



National Offender
Management Service



Working with offenders with personality disorder

A practitioners guide

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities

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Foreword

This guide is intended for staff who work with offenders with personality disorder. It provides practical information and advice on how to manage people whose behaviour 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. This second edition, updates the information, provides additional guidance on working with young adults and women, and developing case formulations.

Personality disorder is a complex psycho-social disorder. Studies have estimated that, whilst it affects between 4 and 11% of the UK population, its prevalence in the criminal justice system is far higher: 60-70% of prisoners and about 50% of offenders managed by providers of probation services. Over the last 10 years, this disorder has become better understood with services more able to meet the needs of this population. This is especially so in the Criminal Justice System.

In 2011, following a public consultation, the Department of Health (subsequently, NHS England) and the National Offender Management Service, jointly commissioned a new approach, targeting specific offenders where defined types of offending are likely to be linked to personality disorder. New services, which aim to form a pathway of care, are now available in the community and prisons jointly led and delivered by clinical and criminal justice staff.

This is a time of innovation as new services, and the staff within them, learn and develop. This guide supports this learning by providing pragmatic approaches for all practitioners.



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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 Ps: 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. Having PD does not automatically flag 'high risk', but pay attention when these features are present.
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 and collaboration. Don't forget to start with crisis planning.
7. Treatment may, however, not be available in all cases, particularly for those who are unresponsive and in denial. Focus on building a strong relationship with clear boundaries: 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. For example, consider how their early experiences may play out in their current behaviour and relationships as this might help.
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 Ps – 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' and these characteristics cause difficulties for themselves or others (*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 Ps

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

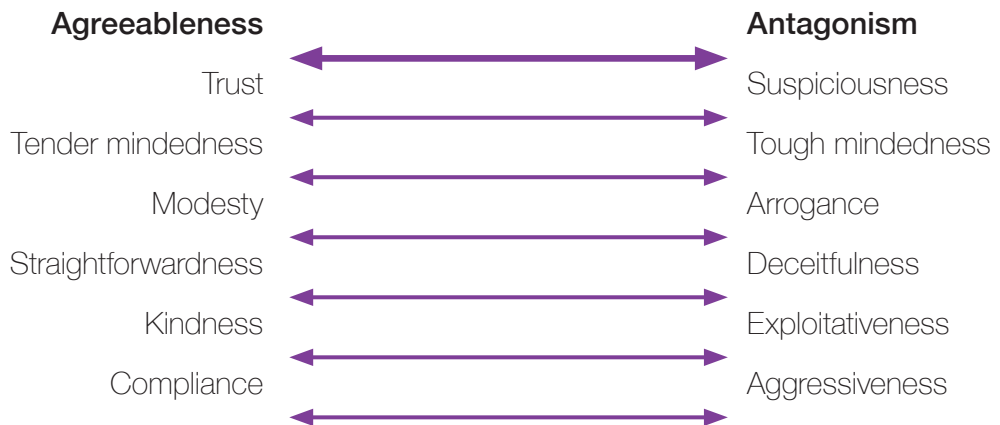
unusual and causing distress to self or others
starting in adolescence and continuing into adulthood

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.

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), 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



Attempts to define 'severity' have been a challenge. One approach is to consider the extent to which the traits are disabling in terms of the individual's life; another approach is to consider the range of traits; that is, the extent to which diverse traits from different personality disorder diagnoses are present. Both approaches have some evidence to support them.

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
- Particular problems in close or intimate relationships with others
- 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 - 5 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 fifth edition (DSM-5). 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: Personality disorders are thought to exist in about 5-10% of the general population, in about 20-30% of general practice patients, in 30-40% of psychiatric patients, and in excess of 50% of prison and forensic samples. Psychopathy is thought to exist at clinically significant levels in between 0.75 and 1% of the population (so, about the same as schizophrenia) and in about 10-15% of the male prison population. There are no good estimates of the prevalence of psychopathy in woman as the traditional ways in which this disorder is measured are biased towards the behaviours of men.

Psychopathy

You will notice that psychopathy is not present among the personality disorders, although it is entirely true to say that is a type of personality disorder. In fact, psychopathy could be thought to be an extreme and co-morbid presentation of antisocial and narcissistic PDs (both elements are required; especially the latter). The definition of psychopathy is characterised by an arrogant and deceitful interpersonal style, deficient emotional experience and expression, and by a wide-ranging pattern of impulsive and irresponsible behaviour. (See Figure 1.1, illustrating the relationship between offenders, psychopathy and personality disorder; see appendix C for top tips for managing offenders with these traits). 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.

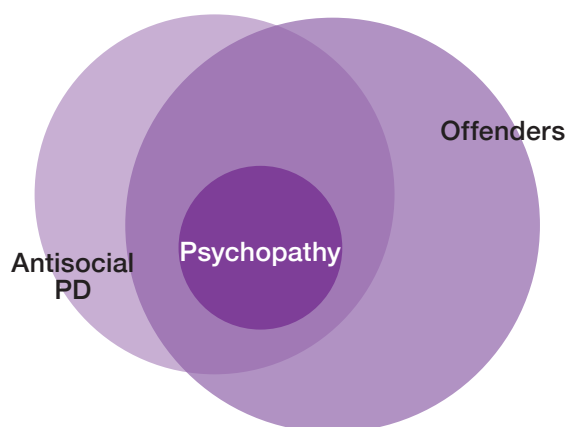


Figure 1.1

Today, when we use the expression 'psychopathy', we think of a clinical disorder, a severe type of personality disorder, which is assessed using specialist instruments and trained assessors. Before the Mental Health Act was last revised, patients detained under the Act could be classified as psychopathically disordered. The use of the term psychopath, with reference to the 1983 version of the Mental Health Act, was quite loose compared to how we use the term now. You might still see reference to psychopathic disorder in the case records of older offenders with a history of having been detained in secure settings under the MHA. It is important to bear in mind the difference between how it used to be defined legally, and its current clinical application, as described above.

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

Lots of mental health problems have been described over the years. Sometimes, it can be hard to distinguish between disorders that have similar presentations, however, the following guidance may help:

- 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 (sometimes combined with psychologically informed approaches) 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 individuals with personality disorder 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.

Top Tip: Whilst it can be a challenge to decide what is going on for a person, taking a good history will help you understand what influences a person's behaviour and how these have developed over time.

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-5) reduces 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 individuals with PD, 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.

It can be difficult to definitively diagnose people with suspected personality disorder, especially if they have other conditions as well, for example, substance misuse. It can, however, be very beneficial to work with such a person to try to understand their lives, and in the course of doing so, to develop a better working relationship and a better sense of how it is for that person to be him or her. Whilst this work is demanding, it can be hugely fascinating at the same time, and this will become clearer in subsequent chapters.

Diversity

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 disorder 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.

There are some differences between male and female offenders with personality disorder. This is explored in more detail in chapter 7. First, generally, you will see more antisocial PD in men and more borderline PD in women. Fewer women, proportionately, are assessed as presenting a high risk of harm to others and large numbers receive short prison sentences for offences related to deception, theft, drugs and prostitution. The emphasis on risk of harm to others can make us focus more on risky men and overlook the risk potential of women. That is not to say that women present a high risk of serious physical harm to others in equal proportion to the male population, rather, that the assumption that only men are risky can lead us to miss or wrongly assess the risk in women. Again, taking a good history, including reviewing collateral information, will help decide what risks an individual presents to themselves and others, and what is best done to manage those risks. 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. However, whilst women are more likely to self-harm, men are more likely to commit suicide. Whilst there may be a greater emphasis on trauma when working with women it is important to remember that many men have also been abused.

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 on 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-5). 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), or Structured Clinical Interview for DSM IV Axis II Disorders (SCID-II). 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. Interviews rely less on the insight and honesty of the person being assessed compared to self-report questionnaires. Interviews also allow you to combine information from multiple sources and to override self-report with more reliable or credible information.

The Psychopathy Checklist – revised (PCL-R) is also an assessment which makes use of file and interview information, although it can be completed without an interview.

How to spot PD

It is not always possible or essential to have suspected PD diagnosed in a person with whom you are working; qualified professionals may not always be available to you to undertake such an assessment. However, it is possible for you to spot some reliable indicators of PD, which could help you decide whether it would be useful to manage this person as if they have a PD. The tools in this guide and elsewhere will help you to detect possible PD but they DO NOT diagnose it.

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

Identifying PD

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

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; this is particularly suggestive of an ASPD profile and possibly 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, individuals with personality disorder 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 individuals with personality disorder. 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, GPs 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 individuals with personality disorder, 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 items which can help to identify people with high levels of antisocial and psychopathic traits. The tool consists of 10 items and these have been developed into a decision tree that can be found in appendix A.

OASys PD screen

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

Suggestion

The presence of 7 or more items might indicate raised concerns.

Guidance on OASys states that if an offender scores positively on all or most items (7 or more) of the PD screen, consideration should be made of a referral to a more specialist treatment intervention. However, a number of individuals with personality disorder (non-antisocial) will score moderately low on the ten items, but will have sexual or violent offending linked to significant histories of childhood adversity. Appendix A provides a scoring checklist for personality disorder associated with high harm offending, which combines the scores for the OASys PD screen with other important features. This checklist – in slightly varied forms – has already been widely used by non specialist practitioners, and found to be a helpful approach. A positive identification of PD on the checklist would suggest that the impact of personality disorder traits should be considered when developing the sentence plan.

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 seven or more of the items endorsed.
- It will only screen for some antisocial, psychopathic and borderline features 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.

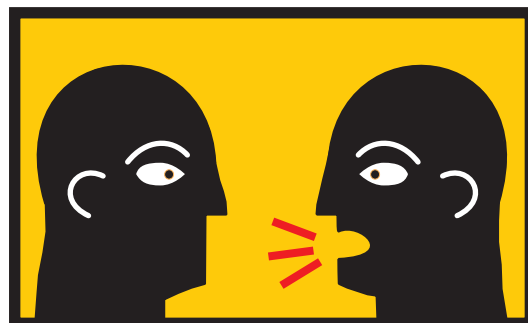
A note on the use of screening tools

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

Services unprepared (unwilling and/or unable) to work with people with PD will experience some or all of the features in the box below. More aware and better trained services will be able to spot the potential problems early. They will be prepared (willing and able) to understand and manage the person and the problems the person experiences by working in psychologically informed ways. 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 8 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. In turn, this can lead to consideration of how to help, understand and manage the person with PD, through consistent, considered psychologically informed approaches by all the staff, teams and agencies involved.

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 a probation 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.

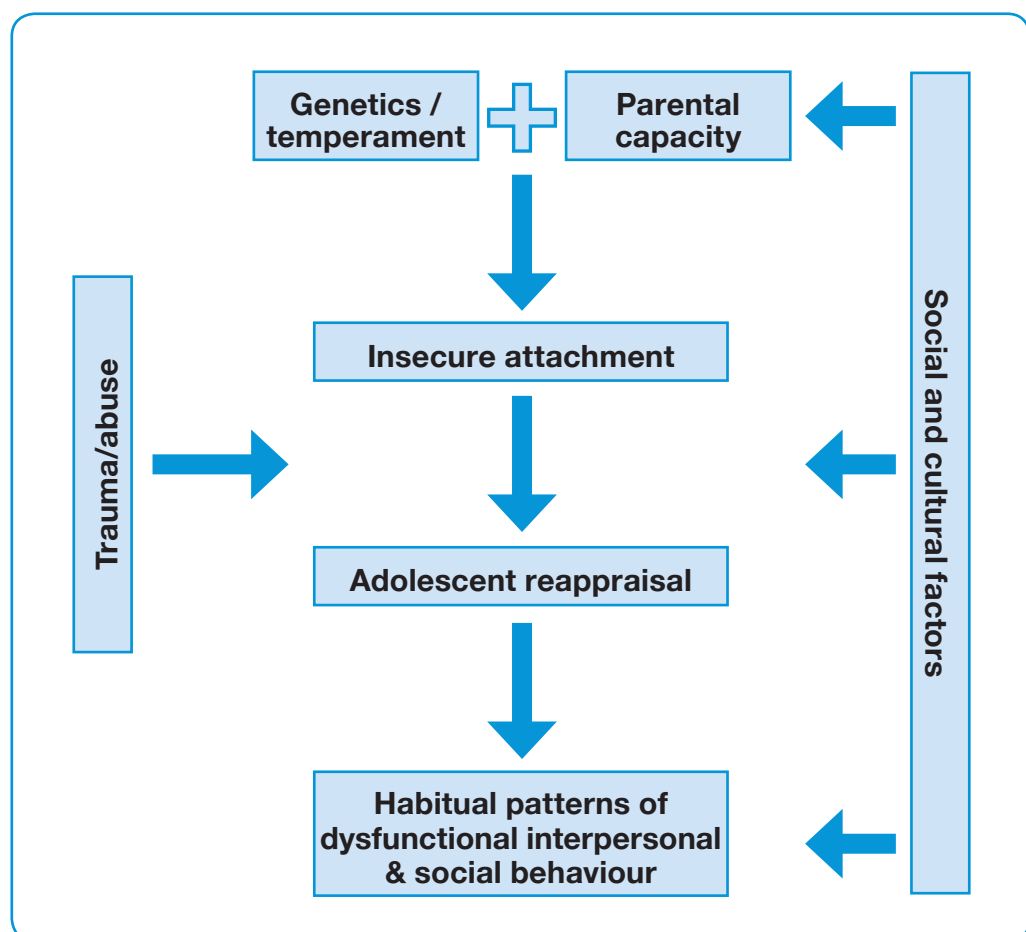


Fig. 2.1



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 individuals with high levels of psychopathic traits, 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 psychopathic individuals 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 offenders with personality disorder. 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:

- 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.

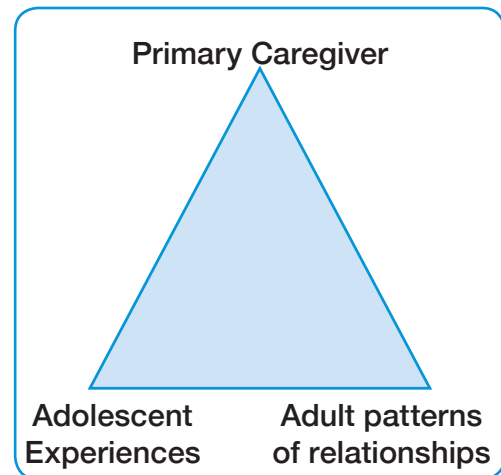


Fig. 2.2

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 individuals with

personality disorder 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 earlier in the chapter – 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.*

Using 'elaboration'
for more detail

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*

Don't challenge,
go for detail

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.*

Use acceptable
words, non
judgemental

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*

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 the unfairness in the family

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.

Starts to relive and merge relationships

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...*

Good/bad memory technique

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.*

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.*

Idealises mum, so separates out this fact

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.*

OM *What did you know about your father?*

High emotion, can't separate self from dad

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.*

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.*

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.*

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

Billy *It 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.*

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.*

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


Care=authority in order to preserve link with mum

Mum and probation have merged in his mind

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 individuals with personality disorder. 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 individuals with personality disorder 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 offenders with personality disorder.
- However, many individuals with personality disorder 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 offender with personality disorder. 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

Formulation

Pulling It All together: A Model For Case Formulation

Introduction

This chapter provides principles and standards to guide practitioners working with offenders with personality disorder, on the role and consistent application of the formulation process. To make sense of the guidance, it is important to have read chapter two on the theoretical principles underpinning the development of personality disorder. Chapter four on psychologically informed management also contains useful information on how to bring a psychological understanding to challenging behaviours.

Formulation can provoke extremely diverse responses in practitioners: prison officers or probation officers may be very new to the concept and initially rather bemused; psychological therapists are more likely to view formulation as lying at the centre of their work with service users, and may be fiercely protective of their particular approach. However, the aim here is to provide a model for formulation which is sufficiently versatile to be accessible to a wide range of professions, generalizable across diverse services, and easily understood by and useful to service users.

What is formulation?

