



Ministry of
JUSTICE

National Offender
Management Service

Working with personality disordered offenders

A practitioners guide

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Introduction

Personality disorder is a recognised mental disorder. Studies have estimated that it affects between 4 and 11% of the UK population and between 60 and 70% of people in prison. Until recently personality disorder was neglected by services and often regarded as untreatable. However, the National Institute for Clinical Excellence has published guidance on management and treatment and, gradually, more services are recognising and catering for this disorder. The evidence base is developing and the prognosis is no longer as negative as once thought.

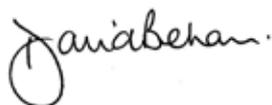
This guide has been produced to support offender managers. However, it is likely to be useful for others, including social workers, psychologists, prison officers, drug and alcohol agency staff and mental health nurses working in community and secure settings.

It provides information about personality disorder and practical advice on how to manage people who can be extremely challenging. It also considers the effect this work can have on staff wellbeing, identifying the signs and consequences, and suggesting how staff can protect themselves.

The guide is of particular use to staff working with offenders who present a high risk of violent or sexual offence repetition and of causing harm to others. Personality disorder is linked to these behaviours. It is also more likely to be present in offenders who:

- end up being recalled to prison
- accumulate adjudications
- breach hostel rules
- drop out of or fail to make progress in accredited programmes
- make complaints about staff
- self-harm
- are transferred to secure NHS settings, and
- cause staff to go off sick.

This guide also supports the delivery of the Department of Health and National Offender Management Service strategy for offenders with personality disorder. NHS and NOMS have a joint responsibility for this population and the needs of offenders with personality disorder can best be met through joint operations along a pathway of active interventions. This guide supports the frontline staff who work day-to-day to make the strategy a reality.



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Executive Summary

Or if you don't intend to read this guide (and we recommend that you do), please take note of the following!

1. The 3 P's: it's not PD unless the symptoms are Problematic, Persistent and Pervasive
2. Look out for: diverse offence profiles, entrenched offending, persistent non-compliance, rapid community failure, high levels of callousness and instrumental violence.
3. To understand PD you have to take a history. Consider the interaction between biological features and genetic inheritance, early experiences with significant others, and wider social factors.
4. Attachment theory is probably the most helpful and understandable theoretical model. Insecure or poor attachments, together with experiences of trauma, tend to lead to difficulties in
 - Accurately interpreting the thoughts and feelings of others
 - Managing relationships, which trigger strong and unmanageable emotions.
5. PD comprises core characteristics (apparent at an early age, difficult to change), and secondary problems (linked to core traits, often behavioural, easier to change). Avoid confronting core characteristics head-on, and focus efforts on secondary characteristics in the first instance.
6. Effective treatment approaches tend to include a shared and explicit model of care, combined individual and group interventions lasting at least one year, and a strong emphasis on engagement, education, collaboration. Don't forget to start with crisis planning.
7. Do not overly rely on treatment approaches, particularly for those who are unresponsive and in denial. Try to maintain a tolerant and patient longer term relationship with the offender, with creative options for communication and rapport-building.
8. Using psychological ideas to inform management can be highly effective. Consider how their early experiences may play out in their current behaviour and relationships.
9. Rule breakers should be given few rules to break. Pick your conditions carefully. Focus on those characteristics or problems most likely to lead to failure, and those which most worry the offender.
10. Look after yourself. Seek psychologically informed supervision and support, take time out to reflect, be realistic about change, and celebrate real success.

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Chapter 1

How to spot personality disorder

The focus of this chapter is the identification and assessment of personality disorder (PD). The chapter starts by offering a working definition of PD, followed by an overview of some of the more technical and controversial issues about PD and its diagnosis. This discussion includes a brief overview of the most commonly used approaches to assessing PD, as well as the current diagnostic systems and individual diagnoses. The chapter concludes with practical advice on how PD may be identified from a practitioner's perspective.



What is Personality Disorder?

If there is one learning point to take from this chapter above all others, it is the 3 P's – the need for personality disorder to be **P**roblematic, **P**ersistent and **P**ervasive.

- For personality disorder to be present, the individual's personality characteristics need to be outside the norm for the society in which they live; that is they are 'abnormal' (*problematic*).
- Personality disorders are chronic conditions, meaning that the symptoms usually emerge in adolescence or early adulthood, are inflexible, and relatively stable and persist into later life (*persistent*).
- They result in distress or impaired functioning in a number of different personal and social contexts; such as intimate, family and social relationships, employment and offending behaviour (*pervasive*).

The 3 P's

It's not PD unless the symptoms are...

Problematic - unusual and causing distress to self or others

Persistent - starting in adolescence and continuing into adulthood

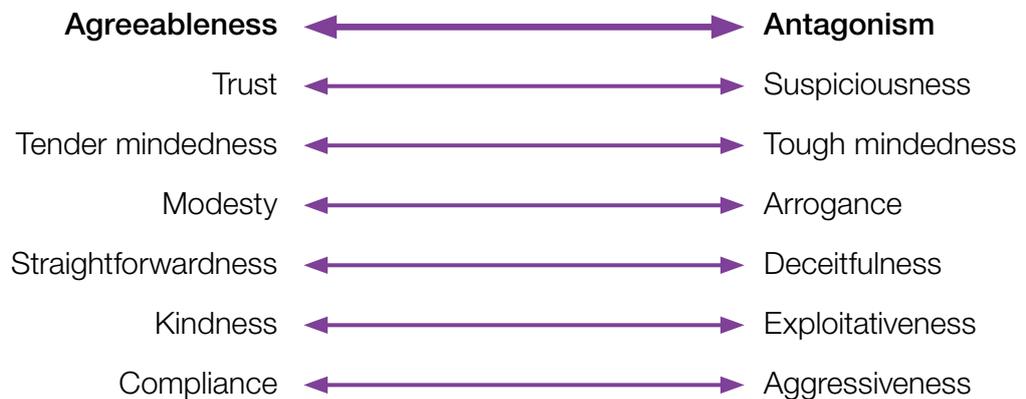
Pervasive - affecting a number of different areas in the person's life

Personality disorder symptoms as problematic extensions of normal personality traits

Before defining personality disorder, it may be helpful to consider what is meant by the term personality. Personality consists of the characteristic patterns in perceiving, thinking, experiencing and expressing emotions and relating to others, which define us as individuals. Personality disorders are best understood as unusual or extreme personality types, which cause suffering to the individual or others and hinder interpersonal functioning.

The symptoms of personality disorder should be understood as problematic aspects of personality attributes which also exist in the general population. Although there is not yet a consensus about the definitive structure of personality, most modern theories of personality suggest that it comprises of a number of broad domains (such as agreeableness or conscientiousness), with each of these domains comprising a number of specific traits.

An example of the relationship between domains and traits is presented below with reference to the domain of agreeableness and its polar opposite antagonism.



It will be noted that some of these traits are adaptive and socially desirable and others less so. While we all possess a range of both adaptive and maladaptive traits to varying degrees, individuals with personality disorder are likely to possess higher numbers of problematic personality traits and experience them to more extreme degrees. For example, an individual with a narcissistic personality disorder may be unusually arrogant and exploitative, while an individual with an antisocial personality disorder may be extremely aggressive and deceitful.

Personality disorders are categorised into different disorders (see Table 1.1, page 5), which would suggest that a sharp distinction exists between normal and abnormal personality and also between the different types. However, the clinical reality is more complex and the severity of personality dysfunction varies greatly from person to person. While some individuals may possess only a few problematic traits, others may meet the criteria for several different personality disorders (this is sometimes called co-morbidity). It may therefore be helpful to think of personality difficulties as existing along a continuum, with adaptive personality functioning at one end and personality disorder at the other end, as illustrated below.

A continuum of personality functioning



What sorts of symptoms should I look out for?

Personality disorder symptoms comprise of a mixture of core personality traits (such as a sense of personal inadequacy), and secondary characteristics. Secondary characteristics can be further sub-divided into symptoms (such as anxiety) and behaviours associated with these traits (such as a tendency to avoid social situations). The sorts of characteristics which might indicate the presence of personality disorder could therefore include some of the following:

- Frequent mood swings
- Very hostile attitudes towards others
- Difficulty controlling behaviour
- High levels of suspiciousness
- An absence of emotions
- Stormy relationships
- Callousness
- Very superior attitudes towards others
- Little interest in making friends
- Intense emotional outbursts
- A need for instant gratification
- Alcohol or substance misuse
- Consistent problems with employment
- Deliberate self-harm
- Constantly seeking approval
- Preoccupation with routine.

Remember

It's not PD unless a number of these symptoms have been present for a considerable length of time and in a range of different contexts

The different personality disorder diagnoses

An official definition of personality disorder, as taken from the American Psychiatric Association's Diagnostic and Statistical Manual - IV is presented below.

An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment.

Different classification systems are used for diagnosis. Table 1.1 provides some guidance for the terms used in the American Psychiatric Association's Diagnostic and Statistical Manual, now in its fourth edition (DSM-IV). Within this diagnostic manual, personality disorders are defined by the clusters of traits, attitudes or behaviours which are characteristic of the diagnosis. The disorders are also grouped into three clusters according to their primary presenting features. They are referred to as the **odd or eccentric disorders** (Cluster A; Schizoid, Paranoid, Schizotypal), the **dramatic and erratic disorders** (Cluster B; Antisocial, Borderline, Histrionic and Narcissistic) and the **anxious and fearful disorders** (Cluster C; Avoidant, Dependent, and Obsessive-Compulsive).

More detailed information on each personality disorder, as well as advice on risk assessment and management can be found in Appendix B.

Note: although personality disorder may be present in about 10% of the general population, it is not usually linked to offending behaviour. However, in the offending population – although estimates vary – it is probably present in at least 50% of the population. This high prevalence is rather misleading, as it is likely that the specific diagnosis – antisocial (or dissocial) personality disorder – accounts for much of this. Given that many young adults with such a diagnosis 'grow out of it' – that is, no longer meet the criteria for the diagnosis ten years later – it is likely that the prevalence of personality disorder **other** than antisocial, in offenders **over** the age of thirty is very much lower.

Psychopathy

You will notice that psychopathy is not present among the personality disorder disorders, although it is entirely true to say that psychopathy – as described by Robert Hare's Psychopathy Checklist-revised (PCL-R) – is a type of personality disorder. In fact, psychopathy could be thought of as a sub-set of antisocial PD, a particularly severe form of the disorder, often with additional narcissistic, paranoid, sadistic and/or borderline traits (see Figure 1.1, illustrating the relationship between offenders and personality disorder). This is a particularly important personality type in offender services as it is linked to very high levels of re-offending, violence, and failure to comply with statutory supervision.

To complicate matters further, psychopathic disorder was a legal category (now no longer in use) of the 1983 Mental Health Act which can be applied to all personality disorders. It does not necessarily indicate someone with a high PCL-R score; it does indicate that an

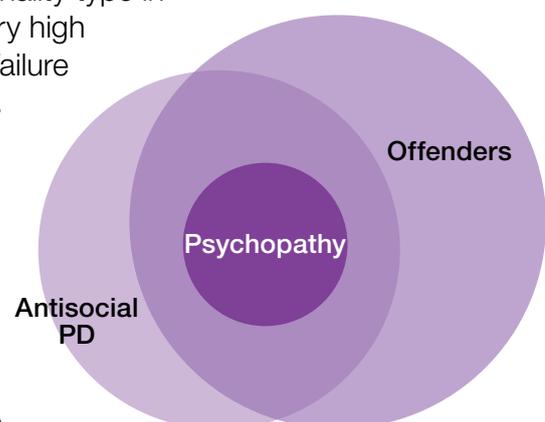


Figure 1.1

individual was placed in hospital on the basis that their primary diagnosis was thought to be personality disorder rather than mental illness. The requirement of the Act is to provide interventions which address some combination of the personality characteristics, associated behaviour and the offences. There continue to be individuals detained in secure hospitals under this category, many of whom will eventually be managed in the community. References to psychopathic disorder may be noticed in reports and case records written before October 2008.

Table 1.1. DSM IV Personality Disorders

DSM - IV Disorders	Primary presenting features
Cluster A	
Paranoid	Distrust, suspiciousness
Schizoid	Absence of attachments to others, flattened emotions
Schizotypal	Eccentric behaviour, discomfort with close relationships, unusual perceptual experiences
Cluster B	
Antisocial	Disregard for and violation of the rights of others.
Histrionic	Attention seeking and excessive emotionality
Narcissistic	Grandiosity, need for admiration, lack of empathy.
Borderline	Unstable relationships, self image, emotions, and impulsivity.
Cluster C	
Dependent	Submissive behaviour, excessive need to be taken care of.
Avoidant	Oversensitive to negative evaluation, feelings of inadequacy, social inhibition.
Obsessive-Compulsive	Pre-occupation with orderliness, perfection and control.

Distinguishing PD from mental illness and learning disability

Mental illness

Although the distinction between mental illness and personality disorder does not always stand up to close scrutiny, they are currently considered to be separate categories of mental disorder. However mis-diagnosis is a common problem.

- Mental illnesses are thought to have an identifiable onset, in which a period of illness interferes with the sufferer's baseline level of functioning.
- Furthermore, severe mental illnesses are traditionally treated with medication and when treated effectively, the sufferer may return to a state of wellness. However relapses can occur.
- In contrast however, the symptoms associated with personality disorder form part of the personality system, are therefore chronic and enduring and are generally less likely to be responsive to medication.
- Despite this distinction, many people diagnosed with personality disorders also meet the criteria for mental illnesses such as depression or schizophrenia. It is also suggested that having a personality disorder may increase one's risk for developing mental illness.

Learning disability

The distinction between learning disability and PD is controversial and distinguishing the two is complex. The reasons for this include the following:

- The behavioural and emotional presentations found in learning disabled groups may mimic the symptoms of personality disorder. For example, some personality disordered individuals may achieve very little academically at school, but it is their emotional state (and life experiences) rather than their inherent cognitive ability which has interfered with a capacity to learn new information.
- The assessment of PD is made more difficult in individuals with learning disability as the individual concerned may not possess sufficient reflective capacity to provide meaningful insight into their thoughts and feelings. For example, poor victim empathy may in fact be related to cognitive difficulties in verbal expression and perspective taking.

However, personality disorder may be identified in individuals with learning disabilities, particularly where the level of impairment is less severe. The greater the level of intellectual impairment, the less likely that personality disorder is an appropriate diagnosis.

Controversies surrounding personality disorder

There are a number of controversies which are often cited within the field of personality disorder.

- Firstly, there has been considerable criticism levelled at the categorical nature of personality disorder diagnoses, as there is considerable overlap between the different disorders. In response to this, the new version of the DSM (DSM-V) (which is due for publication before the end of 2013) is likely to include a proposal to reduce the number of types of personality disorder from ten to five, with greater consideration given to the individual traits which are present in each case and the overall severity of personality dysfunction along a continuum.
- It is also frequently observed that personality disorder diagnosis is particularly unreliable, with differing diagnoses being provided by different clinicians and obtained by different assessment methods.
- Lastly, although recent clinical guidelines suggest that psychological treatments should be provided to PD individuals, the reality is that many mental health services are still reluctant to engage with a group who are often perceived as 'untreatable' and 'difficult'. It is indeed the case that treatment approaches for the more severe forms of PD are still in their infancy. The term personality disorder has sometimes been used as a pejorative label and the diagnosis given as a means of excluding sufferers from mental health services.

Diversity

There are some differences between male and female personality disordered offenders. First, fewer women present a high risk of serious harm to others, although large numbers of personality disordered women received short prison sentences for offences like deception, theft, drugs and prostitution. Second, female offenders are more likely to have experienced trauma as a result of domestic violence, sexual abuse and separation from their children; they are more likely to self-harm and to present a higher risk of suicide than male PD offenders.

Black African and black Caribbean offenders tend to be over-represented in mental health services for people with a severe mental illness, but under-represented in personality disordered offender services. It is not quite clear why this is the case, but it is important to be particularly careful and think about possible biases in attitudes and assumptions when assessing for PD in black and ethnic minority offenders.

Case Vignettes

The use of case studies runs throughout this guide. None of the vignettes represent actual cases although they are drawn from a mix of highly representative case material. The following case studies should serve to illustrate two very different manifestations of personality disorder:

Billy

Billy was taken into Local Authority care when he was ten years old, due to his mother's inability to care for him. While in care he was sexually abused by a male worker and suffered bullying at the hands of other children. His behaviour subsequently deteriorated and he became difficult to manage. He frequently tried to run away from the home and was prone to intense aggressive outbursts. During these outbursts he would damage property and, occasionally, also be violent towards other children and staff alike. At this time he also started to self harm, by cutting his forearms and torso and punching and head butting walls. At age twelve he made a suicide attempt by trying to hang himself from the light fitting in his room. He was consistently truanting from school and eventually left care with no formal qualifications. He was then homeless for a time and supported himself by working as a rent boy and selling drugs. He was also a heavy user of alcohol, heroin and crack cocaine. While in the community, he had never managed to hold down regular employment and had a number of intense but short lived relationships with women. These relationships were volatile and characterised by frequent arguments. His offending history started when he was 14 when he received a Police Caution for Criminal Damage. Since then he has received a number of convictions, mostly for drug related offences, but also including a number of more serious offences. He was convicted of arson after he set fire to his flat whilst in a state of emotional turmoil and after an argument with his partner. He has two convictions for domestic burglaries. In custody he was initially volatile and aggressive and was placed on suicide watch, but he then appeared to settle down and worked as a wing cleaner.

It will be apparent that Billy suffers from personality disorder by identifying the presence of the three P's:

- **Problematic**

Billy's problematic personality symptoms include his impulsivity, self damaging behaviour (substance abuse, prostitution, self harm and suicide attempts) poor impulse control, unstable emotions, intense and volatile relationships, aggressiveness and offending behaviour.

- **Persistent**

These symptoms have been present at least since he was placed into Local Authority care and have persisted into adulthood.

- **Pervasive**

It should also be apparent that the symptoms affect a number of domains of Billy's psychological functioning; namely his thinking, his moods, his behaviour and his impulse control. These symptoms also cause problems for him in a range of contexts, including relationships, employment, prison, education and offending behaviour.

With regards to diagnosis, Billy's symptoms are most representative of a Borderline personality disorder (instability in a sense of self, relationships and emotions) although he also meets the criteria for an antisocial personality disorder (disregard for and violation of the rights of others). The overlap between these disorders is particularly common among samples of offenders. He also suffers from episodes of depression and has gone through periods of misusing substances.

A rather different manifestation of personality pathology is presented below:

Robert

Robert was an only child and was initially raised by both his mother and father. However his mother suffered from schizophrenia and committed suicide, when he was five. His father owned a religious bookshop, was reserved, somewhat puritanical and was a heavy drinker. He was not prone to expressing warmth or affection and never once discussed his mother's death with him. Robert was mostly left to fend for himself, and preferred to spend his time alone. He collected comics and spent time riding his bicycle, but had no close friends. At school he was regarded as a loner and a 'weirdo' by the other children and he experienced quite frequent bullying. Although he did not outwardly express any distress, he would often spend time alone ruminating on his poor treatment by others and fantasising to themes of revenge. He did reasonably well academically, but not as well as might have been expected (given that a later IQ assessment found he had above average intellectual ability).

Robert left school at age 16 and took up work in the Civil Service. He also started to drink heavily at this time and developed a dependency to alcohol. Robert was generally a reliable employee but he was unpopular with his colleagues. He was regarded as aloof, quick to take offence and occasionally abrasive. He became further distanced from his colleagues after he took out a number of grievances against them, after misinterpreting benign emails as being malicious. In his early twenties he also ceased all contact with his father (who was his only social contact) after he failed to send him a birthday card. At around the same time he started to drink in the workplace and was subject to disciplinary proceedings. He had no intimate relationships until his early thirties when he met a woman in his local pub and subsequently co-habited with her.

