offense) and had poor

occupational/educational involvement. Lastly, 46 (44%) participants endorsed current substance use, and 8 (8%) participants endorsed involvement in prosocial activity (e.g., church activities).

Table 3

Study Variables

Variable	*M (SD)*	*N* (%)
Entitlement	36.22 (35.68)	
Sub-clinical threshold		76 (72.4)
Clinically relevant		29 (27.6)
Narcissism	64.54 (18.28)	
Sub-clinical threshold		86 (81.9)
Disorder present		12 (11.4)
Trait present		7 (6.7)
Treatment success		
Unsuccessful		79 (75.2)
Successful		23 (21.9)
Other		3 (2.9)
Treatment duration (months)	4.78 (7.95)	
Central Eight risk factors	3.89 (1.44)	
Antisocial personality traits		96 (91.4)
Antisocial cognitions		72 (68.6)
Family/relationships (lack of involvement)		62 (59.0)
Criminal history		52 (49.5)
School/work (lack of involvement)		52 (49.5)
Substance abuse		46 (43.8)
Pro-criminal friends		18 (17.1)
Leisure (involvement in pro-social activity)		8 (7.6)

As previously stated, one-way ANOVAs were used to analyze the four primary hypotheses. All required assumptions for ANOVA were met, including independence of cases, normality, and homogeneity of variance.

Hypothesis 1

Individuals with more than one violent act will have significantly higher mean entitlement scores on the MCMI-III/IV entitlement subscale than individuals with one violent act.

A one-way ANOVA was conducted among three groups: individuals with one violent act, individuals with two to nine violent acts, and individuals with 10 or more violent acts. The analysis was conducted among three groups to achieve more equal group sizes. Findings revealed no significant mean difference between entitlement scores for participants who engaged in one (M = 35.64; SD = 39.39), two to nine (M = 36.30; SD = 34.13), or 10 or more (M = 36.32; SD = 35.68) violent acts, $F(2, 104) = .002$, $p = .998$.

Approximately 20% of the sample was neither indicated nor convicted of a violent charge. To determine whether these individuals impacted the study's original outcomes, a separate set of ANOVAs were ran, removing these individuals from the sample (n = 83). For Hypothesis 1, the ANOVA was not significant, $F(2, 83) = .585$, $p = 560$.

Hypothesis 2

Individuals with more than one violent act will have significantly higher mean narcissism scores on the MCMI-III/IV narcissism scale than individuals with one violent act.

As described earlier, a one-way ANOVA was again conducted among three groups: individuals with one violent act, individuals with 2 to 9 violent acts, and individuals with 10 or more violent acts to achieve more equal group sizes. Findings revealed no significant mean difference among narcissism scores between participants

who engaged in one (M = 60.36; SD = 18.65), two to nine (M = 65.73; SD = 20.52), or 10 or more (M = 64.68; SD = 16.01) violent acts, $F(2, 104) = .456$, $p = .635$.

A separate ANOVA was again conducted, removing individuals who were not indicated/convicted of violent charges from the sample (n = 83). Findings were not significant, $F(2, 83) = .568$, $p = .569$.

Hypothesis 3

Individuals who had unsuccessful treatment completion will have significantly higher mean scores on the MCMI-III/IV entitlement subscale than individuals who had successful treatment completion.

A one-way ANOVA revealed no significant mean difference among entitlement scores between participants who successfully (M = 31.35; SD = 31.54) and unsuccessfully (M = 37.59; SD = 36.82) completed treatment, $F(1, 104) = .547$, $p = .461$.

Hypothesis 4

Individuals who had unsuccessful treatment completion will have significantly higher mean scores on the MCMI-III/IV narcissism scale than individuals who had successful treatment completion.

A one-way ANOVA revealed no significant mean differences between narcissism scores among participants who successfully (M = 63.91; SD = 19.33) and unsuccessfully (M = 64.72; SD = 18.09) completed treatment, $F(1, 104) = .035$, $p = .853$.