There are a number of definitions of formulation. Two options are detailed below.

A formulation is an organisational framework for producing (generally) a narrative that explains the underlying mechanism of the presenting problem, and proposes hypotheses regarding action to facilitate change.

or

Case formulation is a theoretically-based concise explanation or conceptualisation of the information obtained from diverse sources. It offers a hypothesis about the cause and nature of the presenting problems, and provides a framework to developing the most suitable management or treatment approach.

Why bother with formulation – what outcomes are we expecting?

It will be clear from reading the rest of this guidance that making sense of individuals with complex difficulties and serious offending histories lies at the heart of the OPD Pathway. However, it may not be quite so evident why there should be a consistent approach across services that can be evidenced.

There is a lack of evaluation, to date, examining the impact of formulation on treatment and management outcomes for offenders with personality disorder. That is, practitioners believe it to be a useful tool, but there is little research to support this. In the absence of empirical guidance, it is reasonable to propose the specific but provisional hypothesis that a good formulation:

- i. Has a significant but indirect relationship with the higher level outcome of reduced violent and sexual re-offending. That is, formulation is likely to be significantly related to improved service user engagement, which in turn reduces the likelihood of non-compliance and failure on supervision, which in turn reduces the likelihood of further high harm offending behaviour.
- ii. Is directly related to improved quality of service delivery, both in terms of staff confidence, skill and morale, and service user experience.

Principles for the OPD Pathway

The following principles and quality standards apply to services on the OPD pathway. It is anticipated that they will have relevance to other services and practitioners who are involved in similar work, even though they might be delivering services outside of the pathway.

- a. Every service user on the OPD Pathway should have
 - i. a formulation,
 - ii. a risk assessment drawn from evidence based research and evaluation, relevant to the nature of the risk being assessed, and
 - iii. an integrated plan relating to sentence and risk management, grounded in the formulation.
- b. Although the categories may overlap, for the purpose of consistent and clear communication,
 - Case formulation is defined as a statement of understanding about the whole person, explaining and connecting many aspects of their life experiences to this point in time (likely to include personality, behaviour, and risk, potentially with a multi-disciplinary focus);
 - A problem formulation is defined as a statement of understanding explaining the underlying mechanism of a particular problem/offence as opposed to the whole person (likely to include a detailed analysis of behaviour, but less far reaching than a case formulation); and
 - A risk formulation is defined as a type of problem formulation where the focus is the potential for future harmful (usually violent) behaviour(s) towards self or others (likely to include reference to empirically based risk assessments).
- c. The process of formulation involves:
 - i. organising the available information about the service user
 - ii. making connections between the different pieces of information and how they link over time,
 - iii. forming the basis of hypotheses about change that will guide interventions
 - iv. communicating the understanding gained by the formulation process with others, including the service user when appropriate, and
 - v. reviewing the formulation, as appropriate, in the light of new information

Application of the case formulation approach across services

Quality

There are six standards for formulation that provide the overarching framework for assuring the quality of case/risk formulation. However, these should be applied flexibly according to the context and complexity of formulation.

Table 1

QUALITY STANDARDS
1. The formulation states clearly what it is seeking to explain (i.e., specifically, the case, or the problem/risk, or something else) and why (i.e., what is the purpose of this formulation)
2. The formulation includes an indication of the range, depth and quality of the evidence on which it is based, and makes clear whether it is a formulation expressed with confidence or whether it is in fact a preliminary formulation
3. The formulation accounts for the developmental history of the case and/or the patterns of problem behaviour
4. The formulation provides a psychological explanation of the case or the problem/risk; that is: <ul style="list-style-type: none">a. the formulation organises information relevant to the purpose of the formulation (such as information about attitudes and beliefs, relationships with others, attachments, other situational, social and cultural factors)b. the formulation provides a balanced view about areas of vulnerability and areas of strength, including protective factorsc. the formulation connects pieces of information about the person or the problem/risk in order to create an explanation for the case or the risk/problem under scrutinyd. the formulation proposes hypotheses about the development, activation and maintenance of important problemse. the formulation is developed from an active collaboration between its main author and at least one other relevant person (e.g., the offender manager, the service user him or herself)f. the formulation is clearly and coherently linked to relevant psychological theory or theories

5. The formulation creates hypotheses about action to facilitate change and therefore guides interventions and their prioritisation; that is:
 - a. it provides a basis for decisions about interventions and management and how they should be prioritised
 - b. the formulation should make explicit reference to difficulties that may be encountered and how they could be overcome
 - c. and the formulation should comment on how the service user could be both motivated and enabled to engage with the actions and interventions proposed
6. The formulation is easily understood and relevant to those for whom it is intended (e.g., practitioners, legal bodies such as the Parole Board or Tribunals, the service user, his or her carers, etc); that is:
 - a. the formulation is expressed in language accessible to all those for whom it is intended and avoids the unnecessary use of jargon
 - b. the formulation should be brief enough to be read easily by the individuals for whom it is intended
 - c. the formulation of meaningful and adds to what is already known about the service user
 - d. the formulation avoids the use of judgemental language
 - e. the formulation provides a coherent explanation of the case or problem/risk – the explanation makes sense

Formulation level

Figure 1 provides an explanation of the three levels of formulation, which are intended to provide a consistent means of providing formulations flexibly in response to widely divergent contexts and practitioner needs, and which are the recommended minimum standards for different service types in the OPD Pathway.



Level 1 formulations:

- to be used in community contexts where the service user is progressing according to the sentence plan;
- to be used to train prison officers in order to help them to make sense of difficult behaviours.

Level 2 formulations:

- to be used in community contexts where there is impasse in terms of the sentence plan;
- to be used in PIPES - Psychologically Informed Planned Environments – see chapter 4 (this is optional – a Level 1 formulation may be used as an alternative);
- to be used in non-intensive community treatment settings (standard weekly/fortnightly sessions and/or < 12 months).

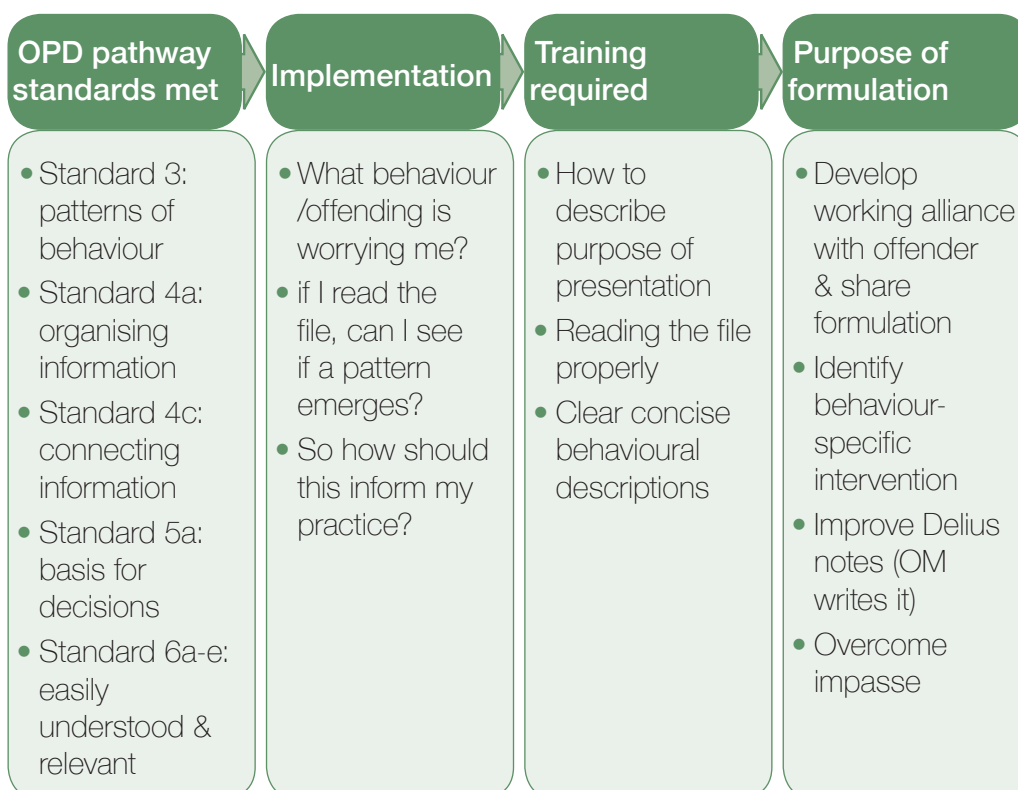
Level 3 formulations:

- to be used in all custodial and secure hospital treatment settings (1 year + duration);
- to be used in all community intensive treatment (> once weekly treatment packages for > 12 months) settings.

With training and support, it is expected that probation officers and prison officers will be able to develop Level 1 formulations as a minimum in due course. There should be a mixed approach to Level 2 formulations, and psychological therapists will take primary responsibility for Level 3 formulations.

However, these guidelines should be interpreted flexibly in the light of service context and practitioner confidence and competence.

Fig.1 Level 1 formulation



Drawing on the case vignettes for Billy and Mark, whose backgrounds are described in other chapters of this guidance, the following table outlines some of the ways in which a level 1 formulation is insufficient.

Table 2

Mark lashes out at other men on Saturday nights	Billy self-harms whenever he does not get his own way.	Descriptions of behaviour are present but there is no underlying or linking psychologically driven explanation.
Mark feels threatened by other men.	Billy needs to feel in control at all times.	A psychologically driven explanation is present but without any link to a described behaviour.
Mark has a diagnosis of antisocial personality disorder.	Billy has a diagnosis of borderline personality disorder.	These are summary statements, which may be factual, but alone, they do not constitute an explanation linking behaviour to an underlying psychological idea.
Mark was contemptuous of his mother as a child and therefore, as an adult, hits other men.	Billy was sexually abused as a child and, therefore, as an adult, self-harms.	There is a psychologically relevant statement and a statement of behaviour, but the two are not linked in a manner that provides a psychologically plausible explanation.
Mark is a bully and a public nuisance.	Billy is manipulative and attention seeking.	These are opinions – not necessarily untrue – but they have no explanatory value.

We know very little about Mark or Billy. However, a possible example of a good level 1 formulation for Mark might be to say: there is a pattern of Mark lashing out at other men when in pubs drinking at the weekend; this aggression seems to occur as a result of his sensitivity to feeling that other men are intending to humiliate or threaten him.

A level 1 formulation for Billy might say: Billy self harms infrequently but regularly, and the triggers seem to be situations when he feels out of control or ignored. The act of cutting himself appears to help him manage his emotions which otherwise feel overwhelming to him.

Figure 2. Level 2 formulations

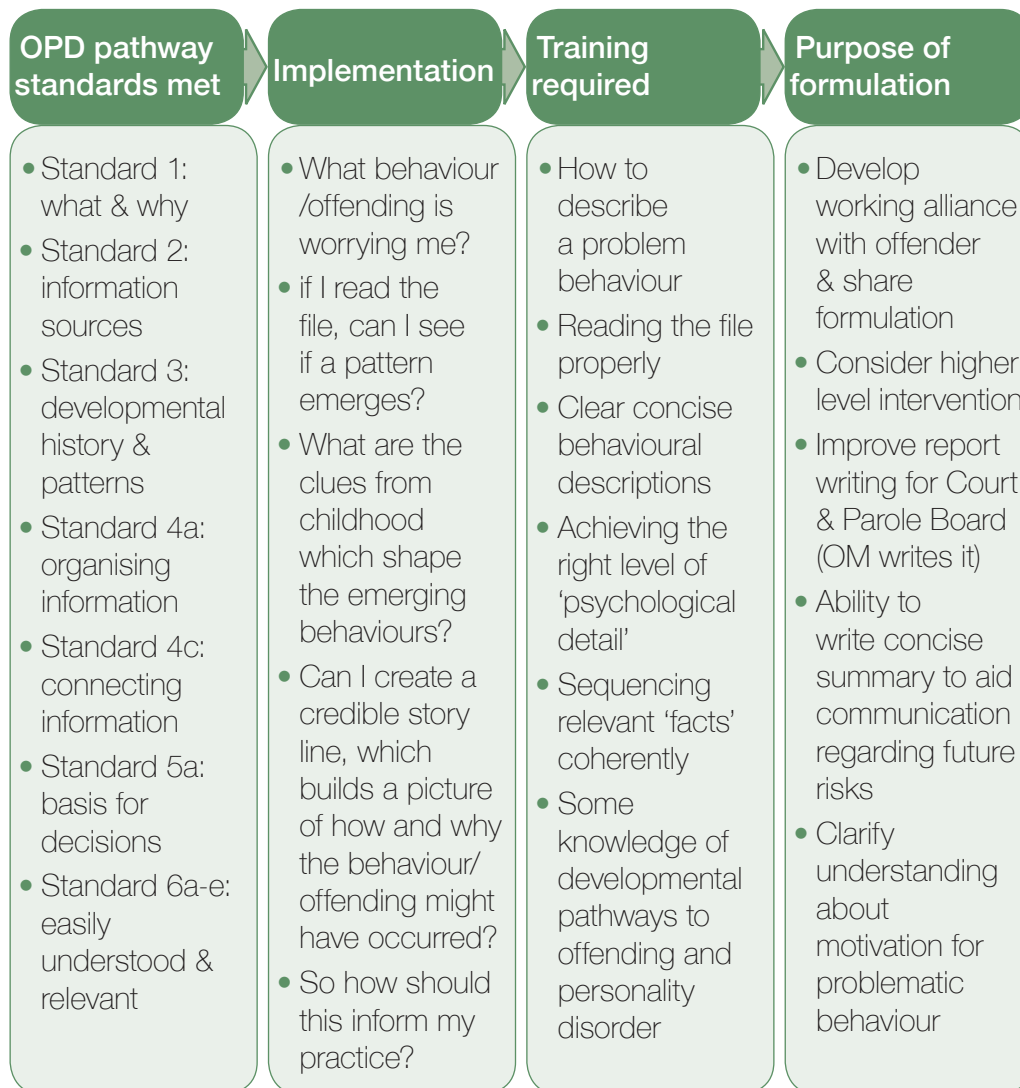


Figure 3. level 3 formulation



In order to help clarify the difference between the three levels of formulation, the following table provides an example of a level 1, 2 and 3 formulation for two new case vignettes. It is important to remember that these are simply examples of good practice, not the definitive answer to a formulation, and that we have provided very brief examples. Indeed, the level 3 formulations do not include all the necessary elements, as recommended in the six standards of the guidance; they are intended merely to demonstrate the increasing complexity of formulations in line with the levels.

Table 3

	John (domestic violence)	Stephen (rape)
Level 1	John has been violent to more than one partner; there is a pattern of him being deeply romantic initially and then increasingly controlling. The victims report John picking arguments about trivial matters, as though seeking an excuse to hit them.	Stephen says he cannot recall all the offence details because he was high on cocaine and alcohol at the time. The evidence suggests that he went off to a nightclub with his friends after a row with his girlfriend who was putting pressure on him to settle down. He picked up a woman at the club who then rejected him; on his way home, helping another drunk woman to find the bus stop, he dragged her off into an alleyway and raped her. He recalled feelings of anger and disdain for her, thinking 'all women are sluts and teases'.
Level 2 (+ level 1)	John was brought up by a depressed and passive mother, and a terrifyingly aggressive father who drank and was violent to his mother. His father always said his mother was the only woman he had ever loved, and they were very wrapped up in each other, despite the violence. As a result John always felt that he and his siblings were ignored.	Stephen was adopted, and felt he was something of a 'disappointment' to his adoptive parents. He was a rebellious teenager, seeking out a peer group where he felt accepted and respected. At the time of the offence, he was estranged from his family, and on something of a downward spiral, without work, money or prospects. He felt too ashamed to go to his adoptive parents for help.
Level 3 (+ level 1 & 2)	John, as a child, was unable to tolerate the tension of wanting to rescue his mother from his tyrant of a father, and yet feeling repeatedly betrayed by his mother's inability to prioritise his needs over his father's. As a teenager, seeking a male role model, he strove to identify with his father, and in doing so, repeatedly sought out relationships in which he anxiously demanded total devotion and attention. This pattern was evident in his offending behaviour, but also in his difficult relationship with his probation officer.	As Stephen increasingly perceived – rightly or wrongly – a sense of disapproval and disappointment from his parents, he became more preoccupied with his origins: his biological parents, his 'real identity'. He sought out a sense of belonging from a less aspirational and antisocial peer group. In terms of the trigger to his offence, he experienced his girlfriend's expectations of him as yet more unbearable pressure, reminiscent of his difficulties at home, and the rejection of the woman at the nightclub as a very public humiliation. He carried with him a sense of 'defectiveness', which was triggered at times when he felt inadequate, and the offence therefore represented an attempt to 'turn the tables' and lash out at what he perceived to be the cause of his humiliation.