The relationship lasted for several months, but deteriorated rapidly, as his partner found him to be emotionally distant, suspicious and accusatory towards her. He also lacked interest in sexual or intimate contact. Robert found the intensity of close personal contact unsettling, became preoccupied with doubts about his partner's trustworthiness and eventually became convinced she was having an affair. He had difficulty sleeping and started to drink heavily. During a heated row in which she threatened to leave him, Robert suddenly lost all self-control, became utterly enraged and beat her to death with a hammer. He subsequently disposed of her body by burying her in a shallow grave near his house.

In prison, Robert has received one adjudication for aggressiveness (when asked to share a cell) and another for disobeying orders, but mostly he has caused few management problems and is observed to 'keep himself to himself'. However, he has steadfastly refused to do any offending behaviour programmes and he is prone to developing grievances against professionals by writing long, acerbic and litigious complaints.

Although the symptoms of Robert's personality disorder are perhaps less obvious (prior to the murder), the three P's may still be identified:

- **Problematic**

Robert has demonstrated a number of pathological traits. These include a preference for solitary activities, a limited interest in close personal or intimate relationships, suspiciousness, a tendency to perceive malicious intent in other's motives, ruminate on grievances, bear grudges and an apparent emotional detachment. He also has problems with alcohol misuse and the build up to and loss of control in the index offence was suggestive of some interpersonal problems.

- **Persistent**

Some of his symptoms have been evident since late childhood (such as the rumination, emotional detachment and preference for solitary activities). All symptoms have been persistently present throughout his adult life.

- **Pervasive**

The symptoms of Robert's personality disorder effect his emotional experience, his thinking style and his behaviour and are evident in a number of different contexts (including his intimate, family and social relationships, as well as at school, work and in prison).

The symptoms present in Robert's case are most characteristic of schizoid personality disorder (absence of attachments to others, flattened emotions) but he also possesses some paranoid traits (distrust, suspiciousness). He also suffers with an alcohol dependency.

Assessing Personality Disorder

There are a number of recognised methods of formally diagnosing personality disorder, which are currently used in clinical practice. Diagnosis is most frequently completed by a suitably qualified mental health professional, in most cases this being a psychologist or a psychiatrist. In certain cases, informants other than the person being assessed may also be consulted, such as a parent or spouse. In fact, trying to obtain corroborative information becomes increasingly important when assessing an offender with antisocial or psychopathic characteristics. The most commonly used methods for assessing personality disorder are described below.



1. Unstructured clinical interview:

Personality disorders may be diagnosed through the use of an unstructured clinical interview, guided by a diagnostic manual (e.g. DSM-IV). To establish a diagnosis, the person's behaviour over time is evaluated and attempts are made by the assessor to establish the presence of the traits characteristic of the diagnosis in a range of contexts and situations.

2. Psychometric Questionnaires

In order to standardise the assessment process, a number of self-report questionnaires have been developed and have demonstrated improved reliability over unstructured assessments. These include the Millon Clinical Multiaxial Inventory - 3rd Edition (MCMI-III) or the Personality Assessment Inventory (PAI). These questionnaires have the advantage of being relatively quick to administer, but they have been criticised for over diagnosing personality pathology.

3. Semi Structured Interviews:

A further standardised approach to PD assessment makes use of semi structured interviews, such as the International Personality Disorder Examination (IPDE), Structured Clinical Interview for DSM Disorders (SCID-II) or the Psychopathy Checklist – revised (PCL-R). These interviews require training to administer, have a structured scoring system and direct the assessor to explore the diagnostic symptoms relevant to each disorder. Although these interviews are thought to be the most reliable way to diagnose personality disorders they often require several hours of interview time to complete. They also rely somewhat on the honesty and insight of the person being assessed (although corroborative file information is emphasized in the case of the PCL-R).

How to spot PD

There are a number of ways that personality disorder may be identified by practitioners and these are listed below. A range of sources should be consulted in considering the possible presence of personality disorder. At the very least this will require a review of the available file information, but ideally should also include an interview with the individual concerned as well as a consideration of their overall presentation.

Look out for any inconsistencies between self-report and factual file information.

Identifying PD

1. Look for:
 - A diagnosis in the file
 - Review the offence history
 - Evidence of childhood difficulties
 - Previous contact with mental health services.
2. Score the OASys PD screen (see Appendix A)
3. Consider interpersonal dynamics
4. Remember the 3 P's.

What to look for...

a) A diagnosis in the file

The first place to start is to identify whether there is already a diagnosis somewhere in the file documentation.

- In psychological or psychiatric reports, the diagnosis is most frequently found in the **Conclusion** or **Recommendation** sections towards the end of the report.
- Be aware that if a psychiatric report states that there is **no evidence of mental illness**, this does not necessarily rule out the presence of personality disorder.
- Other reports which may contain relevant information about personality disorder might include risk assessments, such as the Historical Clinical Risk - 20 (HCR-20), or Structured Assessment of Risk and Need (SARN) which may include sections on psychopathy or PD more broadly.
- Diagnoses given in childhood such as Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD) are often risk factors for developing personality disorder in early adulthood.



b) Review the offence history

An individual's offence history provides useful information about their personality functioning, which should be considered in the context of what else is known about the case.

Personality disorder cannot be determined by an individual offence

BUT

- Diverse offence profiles
- Entrenched (persistent) offending
- High levels of instrumental violence
- High levels of callousness
- Persistent non compliance
- Rapid community failure.

...may be suggestive of personality problems

Factors which might be indicative of PD could include:

- **Diverse and entrenched offence histories:** Where an individual has displayed a pattern of offending over time, this might suggest personality problems. A diverse offence history may be reflective of a general antisocial orientation and is also a diagnostic feature of psychopathy.
- **A high level of instrumental violence** may indicate a sense of entitlement, and a lack of empathy which might otherwise serve to inhibit such acts and is also characteristic of psychopathy.
- **Excessive use of violence or unusually callous offences** may also be associated with personality problems. Such offences may arise through a marked lack of empathy, a thrill seeking motivation, emotions which are out of control, or the use of violent fantasy to regulate self esteem.
- **Non compliance or failure:** Failures such as breaches, recalls, non-compliance with supervision, and offences while on supervision may also indicate personality problems. Where failure is rapid and/or persistent, personality disorder is more likely. Non-compliance or failure may be associated with an inability to control impulses, or to learn from experience or may simply reflect a conscious and wilful decision not to comply. Evidence of behaviour in custody should also be considered, with particular attention being given to high numbers of adjudications, attacks on staff, 'dirty protests', bullying, frequently being placed in segregation and hunger strikes.

c) A history of contact with Mental Health Services

It has already been suggested that personality disorder should be regarded as a vulnerability factor for experiencing other mental health problems. Consequently, personality disordered individuals are heavy users of mental health services. This may be particularly so for individuals with borderline personality features, who may be more treatment seeking than other personality disordered individuals. Consideration should be given to:

- **Previous suicide attempts or self harming behaviour.** This might also include, periods on suicide watch in custody and being subject to Assessment, Care in Custody and Teamwork procedures (ACCT, previously F2052SH).
- **Frequent emotional crises** perhaps manifesting in regular contact with Community Mental Health Teams, GP's or Accident and Emergency departments.
- **Childhood contact with mental health services** may also indicate early emotional or conduct problems, which may later develop into adult personality disorder. For example there is a particularly strong relationship between childhood Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD) and antisocial personality disorder in adulthood.
- **Detention in secure psychiatric facilities** may suggest mental illness, but might also indicate personality disorder. Obviously, if the offender has received treatment in specialist personality disorder facilities (such as the Dangerous and Severe Personality Disorder facilities in the NHS or Prison Service), personality disorder is highly likely to be present.
- **Residence in a Democratic Therapeutic Community (DTC).** Although DTC's were not originally designed specifically as treatment facilities for personality disordered individuals, many of such facilities now either explicitly or implicitly provide services to this group. Where an offender has spent time in a DTC, either in the NHS, or the Prison Service, personality disorder may also be present.

d) Childhood difficulties

A range of childhood difficulties are associated with the development of personality disorder in later life. These include being the victim of adverse experiences, as well as emotional and behavioural problems during childhood.

- Although the experience of trauma alone is neither a necessary nor sufficient explanation of the development of personality disorder, individuals with personality disorder frequently report having experienced a range of adverse childhood experiences, examples of which are listed opposite.
- It is also important to consider the presence of emotional and behavioural problems in childhood. These symptoms may provide evidence of the early onset of personality problems.

Possible childhood precursors to adult PD

1. Victimisation:

- Sexual abuse
- Physical abuse
- Emotional abuse
- Neglect
- Being bullied.

2. Emotional or behavioural problems:

- Truancy
- Bullying others
- Expelled/suspended
- Running away from home
- Deliberate self harm
- Prolonged periods of misery.

OASys PD Screen

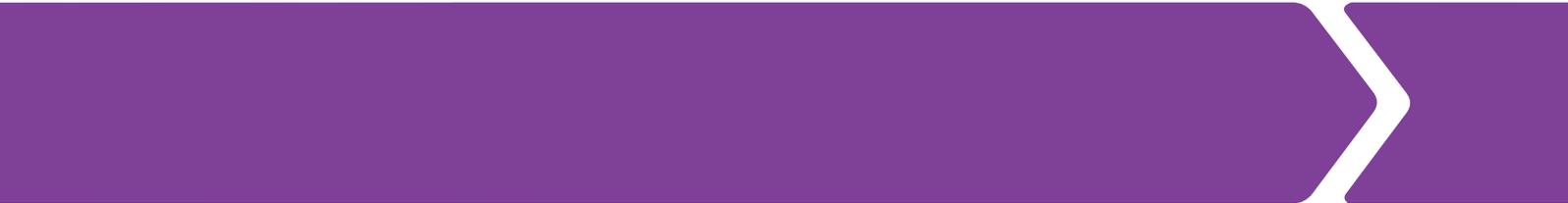
The Offender Assessment System (OASys) contains within it a number of specific questions which can be selected to screen for what has come to be known as Dangerous and Severe Personality Disorder (DSPD). The tool consists of 12 items; however since its development a number of these have been removed from OASys. However, in its entirety it remains useful because the items bear considerable resemblance to diagnostic features of antisocial personality disorder and psychopathy.

OASys PD screen

- a. Number of convictions aged under 18 years
- b. Breaches when subject to supervision
- c. Diversity of offending categories
- d. Violence/threat of violence/coercion
- e. Excessive use of violence/sadistic violence
- f. Recognises victim impact?
- g. Financial over reliance on friends, family, others for support
- h. Predatory lifestyle
- i. Reckless/risk taking
- j. Childhood behaviour problems
- k. Impulsivity
- l. Aggressive/controlling behaviour.

Suggestion

The presence of 8 or more items might indicate raised concerns.



The OASys guidance indicates that a referral for DSPD assessment should be made if an offender scores positively on all or most items. The presence of eight or more items indicates consideration of a referral to a more specialist treatment intervention. A scoring checklist for the OASys PD screen with all the items and scoring instructions can be found in Appendix A.

Some important points to remember about the OASys PD screen:

- High numbers of offenders reach the cut off. It is currently estimated that over 30% of offenders within probation's caseload score at or above a suggested cut off of eight or more of the items endorsed.
- It will only screen for antisocial/psychopathic traits and will not screen for characteristics of other disorders. So other types of personality disorder may be present even if the OASys PD scores are not raised.
- Higher overall scores are likely to reflect a more severe antisocial presentation.
- The label 'DSPD' is misleading here, as a high score does not necessarily mean that a referral to high secure personality disorder treatment services in prison or hospital should be made. See chapter three for more information on this.

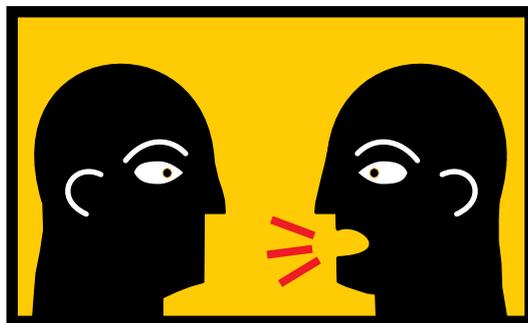
A note on the use of screening tools

There are a number available for personality disorder. Along with the PD screen there is the International Personality Disorder Examination (IPDE) screen, P-Scan (for psychopathy) and the Standard Assessment of Personality – Abbreviated Scale (SAPAS). Of these, only SAPAS has been tested for validity (Lincoln University) with a Probation Trust managed population. Screening tools must always be used with extreme caution. In using any screen it is important to consider:

- 1) **Purpose** – what exactly is it designed to screen for and in what setting?
- 2) **Competence** – what qualifications and skills are required for its use?
- 3) **Validity** – what does the tool claim to do? What evidence is there for its effectiveness? How likely is it to be accurate in terms of who it identifies and who it misses?
- 4) **Next steps** – a screen is exactly what it says it is. It will identify a proportion of people who meet certain criteria; it will also miss some. Screens should only be used when there is clear guidance as to what happens next, for example, further assessments or advice sought from other professionals. Firm conclusions should never be drawn; the results never quoted in reports. Their only purpose is to guide the practitioner to further action.

Attend to interpersonal and interagency dynamics

It should by now be apparent that working with individuals with PD can often be challenging, due to having to manage heightened emotional states and unbounded interpersonal behaviour. These presenting problems may cause high levels of stress and anxiety in the workforce. Following this, your emotional reaction to the cases you are working with (and the emotional reactions of other professionals) may be used as a valuable resource in identifying the possible presence of personality disorder. See chapter 5 for further information on staff wellbeing.



In later chapters it will become apparent that problematic developmental experiences may lead individuals with personality disorder to develop distorted and unstable beliefs about themselves and others. They may expect relationships to be characterised by themes of dominance and submission, with associated roles of bully, victim, abuser or saviour. These themes may emerge in the relationship with professionals, often leading to challenging interpersonal behaviour. This behaviour may in turn provoke unhelpful reactions in the staff group.

- For example, individuals with PD may hold polarised and unstable views of self and others, which may lead to them presenting differently to different professionals. This may in turn trigger different views of the individual in the staff group, thereby encouraging disagreements or 'splits'. If not carefully monitored, these splits can lead to the staff group becoming inconsistent, unstable, punitive or detached in their management of the case, ultimately reinforcing the offender's negative expectations of others.

Thus a practitioner's emotional reaction to individuals with PD (and the emotional reactions of other practitioners) may be used as a valuable indicator in identifying the possible presence of PD.

Possible emotional and behavioural reactions which might indicate the presence of PD

- Staff are falling out
- Agencies are falling out
- You find yourself behaving unprofessionally
- You feel drained after seeing the individual
- You don't want to see the individual
- You get over involved in the case
- You feel threatened in the individual's presence.

Finally...are the 3P's present?

Having considered all the sources above, it should now be possible to consider whether the individual presents with problematic, pervasive and persistent symptoms. Where these can be identified personality disorder is suggested.

What Next?

If you have identified a case who you think may suffer with personality disorder, the issue of when to request further specialist support requires a degree of professional judgment. Although by far the majority of cases are undiagnosed, the prevalence of personality disorder among offender groups is very high. It is likely that 30-50% of your caseload may meet the criteria for one or more personality disorders. Many of these individuals will be primarily antisocial, may be largely unremarkable and may not require specialist intervention or support. DO NOT worry too much about a formal diagnosis.

When trying to decide when to seek further support, the following suggestions may be of assistance.

When to consider requesting specialist support

Ask yourself...

1. Do I have a good enough understanding of the individual's personality and offending?
2. Do I feel another agency could make a reasonable contribution to the management of this case?

This is more likely to be the case when...

- a) You are uncertain about the risk assessment
- b) The offending is odd or unusual
- c) The offender is highly distressed or emotionally volatile
- d) There is something odd or unusual about the offender
- e) The offender is already well known to other agencies who have expertise in this area.

Read on to subsequent chapters to give you ideas about sentence planning and risk management.

Chapter 2

How does personality disorder develop

The biopsychosocial model

Despite professional disagreements, it would be reasonable to state that currently, most experts in the field subscribe to the **biopsychosocial** model for understanding the development of personality disorder.

What does this mean? Personality disorder develops as a result of interactions between

- biologically based vulnerabilities
- early experiences with significant others, and
- the role of social factors in buffering or intensifying problematic personality traits.

The overarching model – which includes work on attachment – is described in Figure 2.1 below.

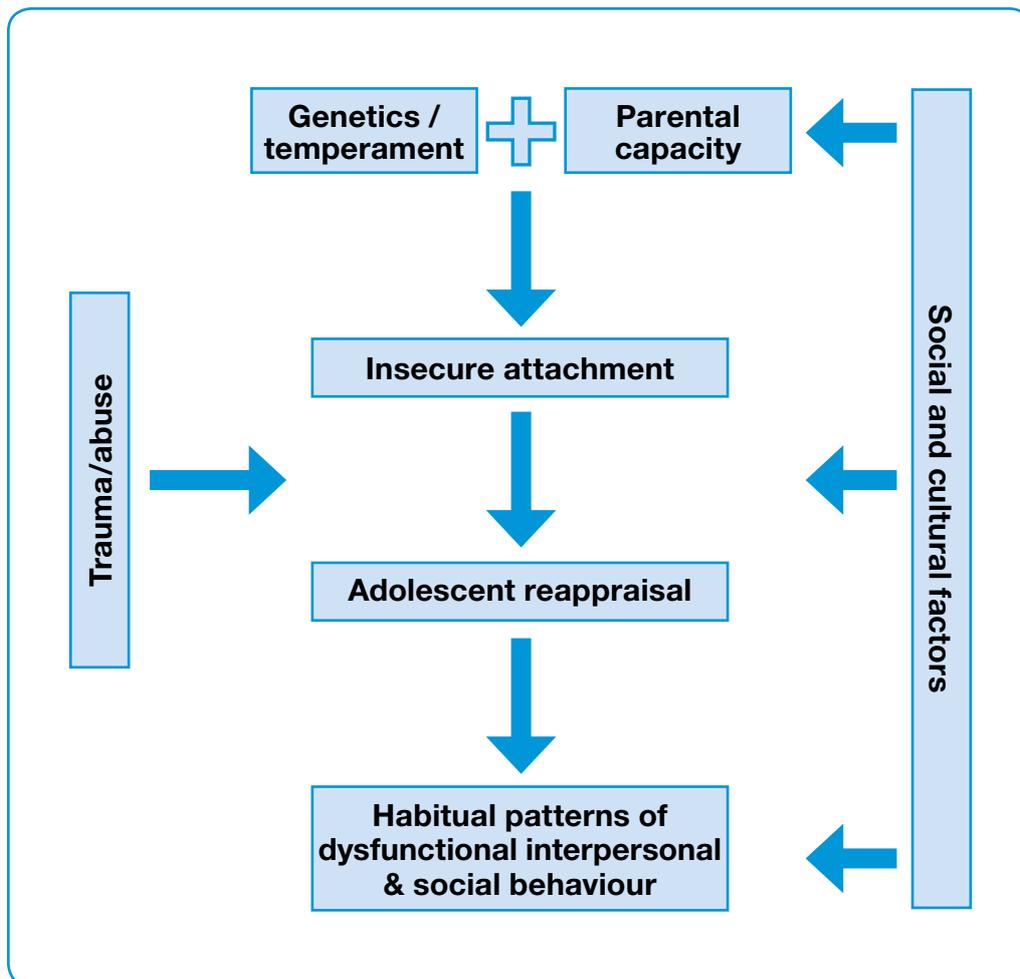


Fig. 2.1

Genetics/temperament

Biological vulnerability includes the genetic and biological elements to personality development. Overall, about half the variation in personality characteristics is thought to be directly due to genetic differences between individuals. A summary of the evidence is detailed below.