Exploratory Analysis

Bivariate correlations were conducted to examine the relationship between the Central Eight risk factors (i.e., total number of factors endorsed; endorsement of each individual factor) and number of violent acts, treatment success, narcissism scores, and

entitlement scores. Significant positive correlations were found between number of violent acts and the total number of endorsed Central Eight risk factors (i.e., how many of the Central Eight risk factors an individual endorsed), $R = .198$, $p > .05$, as well as number of violent acts and presence of antisocial cognitions, $R = .218$, $p > .05$. Significant negative correlations were found between treatment success and antisocial personality traits, $R = -.249$, $p > .05$. Significant negative correlations were also found between treatment success and antisocial cognitions, $R = -.237$, $p > .05$. Contrastingly, a significant positive correlation was revealed among treatment success and involvement in prosocial activity, $R = .195$, $p > .05$ (see Table 4). Further, significant correlations were found between narcissism scores and presence of antisocial cognitions, $R = .254$, $p > .01$, as well as entitlement scores and total number of endorsed Central Eight risk factors, $R = .293$, $p > .01$.

Table 4

Bivariate Correlational Matrix of Central 8 Risk Factors and Dependent Variables

				Central 8 Factors							
Variable	#Viol Acts	Tx Success	Total C8RF	1[a]	2[b]	3[c]	4[d]	5[e]	6[f]	7[g]	8[h]
#Violent acts	1										
Treatment success	-.107	1									
Total # C8RF	.198*	-.054	1								
1[a]	.128	-.018	.569**	1							
2[b]	.188	-.249*	.212*	.099	1						
3[c]	.218*	-.237*	.475**	.137	.086	1					
4[d]	.012	-.058	.458**	.156	.049	.145	1				
5[e]	.070	.020	.379**	-.105	.137	.308**	.283**	1			
6[f]	-.037	-.018	.538**	.200*	-.105	.137	.308**	.283**	1		
7[g]	-.182	.195*	-.002	.003	-.169	-.192*	-.131	-.053	.003	1	
8[h]	.153	.182	.418**	.200*	.065	.102	.006	-.006	-.068	-.109	1

Note. [a] Criminal history

[b] Antisocial personality traits

[c] Antisocial cognitions

[d] Pro-criminal friends

[e] Lack of involvement in family/relationships

[f] Lack of quality/performance in school/occupation

[g] Involvement in prosocial activity/leisure

[h] Substance abuse (current)

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

CHAPTER 5: DISCUSSION

Interpretation and Implication

Findings did not support the study's primary hypotheses, signifying differences between entitlement and narcissism scores among individuals with history of multiple (vs. one) acts of violence. These findings differed from previous literature linking repeated violent/sexual offending with presence of narcissism (e.g., Blackburn & Coid, 1999; Eher et al., 2010; Hepper et al., 2014; Kosson et al., 1997; Pettersen et al., 2020) and entitled beliefs (Mills et al., 2004; Walters, 2002; Walters et al., 2015; Ward et al., 1997). Results also did not support hypotheses proposing differences in entitlement and narcissism scores among unsuccessful (vs. successful) treatment completion. These findings also varied from forensic therapy literature relating differences in criminal and entitled beliefs to treatment effectiveness (Banse et al., 2013; Catlett et al., 2010; Fisher et al., 2008; Walters, 2009).

Several factors may have explained the study's null findings. First, a substantial difference in group sizes for both dependent variables (i.e., number of violent acts; treatment success) could have impacted the robustness of the analysis of variance (ANOVA). For example, only 14 of 105 participants engaged in one violent act, compared to 91 remaining participants. To address this discrepancy, three groups were created (i.e., 1, 2-9, 10+ violent acts); however, the group sizes remained relatively unequal. Similarly, more than 75% of the sample fell under the factor of unsuccessful treatment completion, thus again forcing uneven comparisons between groups. Secondly, most of the sample fell below the clinical thresholds for both narcissism and entitlement, meaning they did not endorse pathological levels of narcissism and/or entitlement. This

discrepancy again led to uneven between-groups comparisons, as well as a limited number of individuals who were of primary interest for the study's hypotheses (i.e., those who met clinical threshold and thus pathological levels of entitlement and narcissism, and diagnosis of narcissistic personality disorder). Interestingly, 11% of the sample did meet criteria for narcissistic personality disorder, a percentage higher than the typical 3% prevalence rate generally found among offenders (e.g., Johnson et al., 2000; Torgersen, 2005).