Presenting a case for formulating

We cannot leave the subject of case formulation without considering the issue of case consultation. If case formulation is the **product**, then case consultation or case discussion is the **event** by which the product can be achieved. This might take place in one to one supervision, as a team gathering or as part of reflective practice group consultation meetings. Of course, formulations can be arrived at, working as a lone practitioner, but with complex high risk cases involving personality disorder, it is crucial to seek feedback and support (see Chapter 8 for more discussion in this area).

Presenting a case to others – particularly in a busy office where time is at a premium - is a surprisingly difficult task, which requires practice in order to hone the necessary skills. Most of us start out with chaotic presentations, missing out key elements, lurching from one observation to another fact, backwards and forwards, and leaving the audience confused and questioning. It is particularly tricky if working largely from file information, without the benefit of a number of face to face sessions with the individual offender.

Why bother with case presentation?

The previous chapter, and further ahead, the chapter on case management, will have made it quite clear that the practitioner needs a space to think about the relationship with the offender, and the layers of understanding required to arrive at a case formulation. The saying, 'a tidy desk is a tidy mind' is pertinent to the management of a large caseload of complex individuals: a simple formulation clears the mind, files away unwanted detail, and sets the direction of travel.

Tips for presenting (the order can be varied):

1. Read the file even if you know the individual, you'd be surprised what facts you had forgotten about.
2. Summarise why you want to talk about the case now
3. Set the scene, with the current circumstances for the individual
4. Provide a brief narrative of the individual's life, preferably in chronological order. You might want to include:
 - Early family relationships and developmental experiences
 - School and work
 - Social and intimate relationships in adulthood
 - Mental health and substance misuse problems
 - Patterns of offending/problematic behaviours
5. Share your observations on the individual's presentation to you and others



Summary

Formulation is the mechanism by which all the preceding work – the correct identification of the offender with personality difficulties, and the assessment and understanding of the presenting problematic behaviours and the offending – can be pulled together. Whether it is the work of a lone practitioner, a multi-disciplinary team, or a service user in collaboration with his/her therapist, depends entirely on the context. Regardless, it underpins and shapes subsequent decisions regarding management and interventions. The next two chapters address these areas.

Chapter 4

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 offenders with personality disorder. The chapter includes guidance on sentence planning for the community and custody and general thoughts about treatment. Here the consideration is about interventions; the next chapter focuses on management approaches.

Pathways for offenders with personality disorder can be difficult to plan, challenging to implement, and often require coordination across a range of service providers. This population can:

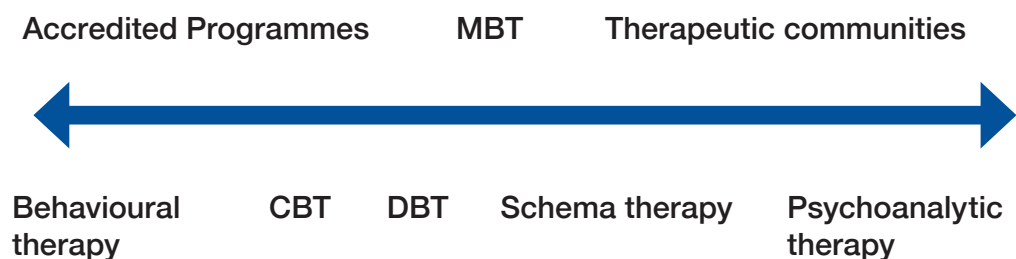
- Make significant demands on and for services, but be unwilling or unable to use them appropriately. Demands are especially high and chaotic in relation to drug & alcohol services, Accident & Emergency, and GPs. Often these services do not know the person may have a personality disorder;
- Be less motivated to engage and cooperate;
- Act in a way that sets services, professionals and individuals against each other.


Consequently, creative, coordinated and carefully planned approaches are required that consider the impact on you as well as the offender.

Some General Thoughts About Treatment For Offenders with Personality Disorder

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 (for example, actions) and as we move to the more analytical end, the treatments focus on more abstract and less easily observed difficulties (for example, mental representations). This is detailed below:





In general, therapies for personality disorder are gravitating towards 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 behavioural treatment (CBT), dialectical behaviour therapy (DBT), mentalisation based therapy (MBT), schema therapy, cognitive analytic therapy (CAT), transference-focused psychotherapy and therapeutic communities (both forensic and 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.

Treatment targeting 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 areas will sometimes be linked: for example depression and / or substance misuse as a result of relationship difficulties caused by the underlying personality disorder. The four areas are;

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

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

For the two most commonly encountered personality disorders: Borderline Personality Disorder (BPD) and Antisocial Personality Disorder (ASPD), the National Institute for Health and Care Excellence (NICE) has published national guidelines on the type of treatment that should be provided:

Antisocial personality disorder: treatment, management and prevention <https://www.nice.org.uk/guidance/cg77>

Borderline personality disorder: treatment and management <https://www.nice.org.uk/guidance/cg78>

It is acknowledged that the National Probation Service (definitely) and Community Rehabilitation Companies (probably) 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 – see below.

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.
- e. Post treatment support to allow integration of new skills and ways of thinking.

Treatment effectiveness

There is a growing body of literature reporting on treatment effectiveness for personality disorder, offenders with personality disorder and offender rehabilitation. 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. Offenders with personality disorder are likely to respond to encouragement, contact outside treatment sessions, help with attending, reminders about failed appointments, and so on. In other words, offenders with personality disorder 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. Additional information and tips can be found in appendix C.



Factors associated with treatment effectiveness, generally, are summarised below. These are more important than the approach used because, without these, any form of treatment is unlikely to be effective. Many of these factors can also be applied to any relationship between a practitioner and offender and are a useful indicator of what is likely to be helpful in effective case management.

- a) The evidence-base suggests effective treatment for offenders with personality disorder includes:
- A strong, but boundaried attachment relationship between the therapist/practitioner and offender
 - Treatment lasting at least a year and completed; completion is crucial
 - A cohesive team approach and philosophy of care, which is well structured
 - Ensuring treatment stays 'on model'
 - A combination of group and individual approaches. Where appropriate, additional family work & telephone contact provided outside planned sessions
 - Targeting high risk groups (expect at least 10-15% reduction in offending)
 - A model which is clearly understood by the therapist/team and the offender.
- b) Good practice in delivering treatment for offenders with personality disorder includes:
- A phased conceptual approach to treatment and management, described by Livesley (2003), as progressing from safety, to containment, regulation and control, exploration and change, and finally to integration and synthesis
 - Clear, realistic expectations by the offender
 - Shared and agreed goals
 - Using creative and flexible approaches, especially, to motivate and engage the offender, and overcome blocks to progress A well-trained therapist for the approach being used and the provision of high quality clinical supervision

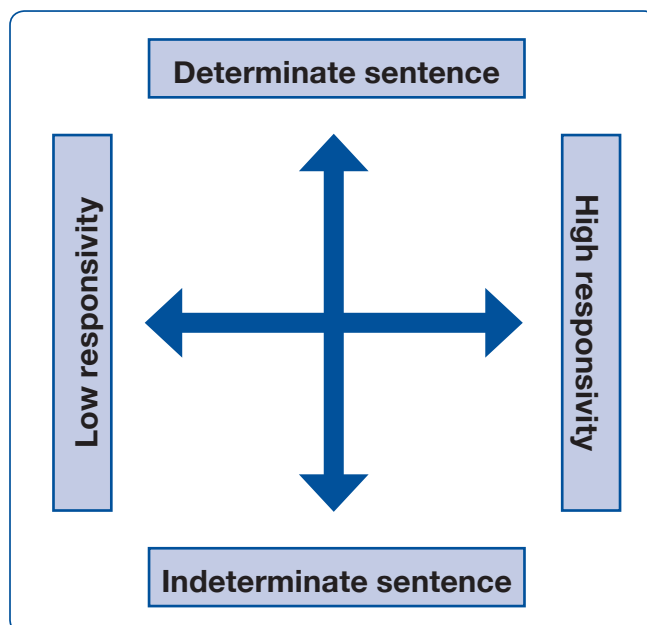
Pathway Planning

There is huge variability in the availability of services, and their willingness and capability to work with offenders with PD. Nationally, the Offender Personality Disorder Pathway Programme has commissioned, in the community, in relation to certain offenders (see criteria later in this chapter):

- Case identification
- Consultation
- Formulation
- Workforce development

These services should be used as a part of the first step in planning a pathway. However, irrespective of the nature and quality of services available, many offenders with personality disorder will be unmotivated or unable to make good use of them. It is, therefore, important to consider what is required to safely manage the case in the community and prisons, and to gain a better understanding of the individual using the case formulation approach.

For prisoners, there are two main interacting factors to consider, 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 offending behaviour programmes or other treatment services. When they have high responsivity, they are both capable of engaging in the programmes (for example, intellectually able) and

motivated to participate. Additional consideration will be given to their level of risk and 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 5).

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 or her 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.

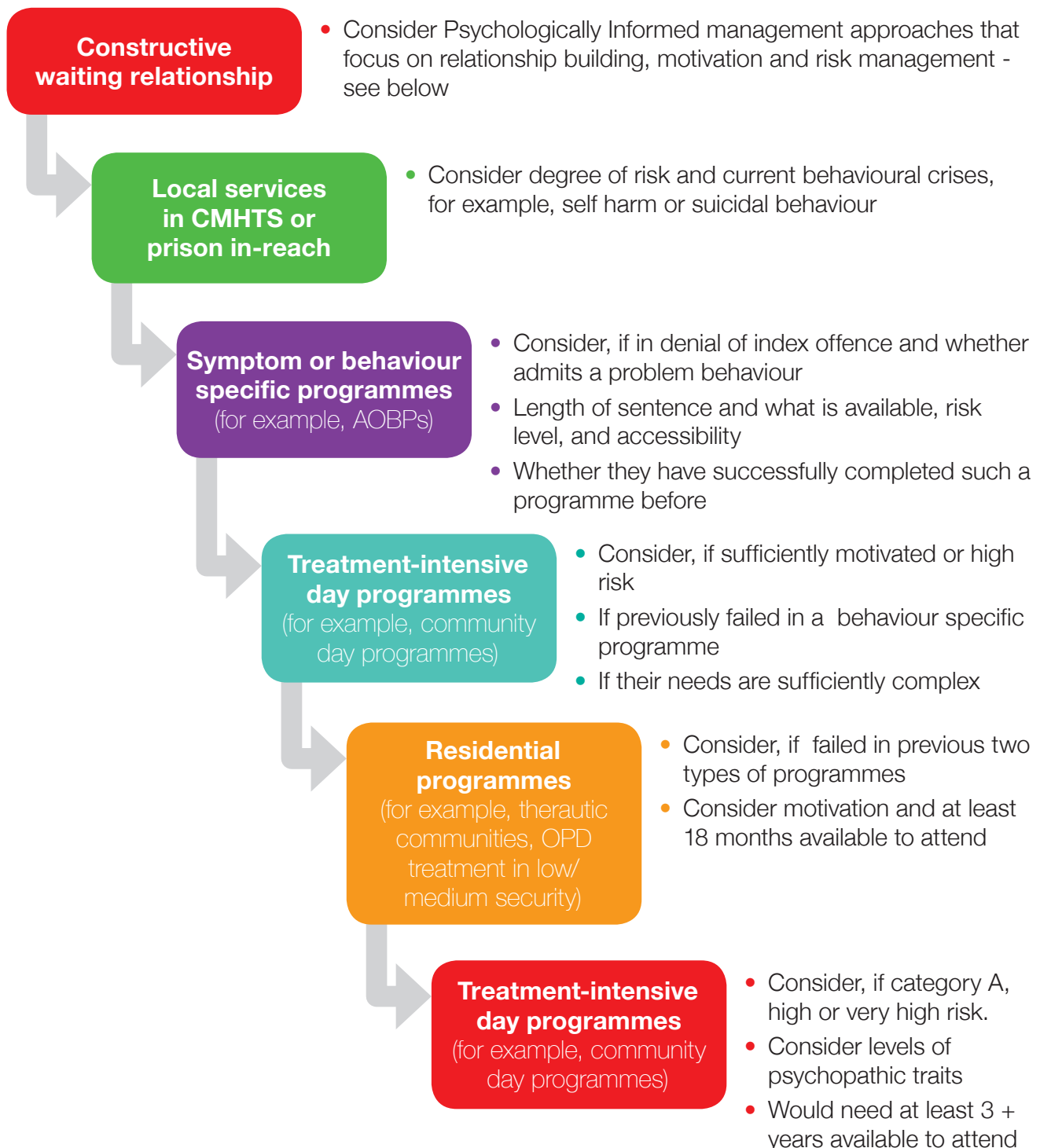
Offenders may not follow a linear pathway, and may wax and wane in their motivation to engage in services and interventions. In addition, offenders may also need to shuttle between services in the criminal justice system and those in the NHS or hospitals, depending on their needs at any one time.

For example:

	Criminal Justice System	NHS
Community services	Accredited Offending Behaviour Programmes Offender Personality Disorder pathway services	G.P. Community Mental Health Treatment Services Community Forensic Mental Health Services
Secure services	Accredited offending Behaviour Programmes Democratic Therapeutic Communities Offender Personality Disorder pathway services	Low, and medium secure services High secure hospitals (all of these usually require detention under the Mental Health Act)

Intervention options

The following is a schematic representation of the options for a offenders with personality disorder offender showing the increasing intensity of interventions.



Constructive waiting relationship

In the first instance, you will need to ascertain the degree to which the offender will engage in the process of planning. For under-motivated, treatment resistant offenders:

- Minimise language which implies obligation or compulsion
- Emphasise the offender's choice and control over treatment options
- Consider carefully the rules that are imposed; which ones are absolutely necessary and when you will enforce them.

For those in prison:

- Consider letter contact outlining treatment options
- Offer telephone/videolink contact to talk through options.

Local Psychological and PD Services

Primary care¹ (GP)

In the community it is important to understand how NHS services are commissioned and those that are available locally. Primary care is the foundation for all health care, at the centre of which sits the GP. This is the first point of contact for most people in most situations. The GP and GP Consortia are all vital to an understanding of how to navigate health services, not least because the geographical location of the GP determines which other health services can be accessed – this is referred to as catchment area responsibility. From this point referrals can be made to other services – including secondary mental health care.

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 have access to their own short-term counseling services or access IAPT (improving access to psychological therapies services), BUT both of these are generally inappropriate for individuals with personality disorder.

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 some areas, duty

¹ Information about health commissioning can be found at: <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/ccg-outcomes.aspx>

CMHTs: first port of call, but mostly deal with crisis management and coordinating care.



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

contact is only available to known service users. If someone is to bypass their GP, for example, in an emergency, they may need to present to A&E or the mental health assessment team, which is often separate from the CMHT.)

In practice, the reason for referral is likely to be a co-existing problem (for example, 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. CMHTs consist of a multi- professional team and use the Care Programme Approach (CPA). 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.

CMHTs 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.

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 therapy 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 CMHTs, 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.

As described above, more intensive day care services may exist in some areas. They provide more intensive input for those with severe personality problems, who pose a risk to self or others. Whilst these services may not be set up to accept referrals for antisocial personality disorder, they may include outreach provision to criminal justice agencies (for example, probation). Such input may involve support, clinical supervision, consultation and assistance with referrals to other mental health agencies.