- There is considerable evidence for similarities in broad personality dimensions across all cultures.
- Some personality traits are linked to particular biochemical markers in the brain; for example, impulsivity and emotional sensitivity.
- It is well established that infants vary in basic temperament such as activity, sociability and emotional reactivity.

Biological vulnerability is particularly important in psychopathic individuals, where research has shown that some features of psychopathy seem to be related to anomalies in certain brain functions and structures, including some related to making moral decisions. This may well be one of the most important reasons to explain why psychopaths find it so difficult to change their behaviour.

Parental capacity and early experiences with significant others

At the core of this factor is the evidence for a biological human attachment behavioural system that brings a child close to its caretaker (usually mother or father). That is, early attachment behaviour in humans provides an evolutionary advantage for the survival of children who remain vulnerable and dependant on adults for relatively long periods of time. Attachment theory is at the core of our understanding of personality disorder, and is, therefore, explained in some detail in the section below.

Social and cultural factors

The role of social factors in personality development is either to aggravate or to buffer against problematic characteristics in individuals. This accounts for much of the variation in types of personality problems across cultures and over time. For example, research has documented a reduction in the prevalence of antisocial personality disorder during times of war, and also in many Asian cultures. In both cases, the promotion of social cohesion, and an emphasis on the role of the community away from a focus on individuality, is likely to be a key factor.

The more local social context is also thought to provide a buffering effect, with employment, housing and social stability all playing a role.

Case vignette

In summary, the case of Mark, described below, demonstrates the way in which biological, psychological and social factors might interact to develop problematic personality characteristics.

Mark

Mark was one of four children. Neither of the two different fathers of the children resided in the family home, or maintained contact with their children. His mother was described by him as loving and concerned to maintain a good home for her children, but she had to work hard to make ends meet, and was often exhausted and depressed during his childhood. Her own childhood had been difficult. She had been cared for by critical and strict grandparents as her own mother was an alcoholic. Mark was described as the 'black sheep' of the family, a boisterous mischievous child who was always in trouble and prone to temper tantrums. His mother expected him to be obedient – as had been expected of her as a child – and responded to his unruly behaviour with harsh physical beatings. At school, Mark was in trouble from an early age, with poor concentration, disruptive behaviour and fights with peers. He was suspended from school at the age of 12, but nothing much changed in his behaviour and he was often truanting with friends. He joined a gang when he was 14, often associating with older delinquent boys, smoking cannabis regularly; and acquired a number of convictions relating to street robberies, and taking and driving away cars.

Here, one can see how an infant with intense emotional states (**temperament**) and difficult to settle might have posed a particular challenge to a mother who herself had few inner resources as a result of her own experiences of deprivation (**parental capacity**). **Temperamentally** inattentive and overactive, Mark's behaviour was exacerbated within a school environment (**social**) in which teachers were grappling with large classes of children with variable abilities and behaviours. With the absence of a strong adult male role model (**parental**), he was drawn to identify with a delinquent peer group in adolescence (**social**) in order to develop a sense of himself as strong, independent and respected.

Attachment theory

Attachment theory has tremendous appeal in thinking about personality disordered offenders. This is partly because it is fairly easy to understand and intuitively makes sense to the experienced practitioner; it has a robust evidence base, and is integrative in its approach – that is, favouring no one particular clinical model. Understanding something about attachment theory is entirely compatible with basic training in taking a personal, family and social history from an offender. It simply provides a model with which to understand how the 'pieces of the jigsaw' fit together.



As already mentioned, attachment theory refers to the attachment relationship and attachment bond between a child and primary caregiver (an early maternal or paternal figure). The origins of the theory were described by Bowlby (a psychoanalyst) in 1969. He believed that infants are genetically predisposed to form attachments at a critical point in their first year of life in order to increase their chance of survival. Behaviours in the infant – smiling and crying – which attract a positive response from the caregiver help develop attachment. Infants become securely attached to caregivers who consistently and appropriately respond to their attachment behaviours. Over time, the infant needs to explore and learn from the environment (separate from the caregiver) while seeking out and keeping the caregiver close at hand during times of danger, thus protecting the infant from physical and psychological harm. Threat (when the baby is alarmed or anxious) activates the attachment system. Subsequent research by Ainsworth and later colleagues found that insensitively parented infants tend either to avoid the caregiver after a brief period of separation (anxious-avoidant), refuse to be comforted by him/her on return (anxious-resistant) or demonstrate disorganised attachments (alternating approach/avoidance behaviours) where the parent is simultaneously experienced as a source of distress and a source of comfort.

It is the caregiver's response to the infant's distress signals – holding, caressing, smiling, feeding and giving meaning – which allows for the development of reflective functioning in the infant. That is, this is how the child learns to understand their own thoughts and feelings, and to understand the mind and intentions of others. Over time, the securely attached child learns to manage their emotions and interpersonal behaviour; and to recognise the unspoken emotional states of others. However, the insecurely attached child may be **more vulnerable** to the possible effects of later experiences of abuse and adversity, resulting in greater difficulties in recovering from the impact of abuse experiences. More recent research in neurobiology supports the relationship between these psychological issues and important changes in brain chemistry, particularly in the ability to manage emotions and states of stress. Over time, this attachment system remains the key to interpersonal behaviour throughout the life span. However, the pathway to personality disorder is not determined by a difficult start in life. Research suggests that the behaviour of securely attached children can deteriorate, and the behaviour of insecurely attached children can improve, both in response to changes in the immediate environment.

Adolescent reappraisal

The most important time of change – both in repairing and in aggravating problems – is at **adolescence**. Puberty is the final period of rapid neurological change in the human brain, at a time when the social task is to transfer attachment relationships to peers and wider social institutions outside the family. With maturity, adolescents have the ability to change

their understanding of themselves, their parents and the world generally, experimenting with alternative ideas and behaviours.

By **adulthood**, the sense of self and attachment to others are much more likely to become self-perpetuating; this is due to the tendency for individuals to both select and create environments that confirm their existing beliefs. In individuals with personality disorder, this results in noticeable patterns in relating to others which are endlessly repeated, even though such relationships are usually problematic – perhaps including conflict, loneliness, rejection and unhappiness. These patterns have two particularly common features:

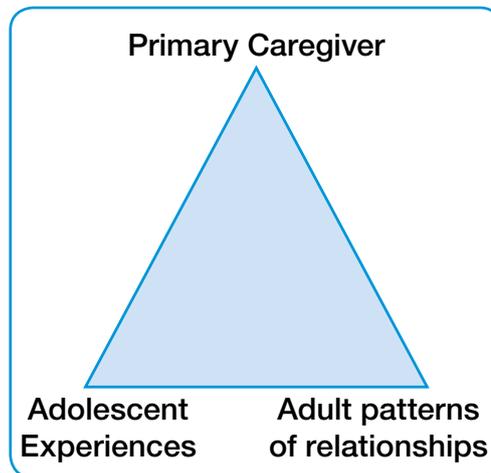


Fig. 2.2

- A difficulty in accurately interpreting the thoughts and feelings of others, and thus making assumptions about others which are distorted.
- Relationships with others tend to trigger intense states of emotional arousal in response to perceived threat (often mis-read) which are difficult to regulate.

Attachment theory – in its simplest form – can be thought of as a triangle of relating, as shown in Figure 2.2.

Assessing attachment in the context of the biopsychosocial model

It will be clear by now that there is no way of understanding the development of personality disorder without TAKING A HISTORY. Understandably, this may not be possible at the first meeting, but should be a priority during the first few weeks of contact with the individual offender. The primary purpose of a personal, family and social history is to understand the developmental pathway, resulting in the emergence of problematic relationships and behaviours in adulthood. This approach is not at odds with a primary duty to protect the public, as understanding the relationship between personality disorder and offending is a crucial element in developing an effective risk management plan. However, there are additional benefits to history taking, most important being the positive effect of striving to work with the individual in arriving at a greater understanding of the person; this greatly improves the chances of engaging in a collaborative relationship.

OASys clearly contains within it all the relevant categories for an assessment – with sections on childhood problems, relationship difficulties, experiences

of education, employment and criminogenic attitudes. However, understanding the development of attachment is dependent on a rather explorative (or 'curious') approach which requires qualitative information to **develop a meaningful story of development which has explanatory value**. This is not always easy, as personality disordered individuals may struggle to access their own thoughts, feelings and reflections on their life. The Assessing Attachment Tips box highlights some of the key issues.

The reality is that some interviews proceed fairly smoothly, while others are more challenging. With experience, interviewers can develop their own ways of gaining quality information from reluctant or emotionally inarticulate individual offenders. Mark – whose attachment history is summarised above (p. 21) – was fairly typical of an individual with antisocial personality disorder. He was not very forthcoming about his personal history, taking the dismissive stance that he could not see its relevance to his offending. This seemed to mirror a more general trait of detachment from others, emphasising his ability to manage his relationships with others, although viewing his problems as resulting largely from the unreasonable or poorly considered actions of others. This in turn appeared to mask an underlying anxiety that allowing his probation officer to probe him about difficult experiences when he was young, would render him vulnerable and exposed – something he wished at all costs to avoid.

Assessing Attachment - Tips

- Individuals with dismissive or detached attachment styles tend to idealise or minimise early difficulties; individuals with anxious avoidant/ ambivalent attachment styles tend to be overwhelmed by their early adverse experiences with strong emotional responses in interview. Both styles indicate poor reflective functioning (capacity to think clearly).
- Do not accept the first response, but be prepared to probe a little for more qualitative information.
- Do not impose your own view of abuse and its consequences; you are interested in the individual's personal experience as it was at the time, and how they might view it now with the benefit of hindsight.
- Thoughts and feelings are probably more important than the 'facts'.
- Don't forget resilience and buffers. Look for good attachments (grandparents or teachers?), positive traits (intelligence or prowess at sport), appropriate anxieties about behaviour.
- Identify specific relationship difficulties and how they might differ in different situations – perhaps in dating relationships as compared to wider social relationships.

A summarised version of the assessment interview with Mark is transcribed below. This clearly was not the first interview, but took place after the interviewer had established a reasonable rapport and had taken the opportunity to praise Mark for successfully completing the Thinking Skills course in prison. Note the techniques used by the interviewer to try and obtain quality information about his parents and his role within the family. Although it requires persistence, Mark does start to reveal more complex feelings about the quality of his primary relationships, often in relation to what he does not say as much as what he does say.

OM *So tell me a bit about your mother.*

Mark *She was a good mum.*

OM *OK, when you say 'good', can you say a bit more*

Mark *What d'you mean?*

OM *Well, maybe give me a few more words to describe her, what comes to mind when you think about her and your relationship with her as a child.*

Mark *...loving, caring, strict though...I suppose, exhausted*

OM *Exhausted?*

Mark *Well she had two cleaning jobs to make ends meet, she worked all hours, we never went without.*

OM *Yes, that must have been tough for her, keeping the family going. How did she manage things like tea and bedtime?*

Mark *What d'you mean?*

OM *I suppose I mean routines, like the bedtime routine...bathtime, story time*

Mark *There was none of that, I sorted myself out...or my older brother was supposed to. I think I was out having fun, playing with my mates.*

OM *You also said 'strict'. How was she strict?*

Mark *You know, the usual.....she expected us to help out, behave, go to school, that sort of stuff*

OM *So were you naughty?*

Mark *(laughs) I suppose so, I was always in trouble, bunking off, letters from the school, hopping out the bedroom window as a kid, I was a rascal.*

OM *So how did she discipline you?*

Mark *I got a good hiding from time to time*

Using 'elaboration' for more detail

Don't challenge, go for detail

Use acceptable words, non judgemental

Notice the unfairness in the family

OM *A whack with her hand, or sometimes a bit more?*

Mark *And the stick, but it was deserved.*

OM *Always?*

Mark *Usually, sometimes I got the blame for my brothers*

OM *So it was unfair sometimes. Were they naughty?*

Mark *Not often, they did all the right things.*

OM *So why didn't you?*

Mark *I was the black sheep...I dunno, always in trouble for some reason. I think I just didn't care when I got told off*

OM *What about your dad?*

Mark *Don't know and don't care.*

OM *He was never around?*

Mark *No*

OM *Did you ask your mother about him?*

Mark *No*

OM *Why not?*

Mark *Why should I? We didn't talk about that sort of thing.*

OM *Did you ever try and see him as a teenager?*

Mark *Only once. I bunked off school and on an impulse went to visit him. I knew where he lived. I was 15 I think*

OM *What happened*

Mark *Nothing much, he wasn't interested, had his own family. He gave me a tenner and said he'd call. Never did of course. But I was alright without him. I had my own life to live by then, my own mates.*

Notice how avoidant of feelings, identifies with peers instead

Contrast this interview with that of Billy. Billy experienced a very disturbed childhood. His mother worked as a prostitute and he was told by her that he was the product of a rape. He never knew his biological father, but did have a relationship with his stepfather who came to live with them when he was aged five. Tragically, Billy's stepfather died unexpectedly of a heart attack when he was aged nine; his mother could not cope and turned increasingly to drink, neglecting Billy. He was placed in a children's home from the age of 10 to 16, where he was sexually assaulted by a male staff member. He ran away and worked as a rent boy on the streets for a year or two, taking drugs and living in a squat.

The assessment interview with Billy was initially much easier, as he wanted to talk and had a lot to say. However, he quickly became emotional and found it difficult to keep to the questions, muddling up information from the past with the present, in a rather chaotic fashion.

OM *I know your childhood was difficult. Can I ask you a bit about your mother, can you perhaps describe her to me?*

Billy *My mum was a lovely woman, beautiful, dark hair, rather like you, long and curly. We had a really special relationship, she was loving and caring, she had had a hard life, all the women in her family had had a difficult time, I think my auntie had been abused by her husband and her dad...*

Starts to relive and merge relationships

OM *Sorry to interrupt you, but can we go back to your mother, and your relationship with her. You clearly were close, can you think of a specific memory of you and her?*

Billy *What sort of memory?*

OM *Good or bad, what comes to mind?*

Billy *She would come home really late at night, and creep into my bedroom and kiss me. She thought I was asleep, but I used to wait for her to come in, and pretend not to notice.*

Good/bad memory technique

OM *Why was she coming home so late?*

Billy *Well she was a sex worker, she kept it really separate from our family life though, I never knew at the time.*

OM *When did you find out?*

Billy *When I was last in prison, another inmate knew my mum's sister, and told me. My mum doesn't know I know, it doesn't make any difference. She's not like that now, hasn't been for years.*

Idealises mum, so separates out this fact

OM *What did you know about your father?*

Billy *Mum said that she was raped, it wasn't her fault, and she always says it was a blessing to have me.*

OM *How do you feel about it, your father I mean?*

Billy *(clenches fists and raises voice) I feel dirty about it I think, the bastard...I sometimes wonder if I'm meant to be like him...I mean I'm not, but I am in a way. I wonder if he thinks about me sometimes.*

High emotion, can't separate self from dad

OM *Can I ask you something about your stepfather?*

Billy *He was good to me, brought me up as his own. I remember Xmas particularly, a real family time, for the first time.*

The past is merging with the present, good parents - bad carers

OM *Is he still around?*

Billy *No (starts to sob), he died when I was 10, a heart attack. I was the one to find him...I had to be brave for my mum, she was heart broken. Have you ever lost someone, you know, so that life isn't ever the same again? I don't suppose you have, I expect life has been ok for you.*

Care=authority in order to preserve link with mum

OM *It was such a difficult time for you, it clearly still hurts to talk about it.*

Billy *I was the end of the happy time. After that, I was taken into care. Abused, thrown out on the streets. Institutions are like that, they pretend to care, it's all front, in reality...I could tell you what goes on in care, it's the same in prison, the officers pretend, but really they're all the same. My last probation officer was all sweetness and light, but then she shafted me, said I was high risk... (starts shouting)*

OM *Can I just bring you back to your time in care. It was a really bad experience, I can see. Did your mum keep visiting you.*

Billy *Not really, I think she tried, but she was poorly, a nervous breakdown, she couldn't get to visit much. I lost contact with her after that.*

Mum and probation have merged in his mind

OM *Were you angry with her?*

Billy *Not really, it was just one of those things...maybe a little. I didn't understand then, but now she's there for me. We're close. She understands, you too, I feel you understand me. But I can't talk to my keyworker, she's always on my case.*

Although much more forthcoming than Mark, Billy still has some difficulty in acknowledging mixed feelings about his mother's difficulty in maintaining consistent care of him. One of the effects of questioning him so closely about deeply personal issues is that his emotions are quickly aroused and it becomes clear that he forms intense – but not always realistic – attachments to those around him, including the offender manager.

Assessing abuse experiences

Practitioners vary in their confidence regarding the assessment of abusive experiences in childhood. In many ways, it is similar to the anxieties expressed when told to ask about suicidal ideas. Asking about suicide does not, as is feared, increase distress or induce a high risk state of mind in the individual; instead, it is experienced as a relief, allowing anxieties about a forbidden subject to be expressed. Practitioners should approach childhood abuse in the same way, anticipating that some individuals will not want to talk about it, but many will experience the interviewer's interest as reassuring.



Although individual experiences are varied, abuse largely falls into three categories: sexual, physical and emotional. Definitions vary, but some guidelines are set out below to help the interviewer.

Sexual abuse is likely to comprise unwanted sexual experiences in childhood, perpetrated by someone at least five years older than the offender (usually an adult). However, some male children would not initially interpret sexual activity initiated by an older woman as abusive (although it is likely to be so), and it may be worth asking about early sexual experiences rather than abuse. Similarly, if physically aroused by the experience, it may not be labelled as abusive. Furthermore, although sexual play between peers as a child may not be inherently abusive or non-consensual, it may be very relevant to understanding disturbed sexual development. The importance of sexual victimisation often – but not always – lies in the cognitive and emotional aftermath; that is, the meaning of the abuse for the child.

Physical abuse can be more difficult to define, and there are cultural and social differences in approaches to physical discipline. However, usually, if physical contact is either unprovoked or excessive in relation to the misdemeanour on a number of occasions, it could be assumed to be abusive. One element would be the individual's own perception of the degree of unfairness of the discipline.

Emotional abuse and neglect is the most subjective and difficult to define aspect of abuse. It could perhaps be thought of as persistent and marked failings on the part of the caregiver to provide adequate and consistent care.

Finally, although not a form of abuse, practitioners should never fail to ask about early behavioural problems, whether at home or at school. Pronounced emotional or behavioural difficulties – listed below – are the single most important indicator of later delinquent behaviour, and subsequently, antisocial behaviour in adulthood. This is particularly the case when the behaviour is noticeably more severe than in the peer group or siblings.

Check for:

- Contact with parents by the primary school because of behaviour problems
- Being suspended or expelled from secondary school, and the reasons
- Persistent truanting, fighting, bullying (or indeed, being bullied) which is not easily resolved
- Less common features, such as childhood self-harm, persistent misery, difficulties making friends, refusing to go to school, unusually late resolution of bed-wetting.

Using attachment theory to make sense of the offence

This guide clearly emphasises the importance of understanding personality disorder when working with offenders: in terms of understanding the offending, risk assessment and subsequent management approaches.

This section focuses on the relevance of attachment theory in developing an understanding of the offending behaviour of personality disordered individuals. Why, you may ask, have we therefore placed the image of an

onion in this section? The onion – comprised as it is of numerous layers each separated by a semi-permeable membrane – represents the ‘layers’ of explanation for offending. The outer layer, readily observable to the external world, can be peeled away to reveal another layer, and so on, until the hidden centre of the vegetable can ultimately be exposed. In this way, understanding the development of personality disorder, its link to relationship problems and, ultimately, to offending behaviour, can represent a way of seeing and explaining which probes beyond the surface explanation.