This study's results added support for literature that highlights discrepancies among reporting rates of violent offenses. Descriptive statistics concluded only 80% of the sample to have been convicted or indicated of a violent charge by the court. However, 100% of the sample underwent a screening process to be included in the study. Therefore, all participants were concluded, by a licensed psychologist with expertise in forensic psychology, to have committed violence, and/or to have themselves admitted to previous engagement in violent acts during their initial evaluation. Discrepancy among conviction rates, offenders' self-reports of offending, and victim reports has been previously found to predominate in cases of domestic violence (Finkelhor et al., 2013; Sumner et al., 2015). Although not conclusive, one should note that 98% of the sample in the current study perpetrated on known victims, often including spouses and offspring. As such, future research must continue studying the offending dynamics of this hidden population of non-convicted violent offenders. Of note, excluding the 20% of the sample who were not convicted/indicated of violent charges from statistical equations did not alter this study's original findings.

Central Eight Risk Factors

Exploratory analyses supported the Central Eight risk factors as predictors of violent offending (Andrews & Bonta, 2010; Bonta & Andrews, 2017). More specifically, the total number of Central Eight risk factors was positively associated with violent acts, suggesting that individuals who endorsed more Central Eight risk factors had also engaged in a greater number of violent acts. Thus, greater presence of Central Eight risk factors was also likely to increase one's risk of reoffending (Bonta & Andrews, 2017; Bonta et al., 2014).

The Central Eight risk factor of involvement in prosocial activity had a positive association with treatment success. As such, individuals who engaged in prosocial activity had significantly greater treatment success. This finding supported literature on dynamic factors, such that they could be altered through psychological treatment (Andrews & Bonta, 2010; Bonta et al., 2014). Of note, only a small percentage of the sample (7.6%) engaged in prosocial leisure activities.

Additionally, significant associations were found among the Central Eight risk factors and the independent variables. Higher narcissism scores were correlated with presence of antisocial cognitions (see Table 4), suggesting narcissistic individuals to likely have antisocial beliefs (i.e., procriminal/antilaw beliefs; Andrews & Bonta, 2010). These associations supported literature on a dimensional conceptualization of personality in which overlap was found among diagnostic classification and presentation among personality-disordered individuals (Dunne et al., 2018). Higher entitlement scores were associated with total number of endorsed Central Eight risk factors, suggesting individuals with a greater sense of entitlement also presented with more Central Eight

risk factors. This association may have subtly supported previous propositions that suggested entitlement to be a psychologically meaningful risk factor, like the Central Eight (e.g., Fisher & Hall, 2011; Mann et al., 2010). Perhaps entitlement was not predictive of violent/sexual offending as a lone construct, but it may have increased offending risk when in tandem with other risk factors. Although this finding is inconclusive, it gives way for future studies to look at entitlement as a criminogenic need, in union with other factors.

Antisociality

Exploratory analyses also revealed significant associations among antisocial cognitions and violent acts. As such, individuals with antisocial beliefs[1] were shown to have engaged in more violent acts. This finding added to the literature base concluding antisocial traits to be a predictor of violent offending/reoffending (Andrews & Bonta, 2010; Bonta & Andrews, 2017; Bonta et al., 2014; Eisenberg et al., 2019; Emmelkamp & Kamphuis, 2007). “Antisocial cognitions” was also the only Central Eight risk factor that was significantly associated with violent acts, by itself. This association provided some support to Eisenberg et al.’s (2019) proclamation that an antisocial pattern of behavior was the strongest predictor of general and violent recidivism. Although the study looked at number of violent acts instead of recidivism rates (e.g., reincarceration, rearrest), the constructs were similar, as both describe repeated episodes of physical/sexual violence.

Further, negative associations were also found among treatment success and both antisocial cognitions and antisocial personality traits (see Table 4). Individuals with both antisocial beliefs and antisocial traits tended to unsuccessfully complete treatment,

[1] As described by their clinician in initial evaluation at forensic program.

supporting literature that antisocial individuals had poor treatment success rates, especially regarding sex-offender-specific and domestic violence treatments (Carr, 2014; Galietta et al., 2010; Olver et al., 2011). Antisocial cognitions and personality traits were again the only two Central Eight risk factors that were individually significantly associated with lack of treatment success. These associations aligned with previous studies showing antisocial personality disorder to have been more predictive of treatment failure than other risk factors (e.g., Chang & Saunders, 2002; Langevin, 2006; Larochelle et al., 2010).