Forensic mental health services

Most forensic mental health services are hospital based (for example, local medium secure units), and there is patchy provision for offenders with personality disorder. 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 offenders with personality disorder. 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 below on transfer from prison to hospital for information on the few specialist personality disorder inpatient units.

Tip:

Where there is a diagnosis of personality disorder or personality disorder is suspected, the offender presents a high risk of harm to others, and the offender manager feels unable to meet his/her needs alone consider a referral to local forensic mental health services.


Where there is a co-existing disorder (for example, anxiety or depression) and the risk of harm to others is not assessed as high, consider a referral to general mental health services (for example, the local community mental health team).

Being clear about the degree of risk and the extent to which this is linked to the disorder will help determine whether the offender is better supported through forensic or general mental health services.

Offence or behaviour specific Interventions

Supporting a pathway of intervention, there is a well-established suite of Accredited Offending Behaviour Programmes (AOBP) that provide treatment approaches targeting specific offending behaviour needs, such as Sex Offending or Violence. These interventions, including Democratic Therapeutic Communities, undergo a process of scrutiny by the independent Correctional Services Accreditation and Advisory Panel (CSAAP). This panel is drawn from international experts, who assess the interventions against a set of specific criteria derived from the published evidence base for the reduction of offending. The objective of accreditation is to provide an evidence-informed structure for peer-reviewing and improving the quality of interventions in England and Wales. CSAAP aims to balance mechanisms for ensuring consistency in practice and adherence to standards, with sufficient flexibility to respond to circumstances and allow professional input.

All offenders, whether on a community or custodial sentence, could be considered for an AOBP, providing they satisfy the assessment and targeting criteria set by



NOMS. Given the current evidence base, these scarce resources are prioritised for those who are higher risk, and judged to benefit the most from the given programme. Thus appropriate offenders will see AOBPs written into their sentence plans. The standard accredited programmes delivered in the community and within the prison system may adequately meet the risk and needs of offenders with personality disorder. 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 addressing offending behaviour. 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 which may probe more intensively into personality development and functioning; these include the Self- Change Programme (when there is a substantive history of instrumental aggression), Chromis (specifically for high risk psychopathic offenders) and the Sex Offender Treatment Programme. Democratic Therapeutic Communities can also be effective for offenders with personality disorder.

All AOBPs follow the principles of Risk, Need & Responsivity, and incorporate approaches which support people to build on areas of strength within their lives. This is in line with the Good Lives model of rehabilitation and the desistance literature.

Sessions are designed to engage participants and there is a strong focus on “doing” rather than simply “understanding and explaining”. Facilitators are drawn from a wide range of disciplines and the format of delivery includes both group and one to one sessions. Methods are used in combination and together to build motivation, awareness and skills of participants. These methods used include cognitive behavioural therapy, mindfulness based techniques, narrative therapy, psycho-education instruction, pro-social modelling and skills orientated learning.

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 behaviour, poor attendance and shamming which can give an indication of the inadequacy of the accredited programme route and whether the individual requires referring to one of the other pathways. The main reasons for looking beyond the standard AOBPs are if the individual has previously failed to complete them or has completed, but this has not led to a change in behaviour. Forensic Psychologists based in prisons may provide assessments that assist with more complex sentence planning.

Tip:

Think creatively about total denial - select a programme that does not require offence admissions. Remember the evidence suggests that denial is not a risk factor for future offending.



AOBPs target four main areas:

- Increasing thinking and social problem solving 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.
- Tackling violence - These programmes tend to target either expressive violence (emotional control and anger management) or instrumental violence.
- Tackling sex offending - A range of programmes designed to provide the right intensity of intervention to match risk level and treatment need.
- Tackling substance misuse - Includes a range individual and group work for alcohol and drug misuse.

The latest information on AOBPs can be obtained from: interventions_businessenquiries@noms.gsi.gov.uk

Intensive Day programmes

As described above, these are sometimes available in the community, through CMHTS. In addition, some OPD treatment services in prisons operate a day programme rather than a residential approach

Residential social milieu programmes

Available in prisons in the form of Democratic Therapeutic Communities and Offender Personality Disorder treatment services in high secure category B, C, women's and young offender establishments. In health settings, these are available in hospital settings, either at low medium or high levels of security. There are also specific Offender Personality Disorder pathway services in Medium Secure hospitals.

The importance of the therapeutic environment

The nature and quality of the therapeutic environment and the relationships within residential services are a key component of their effectiveness.

Theoretically, each service in a pathway of interventions should have a focus on relationships, paying particular attention to their quality and consistency. In the OPD pathway there is a heavy emphasis on this. There are a number of features that support the creation of an effective environment:

- High quality training and clinical supervision, to have a better psychologically informed understanding of the offender's presentation to support effective working, relationship building, risk management and improved levels of care.
- Using a psychologically informed formulation to develop a shared understanding, and inform responses to difficult situations.

- Having clear structures in which to operate, focusing on change and transition, to:
 - support staff and residents to 'make meaning' of their experiences,
 - provide supportive reflective spaces to better inform pathway planning, engagement of the offender in the service, and their movement through a pathway.
- A primary focus on the social context and relationships AND consideration of the role of the physical environment in creating conducive pathway settings. Specific attention should be given to the 'impact of the institution' and its practice.

Enabling Environments (EE)

Enabling Environments can be found in all walks of life. They are places where people live, work or come together for a specific purpose. They can be work places, schools and colleges, hospital wards, prisons, day care units, care homes, children's homes, supported accommodation including Approved Premises or neighbourhoods, etc.

Developed by the Royal College of Psychiatrists' Centre for Quality Improvement, the Enabling Environments process is a standards-based quality improvement process which aims to support the development of healthy social environments and promote the value of relationships in improving overall effectiveness and positive outcomes for everyone involved. An Award can be achieved by submitting a portfolio of evidence.

Enabling Environments are defined as:

- A place where positive relationships promote well-being for all participants
- A place where people experience a sense of belonging
- A place where all people involved contribute to the growth and well-being of others
- A place where people can learn new ways of relating
- A place that recognises and respects the contributions of both parties in a helping relationship
- A place that recognises that carers also need to be cared for

Working towards the EE Award is highly recommended as the process itself can lead to an increased awareness of how the service might create and sustain a positive and effective social environment. More information can be found at: <http://www.rcpsych.ac.uk/quality/qualityandaccreditation/enablingenvironments.aspx>

Democratic Therapeutic Communities

DTCs are a form of social therapy, sometimes delivered in the community, but also an accredited offending behavior programme in prisons. 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 focusing 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.

Treatment in High Secure Environments

For the high or very high risk offender, there are residential services in high secure settings, both in hospitals and prisons. These, and the OPD treatment services in lower category prisons and Medium Secure Units, are mindful of the environment and relationships, and utilize the social milieu along with specific interventions to provide an intensive and holistic treatment.

Supported environmental progression through a pathway

A specific approach for a Therapeutic Environment that has been developed is the PIPEs (Psychologically Informed Planned Environments) approach. PIPEs are specifically designed, contained environments where staff members have additional training to develop an increased psychological understanding of their work. This understanding enables them to create an enhanced safe and supportive environment, which can facilitate the development of those who live there. They are designed to have a particular focus on the environment in which they operate; actively recognising the importance and quality of relationships and interactions. They aim to maximise ordinary situations and to approach these in a psychologically informed way, paying attention to interpersonal difficulties, for example those issues that might be linked to personality disorder.

PIPEs are not designed to be treatment interventions as is understood across the Criminal Justice System (for example, Offending Behaviour Programmes). Instead, PIPEs are an environmental approach designed to enhance the delivery of core work within community and prison settings, where the benefit of additional psychological or 'psycho-social' considerations has been recognised.

There are a number of different settings and applications of the PIPE model. The aim of each of these is to provide the necessary psycho-social conditions to support active and effective engagement in a pathway of services for offenders with personality difficulties/disorders.

PIPE Service	Description
Preparation PIPE	A (prison) residential pre-treatment service focusing on treatment readiness, motivation, engagement and exploration of barriers to treatment.
Provision PIPE	A (prison) residential service which provides an appropriate and supportive environment for those undertaking treatment in a different setting (for example, for those in a day treatment service). A provision PIPE provides the core environmental conditions of a PIPE, whilst supporting residents to actively consider the skills and learning being explored through treatment. A provision PIPE service works closely with the treatment teams and clinicians.
Progression PIPE	A (prison) residential service post-treatment that supports residents in consolidating and generalising their treatment gains, putting new skills into practice and demonstrating improvements in behaviour. Residents will have successfully completed a treatment programme (usually one of high intensity).

PIPE Service	Description
Approved Premises PIPE	A whole-premises approach, focusing on a psychosocial understanding of residents, and supporting effective community re-integration and resettlement. PIPE Approved Premises will integrate model requirements into the core functions of the premises and aim to provide new experiences and pro-social opportunities for its residents. The population will include a range of offenders at different stages of the pathway, for example a mix of those who have completed interventions and those who have not.

The PIPE model incorporates core components which are designed to support and develop individuals living and working on a PIPE. These include enhanced training and support of staff, regular keywork sessions with prison staff, and socially creative sessions.

Using secure mental health services for prisoners

As described above, in the community access to secure mental health services would be through a CMHT. Working out when to consider a transfer from prison into mental health services can be difficult with offenders with personality disorder. Health services are broadly based on a catchment area system and there is patchy provision within medium secure hospitals for offenders with personality disorder across the country. However, more specialist personality disorder services in the high secure hospitals 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 (for example a psychosis), 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.

The Offender Personality Disorder Pathway Programme

Since the publication of the first edition of this guide significantly more new personality disorder services have been jointly commissioned across England and Wales by NHS England and NOMS.

The programme targets the offenders with the most complex needs. Appendix A provides a tool that will help identify some of the offenders meeting the criteria. 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

Entry criteria to access the pathway

MEN	WOMEN
<ul style="list-style-type: none">• At any point during their sentence, assessed as presenting a high likelihood of violent or sexual offence repetition and as presenting a high or very high risk of serious harm to others; and• Likely to have a severe personality disorder; and• A clinically justifiable link between the personality disorder and the risk; and• The case is managed by NPS.	<p>Either the above criteria for men is met or:</p> <ul style="list-style-type: none">• Current offence of violence against the person, criminal damage, sexual (not economically motivated) and/or against children; and• Assessed as presenting a high risk of committing an offence from the above categories OR managed by the NPS; and• Likely to have a severe form of personality disorder; and• A clinically justifiable link between the above.

A set of principle underpins the design and delivery of new services. These are useful because they provide a framework of expectations to guide service design, development and delivery, leadership and decision-making at local and national levels.

Principles	
Shared ownership and responsibility; joint operations	<p>Responsibility for this population is shared by the partner organisations.</p> <p>Operations are jointly delivered demonstrating a collaborative culture in all aspects of service delivery. Partners value respective knowledge, skills and experience.</p>
Community-to-community pathway	A pathway approach is applied providing planned and managed progression in or into the community.
Formulation based approach	<p>The approach builds on a biopsychosocial understanding of the development of personality disorder. Evidence suggests that PD is a result of the interaction of biological (genetic) vulnerabilities, early experience with significant others, and social factors. This understanding informs the development of the case formulation, leading to a better understanding of the person and their behaviour, resulting in a pathway plan reflecting need and the required response.</p>
Psycho-socially informed models and management	Clearly described models in which staff understand the relational approach and boundaries.
Staff have clarity of approach, primary task and role	Staff understand the model and approach to the work, their role and responsibilities. Staff contribute to the design, development and review of the service.
Staff are trained and appropriately supported and supervised for their role	<p>The knowledge and skills required for each staff group and individual within it are identified and a plan is in place to ensure that these needs are met and reviewed. Individual and group supervision is provided, as appropriate.</p>
Gender specific training, planning and delivery	Services for women take account of gender differences in understanding the development of PD, risk, psychosocial needs, service planning and delivery.


Principles

Offenders understand their role and responsibilities and have clarity of approach	Offenders understand the nature of the work delivered. They can describe the commitments they have made, the requirements of them and their personal responsibilities within the service. Offenders' health is improved by the work and their risk of re-offending and harm to the public reduced.
Long-term pathway commitment	This population is likely to require a long period of time over which progress is made and evidenced.
Breakdown and failure is managed	The pathway approach is not linear for many offenders. Challenging behaviour and rule infractions and challenges to the system may lead to breaches of conditions of licence or community sentence, recall to prison, segregation and re-categorisation. Treatment and management plans may not achieve the desired effect. Such breakdown and failure must be managed ensuring that pathway plans are reviewed and revised to support future progression.
Clarity of outcomes	Specific medium and long term outcomes for services are explicit and measureable. They relate to the primary objectives of the offender PD strategy (public protection, psycho-social improvements, and providing a capable and confident workforce) and demonstrate the effect of the work undertaken.

In the community, all National Probation Service Local Delivery Units have access to core services consisting of:

- Early identification – a structured approach to identifying offenders who meet the service criteria as near to the beginning of their sentence as possible
- Workforce development – bespoke local training to increase the confidence and competence of staff working with this population
- Case consultation – generally, a responsive service to support staff managing someone with complex needs. Usually, this will lead to a level one or level two formulation (see chapter 3)
- Case formulation – delivered at one of three levels
- Joint casework – time limited, planned joint work between the health service provider, the Offender Manager and the offender

Some areas have additional services like community based treatment, complex case management, Enabling Environments and PIPEs in Approved Premises



All Approved Premises in the community receive specialist psychologically informed support, as a minimum consisting of access to case consultation and formulation, and workforce development. Some have adopted specific approaches to support a pathway of services. These include the PIPE model and working towards the Enabling Environment Award (described above).

Prison based services for men, women and young offenders

There are an increasing number of services in prisons, which aim to deliver a pathway of care to offenders satisfying the above criteria. They include preparation and progression PIPEs, treatment, therapeutic communities for offenders with learning difficulties and disabilities, and are spread geographically, and in different categories of prison. As yet, there isn't a complete pathway for all prisoners who may need services. For up to date information please contact the OPD team at pd@NOMS.gsi.gov.uk to request the latest Brochures of Offender Personality Disorder Pathway Services for men and women.

Chapter 5

Community Management

Aim

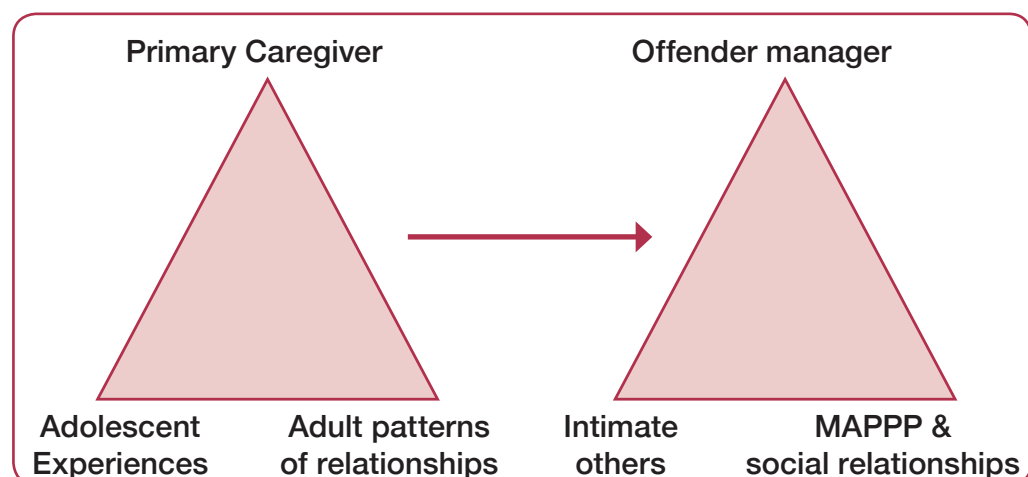
The aim of this chapter is to inspire confidence in the reader: that is, in using an understanding of the model of personality development developed thus far, one can apply the psychological principles to achieve the improved community management of complex offenders with personality disorder. In other 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. Please also look at the DOs and DON'Ts table in the women's chapter, as there are some further helpful suggestions there.