Consider, for example, Mark. He is currently serving a custodial sentence for armed robbery, and has previous convictions for robberies and for street violence. His explanation for the index offence had considerable validity: he was using class A drugs regularly, had no steady employment, and required money – quite a lot of money – to fund his lifestyle. Superficially, this was a reasonable explanation. However, peel away a layer, and one might point to particularly problematic (inherent) personality traits – impulsivity and a propensity for reckless, sensation seeking behaviour – which are associated with a diagnosis of antisocial personality disorder. Such traits were likely to have played a part in his offending; for example, his attraction to the ‘high’ of cocaine and amphetamines, as well as his enjoyment of the intense buzz associated with planning an armed robbery. Impulsivity may have contributed to his lack of success as a career criminal, but is likely to have introduced an element of unpredictability to his behaviour, which could lead to unanticipated problems and perhaps more violence than he had originally envisaged. Peel away yet another layer, and we might speculate that an absent father in childhood, and inconsistent but harsh disciplining from his mother, led to a rejection of conformity with social norms, and an over-identification with a delinquent peer group. His offending therefore enabled him to maintain a strong self image in relation to his peers which necessitated him being dependent on no-one and maintaining respect by means of controlling others.

Personality disorder is very relevant to some sexual and violent offending and you should give this extra attention in your assessment. This is because such offending is always an interpersonal crime in which there is a perpetrator and a victim, and as such, is highly likely to reflect some aspect of the individual’s personality difficulties. The perpetrator-victim relationship may be:

1. symbolic

That is, held in the perpetrator's mind outside of conscious awareness

Peter (who is discussed further in chapter four), was a high risk paedophile with a number of pubescent male victims. He was thought to have a number of narcissistic and antisocial personality characteristics. In interview he would assert that he was 'in love' with his young male victims, and that there was no question of abusing them. Yet it was clear from the assessment that Peter had no understanding of the victims as individuals with their own separate identity, and no real affection for them. He viewed them as rather idealised objects of innocence and purity, and assaulting them, felt he was recapturing something of his idealised youth.

2. objective and real

That is, with a clear and conscious targeting of the victim based on his or her characteristics.

For example, consider a domestic violence offender who himself witnessed chronic violence between his own parents, and grew up unable to cope with the feelings of fear and vulnerability which these experiences had provoked in him. He was repeatedly drawn to needy women with whom he forged intense dependent relationships; such attachments provoked feelings of insecurity and vulnerability. He would control and abuse his partners in an attempt to avoid abandonment.

3. A displacement of painful emotional states

That is, have their origin in actual experiences originating in early life or in failed adult romantic relationships.

If we return again to Billy, he was recently convicted of indecent assault on a woman unknown to him. The offence took place after he had been chatting to the victim in a night club; he was drunk, and after she left, he followed her, hoping that she was interested in him and would respond to his advances. After following her for 50 metres, he came up beside her and commented on her "nice tits". Frightened, she told him to "f*** off", whereupon he became enraged and grabbed her breast, knocking her over. Billy's account, was that he was feeling lonely, wanted to find a relationship, and was attracted to the woman who he believed was attracted to him. He admitted being drunk and misjudging the situation, but was annoyed by her response to his advances. However, an understanding of his developmental history (detailed above, p26) would suggest that the offence revealed something of the complexity of his relationship with his mother – the longing for closeness coupled with a rage at her abandonment of him – which went far beyond his conscious understanding of what had occurred.

Linking an understanding of the attachment issues to the offending behaviour enables the assessor to develop a better understanding of the individual which risk assessment instruments alone – based as they are on group statistics – are unable to achieve. Identifying the particular characteristics of an offender, and the subtle as well as the obvious triggers to offending, assists in the development of a well targeted risk management plan.

Growing out of personality disorder

The pessimism which was once associated with personality disorder and its intractability, is no longer fully justified. There is a growing body of research – particularly with the most commonly encountered personality disorder diagnoses, antisocial and borderline – that suggests positive change over time. When followed up for long periods of time, the majority of personality disordered individuals show fewer symptoms and experience less distress over the course of a decade or so, many of them no longer meeting the diagnostic criteria at follow up.

Why might this be?

- First, it is likely that the diagnosis is rather unreliable under the age of 25; certainly many offenders between the ages of 17 and 25 are likely to present with antisocial and borderline traits associated with repeat offending. Many will mature over time, testosterone levels will drop and so, therefore, will levels of aggression and impulsivity. Personality disorder is, broadly speaking, an exhausting state of being, and individuals lose the capacity to take drugs, engage in fights, experience such extremes of emotion, and so on.
- Unfortunately, personality disorder is also a relatively risky diagnosis, and a significant minority (perhaps as many as 10-15%) of such individuals will have died prematurely. Death may be as a result of self-harm, but also due to accidental overdoses, and as a consequence of other reckless behaviours and as victims of other personality disordered offenders.
- However, many personality disordered individuals are likely to be responsive, at least in part, to a range of interventions. These are detailed in chapter 3, but in summary, perhaps 10% of such individuals will improve with intervention.

It is important to consider quite what it is that changes over time. Current thinking suggests that dysfunctional personality should be divided broadly into two types of trait:

1. Core characteristics, often genetic, or at least apparent at a very early age
2. Secondary characteristics, usually the behavioural expression of the core traits.



The research suggests that there is very little change in core characteristics, but improvements do occur in the secondary characteristics. So, for example, antisocial and psychopathic individuals show little change in empathy deficits or callousness, but do show improvements in behavioural controls, taking increasing responsibility, reduced impulsivity, and setting more realistic life goals. Borderline individuals remain emotionally sensitive, but are less prone to being overwhelmed by intense emotional states, or engaging in repetitive self harming behaviour. Narcissistic individuals remain aloof, arrogant and contemptuous, but are less prone to erupt into a rage when challenged, less driven to demonstrate their superiority by engaging in self-destructive behaviours. And so on... (see chapter four for more information on traits). That is, we would suggest that although there are minimal shifts in core beliefs about the self, the world and other people, there can be more significant improvements in the expressive acts and interpersonal strategies.

Summary

In summary, this chapter has provided an overview of the biopsychosocial model, with a particular emphasis on the importance of tracing the development of attachments in the personality disordered offender. Tips are provided for enhancing skills in taking a history of the developmental pathway, and a link made with understanding the offending within the context of attachment.

Further reading

Ansbro, M. (2008). Using attachment theory with offenders. *The Probation Journal*, 55, 231-244.

Craissati, J., Attachment problems and sex offending. In (Eds.) Beech, A., Craig, L., & Browne, K. (2009). *Assessment and Treatment of Sex Offenders*. P. 1-12. John Wiley & Sons.

De Zulueta, F. (2006). From pain to violence. The traumatic roots of destructiveness. *John Wiley & Sons*

Chapter 3

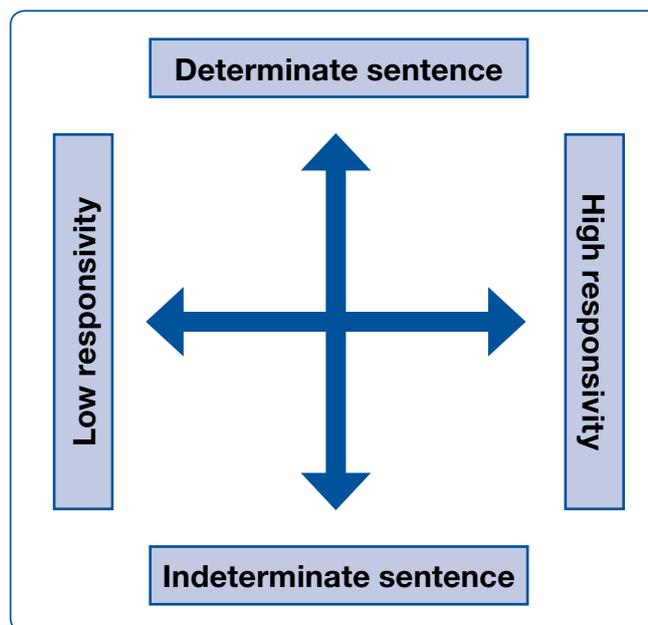
Treatment Pathways

Introduction

Now that it has become clearer how to identify personality disorder, and how to make sense of it in terms of individual development, this chapter focuses on what to do next: designing the right pathway for personality disordered offenders. The chapter is split into two sections: the first section provides guidance on sentence planning, for custody and for the community. The second section provides some more general thoughts about treatment for personality disordered offenders.

Assigning a pathway

There are two main interacting factors to consider here, which are represented in the figure below:



Offenders therefore fall into four categories:

- a. Determinate and high responsivity:** prisoners on a determinate sentence can choose whether to engage in accredited programmes. When they have high responsivity, they are both capable of engaging in the programmes (e.g. intellectually able) and motivated to participate. Additional consideration will be given to their level of need and the timescale in which to work (i.e. length of sentence).
- b. Determinate and low responsivity:** prisoners who are low in responsivity may be less amenable to treatment due to their lack of motivation and/or capacity to derive benefit from therapies (e.g. literacy levels). When these individuals are on determinate sentences, there is little in the way of external incentives that can be offered to encourage participation. The focus will need to be on psychologically informed management approaches (see chapter 4).

c. Indeterminate and high responsivity: prisoners on indeterminate sentences who are high in responsivity (determined by their capacity and motivation to engage in treatments) should be offered the full range of accredited programmes available in prison, according to their criminogenic and emotional needs.

d. Indeterminate and low responsivity: prisoners on indeterminate sentences who are low in motivation or capacity to derive benefit from accredited programmes should be engaged in a constructive waiting relationship. Here the role of the prisoner is to take responsibility for demonstrably lowering his risk; the role of the practitioner is to maximise the opportunities for collaboration and progress. It is important to build in annual reviews as the situation may change.

Constructive waiting relationship

For under-motivated, treatment resistant prisoners:

- Consider letter contact outlining treatment options
- Minimise language which implies obligation or compulsion
- Emphasise the prisoner's choice and control over treatment options
- Offer telephone/videolink contact to talk through options.

PATHWAYS THROUGH CUSTODY

After considering the sentence and responsivity factors, you can now make informed decisions about the custody treatment pathway.

1. Accredited prison programmes

The standard accredited programmes within the prison system may adequately meet the risk and needs of personality disordered offenders. These would be assigned in the usual way via a thorough risk assessment and sentence plan to identify treatment targets encompassing pro-social competencies and offending behaviours. Although personality disorder is not assessed by mainstream programmes, the groupwork often addresses highly relevant issues such as managing impulsive behaviour, emotional self-management or social problem solving. There are also programmes – some of which have very long waiting lists – which may probe more intensively into personality development and functioning; these include the Cognitive Self-Change Programme (when there is a substantive history of instrumental aggression), Chromis (specifically for high risk psychopathic offenders) and the Extended Sex Offender Treatment Programme. In the case of accredited programmes, it is especially important to evaluate progress via the post-treatment reports. There may be problems with partial engagement, disruptive behaviours, poor attendance and shamming which give an indication of the adequacy of the basic accredited programme route and whether the individual requires referring to one of the other pathways. The main reasons for looking beyond the standard accredited programmes are if the individual has previously failed to complete offending behaviour programmes or has completed them but this has not led to a change in behaviour. Prison psychology assessments may be available to assist with more complex sentence planning. Given the range of programmes and changing entry criteria, prison psychologists are a very

Tip

Think creatively about total denial - select a programme that doesn't require offence admissions - anger management or a drug programme.

useful source of advice regarding accredited programme options. The main programmes fall into four main areas:

- **Thinking skills**

These are the most commonly completed short duration programmes, designed to enhance pro-social competencies including impulse control, perspective taking, reasoning skills and interpersonal problem solving.

- **Violence**

These programmes tend to target either expressive violence (emotional control and anger management) or instrumental violence.

- **Sex Offender Treatment Programmes**

A range of programmes designed to provide the right intensity of intervention to match risk level and treatment need.

- **Substance misuse**

Includes a range individual and group work for alcohol and drug misuse.

2. Democratic therapeutic communities (DTC)

Democratic therapeutic communities provide a long-term intervention designed to address risk related to offending, whilst addressing emotional and psychological needs. The expected length of treatment is 18 months, to provide enough time to enable change and practise the use of new skills. Currently there are 12 DTCs in five prisons, one of which is for women.

DTCs are a form of social therapy and an accredited offending behaviour programme. The environment is designed to create a 24/7 'living-learning' experience, where staff and prisoners contribute to the decisions of the community. The programme is structured around large and small therapy groups focussing on community issues, offending behaviour and links between current and past experiences; there may also be opportunities for educational and vocational work. The therapy plan is informed in the usual way via OASys and the sentence plan.

The DTCs largely have common entry criteria and there is a universal referral form, available on request. The prisoner should self-refer as this is regarded as an indicator of motivation. Referrals can also be made by a practitioner. Be aware that the motivation of the individual is paramount to successful referral and where a third party has referred, this should be done with the full informed consent and will of the prisoner. The standard entry requirements include:

- a willingness to work as part of a community, participate in groups and be subject to the democratic process
- a willingness to commit to staying for at least 18 months (i.e. determinate sentenced prisoners must have more than 18 months to serve)

- they should have reached the point in their lives when they say they are ready to change and their behaviour reflects this
- the offending history must include violence (including robbery) and/or sexual offences; other offending is also considered
- there must be deficits in two or more of the following:
 - ✓ self-management, coping, and problem solving
 - ✓ relationship skills/interpersonal relating
 - ✓ antisocial beliefs, values and attitudes
 - ✓ emotional management and functioning.

3. Dangerous and Severe Personality Disorder (DSPD) programme

The DSPD programme was a joint pilot venture between the Ministry of Justice and the Department of Health. The services were developed to provide intensive treatment for people who have severe personality disturbance which is directly linked to risk of serious sexual or violent offending. These individuals are at the extreme end of the personality disorder spectrum. There are two high secure units based within the prison system, and wards specialising in the treatment of personality disorder within the three high secure hospitals across the country. A smaller DSPD service for women is also available. Referrals to individual sites are made initially on geographic location, and up to date information can be obtained from the website: www.personalitydisorder.org.uk. The individual sites have referral templates available on request from the units. Referrals will usually have a minimum of three years still to serve.

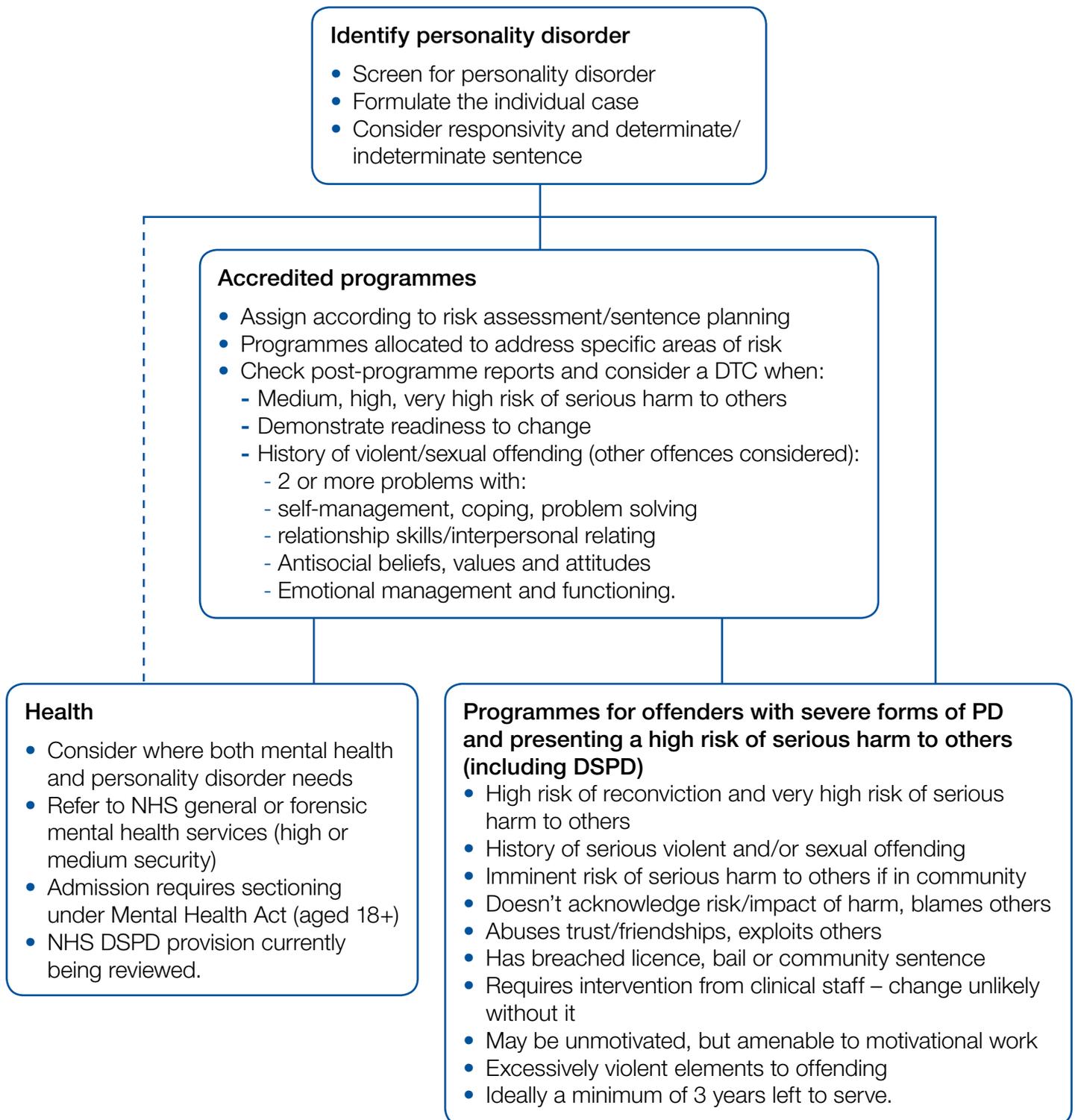
The general referral criteria include:

- more likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the victim would find it difficult or impossible to recover.
- the individual must meet criteria for a severe personality disorder (over the cut-off for psychopathy, and/or must suffer from a range of personality problems over and above antisocial traits).
- there must be a link between the disorder and the offending.

Additional indicators which may warrant consideration include:

- An inability to acknowledge the seriousness of the offending
- A history of institutional violence
- A history of abusing trust and exploiting others
- A track record of reoffending or breaching statutory orders after completing prior programmes
- Excessively violent aspects to the offending
- Hostility and unclear motivation to engage in treatment.

Flowchart of pathways through CUSTODY:



A note on using mental health services

Working out when to consider a transfer from prison into mental health services can be difficult with personality disordered offenders. Health services are broadly based on a catchment area system and there is very patchy provision within medium secure hospitals for personality disordered offenders across the country. However, more specialist personality disorder services in the high secure hospitals do cover the whole country. In order to take this pathway further, you will need the cooperation and agreement of the relevant senior clinicians – usually a consultant forensic psychiatrist. This could be:

- The visiting psychiatrist to the offender's current prison
- The forensic psychiatrist who works back in the offender's home catchment area
- The forensic psychiatrist in the specialist personality disorder provision (who in turn will liaise with the above).

Where the offender's difficulties include both personality disorder and serious mental illness (e.g. a psychosis, where the offender has lost touch with reality), it will be more appropriate to refer the individual to the NHS mental health system (rather than a prison based intervention), whether to a mainstream mental health ward or to a specialist PD ward. Sometimes just the mental illness is treated; other times a more comprehensive package of care is provided. Specialist personality disorder units in hospital may also be important when there is a history of physical health problems, or an unusual diagnostic picture.