Research has also shown that low motivation and inflexible belief systems were specific reasons for poor treatment success and tended to be present among antisocial individuals (Catlett et al., 2010; Galietta, et al., 2010; Wooditch et al., 2014; Żemojtel-Piotrowska, 2016). As Galietta et al. (2010) explained, rigid belief systems led to emotional deficits for antisocial individuals (e.g., experiencing lower distress over the typical stressors for which people seek therapy). Further, the mandated nature of treatment was another contributing factor for minimal motivation/engagement in treatment as it goes against antisocial beliefs of refuting authority and asserting control (Andrews & Bonta, 2010; Galietta et al., 2010). However, prior research (e.g., Festinger et al., 2002) has demonstrated individuals with antisocial personality disorder may achieve greater treatment success when provided with more intensive and structured supervision and interventions.

Overall, this study's most applicable findings were those reflecting a relationship between antisociality and violent acts/treatment noncompletion, and an association between narcissism and antisocial cognitions. The former supported the risk-need-

responsivity model (Andrews & Bonta, 2010; Bonta & Andrews, 2017) as a guideline for treatment, suggesting that specific interventions need to match the individual needs of offenders. As such, future screening and assessment need to be done at the start of treatment to identify specific presence of antisocial traits/beliefs and accommodate treatment accordingly. One suggestion is to increase supervision for antisocial patients (Festinger et al., 2002). Perhaps an adaptation of Dialectical Behavior Therapy (DBT) could be appropriate, as it would address intense supervision needs and emotional deficits (Galietta et al., 2010). Adjusting treatment needs will ultimately, theoretically, decrease recidivism/engagement in violent acts.

The latter finding supported the dimensional conceptualization of personality for interpretation of personality functioning. It showed overlap among antisociality and narcissism. As such, it may be useful for treatment providers to identify and tailor treatment for individuals with specific disordered-personality traits, regardless of diagnostic classification. Use of assessments measuring facets of personality, such as the Millon Clinical Multiaxial Inventory (MCMI), might be used to inform future evaluations for treatment of offenders.

Limitations

One of the study's main limitations was its archival nature. It allowed for disproportionate comparison groups to be formed, limiting the study's ability to measure differences between narcissistic and entitled individuals and those who met subclinical threshold for these conditions.

The archival nature of this study also limited the number of demographic variables that were available for study to only those present in initial evaluation records

(i.e., age, race, gender). As such, unmeasured client characteristics may have impacted or potentially moderated the study's results. For example, socioeconomic status (SES) has been previously found to influence violence rates (Chen et al., 2016; McMahon et al., 2013; Voisin & Neilands, 2010). The findings of the current study probably reflected a mainly low SES sample because of the impoverished, urban nature of the study's setting and a presumed likelihood of middle- and upper-class individuals seeking alternate treatment options.

SES is also likely to have impacted treatment completion. Although forensic therapy is typically funded by government agencies (i.e., Department of Corrections [DOC] or Children & Youth Services), financial aid may not have lasted the entirety of the required duration for successful treatment completion. For example, DOC typically funds 1 year of sex offender treatment, yet successful completion requires at least 2 years. This funding pattern typically leaves offenders having to self-pay and/or use their medical insurance for the remainder of treatment. The available time individuals had for treatment may have been affected by SES and related factors, such as employment restraints. As such, individuals with high SES may have had an advantage over those with low SES to successfully complete treatment.

This study was also unable to consider key differences between perpetration of community versus domestic violence. Literature on domestic violence recognizes several factors that tend to contribute to violence perpetration. These factors include beliefs about oneself, desire for power/control, and gender dynamics (e.g., Neal & Edwards, 2017; Wagers et al., 2021). Due to the often intentional and continuous nature of domestic violence, perpetrators' offending dynamics probably differ from those of community

violence perpetrators, whose offenses are often sporadic and reactive. Psychological or emotional abuse is also typically intertwined in domestic physical and sexual violence and, thus, should be considered in studies of violence perpetration (Gondolf et al., 2002). Due to the retrospective nature of this study, measurement of these additional factors was limited. Aspects of participants' offending dynamics were captured during initial evaluations; however, it could not be done in a uniform fashion or measured across time for change. Insight regarding offending dynamics is also typically discovered by both patients and clinicians throughout time in treatment and can perhaps differ from original presentations seen in the initial evaluation. Again, this information was not readily available for this study.