The attachment triangles

In the first instance, we should return to the attachment triangle in chapter two, which described the developmental pathway of the offender with personality disorder. 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-5). 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 individual with personality disorder, 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 offenders with personality disorder, 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 offenders with personality disorder – 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 offenders with personality disorder 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.

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 offenders with PD 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.



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.

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 offenders with personality disorder. 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 an offender with personality disorder, 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 6

Working with young adults

Perhaps the most important feature of adolescence is progressing from having a primary attachment (regardless of whether it is adaptive) to family or caregivers, transferring and developing these with peers, including, at some point, an intimate peer relationship. One way of viewing the number of sexual and violence convictions during young adulthood is to see it as a difficulty in that core task, for example, difficulty in moving smoothly from family to societal and peer attachments; yet still maintaining the original attachment with parents / caregivers and siblings in a now transformed way.

Where young adults have experienced disruption at a young age and perhaps onwards throughout childhood, their difficulties and ability to attach to new figures can emerge as very problematic during adolescence. The young adult may have had to develop some highly strategic methods to maintain attachment to their care givers, which may not be so adaptive and helpful in their new task. For example, avoidance of intimacy and relationships to cope with a lack of love and care in childhood, will likely result in difficulties developing and maintaining new and healthy peer relationships in adolescence. In addition peer relationships are particularly strong and meaningful at this developmental stage leading to further problems depending on the criminogenic nature of those peers.

The challenge for services², therefore, is to recognise that many young adults in secure or community settings have experiences of disrupted attachment and trauma, and that the service needs to be able to provide some element of 'therapeutic parenting', for example, attunement, co-regulation and repair to seek to maximise the window of opportunity offered at this time. This chapter is written with the young adult male in mind, in particular, but there will be significant overlaps with young females too. It seeks to draw on examples of good practice and offer some ideas and examples for those working with and commissioning services for young adults.

What is adolescence?

What is it to be a teenager and why don't we describe people as either just children or adults? Western Society has constructed a phase in-between childhood and adulthood, and this is influenced differently in different cultures. At an individual level it is affected by each person's development physiologically, emotionally and psychosocially. We know that the brain goes through rapid changes during adolescence and this brings about changes in functioning for the young adult in various areas. Some of these are outlined below. There is consensus now that cognitive development and emotional regulation is not fully developed until at least the mid-20s. So what are the challenges associated with maturation and development?

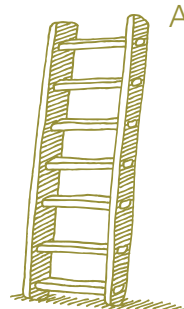
² NOMS has published evidence based commissioning principles for young adult male offenders, which is available at <https://www.gov.uk/government/publications/achieving-better-outcomes-for-young-adult-men-evidence-based-commissioning-principles>

- **Neurological development**

Research into brain development is cautious about making firm conclusions about whether changes seen in the brain are directly linked to behavioural changes. However, during adolescence the brain undergoes significant development and growth to reach the adult profile. This continues in early adulthood by pruning, building and thickening the various branches of neurons that underpin all aspects of cognitive, emotional and physical functioning. So whilst we are not able to say definitively that is the cause of what we might describe as immature thinking and behaviour in young adults, it may play a large part in the various factors you might observe.

- **Cognitive development**

MOVING FROM
CONCRETE THINKING
AND SIMPLE IDEAS to...

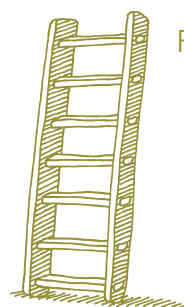


ABSTRACT THINKING WITH
DEEPER MEANING AND
CONTRADICTIONARY IDEAS

Young adults are either at the end of, or still working through the necessary development that allows them to understand abstract thought, to think about what their future looks like and to reasonably plan and take various factors into account. Alongside this is usually an increased ability to think about themselves, to know where their strengths are, to develop their own opinions and beliefs that may change depending on new information. This means then that the young adults with whom we are working cannot be assumed to have developed to the point yet where they are able to work through abstract ideas and contradictions and to be able to think deeply about these ideas [especially for males if these are language based].

- **Emotional development**

MOVING FROM
EMOTIONAL
RESPONSES to...

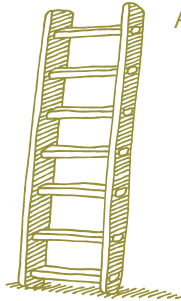


RATIONAL OR
FUTURE THINKING

Linked to the cognitive changes above, are the overlapping emotional changes, some of which are underpinned by changing hormones. As the young adult becomes able to use language and thought in a deeper and more nuanced way, so the instinct to simply respond with an emotion to a situation changes and develops.

- **Behaviour development**

MOVING FROM
RISK TAKING TO...

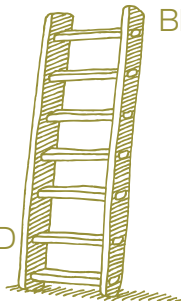


A GREATER KNOWLEDGE
OF RISK AND DANGER

Taking risks is part of everybody's everyday life, as it is necessary to healthy functioning, for example, finding work, developing different types of relationships, exploring our world. Young adults appear to take more risks [this may be related to brain development where young adults take more dangerous risks to achieve the same level as adults of the pleasure chemical dopamine]. Combined with the young adult making decisions based on how they feel, rather than careful consideration of consequences, with a limited understanding of all possible consequences, low self esteem, need to find a place in their social circle etc – and the chances of young adults making more risky decisions is clear.

- **Relationships**

MOVING FROM DIFFICULTIES
EXPRESSING THEMSELVES AND
LANGUAGE PROBLEMS TO...



BETTER SOCIAL SKILLS AND
EMOTIONAL AWARENESS

With all of the above changes taking place, and as the young adult branches out into independence from caregivers, there is a need for social skills, language skills and emotional intelligence. However, until development, experience and ability is mature, we can expect a young adult to find it hard to judge the right level of reaction to difficulties, to hold back from arguments with others, to be able to judge what is the right thing to say in every situation, to grasp a sophisticated point being made by someone else, etc.

It is critical in any service, to ensure that the difficulties being attributed to the young adult, are not simply reflective of the developmental stage they are working through. Difficulties have to be causing significant dysfunction for the person or others, they have to be long standing and be expressed across most areas of their lives. Holding in mind how you coped as a young adult, or how you see other young adults behaving, can be a useful reminder of what is pathological and what is normal.

Tip – remember that the person with whom you are working is a developing young adult first and foremost. This will help steer you away from seeing something as a disorder or illness when it may more commonly be part of the transition to adulthood

What might be different about young adults in the criminal justice system?

It is more usual than not, to find that young adults in the criminal justice system present with multiple, complex and overlapping problems, for example, 95% of 15 to 21 year-olds in custody were found to suffer from one mental disorder and 80% from at least two (Singleton et al. 1998). Whilst being diagnosed with Conduct Disorder is a necessary precursor of an adult diagnosis of Anti Social Personality Disorder, and is linked to hyperactivity and anti social behaviour later on, it does not always mean, that all children diagnosed with Conduct Disorder will develop personality disorder.

Definition – Conduct disorders are characterised by repetitive and persistent patterns of antisocial, aggressive or defiant behaviour that amounts to significant and persistent violations of age appropriate social expectations. Conduct disorders are the most common mental and behavioural problems in children and young adults and nearly always have a significant impact on functioning and quality of life.

Other research suggests higher than expected levels of learning disabilities, of communication difficulties, loss and bereavement, housing problems, drug and alcohol misuse, etc. It is worth considering how any one of those issues alone might have overlapping effects on personality. When working with young adults, it is also important to take account of how their formal IQ score [and hence label of learning disability] may increase. The evidence base indicates how interventions appear to have led in some cases to an increase in IQ score and so caution should be taken when assuming a young adult's abilities are fixed or accurate.

- **Acquired brain injury**

Acquired brain injury can leave cognitive impairments in those with mild traumatic brain injury, for example, young men, homeless people, those with a history of offending, particularly violent offending and those with a history of mental health problems. This is true of course for all those who have suffered similar, but the significance for young adults is that for those working with them it may not yet be identified, and it may appear to overlap with the other and more usual changes in adolescence, for example, risk taking or cognitive development.

The effects of minor brain injury include:


- Physical problems such as sensitivity to light and noise, sleep disturbance
- Cognitive problems such as attention and concentration problems, communication difficulties, planning and organisation difficulties, problem-solving difficulties
- Emotional and behavioural problems such as anger, anxiety, apathy and loss of motivation, depression, impulsivity and self-control problems, mood swings, personality changes
- Social and personal problems such as everyday life problems, employment problems, for example, slowness in carrying out tasks, personal relationship problems, self-esteem problems and social interaction problems

If personality disorder can be thought of as having difficulties with attachment followed by problems with emotional regulation and then mentalisation, it follows that assessing the extent of those difficulties while a person is still developing is a challenge. Even more so as brain injury is hard to detect without a MRI scan. The behaviour is often then confused with the traits of personality disorder.

Tip – the majority of young adults in the criminal justice system do not present with a clear mental illness, or fit one diagnostic category, often presenting a complex mix

• **Cumulative trauma and other impacting factors**

Chapter 2 of this guide has already introduced the idea of attachment as important in understanding behaviour and its use in understanding those diagnosed with personality disorder. In particular with young adults it is often a live issue, as these service users are not far removed from, if at all, the family or caregiver of origin. The recent experience of, or current traumatic events then, added to the usual challenges of adolescence as described above, can combine to produce a highly challenging presentation. This may not be the case for older adults who have had the benefit of more time and possible resolution since the trauma, as well as having completed significant physical changes associated with adolescence. A large body of research shows that people with PD diagnoses report an unusually high number of traumatic events during their childhood. In particular, young offenders have been shown to have experienced adverse and traumatic life events, at home, in the community and in custody and so can be an important antecedent to a range of serious & chronic mental health problems such as PD. Work to prove that trauma in childhood is consistently and specifically linked to later diagnosis of PD is ongoing, as it likely forms part of a web of other contributory factors. It is also difficult to be accurate at this age as to whether demonstrations of a lack of remorse, empathy or affect is indicative of delayed maturation, an early indicator of callous and unemotional personality traits or the consequence perhaps of trauma and neglect during the person's upbringing.



It is helpful then to hold in mind the trauma the young adult may have experienced, how recent that was and how the individual is processing it; as that is key to both engaging them and finding the most helpful way forward. Asking the question each time of how this young adult has adapted to survive in the life they led before contact with you, will focus in on what their style of attachment is, how they manage their emotions, what triggers past memories of cumulative trauma, how they might be re-enacting events from their life, etc. For example, those who are described as frequently talking about violence, fantasising about, drawing pictures of, writing about, rapping about violence, could perhaps be simply enjoying the effects this has on adults and experiencing some level of arousal from it. Or they could also be acting out the violence done to them in various ways throughout their own lives as a way to understand it.

Whilst deviant sexual arousal is a risk factor for repeat sexual offending in adults, and can be an important target in treatment programmes, the available data suggest that only a minority of adolescents who commit sexual crimes demonstrate deviant sexual arousal. The same clinical picture is also true of violence and violent fantasy. Caution should be taken then not to adopt adult-based assessment and treatment on the assumption that if the behaviour is the same then so is the drive and motivation. It may be true of adults that arousal and fantasy is strongly linked to risk of repeat offending, but a wide lens at the point of assessment in young adults is important. This will ensure accurate understanding of the behaviour, to take account of their being in flux and so of what might be transient ideas and fantasy, or of a means to regulating self esteem, as well as what fantasies are present to a certain degree in the general population anyway.

Tip – develop working hypotheses for what the significant drivers, factors and motivations are for the young adult, but always have other ideas as possibilities too. As maturation and development goes forward, hypothesis and formulations should be revised regularly as a multi disciplinary team to ensure the most up to date picture of the service user is agreed

What is different about working with personality difficulties in young adults and what don't we yet know?

Personality disorder is considered to be a result of disrupted development. There is a broad agreement that personality disorder should not be diagnosed in adolescents because personality development is not complete, and symptomatic traits may not persist into adulthood. Whilst the rule of thumb is that diagnosis cannot be made until the person is 18 years of age and then only with provisos, many are in agreement that formal assessment can yield accurate and effective treatment. Adopting strategies to identify high risk individuals early on, particularly in adolescence may be helpful.

Practitioners are also cautious about diagnosing PD in young adults due to the lack of standards for agreeing when a person no longer has a PD. This is reflected in the use of terminology such as 'emerging traits indicative of PD' rather than a firm diagnosis. Even then, these are used cautiously. Some clinicians argue that any personality assessment is not recommended before the age of 25, regardless of whether care is taken with the data, or of the fluidity of personality at this age, or if differential account is given to diagnosis.. This raises the interesting point about the underlying assumption that personality forms during childhood and adolescence and cannot be said to be disordered until adulthood. Whilst the position in the literature for many years was of the stability of personality traits in adulthood, there is however, evidence of change over time and recent studies demonstrate changes in personality in adult samples too. DSM-5 and ICD-11 to come, both support the diagnosis of personality **difficulties** in people of any age.

There are commonly used tools to diagnose disorder once enduring traits have been established [see chapter 1], but there are not yet any guidelines to establish how much change or for how long change must be evident before a diagnosis would no longer be relevant or helpful. There are also problems with the diagnostic tools used, which rely on adult orientated criteria with questions such as 'do you spend so much time working that you don't have time left for anything else?', 'do you have trouble deciding what's important in life?', 'are you easily influenced by other people's suggestions?' without taking account of the context and norms for young adults. Tools conceived for use with adults, are not often able to be sensitive to issues in adolescence such as self harming. As self harming behaviour is prevalent at this stage, it is not necessarily an indicator of Borderline Personality Disorder as it might be for adults.

Tip – The evidence base is weak on the validity of assessing personality in young adulthood. Be alert to the advantages, disadvantages and impact for that person in managing their difficulties and for their future

• Ethical issues relating to the assessment and diagnosis of young adults

Working with young adults with emerging personality difficulties brings into sharp focus the need for transparent and defensible practice. There are multiple, ethical issues of concern for those engaged in personality assessment in forensic settings, for example, considering who the client actually is [service user, general public, prison] and whether someone has full capacity to engage, gaining properly informed consent, etc. This requires special attention to various issues including confidentiality, privacy, clarification of roles, and the intended use and potential recipients of the outcome of any assessment.

With all service users, but especially with young adults, practitioners have to be alert to the need for simple communication, checking of understanding, reminders of important information and sensitive handling of ethical issues. Some young adults may have limited understanding of their rights and the impact of a diagnosis on their future access to services or treatment. The young adult [and very often the whole team] may have little understanding of the stigmatising effects of a psychiatric diagnosis and how self-concept may be affected by a diagnosis. There is scant literature on the experience of being diagnosed with personality disorder whilst young, despite the implications this type of research could have, for example, whether diagnosis at a young age has different implications than one in later life.

Tip – When trying to take a history with a young adult remember they may not see it as “history” as it may be recent or current experiences they have. You may find they are still involved in abusive, traumatic and chaotic situations and you will need to respond to this.

Tip – Pay attention to the issue of the impact of assessment and diagnosis on the young adult and what this means for their identity and future. Consider the impact this may have on the proposed intervention and the possibility of its place as an underpinning factor in the development and maintenance of PD

Tip – Remember, what you write now may be used in 10 or 20 or more years, and referred to in Parole, Court, medical and other reports. Think about what you say now and how it might be interpreted in the future.

Let's think about what we know so far about the presentation of personality disorders in young adults.....

Go back and read the case study of Billy (chapter 1) and consider the factors that are in the vignette that lead to the conclusion that Billy has a personality disorder. It is important to acknowledge all the evidence of an emerging personality disorder, however, without the pervasive element, only available through time, it is also possible to consider alternative pathways for Billy.