PATHWAYS IN THE COMMUNITY

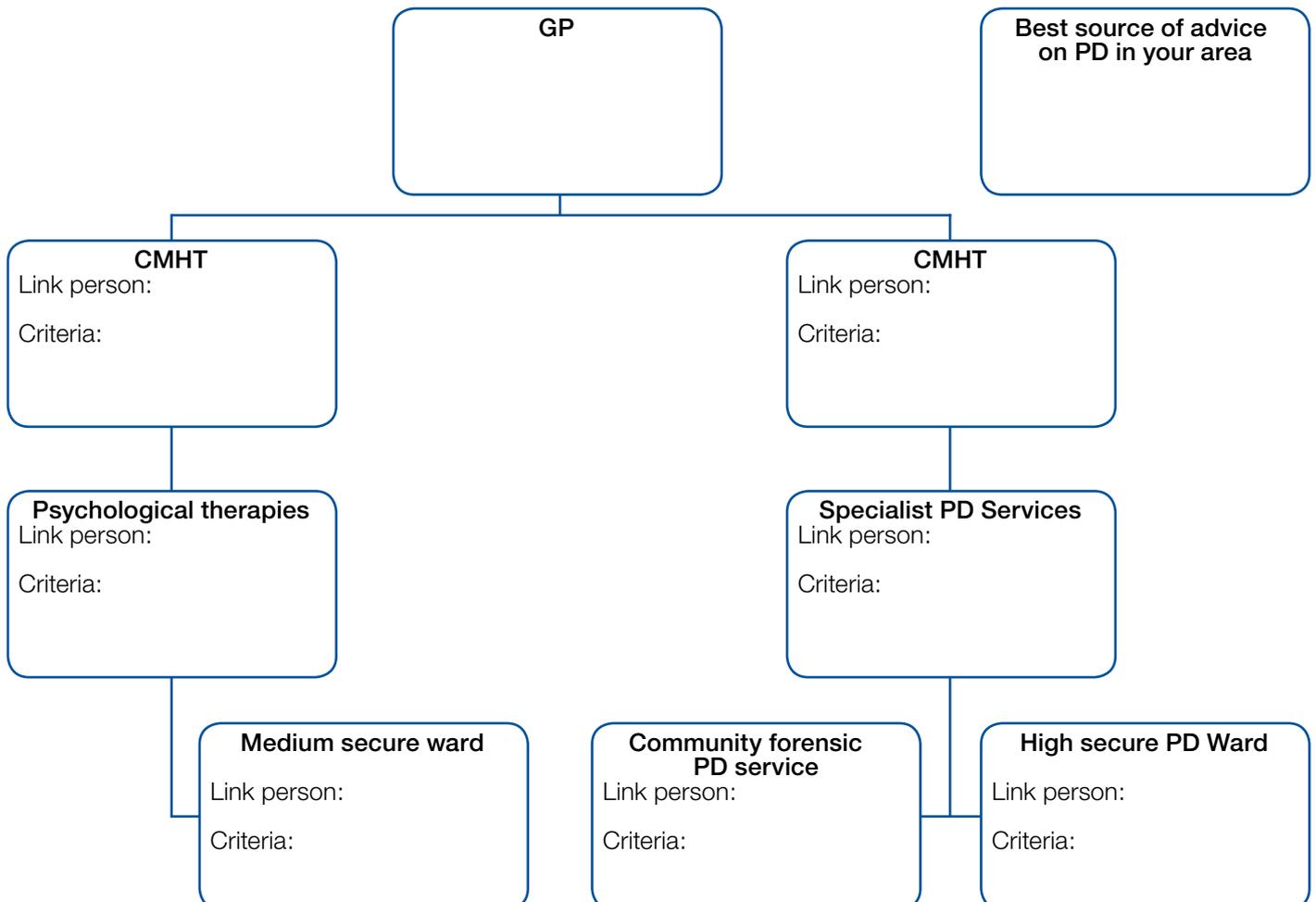
1. Accredited community programmes

As with prison accredited programmes, standard accredited community interventions should be considered initially. They currently include:

- Interventions to enhance pro-social competencies
- Interventions for anger and aggression
- Interventions for sex offenders
- Interventions for substance misuse
- Other interventions (e.g. One to One, Drink Impaired Drivers Programme (DIDP) and Video monitoring).

Example flowchart of community pathways

(fill in your local area)



2. Primary care (GP)

Primary care is the foundation for all health care, at the centre of which sits the GP. The GP, GP Consortia and/or the Primary Care Trust are all vital to an understanding of how to navigate health services. From this point referrals can be made to other services – including secondary mental health care – which cater for that particular catchment area. The GP should be the first port of call when considering a referral, and offenders should be supported to register with a local GP as a priority. This is particularly important as there is considerable evidence that offenders with mental health problems and PD are more likely to have physical health problems than other population groups and for those problems to be overlooked. Many people who present with personality difficulties may only require short-term input for acute emotional difficulties which can be provided at this level. GPs may commission their own short term counselling services or access IAPT (improving access to psychological therapies services), both of which are generally **inappropriate** for personality disordered individuals.

3. Community mental health teams (CMHTs)

For offenders in distress, with a diagnosis of personality disorder, the first point of contact should be the local CMHT. An individual can present directly at the 'duty desk', or be referred by a professional (including probation). In practice, the reason for referral is likely to be a co-existing problem (e.g. distress and self harm) and the personality disorder may not be the focus of intervention. The most common personality disorder diagnosis considered by CMHTs is borderline personality disorder. CMHT's consist of a multi-professional team and use a care programme approach. This is a four stage system of care which includes assessment of health and social care needs, a care plan to meet these needs, a care coordinator to monitor the care and regular reviews to ensure the plan is updated and progressing. The CPA reviews should invite all professionals involved in the client's care to the meeting. This should include probation services, although it may help to remind the service of your desire to attend such meetings. The CMHT coordinates assessment, management plans, crisis plans, risk assessment, treatment and access to acute inpatient care when required.

CMHT's vary in their approach to the care of patients with a diagnosis of personality disorder. This may be directed by the Trust's policy or may be a local team decision. It is helpful to have an understanding of their approach to the care of personality disorder before making referrals – the CMHT may only see such patients in crisis, or may require referrals to be made via the GP. The CMHT may also coordinate referrals to other specialist services in the area and should have knowledge of local service provision.

4. Local psychological therapies or personality disorder services

Access to outpatient services specialising in the treatment of personality disorder can be difficult. The core treatment should be psychotherapeutic 'talking therapies', however this may include prescribing and monitoring psychotropic medication. The service may work in collaboration with the local CMHT, who would continue to provide crisis interventions and social support. Different psychological therapies services provide different models of care, as there is no single accepted model of treatment. These services are likely to accept referrals from a variety of sources including CMHT's, primary care, A&E, drug and alcohol services and probation. However, local services will have local policies and you will need to be aware of their referral procedures.

More intensive day care services may exist in areas where there is a high prevalence of personality disorder. They provide more intensive input for those with severe personality problems, who pose a risk to self or others, relieving demand on primary and secondary services. Whilst these services may not be set up to accept referrals for antisocial personality disorder, they may include outreach provision to criminal justice agencies (e.g. probation). Such input may involve support, clinical supervision, consultation and assistance with referrals to other mental health agencies.

- Local PD services lead on providing specialist treatments, but often concentrate on borderline PD
- Specialist PD day units: intensive input for severe cases, may offer outreach to criminal justice agencies
- Regional residential units: inpatient treatment for severe PD including services for offenders
- CMHT's: first port of call, but mostly deal with crisis management and coordinating care.

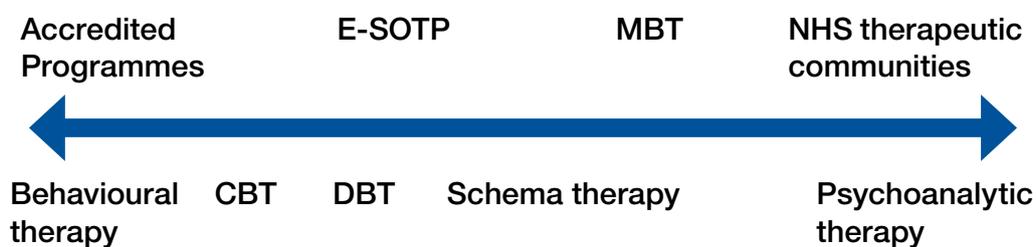
5. Forensic mental health services

Most forensic mental health services are hospital based (i.e. local medium secure units), and there is very patchy provision for personality disordered offenders. Some will only provide inpatient treatment and are likely to specialise in treatment for psychosis rather than personality disorder. Others will have community provision and may offer assessment and treatment for personality disordered offenders. Each forensic mental health service will have its own provision based on available resources and expertise and you will have to contact the service to find out what they can provide for your offenders. See the section on transfer from prison to health for information on the few specialist personality disordered offender inpatient units.

SOME GENERAL THOUGHTS ABOUT TREATMENT FOR PERSONALITY DISORDERED OFFENDERS

1. Different treatment approaches

The types of treatment can be thought of as lying on a continuum from behavioural to psychoanalytically-informed interventions. At the behavioural end the treatments target more concrete observable difficulties (e.g. actions) and as we move to the more analytical end, the treatments focus on more abstract and less easily observed difficulties (e.g. mental representations). This is detailed below:



In general, therapies for personality disorder are gravitating to the middle, incorporating both psychoanalytic and behavioural elements into one package. That is, there is an emphasis on an attachment based formulation of the offender's difficulties, with interventions which include an element of psycho-education, skills development, and the development of a capacity for reflection and self-awareness. Some of the evidence-based treatments include cognitive behaviour treatment (CBT), dialectical behaviour therapy (DBT), mentalisation based therapy (MBT), schema therapy, cognitive analytic therapy (CAT), transference-focused psychotherapy and therapeutic communities (non-forensic). A review of the evidence base for personality disorder treatments can be found in Bateman, A., & Tyrer, P. (2004). Psychological Treatments for Personality. *Advances in Psychiatric Treatment*, 10, 378-388.

2. Treatment targets different areas

When you are referring someone for treatment, it is worth considering the reason for the intervention, which can address four separate areas. These are:

- the underlying personality disorder itself
- treating symptoms and behaviours associated with the disorder (e.g. impulsivity and aggression)
- treating problems which commonly co-exist with the disorder (e.g. substance misuse or depression)
- addressing offending behaviours.

Think about which aspect you are interested in targeting, as this will partly dictate whether you refer, and where you refer the person to.

For the two most commonly encountered personality disorders (Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (ASPD)), there are national guidelines on the type of treatment that should be provided (National Institute of Clinical Excellence – NICE. <http://www.nice.org.uk/nicemedia/pdf/CG77NICEGuidelineWord.doc>). It is acknowledged that probation services manage a high number of individuals who would meet criteria for ASPD. These people should not be excluded from NHS treatment services on the basis of their diagnosis or history of offending behaviour, although the NHS may be limited in the interventions it can offer. It is important for probation to be aware of this as a potential diagnosis and where it is suspected as present, **the individual is seeking help**, and probation cannot meet his/her needs alone, consider referring to a forensic mental health service. Where there is co-existing disorder (e.g. anxiety or depression) consider referring to general mental health services (e.g. the local community mental health team) and where the treatment directly relates to the personality disorder, the individual should be referred to a forensic or specialist personality disorder service.).

3. Treatment sequencing

There has been a good deal written about the importance of delivering interventions in the right order. Generally, the following sequence is agreed:

- a. Proactive development of contingency plans to anticipate crises and to determine the limits of confidentiality
- b. Establishing a working relationship, and dealing with immediate problems (such as panic attacks or depression)
- c. Learning to develop skills in controlling feelings and impulses
- d. Delving beneath the surface to explore, process and potentially resolve longstanding psychological issues.

4. Treatment effectiveness

There is a growing body of literature reporting on treatment effectiveness for personality disorder, offender rehabilitation and personality disordered offenders. For a detailed account, recommended reading is provided at the end of this chapter. As a general guideline treatment effectiveness can be subdivided according to the level of risk. Interventions for low risk cases may make offenders worse (although exactly why this is the case is not fully understood); for medium to high risk cases the effectiveness is better.

Treatment completion is important, and there are consistent findings that those offenders who drop out of treatment – whether in prison or the community – reoffend at significantly higher rates, more so than those who

refuse to commence treatment at all. Given that personality disorder is linked to a greater likelihood of treatment non-completion, you will need to pay particular attention to this issue. PD offenders are likely to respond to encouragement, contact outside treatment sessions, help with attending, reminders about failed appointments, and so on. In other words, PD offenders may need **more not less** attention when they are attending a programme.

Is psychopathy treatable? Research would generally suggest that there are some grounds for optimism in thinking about interventions for psychopathic offenders. In particular, a mixed approach of individual, group and family work, delivered by a confident and well supervised staff team, may offer a chance of success. Interventions most likely to be effective are those which focus on 'self interest' - that is, what the offender wants to get out of life – and works with them to develop the skills to get those things in a pro-social rather than antisocial way.

Factors associated with treatment effectiveness generally are summarised below.

Summarising successful treatments:

- Combining group and individual treatments works best
- Consider additional family work & telephone contact outside planned sessions
- Treatment completion is crucial
- Target high risk groups, and expect at least 10-15% reduction in offending
- Treatment programmes lasting at least one year
- A cohesive team approach and philosophy of care, which is understood by the offender.

Recommended reading

Warren et al., (2003) Review of treatments for severe personality disorder. *Home office online report, downloadable at: <http://rds.homeoffice.gov.uk/rds/pdfs2/rdsolr3003.pdf>*

N. Murphy & D. McVey (Eds.) (2010) *Treating Personality Disorder*.

A. Roth & P. Fonagy (Eds.) (2006) *What Works for Whom?: A Critical Review of Psychotherapy Research*.

M. McGuire (1995) *What Works: Reducing Reoffending: Guidelines from Research and Practice (Wiley Series in Offender Rehabilitation)*

Chapter 4

Community Management

Aim

The aim of this chapter is to inspire confidence in the reader: that is, in using an understanding of the model of personality development developed thus far, one can apply the psychological principles to achieve the improved community management of complex personality disordered offenders. In other words, treatment interventions are not the only option for reducing risk, and you should not despair if an individual refuses to engage or is found to be unsuitable for programmes or therapy.

Some familiarity with attachment theory – as described in chapter two – helps practitioners to understand how entrenched patterns of problematic interpersonal behaviour can develop as a result of early experiences in life. These patterns may be evident in the offence itself, and can be triggered within the relationship between the practitioner (offender manager) and the offender.

The attachment triangles

In the first instance, we should return to the attachment triangle in chapter two, which described the developmental pathway of the personality disordered offender. Figure 3.1 shows how one might compare the development of a core understanding of oneself in relation to others – patterns of interpersonal relating – to a triangle of the here-and-now, linking these patterns to intimate and social relationships as well as the relationship with the offender manager and MAPPP.

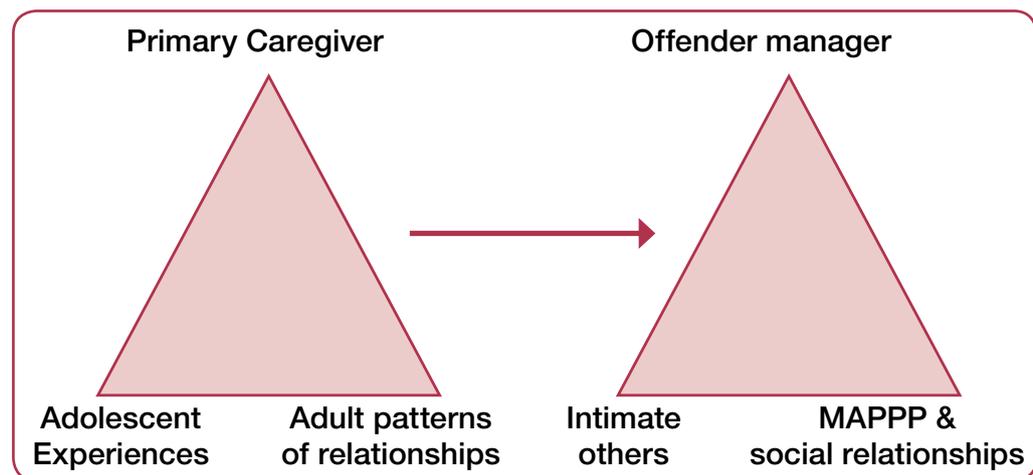


Fig. 3.1

In other words, if the development of attachment and early experiences of trauma sets up a repeated pattern of relating to others, what does this suggest that we – the offender manager, the hostel, MAPPP or the community mental health team – might expect in terms of behaviour and interpersonal functioning?



If we return to the case of Billy (detailed in previous chapters), we know that he experienced his mother as seductive and loving, but also as erratic and rejecting of him. His father was apparently a rapist, and a subsequent positive relationship with his step-father was abruptly severed with his sudden death. In adolescence he was placed in Local Authority care, and the only attention he received was in the form of sexual abuse by a male staff member – the sexual contact was unwanted but better than no attention at all. In adulthood, Mark began by selling his body to men, working as a rent boy; this reflected the sexual way in which he defined himself. He went on to have intense, but brief and conflictual relationships with women. Finally, the index offence – indecent assault – appeared to have been an expression of rage, triggered by the victim's understandable rejection of him.

What might we therefore expect in terms of Mark's relationship with others, following his release from prison into an approved premises?

- Intense, rather sexualised relationships with women, particularly those in authority?
- He may be particularly sensitive to signs of betrayal or rejection?
- It is not clear whether he will see himself as a victim of authority (arising out of his experiences in care), or somehow bad like his father with whom he identifies....maybe he will alternate between victim and perpetrator stances?
- He is likely to get into a rather delinquent relationship with other men in the hostel, perhaps engaging in conning or mildly subversive behaviour – breaking rules?

An alternative way of developing a community management plan would be to focus on what we know about core and secondary personality characteristics. Table 3.1 outlines the core beliefs, and interpersonal styles of each of the personality disorders (as defined by DSM-IV). These ideas are drawn from Millon and Padesky, and link closely to cognitive behavioural theories of personality disorder.

Self-schema relates to the individual's core belief about himself, usually drawn from early developmental experiences and/or inherent traits, and reinforced over the years.

World schemas describe the key traits with which the individual views himself in relation to the world around him/her.

Expressive acts refers to the way in which others experience the personality disordered individual, the observable behaviours

The **interpersonal strategy** describes the primary means by which the individual approaches and relates to others.

Personality type	Self-schema	World schema	Expressive Acts	Interpersonal strategy
Paranoid	Right/noble	Malicious	Defensive	Suspicious or provocative
Schizoid	Self-sufficient	Intrusive or unimportant	Impassive	Isolated or unengaged
Schizotypal	Estranged	Varies	Eccentric	Secretive
Antisocial	Strong/alone	A jungle	Impulsive	Deceive or manipulate
Borderline	Bad or vulnerable	Dangerous	Spasmodic	Attach or attack
Histrionic	Inadequate	Seducible	Dramatic	Charm or seek attention
Narcissistic	Admirable	Threatening	Haughty	Compete or exploit
Avoidant	Worthless	Critical	Fretful	Avoid
Dependent	Helpless	Overwhelming	Incompetent	Submit
Obsessive-compulsive	Competent or conscientious	Needs order	Disciplined	Control or respectful

Table 4.1

Consider Peter again. In chapter two he was identified as being largely narcissistic – with a few antisocial traits - in his presentation and history. That is, he repeatedly holds an extremely positive view of himself as admirable and right, experiencing others as potentially posing a threat to this self image if they stand up to him or thwart him. Almost always, he is experienced by others as haughty and contemptuous in his attitudes, and others often feel that he pushes them into a competitive stance, or that he uses and manipulates them. How might these characteristics be reflected in his pattern of offending – sexual assaults on pubescent boys – and in his behaviour with others?