The study's design also limited its ability to measure variables that may have influenced both treatment completion and engagement in violent acts dynamically. For example, the Central Eight risk factors were solely considered as static because they could not be compared at different time points. As such, their influence on current risk was limited, and the effectiveness of treatment on altering these factors also could not be determined.

Another limitation was the sole use of the MCMI to measure narcissism and entitlement. Both the MCMI-III and -IV are reliable, valid, and widely used measures of personality that have been used extensively in correctional populations because of their admissibility to the court (McCann, 2002; Millon et al., 2009, 2015). The Grossman Facet subscales are also a reliable and valid categorization of facets of personality measurement (Millon et al., 2009, 2015). However, the subscales that together make up the narcissism scale tend to mainly capture a grandiose presentation (Millon et al., 2015).

The scale does not sufficiently measure vulnerable narcissistic presentations. As such, use of alternate measures, such as the Pathological Narcissism Inventory (Pincus et al., 2009**)** may have measured both grandiose and vulnerable narcissistic presentations present in the sample.

Similarly, the MCMI Interpersonally Exploitive subscale, used to measure entitlement in this study, may have captured only aspects of entitlement. It specifically measures one's expectations of receiving "special favors without reciprocation" and the use of others to serve one's own needs (Millon et al., 2015). However, it fails to capture specific entitled beliefs, such as those pertaining to ownership of others (as seen in domestic violence cases, e.g., Baumeister et al., 1996; Eisler et al., 2000; McDermott et al., 2012; Vass & Gold, 1995) or right to engage in desired sexual acts (as seen in sex-offending populations, e.g., Hanson & Harris, 2001; Hill & Fisher, 2001; Pemberton & Wakeling, 2009). As such, use of measures that capture entitlement more in depth, such as the Entitlement Attitudes Questionnaire (EAQ; Żemojtel-Piotrowska et al., 2017), which measures active, passive, and revenge entitlement, may have more accurately measured a spectrum of entitlement that was possibly represented within the sample in the current study. Again, the archival nature of the study predisposed the sole use of the MCMI for measurement of narcissism and entitlement.

Finally, the study used a single-treatment program, thereby reducing its generalizability and external validity. There may have also been logistical barriers and subjectivity among who was given an MCMI within the treatment program. For example, certain providers (e.g., DOC.) may not have been willing to pay for individuals to receive a full evaluation at intake (i.e., full battery including personality assessment). The type of

personality assessment given to an individual (e.g., MCMI vs. Personality Assessment Inventory [PAI]) was also up to the discretion of the treatment providers. Logistical barriers and provider subjectivity may have then limited the pool of eligible participants, as many individuals who were treated at this center met all criteria, except for having MCMI scores.

Future Directions

Future research may consider replicating this study's hypotheses prospectively and longitudinally. This research would then entail selecting comparable group sizes among individuals who meet clinical threshold for narcissism and entitlement and those who do not. The constructs of entitlement and narcissism can also be further studied through addition of scales, such as the EAQ, to measure various types of entitlement and the PNI to measure various narcissistic presentations. These scales could be given at different time points to measure if time in treatment affects rigidity of held entitled beliefs. Demographic factors, such as SES, that may have potential moderating effects could also be analyzed to determine if they significantly affect the primary relationships between narcissism and entitlement, and violent acts and treatment completion. Prospective studies can also further analyze the dynamic nature of some of the Central Eight risk factors to allow for their measurement across various time points in treatment.

Further study of the similarities between constructs among antisociality and narcissism is also necessary. Future studies may benefit from additional analysis of these constructs, perhaps along a spectrum rather than a categorical fashion, in comparison to engagement in violent acts and/or successful treatment completion. In addition, future research on the use of DBT for individuals not only meeting criteria for APD but also

being within a spectrum of antisocial cognitions and personality traits may also be warranted.

Incorporation of qualitative questions in addition to self-report is also suggested in future studies of repeated violent offending. Many individuals' violent acts may not have led to an arrest or conviction. As such, they may go unknown to treatment providers and parole agents. This information may be better captured through individuals' self-reports (e.g., target interviews, focus groups). Qualitative research can also add to literature on interpersonal and domestic violence by eliminating the sole focus on convicted violent offenders and measurement of recidivism through specific conviction and rearrest rates. Qualitative research can also be an avenue to gather clinician insight onto perpetrators' offending dynamics. This insight can help the field further understand and prevent repeated domestic violence perpetration.

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