Evidence of a Personality Disorder	Alternative options which could support Billy to develop a functional personality
Abuse in childhood and relationship instability	Billy receives 1 to 1 and group therapy to work through his feelings of blame and anger
Impulsivity	In his early 20s Billy becomes physically and emotionally developed and he is more able to rationalise his behaviour. He also receives NICE recommended group interventions which aim to develop his thinking skills
Self-Harm	Billy receives monitoring and support via the ACCT system in custody and is linked to a listener on the wing who helps him express his feelings verbally. Billy is given a work role and some activities to do in his cell which allows him to be occupied and focused on productive things. He finds this helps his urges to self-harm
Homelessness	Billy is given a structured and supportive resettlement plan which allows him to prepare for community living
Drug addiction	Billy engages in a full group and individual drug programme in custody and finds that he benefits from weekly meetings with fellow peers. He has community drug services as part of his resettlement plan to continue this support
Criminal activity	Billy has a good relationship with his offender manager and has a clear sentence plan in custody. Consultation with psychological services informs the sentence plan and Billy spends time addressing his offending behaviour. He also works on how he will spend his time in the community in a pro-social, productive and meaningful way

It is easy to see how the evidence for Billy's personality disorder stacks up into a diagnosis in chapter 1. However, when working with young adults it is essential that staff hold the hope that there can be a different outcome. With the right support in all the areas of need underpinned by adolescent sensitive practice, we can see that the outcome for Billy could be different.

Clinical pathways and treatments

What is rewarding about working with young adults is the potential you have to make a difference to their future; we have an opportunity to intervene before habitual patterns develop into lifelong problems. Adjusting therapeutic interventions for young adults needs to take into account that they are likely to have issues that we will have to accommodate in order to work together:

Features often seen in adolescence	How we can accommodate these
<ul style="list-style-type: none"> • Exhibit higher levels of impulsivity • Exhibit higher levels of behavioural instability and disturbance • Experience hormonal changes which can affect mood stability • Self-management of the above through substance misuse 	<ul style="list-style-type: none"> • Expect the unexpected in all sessions • Be alert to changes in mood and adapt your approach in line with this • Ensure there is practical safety in the environment • Ensure you have training in de-escalation and personal safety • Allow a graceful exit to sessions if this is possible • Provide a consistent approach • After events discuss what lead to the behaviour change and try to identify triggers together to increase self-awareness • Provide specific substance misuse support
<ul style="list-style-type: none"> • Suffer with higher prevalence of developmental disorders such as ADHD and Autism Spectrum Disorder (ASD) • Often lack concentration • Struggle with long and unwieldy treatment interventions 	<ul style="list-style-type: none"> • Provide small, stimulating fragments of information • Provide brief bursts of discussion based input, of less than 30 minutes • Provide interventions which complement talking therapies (for example, art, music, gym) • Find out what their particular interests are and use these to engage them practically if possible or at least in discussions.

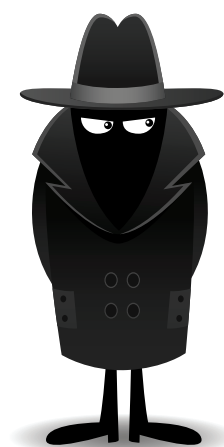
Features often seen in adolescence	How we can accommodate these
<ul style="list-style-type: none"> • Experience relatively rapid fluctuations in levels of motivation and engagement • Have limited meaningful occupations and few productive roles • Lack skills to manage adult transitions 	<ul style="list-style-type: none"> • See all engagement, even if fleeting, as positive • Find out what their interests and strengths are and use these in therapy • Provide a strengths based model • Provide opportunities to practice skills such as being independent and taking responsibility and evaluate the success using a strengths based approach • Use different media in sessions • Provide therapy which does not allow for failure until they are able to maintain engagement. Perceived failure in the early stages will lead to withdrawal.
<ul style="list-style-type: none"> • Demonstrate less ability to focus upon the long-term consequences of their actions 	<ul style="list-style-type: none"> • Look at their life journey and how they have come to be where they are • Find out what their goals for the future are • Look at their actions in relation to the impact this can have on their future goals
<ul style="list-style-type: none"> • Have dysfunctional attachments to their peers, such as gang affiliation 	<ul style="list-style-type: none"> • Encourage them to consider the reasons they are in a gang / linked to peers • Acknowledge the function the gang / relationship plays for them • Demonstrate understanding to them • Consider together other ways they could have these needs met • Provide specialist support from third sector organisations • Explore trauma related to gang affiliation such as experiencing victimisation, bullying and trauma related to offences they commit as part of the gang • Provide practical support for leaving a gang or peers who are a negative influence

Features often seen in adolescence	How we can accommodate these
<ul style="list-style-type: none"> • Are often suspicious of authority figures 	<ul style="list-style-type: none"> • Remember it is your responsibility to show them they can trust you • Explain confidentiality rules clearly • Ensure you are clear about the remit of your role with them • Keep to appointments and time boundaries • Provide a consistent approach • Build your relationship over time, show that you remember what was happening for them when you last met • Be open to the possibility of recent or on-going abuse from an authority figure and allow space for disclosure when the young adult is able to. • Follow safeguarding procedures to demonstrate that adults can be protective • Show that you care

In the rest of the guide the theories that underpin treatment remains the same for young adults as older adults, but what is needed is a stronger emphasis on developing the young adult's skills in a strengths based model. Clinical treatment of a young adult should be aiming to help them develop an understanding of themselves and the way they interact with the world. It is essential that treatment offers them opportunities to have a pro social lifestyle both in their belief about themselves and in their skill development. For example there is no point someone having a desire to work when they leave a YOI without any skills to do so, and equally, there is no point having work skills if you are not motivated to work.

When working with young adults it is essential that we help them understand their secondary characteristics (refer to chapter 2) as these are the factors that change over time. Treatment should be aiming to provide different ways of expressing themselves and behaving. To this effect, we must, more than in adult services, provide positive role models, new experiences and ways of having a different life.

It can be helpful to think of treatment as having “undercover aims” as it is best provided through activities that are of interest to the young adult, or that which provides a different experience to that which they have had in their life so far. So what do “undercover” treatment aims look like.



Treatment	What you see	“Undercover” Aim
Music session with a rap music producer	The young adult creating their own lyric. Writing the music and producing a CD of their song.	The young adult reveals parts of their childhood and upbringing in the lyric writing that can be discussed with them to help them frame these experiences in a helpful way. They develop skills, concentration and self-confidence in the music writing. Improved literacy and computer skills which are praised by the worker and develop self-confidence. When showing their CD to peers and other therapists they receive praise and recognition for something pro-social which they have not had before.
Playing a game of three a side football	The young adult working with the team to try and win. You may see them experiencing positive and negative feelings depending on if they are the team who are winning.	The young adult will be learning to manage themselves within the rules or boundaries of the game. This can be a huge challenge to those with chaotic upbringings. They will be working with other team mates and trying to achieve a joint goal of winning the game, meaning they have to work on social skills and building relationships with others. They will need to develop skills in managing their frustrations when they are not winning; these skills are invaluable in self-management in other conflict experiences. You could also consider other ways of using the young adult's interests such as changing a key worker to someone who likes football so that the shared interest can be used to demonstrate helpful attachments.

Art session	The young adult designing and creating their own street art.	Through the design the young adult develops concentration and self-determination. They may have to manage feelings of frustration if things do not go according to plan. Art as a media often reveals parts of people's life story either through the process of creation or explicitly in the piece produced, this can then be used towards someone's formulation. They consider helpful expressions of emotions and pro-social meaningful uses of time.
"Just hanging out"	The worker and the young adult having a cup of tea and flicking through a magazine together	Here there is the development of a relationship, the worker is aiming to build trust with the young adult and show that they can communicate about issues other than the offence. It is important to show you value the young adult's interests and their life as a whole entity. Of course there needs to be safe boundaries to the discussions but the aim of developing an appropriate relationship is paramount to the basis of many other treatment goals. You are demonstrating that adults can be interested and care for others which may be a new feeling for many of the young adult we work with. In itself this can be a massive therapeutic goal achieved through seemingly simple human interaction.

It is very important that there are set individual psychologically based sessions to help them look at their life in depth but this must be when they are ready to do so. It is vital that until this time treatments are based on the young adult's interests and development stage where work on "undercover aims" can be done.

It is also essential that treatments have options for engagement that give the young adult choice. We all know that teenagers are more inclined to do the opposite of what they are told to do, so having choices and letting them engage in what they can is vital at keeping them engaged with the treatments. You and the services you work in need to show care and consideration to the young adult's stage of development and readiness. As stated in other parts of the guide children need to feel a sense of care, this can be best achieved by you making an effort to collaborate on the treatment goals even if the reason for the goal is different.

Service user engagement

While discussing treatment it is appropriate to point out the importance of service user engagement in young adults services. Although this important in all areas of healthcare and custody it is vital with young adults. Due to the developmental desire to shake off parental influences and adverse experiences of authority as children, it is often the case that services do not have buy in from young adults. This can be addressed through service user involvement by:

- Involving people with lived experience of using services, to develop and deliver services
- No decisions are made about people in the service without consultation with those in the service.
- A co-production approach, which seeks to involve the service users and staff from an early stage in setting priorities and planning solutions, i.e. we're better together.

The benefits of service user engagement include:

- Individuals achieving greater psychological health / stability / recovery by facilitating hope, self-esteem, acceptance, support, social interaction, and understanding.
- Involvement can support a staff team in promoting best practice, resilience, healthy team working, and feedback.
- Involvement can support better service models; which demonstrate respect and accountability they also mirror healthy community involvement.

Treatment pathways

Treatment pathways for young adults should ultimately aim to provide support which attempts to divert the emerging personality disorder. If services are able to develop the skills of a young adult both psychologically and practically it may mean that the young adult will not develop a dysfunctional adult personality disorder.

Before attempting to understand the treatment pathways for young adults please ensure you have read *Chapter 4 – Pathways*. In relation to young offenders most sentences will be being served in the community, however, responsivity is hugely fluctuating in this group. Practitioners should always be aiming to work on engagement to develop responsivity. Many young offender services in custody have accredited prison programmes covering thinking skills, violence, sex offender treatment and substance misuse which are used in sentence planning for many young offenders. It is fair to say that those young offenders who require these treatments and who have an emerging personality disorder often find it hard to engage in and complete these programmes. As a result there are a number of new services for those young offenders with emerging personality disorders being developed which look at a more individually based treatment approach. These are briefly described over:

Pathways in the community

1) Primary Care (GP)

Community pathways are largely the same as for adult offenders with the GP being the foundation for all healthcare. Many young adults will have taken themselves, or been taken by relatives to GP's for help with chaotic and non-conforming behaviour. This often leads to confidentiality issues with significant others, where despite being a child, they have the same right to confidentiality as adults except in cases of abuse, neglect and safety for self and others, where safeguarding principles must be followed by the healthcare provider. Many of the presenting issues that a GP manages may not be seen as part of an emerging personality disorder and it is true to say that GP's often help families manage the crisis successfully without the need for other types of intervention. If however, a pattern of concerns arise it is likely that the GP would refer the young adult to secondary care.

2) Child and Adolescent Mental Health Services

These services are the young person's equivalent of the community mental health teams. In the same way as adult services people can take themselves to CAMHS however, in reality it is often parents, teachers or social services that would instigate this help. CAMHS have a variety of supports and treatments available to them depending on the area the team are based. They are able to provide additional help and support for young people and, where possible, their families in the same way a CMHT does for adults (see chapter 3). These teams are often community based however, where required for the safety of them or others, there are limited forensic inpatient services available for young people. These should be used where there is no other treatment option available in the community and admission should always be for the shortest time possible. This is to try and avoid young people becoming reliant on services in an institutionalised manner.

There are also some well know issues related to the transition of children in CAMHS into adult service provision. Traditionally young people are discharged from CAMHS when they leave school, for many of those with emerging personality disorders this can be very young and indeed there is a gap in the adult service provision that does not always cater for the needs of a young person particularly well. People involved in cases where CAMHS are involved should be alert to the potential drop out of young people at the transition phase and support them in accessing services after CAMHS.

3) Local psychological therapies

There are many community based psychological therapies for young adults. There can be accessed through GP's, CAMHS and Inpatient teams. They often provide skills based treatments and crisis care. Across the country there are a range of community services on offer with different referral processes, so it is important that you investigate these in your area. There is also a large amount of youth work and charity based organisations that specialise in helping young adults develop into functioning and fulfilled adults and social interventions for issues such as gang affiliation. These services are often strengths based and use relevant activities to engage young adults in pro social meaningful routines. There are also specific psychological therapies which have a strong adolescent offender evidence base such as Multi-Systemic Therapy which is available in some areas.

Tip – Investigate the youth services and charity organisations available in your area.

Pathways through Custody

1) Treatment services

There are non-residential treatment services in the young offender custodial estate. These teams work across the prison in which they are based in and would see the young adult wherever they are in the prison; this may be on the wing, in segregation, in education, in work, etc. Services offer a graded approach to treatment based on individual needs and, therefore, have treatments that are specifically designed to engage a young adult, “undercover treatments” and more traditional psychologically based individual and group options.

2) Enabling Environments (EE's) and Psychologically Informed Planned Environments (PIPE) services

There are new EE and PIPE services developing in custody for young adults, these services use the principles described in chapter 4 of the guide in a manner specifically attuned to the needs of young adults.

Tips:

- Develop links with the services such as GP's and CAMHS, as well as small charities and third sector providers so you can refer quickly when necessary
- Consider what treatments you can provide yourself using ideas in the guide, remember that undercover aims are highly effective.
- Remember that you are at the start of the OPD pathway with young adults and you should be planning for the transition into adult services to aid a successful future pathway.

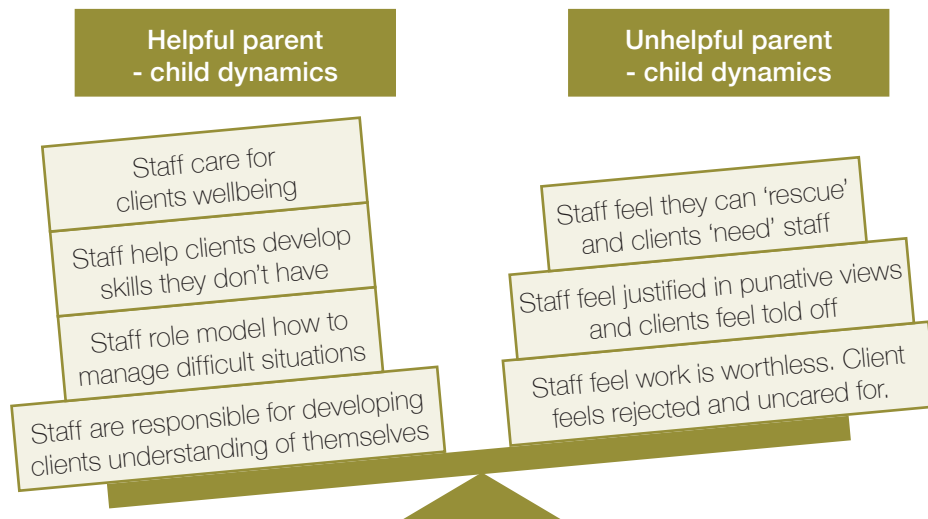
Staff skills and wellbeing

As with all personality disorder services it is essential that the staff with the correct skill set are employed. It is also essential that all staff are supported by the organisation they work in, please read Chapter 5 on staff wellbeing as the core principles of this apply to young offender services as well as adult services.