- His attitude to boys is rather like narcissus looking at his reflection in the pond, he sees them not as individuals but as an extension of himself – something pure, unsullied, innocent and lost.
- He relies on literature, and inconsistencies in the law, to argue for and justify ‘man-boy love’, and pushes all professionals into a debate about it. This always results in an argument about the sexualisation of children.
- He relates only to others who collude with his beliefs, either via the internet, or as a result of cell sharing on the prison wing.
- He tends to avoid other peer relationships, preferring to seek out rather vulnerable younger men who look to him for help.

Any risk management plan, with Peter, would have to consider the relationship between his personality traits and his offending and behaviour, and try to disentangle those aspects which were primarily linked to future risk from those characteristics which were perhaps annoying but ‘harmless’.

Basic principles

There are some principles to the psychologically informed community management of personality disordered offenders, which apply to most types of personality disorder. They are summarised in the box below.

First, consider the options for management – personal, external and environmental. By this, we mean, the capacity for personal change by means of therapeutic interventions, anxiety about behaviour and motivation to change; the likely degree of compliance with external controls – such as curfews, exclusions, abstaining from drug use etc; and finally, the possibility that by changing the environment, traits no longer become problematic. An example of the latter case might be the decision to place a paranoid man in his own flat rather than approved premises (despite the seriousness of his offence) because there is less to be paranoid about in his flat.

Second, many personality disordered offenders – particularly those in cluster A (odd) and cluster B (dramatic) are rule-breakers (see chapter 1). This may well be due to impulsivity, or to anti-authoritarian attitudes and beliefs that ‘the rules don’t apply to me’. The intuitive response of any practitioner, when faced with a rule-breaker, is to try and exert more control. This is why licence conditions for personality disordered offenders tend to be longer than most. Unfortunately the drive to break rules is too ingrained, too compelling, this strategy simply provides the individual with more rules to break! Even worse, the practitioner cannot manage too many rules and the plan becomes inconsistently enforced. The recommendation is to act in a counter-intuitive way: cut down the rules to a bare and essential minimum – those which best manage risk – and then enforce them with consistency and rigour. However, it is still important to try and build in some kind of goal system – positively oriented - which allows for encouragement and a sense of progress. As with all behavioural approaches, make sure these goals and the indications of progress are thought out in advance, clear, consistent and easy to achieve.

Third – and we have already covered this – anticipate problems rather than react to them. Develop the attachment understanding, consider the personality traits, and link them to possible patterns of behaviour in the here and now. Having a plan of action in advance is much more likely to succeed, than trying to repair a problem once it has started.

Basic principles

1. Consider three aspects of management
 - Capacity for personal change and control
 - Likely response to externally imposed controls
 - Options to alter the environment to complement traits.
2. Generally PDOs are rule breakers, so give them fewer (not more) rules to break
3. Anticipate rather than react; use the attachment triangle
4. Having been in care, don't be surprised if the individual irrationally opposes or undermines your (and others') authority
5. Separate core from secondary characteristics; soothe the former and tackle the latter
6. Choose your battles carefully: prioritise with high risk offenders
 - The characteristics or aspects more likely to lead to failure
 - The characteristics or aspects which most worry the offender.



Fourth, a special mention about Local Authority care. Practitioners are often puzzled at the apparently unnecessary and irrational oppositional – sometimes frankly hostile – behaviour shown by some personality disordered offenders. This can even be hurtful when the practitioner is genuinely trying to establish rapport and be of assistance. It is worth checking whether the individual has a history of being placed in care, sometimes fostered but often a children's home or boarding school. Why might this be relevant? Children want to preserve a sense of having been loved and cared for – it is part of the biological drive to form attachments to caregivers – and will go to great lengths to ensure that no experiences shatter these beliefs. When placed in care, they therefore separate out in their mind their parents (good and loving) from the Local Authority care (indifferent and neglectful) and seek to form links with the other children to undermine the authority of the 'false parents'. Even in adulthood, it remains important for the individual to believe in the inadequacy and failures of institutions and authority, in order to preserve a shaky belief in their family of origin.

Fifth, think about personality disorder in terms of core and secondary characteristics. This was a model discussed in chapter two, and again in this chapter in relation to Table 4.1. Just to recap, there seems to be evidence that core characteristics do not really change over time – may even be genetically driven – but there is cause for optimism in considering secondary characteristics which appear to mature and to respond to interventions. Furthermore, we know that some situations or interactions directly tap into and provoke core characteristics (such as the paranoid man in approved premises, or Peter provoking his offender manager into trying to persuade him his beliefs are wrong) whilst others are less provocative. As with rule-breaking, practitioners are intuitively drawn to identify and challenge the core characteristics, when paradoxically, these are the very aspects of the individual's presentation to soothe or avoid.

Finally, when working with a high risk of harm offender, think about prioritising. There is nothing more demoralising than considering a very long list of potentially problematic attitudes and behaviours. It instils despondency in both the practitioner, and in the individual offender who believes that he has been 'condemned to failure'. There are two ways to prioritise, and we recommend doing both:

- target the risk factor most likely to lead to serious failure, and
- address the issue which most bothers the offender.

In this way, the individual understands exactly where the risk management plan has come from, but is also engaged in a more collaborative approach which values his own agenda as well as that of 'authority'.

Why bother about ‘psychologically informed’ management?

The simple answer is it helps to manage or indeed, to reduce risk. By understanding the thinking and relationship style of a personality disordered offender, the practitioner can do three things:

- Maximise the chances of successful completion of statutory supervision, which in turn reduces the risk profile
- Focuses the risk management plan on those areas of an offender’s behaviour which are most likely to result in harm to others
- Keep a calm and controlled oversight of a case which might otherwise cause exhaustion and despair (see chapter five).

Management plans – the case vignettes

We have repeatedly returned to the case vignettes in this guide. They are disguised cases, and deliberately adjusted to illustrate learning points. Below, is described the management plans for three of the vignettes. Note the ways in which the cases do or do not follow the basic principles for psychologically informed management plans.

Peter

To recap, Peter is the offender with an extensive – but apparently intermittent - history of sexual offending against pubescent boys. The most notable feature of his childhood was the contrast between his emotionally cold home life, and his vibrant and idealised participation in frequent sexual play with his male peers at boarding school (where he was sent after his explosive temper tantrums were felt to be unmanageable in mainstream schooling).

Peter has predominantly narcissistic traits, with some antisocial features, particularly rule-breaking and excessive alcohol use, and one episode of paranoid psychosis (losing touch with reality, believing his food was poisoned) after he was thrown out of the prison SOTP for arguing with the group leaders: they would not accept his reasoning regarding the ability of young boys to seek out and enjoy sexual contact with men and, under some pressure, he ultimately broke a chair in a rage.

Peter is being released from prison to approved premises. He has achieved notoriety as he claims he is writing a book about man-boy love, and is in frequent correspondence with a notorious child killer. As a consequence, there is considerable agency anxiety about him and he is subject to the oversight of a level 3 MAPPA panel. At the meeting, it is clear that there is a split emerging, with the police and Local Authority emphasising the risk he poses to children, in contrast with the probation team who feel Peter is deliberately provocative. A compromise was reached, when it was agreed

that the police would concentrate on pursuing the option of a SOPO (sex offences prevention order), while probation would focus on the management of the licence.

The probation team linked up with a local psychologist and agreed the following approach:

- a. To allocate Peter to reasonably experienced keywork and probation staff, who (somewhat tongue in cheek) were both **absolutely forbidden** from discussing the question of children's sexuality, or victim empathy, with Peter. The rationale was that these features had led to a breakdown in management in the past, by enflaming Peter's core traits and triggering destructive competitive impulses. Furthermore, offence-related cognitions only have a weak link with re-offending risk in the literature, and there was little evidence that they were amenable to change in Peter's case.
- b. To ensure that Peter's risk management plan was evenly balanced between avoidance and approach goals; i.e. he was not allowed to do a few risky things (loiter in parks), but he would be actively encouraged to do other things (undertake research in the local library once a week) which provided meaningful structure and maintained his self-esteem, in a way which could be monitored.
- c. To limit the risk management targets to two key areas. First, from the probation officer's point of view, alcohol and impulsive decision making at times when a potential victim was available was the combination of triggers most likely to lead to future offending. Peter agreed with this (although he did not define it as offending, but as the likelihood of him getting caught). Second, Peter's primary concern was not to return to prison – he realised the likelihood of getting out again was slim – and he was motivated to avoid this. Collaboration on these two issues was achieved in supervision.

There was a problem in Peter's progress, six months after release, when the probation officer – busy and frustrated – could not restrain her irritation at yet another attack on her professional integrity (Peter having suggested that he would be better suited to a more educated probation officer who would be more able to understand his philosophy, and who derived more enjoyment from her job!) She angrily responded by challenging his 'philosophy', expressing her views about the damage he had caused his victims, and agreed that perhaps he needed another officer. However, it was to the credit of the probation officer, that with the supervision and support of her line manager, she was able to talk with Peter in a subsequent session, both owning her own feelings of anger, but also explaining (calmly and without any accusation) how his constant criticisms were destructive to their relationship. Although Peter never acknowledged his behaviour, this incident seemed to mark a positive shift in their relationship. Three years later, Peter completed his period on licence without apparently offending, was living independently – albeit requiring support because of his extreme isolation – and was seeing a psychologist once a month for what might be described as supportive psychotherapy.

Mark

To recap, Mark was in many ways a typical antisocial offender, with a history of behavioural problems from early childhood, a delinquent adolescence, and a long string of acquisitive and violent offences behind him – largely robberies. He had had significant problems with class A substance misuse which was usually the main trigger for his offending, but he also associated with a fairly criminal subgroup, and certain traits relating to antisocial PD – reckless sensation seeking (core trait) and impulsivity (secondary behaviour) – were probably also highly relevant. He scored very high on the OASys PD variables.

Having received a fairly long custodial sentence, Mark settled down after a turbulent start (with adjudications for violence and drug dealing). He seemed to mature, and completed drugs related programmes receiving positive reports; mandatory drug testing was negative for the two years prior to his release. He was released on a two year licence, with the usual conditions, including a need to address his offending behaviour, his substance misuse, engage with Employment and Training, and reside at an Approved Premises. He was managed within the main Offender Management team, and expected to report on progress regarding engagement with Think First (a thinking skills programme), the community drug worker, signing up for further training and seeking employment.

Six months into his licence, Mark appeared to be compliant and motivated although he had not made much progress with his requirements: there had been confusion regarding appointments with the drugs worker, and he was vague about his intentions regarding work or training. Although the probation officer had given up asking probing personal questions of him – as he always became defensive and uncommunicative at these times – he was otherwise pleasant and cooperative. He had started Think First, and received a good report for his participation in the first few sessions, although the course leaders had had to ask him not to hang around with the other group members after the sessions. The probation officer also noted a three week period when Mark's level of self care – usually excellent – appeared to deteriorate; he had explained that he had been a little bit under the weather, with flu and low mood, and his appearance soon improved.

In month seven of his licence, Mark was arrested and subsequently charged with the murder of an elderly man in his home. It transpired that he had returned to using cocaine, and – with a couple of friends - had been planning the robbery of a jewellers shop. They took flick knives with them, but the jewellers was closed when they arrived; in frustration (and somewhat irritable and edgy) Mark had gone off to rob someone. He broke into a house that appeared to be empty, but was surprised by the elderly resident who stood in the doorway with what appeared to be a pair of scissors in his hand. Trapped in the room, shocked and panicky, Mark got out his knife and thrust it wildly at the man as he pushed him aside to run out of the house.



With a further offence committed by someone on her caseload, the probation officer will have been devastated, and under extreme stress. The question we might ask is whether, with the complacent benefit of hindsight, we might have done anything different ourselves. The first problem is that Mark – particularly within an urban environment – is an entirely unremarkable and common probation case, thousands are like him. The second problem is that he was cooperative, albeit rather superficially, in his dealings with probation. We probably have to come to the rather uncomfortable conclusion that this was an entirely unpredictable event – or that one could only predict it if one included literally hundreds of similar offenders into the ‘potential SFO bag’. On the other hand, there may be some learning points from this case (although it is uncertain that knowing them would have avoided the outcome):

- Catastrophic harm most commonly arises as a result of carrying a potentially lethal weapon, not from personality characteristics of the offender; focusing on harm reduction (educating against the carrying of weapons) is both potentially useful and defensible.
- If someone has been behaviourally disturbed from a very early age (primary school years) and has a family history of substance misuse, take a more cautious approach to apparent maturation in adult years – there is a powerful pull back to inherent traits.
- Look beyond compliance in antisocial offenders as they can be rather chameleon-like; Mark learnt at an early age to present himself as compliant to his mother, whilst persistently subverting her authority at the same time. Put more emphasis on objective evidence of behaviour rather than relying on self-report.

Robert

Robert’s background and offence were detailed in chapter one. In summary, he was an only child, with a history of mental illness in the family; by his peers he was considered to be a loner and ‘weird’, he was bright but a poor achiever, and worked for years in the Civil Service (although disliked by peers and he made little progress). He was rigid and suspicious in his views, drank heavily, and was prone to brooding on grievances. He only had one intimate relationship, and after a few months, during a row when his partner threatened to leave him, he killed her in a sudden rage. In prison, he objected to sharing a cell, was officious and litigious if prison rules were breached, and refused to participate in group work, but otherwise caused few management problems.

Robert clearly fits the diagnostic category of schizoid personality disorder with paranoid traits. If thought of in terms of core and secondary traits (see Table 4.1), he has a self concept of being self-sufficient and righteous, viewing others as either intrusive or unimportant to him, and tends to remain unemotional, isolated or unengaged with others. If forced to engage, his style is largely suspicious of others.



The probation officer managing the life licence brought Robert to consultation with the forensic psychologist. The officer had tried to develop a management plan which addressed anticipated problems, but was dismayed to find that Robert was becoming increasingly irritable and withdrawn. The plan included:

- Co-working Robert with another team member, to anticipate complaints and litigious action.
- Putting in a condition that he attend IDAP (the domestic violence programme) as he had not completed group work in prison
- Placing Robert in a hostel in order to ensure that he was well monitored
- Recommending that he engage with the psychology service for additional individual therapy
- Attend a community alcohol project and a Employment and Training agency.

So why might this entirely sensible and straightforward plan have been going awry, and was Robert's risk increasing as a result? The problem was that the probation officer had intuitively designed a risk management plan which confronted Robert's core traits and exacerbated his habitual responses as a result. The plan would have been experienced by Robert as intrusive and provocative, provoking him into a suspiciousness and defensiveness demeanour; he would have been unsettled by having to report to a number of separate agencies and individuals, and would have loathed the relative chaos and proximity to others of an approved premises. His capacity for stubbornly refusing to participate in a group would have been substantially greater than the officer's capacity to persist doggedly with this request! It was therefore agreed to:

- Reduce his supervision to a single worker; however the probation officer could not comply with the psychologist's suggestion of reducing the sessions to fortnightly.
- Robert was fast tracked into independent accommodation.
- He was removed from the IDAP waiting list.
- He was breathalysed for alcohol on a random basis, but it was agreed that he would only need to attend an alcohol service if he started drinking again.
- He met with the forensic psychologist on a six weekly basis, simply to monitor his mental state and talk about relationships if possible.
- The probation service made every attempt not to change his probation officer, even when she moved teams locally, and supported him in finding work as an office clerk.

Interestingly, the lower the intensity of the intervention, the better Robert responded, and concerns about his risk diminished.



Summary

Psychologically informed management is greatly underrated – often the poor cousin of treatment, both in terms of attention and resources – but hopefully this chapter will have inspired to reader to greater confidence and creativity in the management of this group of offenders.

Chapter 5

Staff Wellbeing

The aim of this chapter is to focus on staff – the vital heart of any service for personality disordered offenders. The skills and resilience of practitioners matters to an organisation, particularly when working with risk.

Challenges

Practitioners working with personality disordered offenders face substantial challenges in their day-to-day work. Given that personality disorder is characterised by an ingrained pattern of maladaptive behaviours that are damaging to the individual or others around them, working with this client group can raise very strong opinions and high emotions in individual practitioners and staff teams. Furthermore, unexpected behaviours and high re-offending or drop out rates can be very demoralising. Examples might include the offender who:

- functions well in the prison environment and does well in prison offending behaviour programmes, but reacts desperately when released into the community or when they are coming towards the end of their period under licence supervision
- appears calm, in control and motivated to improve things and then chaotically self-harms soon afterwards
- appears to want and need help but is hostile, insulting, undermining and belittling of your attempts to help him/her
- constantly checks and suspects our motives, withholds information and frequently tests whether our reliability is good enough
- talks about the harm they have caused to others but calmly rationalises, minimises or denies it
- places high demands on staff time, with a sense of entitlement, hostility and verbal abuse
- appears to be making good progress, but continues to offend or behave antisocially.

On the surface, these perplexing behaviours reflect very complex difficulties that have developed over a lifetime as a result of the complicated and unique interaction of temperamental, psychological, social and environmental factors.

Personal reactions

When faced with such polarised behaviours in the above examples, it is very often the case that practitioners will automatically (unconsciously) react to these kinds of behaviours by feeling:

- puzzled and irritated
- frustrated
- helpless to help them change

- defensive when with them
- fearful of upsetting the person and getting into an argument
- manipulated by the person.

The cumulative effect of working with such behaviours combined with other sources of stress in our lives (see below) can result in our emotional responses becoming amplified. If we cannot make sense of these challenging, extreme and sometimes risky behaviours we may begin to feel exhausted, personalise their responses and feel critical towards them and lose our capacity for empathy for them. We then risk automatically reacting by:

- becoming punitive and hostile
- becoming over-involved
- avoiding them.

In addition, practitioners might experience problems in getting much needed input from other mental health and social care services for PD offenders, inconsistent inter-agency working and having to work within narrow and rigid organisational protocols to managing risk and highly challenging cases. As a result, probation practitioners are at increased risk of burnout.

Remember

The personality disordered offender unconsciously provokes feelings in others which they themselves have experienced, most commonly, feelings of anger, rejection and unfairness

The above are common occurrences, experienced by many if not all staff. However, in a small minority of staff, working with personality disordered offenders will expose their own dysfunctional personality traits. In such colleagues, unexpected outbursts of extreme hostility or rigidity, or entangled or overly involved alliances with offenders may emerge. You will need to consider talking with such colleagues, and if need be, alerting a senior member of staff to your concerns.

Staff burnout

There has been a good deal of research published on staff burnout generally. The term “burnout” describes workers’ reactions to the chronic stress common in occupations involving numerous direct interactions with people.

With the relentless pace of the day-to-day job, high workloads and the focus on dealing with the next crisis, there is the risk of staff burnout developing unnoticed. In the long-term, this is not helpful for the practitioner, the organisation, the offender and the general public. This chapter focuses on the signs of staff burnout so that you can be aware of how working with PD offenders can affect you personally. It also looks at a number of strategies that could help to protect you from burnout.

So what are the signs of burnout? The box (right) shows the three main components to look out for.

a. The development of negative, cynical attitudes and feelings about offenders. This depersonalisation of individuals occurs as practitioners become discouraged by their job and become less and less professionally concerned. When this becomes more severe the practitioner can take a callous and dehumanising view of offenders that leads them to take the view that they are deserving of their troubles.

b. Another aspect is when the practitioner feels less effective in their work (e.g. feelings of inadequacy and failure), particularly regarding their work with offenders. The practitioner feels unhappy about themselves and dissatisfied with their accomplishments at work.

c. The final aspect is when emotional exhaustion sets in. This is when the practitioner's emotional resources are so depleted that they feel they are no longer able to give of themselves at a psychological level.

Symptoms of burnout

- **Depersonalisation and Cynicism** - Negative and cynical attitudes and feelings about offenders which can lead staff to view them as somehow deserving of their troubles
- **Feeling ineffective** - feeling unhappy and dissatisfied about personal accomplishments at work
- **Emotional exhaustion** - physical fatigue and a sense of feeling psychologically and emotionally "drained" from excessive job demands and continuous stress.

Risks of burnout

The unfortunate consequences of burnout can be deterioration in the quality of care or service that practitioners provide, high staff turnover, staff absenteeism, low morale, increase in mistakes made, personal distress, problems with sleep, increased alcohol use, marital and family problems, and developing a feeling that nothing works.

The personal risks for staff of burnout include:

Physical	Mental
<ul style="list-style-type: none"> • Increased blood pressure • Coronary heart disease • Poor immune system • Recurring illnesses • Physical exhaustion. 	<ul style="list-style-type: none"> • Depression and mental exhaustion • Change in professional goals • Psychological withdrawal from work • Growing concern for self instead of others • Dread about work • Negative attitude towards life in general.

Emotional	Social
<ul style="list-style-type: none"> • Emotional exhaustion or detachment • Irritable and impatient towards others • Depersonalisation of clients. 	<ul style="list-style-type: none"> • Feeling isolated from colleagues • Rude towards offenders • No time for colleagues or activities • Unwillingness to help offenders.

Could I be at increased risk of burnout?

There is some evidence that staff working with offenders are at increased risk of burnout symptoms, particularly for those practitioners who are established in their roles but less experienced. In addition to the particular characteristics of personality disordered offenders which contribute to the difficulty, organisational factors – such as role conflict (enforcer versus carer) and lack of participation in decision-making – contribute to burnout.

Causes of burnout

It has been argued that burnout is more likely to happen when there is a mismatch between the nature of the job and the nature of the person who does the job. The <http://stress.about.com> (Scott, 2006) website helpfully separates the causes into three categories: Job factors, lifestyle factors and psychological factors. Why not have a read and consider which ones might be relevant for you personally.

JOB FACTORS

Unclear Requirements

If the job description isn't explained clearly, or if the requirements are constantly changing and hard to understand, practitioners are at higher risk of burnout.

High-Stress Times with No "Down" Times

Many jobs and industries have "crunch times", where practitioners must work longer hours and handle a more intense workload for a time. This can actually help people feel invigorated if the extra effort is recognised, appropriately compensated, and limited. It starts becoming problematic when "crunch time" occurs year-round and there's no time for practitioners to recover.

Big Consequences for Failure:

People make mistakes; it's part of being human. However, when there are dire consequences to the occasional mistake (like the risk of a serious further offence, for example), the overall work experience becomes much more stressful, and the risk of burnout goes up.

Lack of Personal Control

People tend to feel excited about what they're doing when they are able to creatively decide what needs to be done and come up with ways of handling problems that arise. If restricted and unable to exercise personal control over daily decisions, practitioners can be at greater risk for burnout.

Lack of Recognition

Awards, public praise, bonuses and other tokens of appreciation and recognition of accomplishment go a long way in keeping morale high. Where accolades are scarce, burnout is a risk.

Poor Leadership

Depending on the leadership, employees can feel recognized for their achievements, supported when they have difficulties, valued, safe, etc. Or they can feel unappreciated, unrecognized, not in control of their activities, or insecure in their position.

LIFESTYLE FACTORS

Too Much Work With Little Balance

A life consistently working above your contracted hours with no down time is a classic high risk scenario for burnout. Those who devote all their time to work activities, and put other areas of their lives—like relationships, hobbies, and exercise—on hold, put themselves at higher risk of burnout.

No Help or Supportive Resources

Having the feeling that, "If I take a day off, things will fall apart," causes a generally elevated sense of stress. We all need support, backup, and others we can offload responsibilities to if need be.

Too Little Social Support

In addition to needing people who can help us with responsibilities, we need people to help us shoulder the emotional burdens in our lives. Having someone to talk to about what stresses us, someone to play with when we have free time, and someone to understand us when times are tough, are all important and necessary aspects of social support.

Too Little Sleep

People don't always realise the importance of this one, but if you don't get adequate sleep, you are less able to handle stress, and you're also less productive and suffer other consequences.

Too Little Time Off

Part of living a balanced lifestyle is having regular times off. Taking a holiday at least once a year can help you get into a different situation and remind yourself who and why you are—outside of your responsible roles.

Poor Leadership

Depending on the leadership, employees can feel recognized for their achievements, supported when they have difficulties, valued, safe, etc. Or they can feel unappreciated, unrecognized, not in control of their activities, or insecure in their position.

PSYCHOLOGICAL FACTORS

Perfectionist Tendencies

Striving to do your best is a sign of a hard-working practitioner and can be a positive trait that leads to excellence. However, perfectionism can cause excessive stress and sometimes be crippling.

Pessimism

Pessimists tend to see the world as more threatening than optimists. They worry more about things going wrong, expect more bad things than good, and believe in themselves less.

Excitability

Some people are just naturally more excitable than others. They have a stronger response to stress, and it's triggered more easily. There's not much you can do to change your body's chemistry, but you can practice tension relieving strategies that can help you calm down when you do get stressed.

Personality

'Type A Personalities' put people at an increased risk for cardiac disease and other health and lifestyle difficulties. The two cardinal characteristics are 1) time impatience and 2) free-floating hostility. Being 'Type A' (or working closely with someone who is) can cause additional and chronic stress, increasing burnout risk.

Lack of Belief in What You Do

Some jobs are poorly compensated, but supply great rewards in terms of making a difference in the lives of others and making the world a better place. For those who believe in what they're doing, stress is less of a factor.

Having read the above, if you think you might be at increased risk of burnout, and want more information or would like to take informal tests:

http://stress.about.com/od/selfknowledgeselftests/a/burnout_quiz.htm

http://www.mindtools.com/pages/article/newTCS_08.htm

How to protect against burnout

Peer support and supervision

It is **not** a weakness to seek peer support and (individual or group) supervision. We would suggest that it should be a **priority** in this type of work, and not optional.

- **Training**

Develop a good understanding about why offenders with personality disorder present with such challenging behaviours, and have a set of clear and helpful management strategies for responding to different PD presentations. **Read this guide!**

- **Expectations**

It can help to maintain realistic expectations about the work, such as not expecting to like PD offenders or be liked by them, and staying calm and not taking things personally. In particular, having realistic expectations about change and what is reasonable and possible, helps in achieving a sense of progress.

- **Humour**

Practitioners in forensic services are known for their dark humour – in small doses, it can help to relieve tension and put difficulties in perspective.

- **Clarity about the job**

It helps practitioners to have clarity about the role and responsibilities within the team and within the organisation. Leaders should articulate clear organisational values to which practitioners can feel committed.

- **Thinking time**

Practitioners need to have regular protected reflective time put aside. This 'thinking space' is used to reflect on how staff work together as a team and with their clients rather than on the management of rotas, tasks and forms, etc. This can help to stimulate personal and professional growth, improve the quality of service delivery and close the gap between principles and practice.

- **Seek feedback**

This can sometimes be the only means of gaining praise to balance out criticism.

- **Workload**

Reviewing your workload, prioritise, and cut down on "low-yield" work

- **Support network**

Develop a healthy support network in and outside work

- **Have a life outside work**

Maintain a healthy work/life balance

- **Learn to relax**

Practice regular stress management, take regular holiday breaks and get enough sleep and rest.

Reflective practice means

- Taking thinking time once a week instead of clearing your in-tray
- Chatting informally with peers about cases
- Presenting cases to your supervisor and exploring the offender's life narrative and your responses to it
- Drawing on current knowledge to improve your confidence
- Knowing when you feel overwhelmed
- Getting better at time management and prioritising tasks
- Thinking constructively about why a situation went wrong
- Giving yourself a pat on the back for something that went well.

Appendix A

OASys PD Screen

Item (relevant OASys section in bold)	Definitely present? Y/N
1.5 1 or more conviction aged under 18 years?	
1.11 Any breaches?	
1.12 3 or more different categories of conviction (as an adult)? (Categories: Murder/manslaughter/attempted murder, burglary, theft, arson, drug offences, GBH/wounding/robbery/abduction, other violence, criminal damage, sexual offences, driving offences, fraud and forgery)	
2.2 Any of the offences include violence/threat of violence/coercion?	
2.2 Any of the offences include excessive violence/sadism?	
2.6 Does the offender fail to recognise the impact of their offending on the victim/community/wider society?	
*5.5 Over-reliance on friends/family/others for financial support?	
*7.4 Has a manipulative/predatory lifestyle?	
7.5 Evidence of reckless/risk taking behaviour?	
*10.7 Evidence of childhood behavioural problems?	
11.2 Any Impulsivity?	
*11.3 Any Aggressive/controlling behaviour?	
Total number of items endorsed	

Note: This is the full (12 item) version of the PD screen using OASys items. However, 1.11 and 1.12 have been removed from the latest version. We would recommend using the full 12 item screen as there is some evidence to support its use and items 1.11 and 1.12 are highly indicative of antisocial personality features. Items marked * are only available in the full (Layer3) OASys.

Cut off: We suggest a cut off of 2/3rds of the items endorsed (i.e. 8/12). Careful consideration to risk management should be given to cases scoring above the cut off.

However, note that a large numbers of offenders will reach the cut off; at least 30% of offenders on a caseload score at or above a suggested cut off of 2/3s or more of the items endorsed. However, this rapidly decreases as the number of items present increases. Higher scores are likely to reflect a more severe antisocial presentation.

This tool will only screen for antisocial/psychopathic traits and not for characteristics of other disorders. Other types of PD may be present even if the scores are not raised.

For further guidance, see the sections on the OASys PD screen (p.15), the use of screening tools (p.16) and working with ASPD (p.73).

Appendix B

PD Diagnoses - Top Tips

- 1. Schizoid Personality Disorder**
- 2. Narcissistic Personality Disorder**
- 3. Anti-Social Personality Disorder (ASPD)**
- 4. Paranoid Personality Disorder**
- 5. Cluster 'C' Personality Disorders (Avoidant, Dependent and Obsessive-Compulsive)**
- 6. Borderline Personality Disorder (BPD)**

Note that histrionic personality disorder is missing entirely, that there is only a brief description of schizotypal personality disorder (at the end of the schizoid personality disorder section) and Cluster C disorders have been collapsed into one. This is because:

- a) these personality disorder diagnoses are less commonly encountered in an offending population
- b) experienced clinicians sometimes struggle to differentiate schizotypal from schizoid personality disorder; or to differentiate histrionic from borderline personality disorder

1. Schizoid Personality Disorder

Quick Reference

Overview: Characterised by a lack of interest in forming relationships with others and a flattened emotional state.

Link to Offending: Most never come into contact with Criminal Justice. Offences are often unpredictable, may be related to their unusual fantasy life, their lack of empathy for others or the emergence of psychotic symptoms when under stress.

Tips: Be respectful of their need for space within interpersonal relationships and their perception of others as intrusive.

View of Self	View of Others	Main Beliefs	Main Strategy
Self sufficient/ Loner	Intrusive	“Others are unrewarding” “Relationships with others are messy, undesirable”	Stay away

Profile of the Schizoid Personality

The central features of the schizoid personality are an apparent lack of interest in relating to others and a marked emotional detachment. Such individuals often see themselves as loners or misfits, have a strong need for autonomy and perceive other people as intrusive. They may have difficulty experiencing strong emotions and struggle either to reflect on or express their emotional needs. They may have a monotonous quality to their speech and appear reserved, inexpressive, humourless and emotionally flat. They often lead isolated lives, prefer solitary pursuits and frequently withdraw into an engrossing, private fantasy life. For some individuals, despite an outward appearance of self sufficiency there may be an inner longing for closeness, somewhat hampered by their acute sensitivity. For others the need for attachments may be absent. Schizoid individuals may have relatives who suffer from mental illness; they themselves may suffer from depression or anxiety at times of stress, and they cope poorly with change. They may drink heavily in an attempt to ‘fit in’. There is also considerable overlap with Avoidant and Schizotypal PD and Asperger’s Syndrome (Autistic Spectrum Disorder).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies common features:

- Neither wants nor likes close relationships, including those within a family
- Nearly always prefers solitary activities
- Has little interest in sexual activity with another person
- Enjoys few activities if any
- Other than close relatives, has no close friends or confidants
- Does not appear affected by criticism or praise
- Is emotionally cold, detached or bland.

Relationship to offending

- Schizoid PD has been shown to hold a modest, but significant relationship with risk of violence. It has been found to be present in 7% of prisoners, with higher rates found among violent and sexual offenders; including a subgroup of sexual murderers.
- Schizoid personality features may be linked to offending in a number of ways:
 - Schizoid individuals often feel little empathy for others, which might otherwise inhibit aggressive acts.
 - Violence committed by schizoid individuals may be related to an unusual fantasy life.
 - There may be a tendency to over-control and suppress emotions leading to a build up of frustrations and the possibility of an emotional breakdown. At such times, uncharacteristic and sometimes extreme acts of aggression may occur and psychotic symptoms may also emerge.
 - Sexual offences perpetrated by schizoid individuals may be associated with difficulties establishing intimate attachments with adults.
 - Certain emotional elements of the schizoid personality overlap with features of psychopathy (e.g. shallow affect, lack of empathy etc.). This can lead to higher scores on the PCL-R which may be misleading.

Working with Schizoid PD

Tips for one-to-one working:

Respect their need for space

It will be recalled that schizoid individuals may experience others as intrusive, and are generally wary of others. Tolerate silences, limit intrusive questioning, keep a regular structure to sessions, don't meet too often, and avoid emotionally complex questions.

Adopt a patient approach

For schizoid individuals, the pace of supervision may need to be slow to allow for the gradual establishment of a collaborative relationship. Remember, stubbornness is part of the disorder, and they will always be more rigid and obstinate than you could ever be!

Attempt to facilitate engagement

Negotiate collaborative goals for supervision and weigh up the pro's and con's of addressing these. Focus supervision on the goals or life difficulties which directly relate to offending behaviour. Encourage structure, but avoid pushing the offender into social activities.

Stay mindful of becoming detached:

The compliant, passive and at times boring presentation of schizoid individuals may provoke others into becoming detached and withdrawn, thus mirroring the schizoid pathology. It should be recalled that despite an apparent indifference, for certain individuals there may be an underlying hypersensitivity to the comments or behaviour of others. Try and remain consistent, reliable and responsive, during supervision.

Tips for general offender management:

Offending Behaviour Programmes

For some, groupwork is entirely inappropriate, and schizoid individuals will respond with outright refusal, or become increasingly bizarre in their interactions in the group. Such individuals will do better in supervision alone, or some additional individual psychological therapy. Others might be able to participate, but expect – and tolerate – a rather detached, intellectualised and superficial manner. Such individuals are unlikely to change attitudes, but might benefit from the social modelling of interactions in the group.

Sentence planning

This should be guided by an understanding that social interaction for such individuals is likely to be difficult and hold the potential to cause destabilisation. It may be that the risk posed by such individuals will be more appropriately managed by allowing them a degree of freedom and responsibility. Hostel placements and therapeutic communities are contraindicated. Try and keep the number of agencies and professionals involved to a minimum. Avoid change where possible.

Monitor new relationships

Most schizoid individuals will avoid intimate relationships, although they may be interested in sexual relationships. Any new relationship should be monitored carefully as it is likely to be a rather bewildering and stressful experience for the offender. Consider how relevant it might be to the index offence.

Schizotypal personalities are also characterised by anxiety and discomfort within close personal relationships. However, where Schizoid personalities are emotionally flat and unremarkable, Schizotypal individuals may experience psychotic like experiences and behave in an eccentric or odd manner. Their psychotic like experiences will be less severe and cause less distress than those found in schizophrenia, but may include magical or paranoid beliefs and unusual sensory experiences.

2. Narcissistic Personality Disorder

Profile of a Narcissistic Personality

Narcissistic personality disorder suggests an overvaluation of self-worth, directing affection to the self rather than others and holding an expectation that others will recognise and cater to their desires and needs. This self-impression can collapse when the illusion of specialness is challenged. Their self-esteem is brittle and when exposed, can be reacted to with outbursts of rage.

A narcissistic view of oneself as special and deserving can have the accompanying presumption that others will see you in the same light. One would therefore expect others to be admiring of that specialness. These views give rise to beliefs of entitlement, such as *“I am above the usual rules.”*

Holding these beliefs can make someone with a narcissistic view treat others with contempt, particularly as competitors needing to be defeated or overcome. Such individuals may avoid peers who are their equal, seeking out ‘inferior’ or less challenging others. However, some narcissistic features – if modest and held in check – are highly desirable and drive people to become strong leaders, or to persevere in achieving goals, against all the odds. In those with a narcissistic personality disorder, the traits are excessive and destructive, so that an individual’s potential is never achieved.

Quick Reference

Overview: Inflated self worth, self-focus, exaggerates achievements/abilities. Often hold an expectation that others will recognise and cater to their desires and needs. Little reciprocity.

Link to Offending: May feel entitled to exploit others. When sense of superiority is threatened, may be prone to feelings of shame and rage. Risk elevated when combined with antisocial traits, present in a subgroup of high risk paedophiles.

Tips: Try not to provoke feelings of inferiority/shame, which may hinder collaboration. Be mindful of possible attempts to exploit.

View of Self	View of Others	Main Beliefs	Main Strategy
Special/unique superior/above rules	Inferior Admirers	“As I’m special, I deserve special rules” “I am better than others”	Use others, Transcend rules, Manipulate, compete

Relationship to offending

Narcissistic PD alone is not frequently associated with serious offending. There may be transgressions when the individual will not adhere to social rules; alternatively if the illusion of specialness is exposed, and vulnerability unprotected, shame may result in eruptions of rage. When narcissism combines with antisocial traits, the likelihood of offending is higher. Narcissistic traits are evident in some offenders who lash out in response to perceived slights, and in a subgroup of high risk paedophile offenders who believe themselves to be attractive to pubescent boys.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies common features:

- Inflated self-esteem (e.g. exaggerates achievements, displays pretentious self-assurance)
- Interpersonal exploitativeness (e.g. uses others to indulge desires, expects favours without reciprocity)
- Expansive imagination (e.g. immature and undisciplined fantasies, prevaricates to redeem self-illusion)
- Supercilious imperturbability (nonchalance and cool unimpressibility)
- Deficient social conscience (e.g. flouts social conventions, a disregard for personal integrity and the rights of others).

Tips for working with Narcissism

The core theme of narcissistic PD is self gratification and independence from others. Greater consideration is given to factors which impact on the self and little consideration is given to factors important to others/society. Tips for one-to-one working:

Tips for one-to-one working:

Entitlement, specialness & arrogance

These core traits of narcissistic PD should not be challenged head on. Anticipate being provoked by unreasonably contemptuous comments, and resist the temptation to rise to the bait. However, everyone loses their temper with a narcissistic individual at some point!

If the offender is better read, more educated, has more sophisticated tastes than you, then acknowledge it in a neutral way. If the offender makes false claims about qualifications, ignore it (unless he/she is engaged in fraudulent activity).

Exploitativeness:

The individual may try to exploit your relationship. Try to soften refusals to exploitative requests and minimise outrage by pinning reasons on neutral factors rather than those relating to the individual.

Alternating idealization/devaluation;

Be aware that references to you and others may be objectively out of proportion. It may help not to react to either overly positive or negative references to yourself, to help keep balance.

Need for superiority:

Be mindful of the power imbalance in the professional/client relationship. Steps to reduce this include collaborative decision-making, underplaying the hierarchy, offering choice, and avoiding jargon.

Tips for general offender management:

Offending Behaviour Programmes

The narcissistic offender will be dismissive of groupwork or therapeutic endeavours, because of the fear that exposure will lead to humiliation. He may be undermining in the group, but if his core traits (specialness and arrogance) can be enlisted and engaged, he may decide to take on the role of group leader in a constructive fashion. Within reason this should be encouraged, not squashed.

Sentence planning

Use controls sparingly, and ensure that the reasoning behind them is robust – the narcissistic offender will be driven to highlight inconsistencies and flaws in an attempt to restore self esteem. Be transparent about the rules and try to reduce the personally confrontational element to them.