So, what different skills do you need to have when working with young adults? The main things needed are personal attributes rather than skills, these being:

- **Patience and Flexibility** – Young adults can take a long time to engage and also have highly fluctuating engagement so it is essential that you are able to have patience and work with where they are and not where you would like them to be.
- **Compliance** – It is unlikely that young adults will attend traditional appointments and therapy so you may need to consider alternatives that will suit them better.
- **Understanding** – It is helpful to have an understanding of attachment theory and normal adolescent behaviour but it is also important to understand what the young adult with whom you are working has experienced in their life and what this meant to them. When faced with challenging behaviour it can be easy to forget the possible reasons for this emotional expression.
- **An ability to show you care in a boundaried manner** – All children and young adults will challenge boundaries and when this is combined with emerging personality disorder traits it can be particularly hard for staff to maintain the balance between caring too much or being punitive. This can also be described as becoming the “over caring mother or the punitive father figure” or being “mates” with them, especially for younger staff.
- **An ability to hold a long term goal in mind** – It is vital that as the staff member you hold the hope even when the young adult is unable to, this to some extent form parental modelling, however, is also important for you both to remember what you are working towards no matter how far off this is.
- **An ability to work collaboratively**. Staff who feel they are the “experts” will find it hard to engage young adults as they will often fight against this type of approach.
- **An ability to work in a counter intuitive way** – Young adults are inherently self-focused (some might say selfish!) and an ability to work with this in order to develop pro social skills is often very helpful. This again relates to joint goal setting in that staff should look for collaboration of goals even if the reason or motivation for the goal is enlightened self-interest.
- **Humour** – Young adults are fun and funny. Staff in young adults services need to be able to use humour in the work they do and manage the humour from the young adult.

It is unavoidable that the practitioner finds themselves in a role as 'loco parentis' this can be due to where they or the young adult places themselves. Therefore it is important to think about the relationship as a parent-child one. The diagram below identifies the helpful and unhelpful parent-child dynamics which staff should be aware of:



Practitioners with teenage children will understand some of the demands on their skills from experiences as a parent. You need to let them make their own mistakes but keep them safe and you are expected to wash their socks even though they are old enough to drive. The constant dilemmas and demands on parents is also reflected in our relationships with the young adults we work with. Staff should aim for neutral and reflective practice at all times as this will allow the young adult's attachment to fluctuate without it affecting treatment. It is important that staff are able to acknowledge their position on the parental continuum of "over involved parent" to "punitive parent"; and work with this, identifying when it is at extreme ends how they can work against it themselves. This can only occur through staff reflection, supervision, managerial support and effective work life balance. What is extremely rewarding in working with young adults is the energy and enthusiasm they bring. This can often be what staff report as what they enjoy about working in such settings. It is therefore important for everyone's wellbeing that elements of fun are paramount.

Recommended reading

- Saunders, A. [2014] The Bradley Commission Briefing 2: Young adults (18-24) in transition, mental health and criminal justice. Centre for Mental Health. London
- Miller, A. & Muehlenkamp, J. & Jacobsen, C. (2008) 'Fact or Fiction: Diagnosing borderline personality disorder in adolescents'. Clinical Psychology Review. 28, 969-981
- Scott, S. & Knapp, M. & Henderson, J. & Maughan, B. (2001). 'Financial cost of social exclusion: Follow up study of anti social children into adulthood.' British Medical Journal 323, 191.

Chapter 7

Working with women

This chapter focuses on the characteristics and needs of women with personality disorder, particularly where these differ to those of men with personality disorder.

The academic literature indicates that men and women offenders generally show differences in the following areas:

- The social and personal circumstances in which men and women live their lives, and what their priorities are and the challenges they experience
- The ways in which they present their personality difficulties, and the offending behaviour linked to those difficulties
- How their risks are perceived by others both in terms of nature and severity
- And the nature of their experience in the Criminal Justice System (CJS)

A pause for thought...

Women are more likely to:

- Have a multitude of psychosocial problems, in addition to and interacting with difficulties linked to mental health and personality
- Be on a merry-go-round of challenging life events, one compounding the other
- Have convictions for non-violent crimes in the main, for which they serve usually short sentences in custody that can be massively disrupting; assessed as high risk of harm to others in only small numbers compared to men

What's so special about women?

Let's think about those gender differences in more detail, because it is only when we are clear how women's lives and experiences are different from those of men, that we can be clear about what is required of services for women and of the practitioners who work in them. Consider the detailed list in Table 1 below.

Table 1: Some of the important ways in which men and women differ in their experience and expression of personality disorder

SOCIAL CIRCUMSTANCES	<ul style="list-style-type: none">• Women experience high levels of social deprivation, such as in education and employment opportunities and linked to financial insecurity, often linked to early pregnancy, the consequences of which can be negative for her and those for whom she cares• Women have a central role in caring for others, which means that any disruptions such as due to periods of crisis or spells in custody are more likely to impact severely on the wellbeing of those dependent others
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**SOCIAL
CIRCUMSTANCES
(continued)**

- Women are more likely than men to be involved in exploitative relationships with others, which can make them vulnerable to further exploitation, to their own detriment and to the detriment of those they care for
- Women experience high rates of intimate partner violence, unstable relationships and relationships in which they experience coercion compared to men

MENTAL HEALTH

- Women experience more mental health problems – concurrently and across the lifespan – compared to men
- Women report experiencing intense and labile emotions, which can make it hard for them to cope, to think straight, and to manage their behaviour, especially at times of demand – leading to crises that can compound the negative ways in which they feel and their reliance on unhelpful ways of coping, such as substance misuse or self-harmful thoughts or behaviours
- Women are more likely than men to experience and to report self-harmful thoughts and behaviours – though men are much more likely than women to complete suicide

**EXPERIENCES IN
CJS**

- Women make up just 5% of the prison population in England and Wales
- Women in prison exist within a system designed primarily for men
- Women are generally given shorter sentences on average and fewer requirements in their supervision orders
- There are very few accredited programmes designed specifically for women or that have been specifically designed with their needs in mind
- A third of women lose their homes whilst in prison
- Not many children remain in their homes when their mother is in prison
- Women in prison are reluctant to move to other women's prisons, which are many miles apart, because it makes it problematic to maintain the family relationships on which they may have to rely for childcare and on their eventual release
- Women's prisons report high levels of self-harm among their service users.

**SUBSTANCE
MISUSE**

- The traumatic experiences of women – physical, sexual, emotional abuse and neglect in childhood and adulthood – have a key role in shaping the self-image of women, which has a direct effect on the kind of parenting experience that they can offer the children in their care.

TRAUMA	<ul style="list-style-type: none"> • More likely to have experienced childhood abuse (emotional, physical, sexual and neglect)
OFFENDING	<ul style="list-style-type: none"> • Women who are harmful towards others tend to be harmful towards those to whom they are closest – their children, their partners, family members, in the context of intense co-dependent relationships – whereas men are more likely to be harmful towards male acquaintances in the context of conflict or competition • Serious offending behaviour in women challenges the stereotype of female offending being largely in the domestic arena and the product of crisis and victimisation – women whose harmfulness cannot be ‘excused’ by their circumstances or mental illness are thought to be ‘doubly deviant’ – they have offended against the rule of law and against their gender • There are proportionately more women in prison for offences related to fire-setting compared to men • Women are prosecuted for sexual offences at low rates and, on release, they reoffend sexually at lower rates than men.

These are just some of the ways in which men and women differ in respect of their involvement in the CJS and in their pathways in and through custody. The practitioner working with women with PD will frequently encounter an individual with multiple problems. The range of problems that one might encounter as a practitioner include a chaotic lifestyle, vulnerability to domestic violence and sexual exploitation, financial and accommodation insecurities, distressing past experiences, limited social support, ways of coping that are not always helpful and can be self-defeating, poor impulse control, and a history of disengagement from the community and services.

In their interactions with women, practitioners may be faced with anger, frustration, lack of trust, scepticism, and exhaustion. Whilst these issues could be potentially overwhelming for any member of staff - and working with women offenders with personality disorder is not for the faint-hearted or disinterested - these challenges and the satisfaction to be gained from putting even some of these areas right with service users make it an enormously rewarding area of work with real potential to change lives for the better. Recognising and understanding these characteristics and the differences between women and men are essential to ensure services are sensitive to the needs of those in their care and proportionate in their responses.

Understanding the risk posed by women with PD

TOP TIP: Key areas for attention when you are thinking about the risks posed by women with personality difficulties:

- Relationship skills – or the lack of them – and how difficulties in this area can lead to conflict with key others and a cycle of disadvantage
- Skills in emotion management, thinking and problem-solving – as well as hopes and desires and the barriers that block their achievement
- Childcare and experiences of motherhood, pregnancy, childbirth and parenting

On the whole, women present a lower risk of physical harm to others compared to men - women are thought to use violence less frequently than men and with less severe outcomes in general. However, harmfulness comes in several forms and emotional and psychological abuse and neglect of others are also an important consideration. Risk of harm to self is a common concern in services for women and practitioners working with women who are the users of their services - although it is a fact that men are more likely to complete suicide. Risk of harm to others and to the self are linked to PD through a variety of mechanisms including poor impulse control, problems with regulating emotions, poor relationship skills and expectations, and thinking problems such as a tendency to catastrophise or to see things only in black and white. Risk assessment with women has to be broad, to incorporate risks to self and to others.

Despite the fact that men and women are different in how they think and feel and behave, the formal ways in which we structure our assessments of risk tend to be based on what we understand about the behaviour of men. There has been some exploration of alternative tools to assess risk – such as the Female Additional Manual for use with the HCR-20 version 3. However, it is not clear how much this framework adds to a good risk assessment. This makes it very important that any evaluation of risk be accompanied by a formulation, in which one's understanding of harm potential and the influence of gender can really be explored and expressed.

A Case Study

The following case study illustrates the presentation of a woman with PD who has harmful behaviour and is in need of a good risk management plan.

Michelle


In her childhood, Michelle has problems in her family because her mother was dependent on alcohol, her father was absent, and she experienced sexual abuse by a family friend. When Michelle disclosed her abuse to her mother, she was not believed and her mother rejected her. Michelle said that the time she lived with her family after her disclosure was difficult because her mother was very critical of her, humiliated her in front of others, and encouraged her siblings to criticise and reject her.

Michelle was the eldest of her brothers and sisters and spent a lot of time caring for them – and not being cared for herself – so her rejection by her siblings as well as her mother and father was a terrible blow to her and made her feel worthless and unwanted. However, she did have a good relationship with her grandmother, and from when she was about 9, she spent a lot of time visiting the older woman and staying at her house, sleeping on the sofa. But her grandmother wasn't really able to care for Michelle, and sometimes Michelle felt in the way and unwanted there too, especially when her grandmother had a new boyfriend and wanted to be alone with him.

Michelle's sadness and isolation attracted the attention of her peers and she was soon picked upon and bullied at school, and ganged up on by groups of girls who laughed and jeered at her and broke the few possessions she had, such as a necklace her grandfather gave her when she was a child, before he left.

At school, from when she was about 12, Michelle spent time on the internet and learned that there were places there she could go to where people were kind to her and said nice things about her. She moved onto an internet café and spent longer and longer online with boys and men who were nice to her and encouraged her to meet with them. When she did, they took advantage of her sexually, but she didn't mind at all as it was nice to have the attention. However, the nice feeling didn't last long and she was very jealous of the girls in her school who had boyfriends who cared for them. When she felt really sad, she found it helpful to cause herself pain by cutting her arms. She also started stealing alcohol because getting drunk helped her to feel numb, though this sometimes made her vulnerable and some men sometimes took advantage of her.

Michelle left school at 14 as soon as she could and without telling anyone, lived rough and in the company of some drug using homeless men. They took advantage of her, which made her cut and drink alcohol more, and she sometimes used their drugs too. She formed a closer relationship with one of the men, who had a bedsit, but he was violent towards her – and she was violent back to him. Michelle had further unstable, volatile relationships and often police were called to which ever property she was in for domestic violence incidents. On one occasion, whilst intoxicated, she was charged with criminal damage and assaulting a police officer. Due to a previous convictions for public order and drug offences, she was given a short custodial sentence.



During her time in custody, her self-harming escalated as she learned new methods from the other older girls and young women. She was challenging for the staff to manage, and was told by staff that they thought her selfish and manipulative, so increasing Michelle's sense of shame and worthlessness. On her release from custody, she took up with a drug user she knew from before, became pregnant, then stabbed the man to death following a row over money.

Selected aspects of Michelle's past will be discussed in terms of the relevance of her emerging personality difficulties to her problematic behaviour.

Personality difficulties

Michelle has had poor and inconsistent parenting and her sense of herself is poorly formed and fragile – she goes with people who seem to like her, for whatever reason, regardless of whether she likes them or whether or not they are any good for her. She puts herself at risk because she needs others to like her, even a little, in order to feel good about herself. But deep down, she knows this isn't right, that other women have more pride and sense of self-worth, and it makes her ashamed that she settles for so little. She hates herself, and punishes herself physically and mentally as a result, and she hates the men who treat her with such disregard. In the absence of any opportunity to think otherwise, in the presence of staff in prison who confirm her worst fears about herself, she sees no prospect of change and the future looks very bleak.

A note about biology

Given her family history of alcohol use and poor coping, it is likely that Michelle has at least to some degree inherited her emotional sensitivity and her growing problems with addictions. Biological influences such as these will help to shape both her response to problems and their cyclical nature.

Insecure attachments

Michelle's parents were both emotionally and physically absent in her childhood. Because of their own needs, they were not able to meet her physical, emotional and psychological needs in anything other than in the most superficial ways, and at that, inconsistently so. This would have made it hard for her to know her own emotions, to be able to understand and even label them consistently, and therefore to know what to do to be able to regulate and manage them safely and without damaging herself. In all likelihood, this experience would have encouraged in her both a low expectation of herself and others and a strong sense that relationships are dangerous, frightening, exhausting and unsatisfying. Michelle's slightly more positive relationship with her grandmother may be protective, which means it could be developed as a template for security and closeness in the event that she is able to access supportive therapy in the future.

Relationships with others

Girls and women place great weight on their relationships with one another, individually and in the small social groups to which they feel a sense of belonging and shared identity. The fragmentation of Michelle's family, her early departure from the family unit, and her rejection by her peers and their substitution by a changing group of exploitative older men, was a significant loss to her in terms of her emerging identity and her ability to trust relationships to help her feel safe and secure and to know her own wishes and desires. Fragile and volatile relationships with men who undermined her, at times when her emotions were poorly controlled and understood and when her behaviour was becoming more expressive and challenging, created the context in which her anger towards others, especially men, would be expressed with violence.

Problem behaviours as a habit

By the time she was a young adult, Michelle was in a repeating pattern of intimacy seeking-rejection-shame-self-punishment followed by intimacy seeking all over again to try to find even some short-term relief for her loneliness and isolation. But what is seen by the outside works is her inconsistency, her selfish indulgence in her own needs and concerns, her crude efforts to try to influence and manipulate others, her changeable and sometimes volatile moods, her violent expression of emotions where her violence is directed equally towards herself as towards others in the form of verbal and physical abuse. The homicide, when it came, was not a surprise to anyone who knew Michelle, confirming in her own mind the impossibility of change, and the hopelessness of her future. Michelle so wanted her life to be different, but she didn't know how to make it different or to form the relationships with the people who could help her to find a way.

The future for Michelle

Michelle can have a better future. But it will take time, effort, patience and focus to make it happen. Central to change is a quality working relationship with one or more practitioners who will make the effort to try to understand Michelle in order to help her understand a bit more about herself, to help her develop new skills at emotion management, problem solving and thinking, thus bringing her behaviour and her thoughts and feelings more into her control. In order for Michelle to have hope for her own future, others have to show her that she is worthy of feeling this way, that change is possible and worth the effort, and how to set about making it happen.

Common difficulties for practitioners who work with women with PD

The nature of women's harmfulness

Because women's harmfulness, whether directed at themselves or others, is such an intimate act of aggression, this can place considerable demands on the skills and personal resources of the practitioners who work with them. Violence


or neglect by a woman towards her child, or towards her own body and identity as a woman, is an intense experience for practitioners who can understand her distress and the feelings these acts appear intended to express. How can we help practitioners withstand the demands of such work whilst retaining their professional role and integrity, their humanity, and their hope for something better in the future for the women in their care?