Pursuing work, training or personal interests, is important to the narcissistic offender. Achieving in these areas in a pro-social way is usually a very important part of reducing risk. It is important to try and avoid deflating the individual, or putting too many obstacles in his path; this will be tempting because he will exclude the practitioner from these areas of his life, boast about his abilities, and dismiss other aspects of the sentence plan.

3. Anti-Social Personality Disorder (ASPD)

View of Self	View of Others	Main Beliefs	Main Strategy
Loner Autonomous Strong	Vulnerable Exploitative	“I’m entitled to break rules” “Others are wimps” “I’m better than others”	Attack, rob, deceive, manipulate

Profile of the Antisocial Personality

Individuals with ASPD may rigidly view the world as a hostile, ‘dog eat dog’ place, where survival is only possible through exploiting others. They may struggle to hold others’ points of view, be dismissive of close attachments and view relationships along a continuum of dominance and submission. At one end of the antisocial spectrum are highly psychopathic offenders who are likely to present a very high risk of harm to others. Such individuals may show conduct disorder from an early age, be highly callous or even sadistic, view others with contempt, have a strong need for dominance and a low tolerance for frustration. They may use both instrumental and explosive aggression, feel entitled to exploit others for their personal gain and be highly treatment resistant. At the other end of the continuum are prolific – but low harm – offenders whose problematic behaviour may begin in adolescence and not persist past early middle age (antisocial burnout). There is more likelihood of treatability at this end of the continuum, including a response to accredited programmes.

Quick Reference

Overview: Characterised by childhood conduct disorder and impulsivity, irresponsibility, remorselessness and frequent rule breaking in adulthood. A very broad category which includes high numbers of offenders along a continuum of severity.

Link to Offending: Associated with an increased likelihood of general, violent and to a lesser extent sexual offending (although much more common in rapists than in child sexual offenders).

Tips: Important to identify the more psychopathic sub-group and seek specialist support. Target normal criminogenic variables (particularly substance misuse), be wary of attempts to manipulate and deceive, do not rely on empathy and rapport, and focus on external controls.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies common features:

- a** Conduct disorder with onset prior to age 15 years
- b** Since age 15 years, three or more of the following must be present:
 - Failure to conform to social norms with respect to lawful behaviours
 - Deceitfulness (repeated lying, use of aliases, or conning others for personal profit or pleasure)
 - Lack of remorse
 - Impulsivity or failure to plan ahead
 - Irritability or aggressiveness as indicated by repeated physical fights or assaults
 - Reckless disregard for the safety of self or others
 - Consistent irresponsibility.
- c** Age at least 18 years

Relationship to offending

- Almost 50% of UK prisoners may meet the criteria for ASPD. It is associated with an increased likelihood of general recidivism, violence and, to a lesser extent, sexual offending. Among sexual offenders it is far more common among rapists than child sexual offenders.
- ASPD may be linked to offending in a number of ways:
 - Sufferers may have failed to internalise a social conscience, which might otherwise inhibit antisocial behaviour.
 - They may have a tendency towards acting out aggressively when faced with inner conflict (such as feelings of frustration, anxiety or helplessness).
 - They may experience others as threatening and therefore possess a strong need for dominance.
 - They may be highly impulsive, this is likely to get them in to trouble.
 - It often occurs in combination with other PD diagnoses. These traits (such as a paranoid thinking style, problems controlling emotions and a sense of superiority over others) may therefore also contribute to an increased likelihood to offend.
 - Substance misuse is common and when combined with antisocial traits, risk of harm (self and others) increases considerably.

Tips for working with ASPD

Tips for one-to-one working:

Monitor your own emotional reactions:

It is easy to become too punitive or submissive when working with highly antisocial individuals.

Limit excessive expectations of improvement (particularly in the short term):

The evidence regarding treatability is mixed and motivation is a problem. Most antisocial offenders desist by their late 20s as being antisocial is exhausting, and maturation sets in. Be positive, transparent, respectful, but not overly invested in the outcome.

Be firm and persistent;

Take a behavioural approach to problematic behaviours; give clear feedback, provide consistent responses, never make a threat you are not prepared to carry out.

Use 'enlightened self-interest':

Identify shared goals – perhaps money for lifestyle, or keeping out of prison – and encourage the offender to explore the costs and benefits associated with offending or a problem behaviour.

Be mindful of attempts to deceive or manipulate:

Do not be too trusting as it will make ASPD individuals suspicious. If anxious, they will manipulate or deceive you to restore the 'status quo'. Try not to feel personally humiliated or defensive if you are caught out.

Tips for general offender management:

Address criminogenic need in the usual way:

For most individuals, general offender management targeting criminogenic variables with standard interventions is appropriate. Specialist assessment or intervention is likely to be needed with certain high risk, high harm, or high psychological dysfunction cases only.

Consider co-morbidity:

There are also sufferers of ASPD with more complex presentations. These individuals may present with mood disorders, may be highly psychopathic, or also meet the criteria for other personality disorders (e.g. borderline, narcissistic, paranoid). Signs which might suggest the need for further specialist assessment or support would include very early onset conduct problems, a history of serious childhood trauma, a diverse offending history, sadism, high levels of instrumental violence, very difficult or volatile interpersonal behaviour during supervision, attacks on staff, suicide/self harm, or a history of engagement with mental health services.

Target substance misuse;

This is a priority, due to the strong association with antisocial traits, substance misuse and risk of violence.

Prioritise external controls but NOT rules

ASPD offenders are rule breakers, so do not create long lists of conditions which they will inevitably break! Prioritise.

Sanctions

Think about these in advance, as you will need them! Anti-authoritarian rule-breakers with chaotic lives, miss sessions, drop out of programmes, and re-offend before completing orders. Make sure the offender knows and understands the consequences in specific, not general, terms.

4. Paranoid Personality Disorder

View of Self	View of Others	Main Beliefs	Main Strategy
Right/noble Inviolable	Malicious Demeaning	World is hostile World is complex	Suspicious Provocative

Quick Reference

Overview: High levels of mistrust and suspiciousness. Easily provoked into feeling unfairly treated or attacked, developing grievances and harbouring resentments.

Link to Offending: May facilitate angry aggression due to perceiving others as threatening, undermining, disloyal or dangerous. Linked to domestic abuse and stalking.

Tips: A more distant management approach in which trustworthiness may be proved over time is advised. Limit direct challenges to paranoid thoughts and behaviours.

Profile of a Paranoid Personality

Mistrusting and suspicious with a tendency to hold grudges against others. They are often guarded interpersonally and distant in relationships, avoiding closeness. They may be hypervigilant to threats in their environment and are prone to over-reacting to seemingly innocuous situations. Their thinking style may be rigid and inflexible, making them harder to rationalise with.

A person experiencing paranoia sees other people through a lens which emphasises hostility, malice and persecution. They more readily interpret the actions, words and intentions of others as potentially damaging to them. The world is viewed as complex and intricate, a place that needs to be unpicked and interpreted with caution. Situations and interactions are less likely to be taken at face value and the individual may search for hidden meanings which confirm their suspicions. The world is seen as a controlling and intrusive place which conspires against the individual. A paranoid person may wish to seek refuge from these dangers that they see all around them. Paranoid people tend to see themselves as righteous and noble. They may feel incorruptible in a corrupt and manipulating world. Their stance becomes rigid, inflexible and closed off. They may feel the need for assistance, but doubt the sincerity of that help when it is offered and just reject it. They

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies common features:

- Suspicions that others are deceiving, exploiting or harming the individual
- Preoccupations with unjustified doubts as to the loyalty or trustworthiness of associates/friends
- A Reluctance to confide in others, fearing information will be used maliciously
- The perception of hidden, demeaning or threatening content in ordinary events/ comments
- A persistent bearing of grudges
- Perceptions of personal attacks on their own reputation or character, responding quickly with anger or counterattacks.
- Unjustified, recurring suspicions about the fidelity of spouse/sexual partners.

may refuse to engage in rational discussion. To protect themselves against the feeling of being controlled, they may act with stringent autonomy. They may try to counter feelings of persecution by making complaints or threats.

Relationship to offending

Some examples of offending include:

- Domestic violence – possibly escalating from arguments about the partner's fidelity.
- Reactive aggression – this may occur spontaneously when the individual perceives a (real or imagined) threat.
- Planned pre-emptive strikes – this may occur when a paranoid individual takes preventive action against a threat (the perceived cause of the paranoid belief system).

Tips for working with Paranoid Personality

Tips for one-to-one working:

Respecting the core traits and interpersonal style:

- Expect and ignore demeaning comments and hostility. The offender is defending himself.
- Do not challenge distorted core beliefs and thoughts as this will lead to a fight that you will lose.
- Excessive friendliness may appear cunning and deceitful, as if the offender is being lulled into a false sense of security.
- A major goal is to free the individual of mistrust. Take slow and progressive steps to develop trust.
- Retreating behind procedures and keeping the client out of the loop may increase paranoia.
- Deliberately counteract suspicion: increase transparency, share documentation, Avoid secrecy and explicitly describe steps involved in decision-making.
- If the paranoia centres on you, consider third party mediation (your senior's help) to lessen grievances.
- Reacting defensively may heighten their state of paranoia and confirm their view of the world as hostile. Do not co-work with two of you in the room.
- Without colluding in the distorted world vision, try and understand and empathise with the development of the belief and its emotional impact.

Tips for general offender management:

- Consider a central point of contact (e.g. a keyworker) through which other agencies can communicate, and try to cut down on multiple reporting systems.
- Persistent offers of too much contact, either in regularity or intensity, may be experienced as overwhelming. Keep modest aims in forming an alliance – a more distant approach may be beneficial. Be as flexible as possible about setting the frequency and regularity of contact.

- 
- Behavioural controls may threaten their autonomy, heighten powerlessness and increase a sense of persecution. Use restrictions sparingly and give careful consideration to which are necessary. Try to include the individual in setting up these controls.
 - Do not confuse antagonism with non-compliance. Try not to increase controls in response to a paranoid response as this may have an adverse effect. Instead, stay focussed on compliance with reasonable requests.
 - Try to enhance the individual's control over areas of personal importance.
 - It is rarely advisable or helpful for paranoid individuals to live in shared accommodation.

5. Cluster ‘C’ Personality Disorders (Avoidant, Dependent and Obsessive-Compulsive)

Profile of the Cluster C PD’s

Cluster C PD’s are sometimes referred to as the anxious and fearful disorders, due to the underlying sense of anxiety which is common to all. The pathology may be less obvious than some of the other PD’s making them easy to miss.

Avoidant PD is characterised by high levels of social anxiety, which stems from an underlying sense of defectiveness and inadequacy. Individuals with avoidant PD are typically socially withdrawn, apprehensive, shy and awkward. Due to an inner sense of inferiority, they are ever vigilant for signs of rejection and failure and avoid situations in which they fear that their perceived shortcomings will become apparent to others. They may desire close personal relationships, but are also hypersensitive to rejection. Substance misuse may be used as an escape.

Dependent PD is characterised by a negative self concept associated with core feelings of helplessness and inadequacy and a corresponding need to be taken care of. They fear being alone and actively attach themselves to others who they feel will be able to meet their needs. They may be highly suggestible and struggle to make decisions without considerable help and reassurance. Emotionally they suffer with pervasive feelings of anxiety and behaviourally they are passive, under assertive and submissive.

Obsessive Compulsive PD is characterised by excessive self-control, a pre-occupation with order, rules, hierarchies and an unwavering conviction in their high moral, ethical and professional standards. Sufferers may be highly self-critical with any inability to attain their high standards being viewed as a catastrophic failure. They may also expect others to meet their high standards and be highly critical of those with different ideals. They are likely to possess a rigid and ruminative thinking style, be highly perfectionist, procrastinate for lengthy periods and therefore struggle to complete tasks. May be confused with schizoid PD.

Quick Reference

Overview: Often referred to as the anxious and fearful disorders due to the behaviours which are symptomatic of the individual disorders.

Link to Offending: Generally likely to be low risk and obsessive-compulsive traits may actually be a protective factor for risk of recidivism. However, Dependent PD may be associated with domestic violence and avoidant and dependent PD’s are some of the most commonly found PD’s in child sexual offenders.

Tips: Avoid confrontational approaches, reward compliance and work towards developing greater autonomy and assertiveness over time.

PD	View of Self	View of Others	Main Beliefs	Main Strategy
Avoidant	Inadequate, worthless	Critical, demeaning	“It’s terrible to be rejected, put down” “If people know the real me they’ll reject me”	Avoid
Dependent	Weak, helpless	Strong, overwhelming	“I need people to survive, be happy” “I need to have a steady flow of support, encouragement”	Attach/Be submissive

PD	View of Self	View of Others	Main Beliefs	Main Strategy
Obsessive Compulsive	Responsible, competent	Irresponsible, incompetent	"I know what's best" "Details are crucial" "People should do better"	Control

Relationship to offending

Cluster C PD's in general are not strongly associated with a high risk of serious offending and obsessive compulsive traits in particular confer a particularly low risk. Despite this, personality characteristics associated with cluster C PD's may facilitate offending behaviour in a number of ways:

- Dependent personality features are characteristic of an established typology of male domestic abusers. In such individuals violence may be facilitated by a pre-occupied and anxious attachment style, a resulting fear of abandonment and a tendency to experience jealousy.
- Avoidant and Dependent PD's are some of the most frequently identified personality disorders in child sexual offenders (and internet sexual offenders) and may be associated with difficulties establishing rewarding intimate relationships with adults, social withdrawal and loneliness.

Tips for working with Cluster C PD's

Tips for one-to-one working:

Develop rapport through empathy:

Avoidant and dependent individuals are likely to be anxious and inhibited in supervision. Providing empathy, understanding and re-assurance may facilitate collaborative working.

Avoid confrontational approaches:

As these will trigger anxieties about rejection or criticism.

Expect forms of avoidance at certain times to manifest in supervision such as lateness, or missed sessions, dropping out of treatment and a reluctance to talk about thoughts, feelings and offending behaviour. This is despite cluster C individuals usually being compliant. It usually relates to negative feelings which cannot be expressed directly for fear of rejection.

Work towards developing greater autonomy and assertiveness over time

With dependent individuals it is particularly important to avoid being drawn into being too directive and 'taking control' as this is likely to encourage further dependence and confirm feelings of helplessness. Instead, take gradual steps towards encouraging greater social integration and autonomy.

Be mindful of endings as they may be particularly destabilising and trigger fears of abandonment, which are not openly expressed. Sometimes, offending can occur within days of the ending, in order to resume contact with the practitioner. Explicitly planning the end of supervision and allowing a gradual reduction in the frequency of contact will help.

Tips for general offender management:

Offending behaviour programmes may provoke considerable anxiety, particularly for avoidant individuals but may ultimately be highly rewarding and particularly therapeutic. Anticipating concerns and providing additional support initially will help in the longer term. Occasionally you may need to liaise with GP or mental health services, as depression or anxiety can be used as means to avoid difficult group work.

Sentence planning

Behavioural controls and sanctions are likely to be less important with cluster C individuals, who may be generally compliant, and experience the consequences of arrest and punishment as being highly aversive. Reward compliance and any evidence of trustworthiness and use restrictions sparingly.

However, where substance misuse is a relevant offence antecedent, this should be considered to be a priority target for intervention.

6. Borderline Personality Disorder (BPD)

Profile of a borderline personality

A disorder of emotion regulation, including unstable moods, interpersonal relationships, self-image, and behaviours. Moods may be extreme in nature, experienced with greater intensity and shifting rapidly (i.e. lasting hours rather than days). Their relationships may be very unstable, as their view of others pivots between idealization (highly positive regard) and devaluation (intensely negative feelings). They may quickly form intense and tempestuous attachments to significant others. Individuals with BPD can be very sensitive to the way others treat them, reacting strongly to perceived criticism or hurtfulness. There is a particular sensitivity to rejection and abandonment, even minor separations may induce intense feelings of anger and distress. Their self-image is also unstable, varying from positive to negative regard. They may express feelings of emptiness and lack of purpose in life. They may respond to their intense mood states and interpersonal conflicts with impulsive behaviours. These are sometimes understood as efforts to regulate their distressing feelings and may include alcohol or drug abuse, promiscuous sex, gambling, self-harm and suicide (with varied levels of intent).

Quick Reference

Overview: Unstable sense of self, moods and relationships. Frequent emotional crises, 'black and white' thinking, deliberate self-harm, suicide attempts, impulsive and risky behaviours.

Link to Offending: Related to domestic abuse and expressive, impulsive aggression. May also offend as a means of drawing other's attention to their internal distress.

Tips: Manage 'splits' between agencies/staff, be mindful of cycles of idealisation and devaluation. Adopt a bounded, but validating (empathic) approach with clearly defined roles for all. May need to settle crisis behaviours before offence focused work is possible.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) identifies common features:

- Frantic efforts to avoid real or imagined abandonment
- A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
- Identity disturbance: markedly and persistently unstable self-image or sense of self
- Impulsivity in at least two areas that are potentially self-damaging (e.g. promiscuous sex, eating disorders, binge eating, substance abuse, reckless driving)
- Recurrent suicidal behavior, gestures, threats or self-injuring behavior
- Affective instability due to a marked reactivity of mood
- Chronic feelings of emptiness, worthlessness
- Inappropriate anger or difficulty controlling anger
- Transient, stress-related paranoid ideation, delusions or severe dissociative symptoms.

View of Self	View of Others	Main Beliefs	Main Strategy
Bad/vulnerable Uncertain	Malevolent Dangerous	Idealistic Devaluing	Attach Attack

Relationship to offending

Types of offending can be divided into three subgroups:

- reactive acts of aggression to perceived interpersonal difficulties, such as impending abandonment/rejection (e.g. violence to partner/significant other).
- Impulsive acts of recklessness as a means of emotion regulation (e.g. substance misuse, prostitution, suicide attempts).
- Expressive acts of need (e.g. fire-setting, or other rule-breaking which results in containment).

Tips for working with BPD

Tips for one-to-one working:

Alternating idealization and devaluation

Be aware that references to you and others may be objectively out of proportion. Both positions are exhausting. Try not to react to either overly positive or negative references to yourself – they are unrealistic!

Splitting

as the individual changes between attaching to and attacking others, 'splits' can occur within staff groups, leading to conflict: some experience the individual positively and others negatively. This is not a problem as long as you recognise it quickly, and sort it out.

Demanding and overly attached:

Watch out for excessively long 'counselling' sessions, multiple crises, lots of practitioners each putting in much hard work. This can lead to huge investment followed by disillusionment in the staff group. Draw up a contract, divide the tasks, set boundaries to the time allocated, and then stick to the plan.

Expressive acts of need

Repeated and dramatic expressions of distress may become difficult to comprehend or manage, especially if they appear objectively out of proportion to the events described. Most commonly in offenders, it will be self harm, or fantasies and threats to harm others. This raises anxieties in practitioners who then provide too much attention to the behaviour, and/or too little attention to the underlying emotion. Focus on the experience, not the behaviour, and always validate their inner experience - no matter what your subjective view may be.

Tips for general offender management:

Hospital admission

Compulsory admission to hospital is seen generally as unproductive, particularly for ongoing treatment, and should only be used as a last resort. Brief crisis admissions can be very helpful, if there is good follow up afterwards.

Health versus CJS

Here is the most likely place for 'splitting' to occur. Strive for a partnership, with CJS at the centre, strongly supported by health.

Residential hostel placements:

Provide a level of structure and containment beyond that which outpatient appointments can manage. Do not under-estimate how much a borderline PD offender will miss the hostel, despite causing chaos when living there!

Non-statutory agencies

Agencies outside of the NHS and CJS may provide support that is uncontaminated by the threat of legal detainment. It may be worth researching voluntary sector services such as crisis houses, groups or day centres which operate in the local area.

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