Top tips for engagement with women with PD who are harmful:

- Do not try to make interpretations about how she is feeling or question her closely about her family history, as this can feel intrusive to her and, if it triggers difficult emotions, is likely to make her less, not more, able to think clearly. Although taking a history is really important, it will be far easier to do once you have already got a good working alliance.
- Start with the 'here and now' of what is going on for her at the present. Get round to how she feels after you have an understanding of the facts of what is happening for her.
- Express empathy, interest, and patient and tender curiosity about her situation, without assuming you know why she is feeling as she does and even behaving aggressively.
- Try to maintain a position of 'not knowing' about her, rather than risking her anger or defensiveness if you suggest you can read her mind
- Remember to keep your own boundaries, in terms of time, place and self-disclosure—do not get drawn into revealing personal facts as a way of trying to establish intimacy, and don't offer to do things that are outside of your professional remit.
- Keep perpetrator and victim in mind: the woman before you is likely to have been both a victim and a perpetrator, and you need to avoid being either the practitioner who rescues her from her trauma or the one who punishes her with the disapproval you feel towards her. Instead, try to be as non-judgemental as you can, as patient and as tolerant as you can be, in order that she can begin to trust rather than test you, and to work with you towards a different way of living.
- Working with women who have been let down frequently and who will test your commitment to them by being inconsistent with you, requires you to be as consistent and as reliable as possible as a basis for the development of mutual trust and respect.

Interventions: How services can provide effective support for women with PD

The aim of models that address trauma and attachment for women offenders with PD is to provide acknowledgement of interpersonal and relational difficulties, to attempt to soothe pain and voids in relationships and memories, and to manage risk. Emphasis is placed on redressing the isolation a woman



experiences when in hurtful, unfulfilling and abusive relationships and how these affects the self, particularly in terms of empowerment and self-worth. A holistic approach to help women with PD is endorsed within the current literature, aiming to help prevent offending in women in the context of providing intensive support. This approach is represented in 'one stop shops', such as women's centres, where they support women with in managing the range of their complex needs. Within the community, there are currently no accredited programmes specifically designed for women offenders, which limits the amount of specialist support they can receive under probation supervision. However, women may well benefit from gender-neutral programmes (preferably provided within an all-female environment), and one-to-one interventions around thinking skills, problem solving and offending behaviour.

As with male offenders with personality disorder, community mental health services are anxious and rather avoidant in terms of access to psychological therapies. However, women, more than men, might be accepted for IAPT (Improving Access to Psychological Therapies) in primary care, and for day treatment programmes such as DBT (Dialectical Behaviour Therapy) and MBT (Mentalization Based Treatment). This is a viable option when self-harm is a pronounced problem.

Within custodial settings, given the low prevalence of women in prison (around 5%) most accredited offender behaviour programmes (OBPs) target the criminogenic needs of men or are gender-neutral, for example, the Thinking Skills Programme. However, the CARE (Choices, Actions, Relationships and Emotions) programme has been designed specifically for women with violent offences and complex needs. There is also an accredited Democratic Therapeutic Community for women at HMP Send.

For other services suitable for women offenders with personality disorder, both in custody and the community, please see the Brochure of Women Offender Personality Disorder Pathway Services, which is available on request from pd@noms.gsi.gov.uk. Services include personality disorder treatment services in prisons, progression services in prisons and approved premises, and mentoring and advocacy services.

DO'S and DON'TS when working with women

PROVIDING EMOTIONAL CONTAINMENT

Provide each woman with the space and time to explore her thoughts, experiences and feelings in her sessions with you. Talk little, listen lots, keep a focus on the topics you agreed to discuss, but be flexible, keep your voice low and your eye contact in the form of a respectful gaze – regardless of how she treats (tests) you. She has to know you can cope with whatever she tells you – she has to see for herself that you are capable of managing the chaos inside of her. Plan your sessions so that she has some control over where and when they happen, and always allow about 10 minutes at the end of a review, some reflection, and a discussion of what she will do next so as not to dwell painfully on what you have discussed.

Validate emotions with empathic responses. Therefore, if she expresses anger towards someone she is telling you about, you could say something like 'It sounds to me like it makes you angry to talk about this person – is that right? Can you tell me more about these feelings you are having right now?'

Be honest and reliable with your contact arrangements. If you are running late or need to cancel your planned session, keep your client informed. Inconsistency, unreliability and being 'fobbed off' are likely to trigger dysfunctional beliefs about you and your trustworthiness, and high emotional arousal along the lines of you 'just being like all the others' who have let her down in the past. This is a hard position to recover from.

Be interested in the stories of each of the women you work with. Genuinely held interest leads to genuinely expressed curiosity and compassion, which will be gratifying to hear and will make a big contribution towards your working relationship and engagement.

Help those who also work with the women in your care to understand the reasons why clients can be challenging – that they can be rejecting when they are really desperately seeking their care and support, that they can be rejecting of individuals when they are only trying to express their fear of being rejected. Formulation is the process we engage in when we try to understand and explain complex behaviour in order to try to respond more sensitively and compassionately and to encourage belief in alternative ways of being.

Helping the woman to express powerful emotional struggles helps her to see that she can tolerate such feelings, just as can you, and this will be in contrast to the rejection she perhaps anticipated.

Regular and fairly frequent sessions rather than widely spaced sessions interspersed with reactive responses to crises will help women to develop emotional tolerance and self-management skills.

Instil hope – validate feelings but remind the woman that she doesn't always feel this way and that she is entitled to feel okay sometimes, whatever she has done.

If over-aroused and struggling, consider asking the woman to take 'time out' to compose herself, returning to the session as quickly as possible to resume with an initial focus on facts rather than feelings till she feels comfortable returning to the state of her emotions.

Help women improve their self-esteem and worth through self-care and opportunities for self-improvement or development. Stress their resilience, competencies, strengths and social capital of each of the women in your care.

Do not infantilise or patronize the women – consider how language may contribute to this, for example, as when they are referred to as 'girls.' Ask your clients how they would like to be referred to, challenge the use of labelling, and stick to the terms you agreed to use.

Be flexible – don't always expect the woman to come to you. Every practitioner can be a 'one stop shop' and expect to take your skills to the woman and to try to work collaboratively on their application.

Be aware of anniversaries – for example, of their offence or their sentence, or their children's birthday, and so on.

Test how gender responsive your service is – for example, check it out by going here: centerforgenderandjustice.org/response.php


Ensure women have opportunities to be meaningfully engaged in how the service is designed and delivered, including being involved in decisions about the physical environment where possible.

If the woman you are working with tells you that you are useless or that you don't care, rather than try to tell her you do care or list all the things you have tried to do for her, respond to the underlying feeling she is expressing 'You feel that no one can help you right now' or 'You feel no one cares enough about you'. Such a response helps you to avoid feeling victimised and is much more likely to generate further helpful discussion about what is going on for her rather than your role in it.

MANAGING SELF HARM

Put an appropriate crisis management plan in place before any crisis emerges that results in actual, attempted or threatened self-harm. Crisis plans should outline who is to be contacted in a crisis, what should be done to help and what response should be avoided, and who the plan and the crisis is to be shared with and for what reason. It is good practice to review crisis plans following a crisis to reflect on what worked and what did not, and to amend the plan accordingly.

Discuss with your client what you can and cannot do in relation to any act of self-harm – your likely responses to threats, your responses to actual incidents of self-harm. Encourage her to make her feelings known before she harms herself to give you both the best possible chance of averting that outcome and demonstrating that the behaviour is manageable.



Do not make promises in order to reduce self-harmful behaviour initially. Abstinence should not be your goal – this is just setting your client up to fail. Self-harm is a very powerful activity that works for women though only in the very short term. Help her find alternative ways of expressing her feelings and coping with them, and help her see that though not initially as powerful or as effective as self-harm, she doesn't feel so ashamed or hopeless afterwards if she does something different like talk to you or some other non-damaging response.

Develop your formulation for self-harmful behaviour together with your client if at all possible. Share your collaborative formulation with other relevant professionals, in order to ensure a consistent approach to her.

ENSURING STAFF WELLBEING

Ensure that regular opportunities for supervision and case discussions are in place for you and your team. Do not skimp on supervision because you have a heavy workload and you think supervision is a bit of a luxury – it's not, supervision is a necessity.

Think about monitoring staff wellbeing using 'self-help' questionnaires from the internet (see chapter 8) or using the Maslach Burnout Inventory every six or so months. This might inform the service as to any requirement for additional staff support.

Normalize the experience of strong emotions in relation to this challenging client group of women with PD; encourage self-reflection, openness and good communication.

Use the process of formulation in order to enhance your understanding of the difficulties your clients describe and present; an intellectual understanding can support improved emotional coping with complex clients and more compassion for challenging and complex, sometimes hard to like, individuals.

Viewing the woman as both a victim and a perpetrator can often help to encourage a balanced approach, and to manage angry feelings that you might have towards her.

Staff wellbeing plans can be helpful in encouraging staff to recognise the signs of stress, and put actions in place in a timely fashion.

MANAGING BOUNDARY VIOLATIONS

Maintain a predictable routine with the woman to ensure a structure – duration and regular day of the session – and adhere to the security and operational procedures of the service.

Ensure all staff are aware of the types of boundary violations (such as one practitioner treating a woman service user as if she is more deserving than any of her other clients, for example) that can lead to splitting in teams and an increased risk of fragmentation and failure.

Put in place good systems of communication and team meetings in order to manage potential splits and to reinforce consistent approaches.

Watch out for those women who staff may view as being 'special' or 'favourites' as well as those less popular women who may be avoided or neglected.

For male staff, consider the potential for vindictive allegations, and manage any anxieties that arise as a result by seeking supervision to retain clarity about the sentence plan, maintaining boundaries, and keeping colleagues 'in the loop'.

TRAUMA-INFORMED SERVICES

Assume everyone may have experienced trauma – but remember this is perceived and experienced differently for each individual.

Provide women with choices regarding what, who, when and if they want to address any traumatic experiences.

Providing choice and control for the individual woman is key in aiming to avoid re-enacting trauma and abuse.

Be aware of the potential to trigger traumatic reactions as well as to re-traumatise her by asking her to speak about her experiences when she is not ready or adequately prepared to do so.

Recognise survivors' ability to manage their trauma symptoms successfully so that they are able to access, retain and benefit from the services.

Prepare clear guidelines on personal disclosures in group settings.

Consider the appropriateness of using all-female facilitators in sessions with women who have been abused by men.

Allow women time-out, mindful and relaxation opportunities to help them regain control over their feelings.

Provide necessary time and support to enable women to develop and test out their ability to trust staff and each other.

What have the women in services said?

1. Women say that realising they are not alone is a big plus.

"It is a comfort to me to know that I am not alone and that there are hundreds of other young women and adults out there in the same situation as myself"

2. Women want more than just courses which can feel like "ticking the right boxes", but instead want relational support and knowing that someone is there to assist them working work through very complex issues.
3. The problem for women with doing courses is that when they are finished there is often not further support
4. Women want services and therapies to be linked rather than regarded as completely separate, independent interventions.
5. Women want consistency in the practitioners they have contact with.

'I seem to fail because I get workers who are supposed to be permanent then leave and the new worker don't know nothing about me which then I don't want to go through it again.'

6. Being able to sort one issue at a time and at the right time is important:

"It was like the washing was getting sorted and I can take one item at a time and deal with it"

7. It isn't all about the intensive therapies; having a 'safe haven' with the opportunity to relax and have some fun is important too.

Chapter 8

Staff Wellbeing

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

Challenges

Practitioners working with offenders with personality disorder 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 your motives, withholds information and frequently tests whether your 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

Working with an offender with personality disorder can unconsciously elicit feelings in staff that the offender has or is experiencing, most commonly feelings of anger, rejection, anxiety, fear and unfairness.

The above are common occurrences, experienced by many if not all staff. However, in a small minority of staff, working with offenders with personality disorder will expose problems or vulnerabilities related to their own personality. 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. Likewise, if you notice these types of emotional reactions in yourself, you can talk to peers, a senior member of staff, OPD specialist or (reflective practice) supervision group (see final section of this chapter).

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. The rest of 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

Maslach's 3-factor conceptualisation of staff 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 offenders with personality disorder 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 of 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 recognised for their achievements, supported when they have difficulties, valued, safe, etc. Or they can feel unappreciated, unrecognised, 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 recognised for their achievements, supported when they have difficulties, valued, safe, etc. Or they can feel unappreciated, unrecognised, 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, maybe try out the free tests on the following commercial websites:

<http://stress.about.com/od/selfknowledge/selftests/a/lifestylequiz.htm>

<http://www.mindtools.com/pages/article/get-started.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

Step 1: Check risk level	Check one or more boxes to progress
a. Indeterminate sentence (IPP or life)	
b. Men and women - determinate sentence for sexual or violent offence Or women only – any sentence type for an offence of violence, criminal damage, sexual (not economically motivated), or against children	
c. Currently high or very high risk of harm in OASys and managed by NPS	
d. Currently medium risk of harm to others, with current/previous sexual or violent offences	
e. Women only: high risk of further offences of violence, criminal damage, sexual (not economically motivated), or against children	
If you have ticked ANY of the above boxes, please complete the section below	
Step 2: Check for personality disorder indicators	Check one or more boxes to progress
a. 7+ PD items endorsed - (<i>please see below for the PD items</i>)	
b. Childhood difficulties - physical, sexual, emotional abuse and neglect and/or childhood behavioural problems	
c. History of mental health difficulties - that are <i>persistent</i> over time. Isolated incidents related to adjustment problems would not be scored here	
d. Self-harm/suicide attempts - <i>persistent</i> over time. Isolated incidents related to adjustment problems would not be scored here.	
e. Challenging behaviour - <i>persistent</i> and/or <i>pervasive</i> . May include making frequent written complaints, adjudications for violence, failures while under supervision, dismissal from treatment provision	
CONSIDER PERSONALITY DISORDER IF EITHER a), OR 2 of b) to e) PRESENT	
NEXT STEP – make an informed decision about whether the person meets the OPD pathway criteria	

OASyS Location	PD Item	Present?
1.5	One or more conviction aged under 18 years?	Yes / No
2.2	Did any of the offences include violence/threat of violence/coercion?	Yes / No
2.2	Did any of the offences include excessive violence/sadism?	Yes / No
2.6	Does the offender FAIL to recognise the impact of their offending on the victim/community/wider society? <i>(Please note this is a reverse scored item)</i>	Yes / No
5.5	Over-reliance on friends/family/others for financial support?	Yes / No
7.4	Manipulative/predatory lifestyle?	Yes / No
7.5	Reckless/risk taking behaviour?	Yes / No
10.7	Childhood behavioural problems?	Yes / No
11.2	Impulsivity?	Yes / No
11.3	Aggressive/controlling behaviour?	Yes / No
Each question answered 'yes' scores one point		Total Score /10

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

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 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.

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).

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 obstinent 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-5) 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. For those with a high level (and range) of antisocial traits, there may be features of psychopathy, although ASPD is only one element - albeit an important element - of psychopathy. 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-5) 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,

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) 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.

but doubt the sincerity of that help when it is offered and just reject it. They 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 boundaried, 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-5) 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.

Appendix C

Psychopathy

View of Self	View of Others	Main Beliefs	Main Strategy
Superior / above the rules, lack insight	Inferior, no need to attach ,	“It’s me and what I want that matters” “I’m better than others” “I don’t really care”. “I’m better than others”	Dominate, play the game, exploit

Profile of the Psychopathic Personality

Individuals with high levels of psychopathic traits may be grandiose, egocentric, manipulative, controlling and emotionally detached; lacking in empathy, anxiety and genuine remorse and guilt. Behaviourally they can be impulsive, sensation seeking and think nothing of breaking the rules. While there are clear overlaps between psychopathy and ASPD, psychopathy also encompasses traits from a range of other PDs including; Narcissistic, Histrionic, and Paranoid PD. As such, highly psychopathic individuals may be callous, view others with contempt, have a strong need for dominance and a low tolerance for frustration. They may also be highly charming and quite interpersonally skilled in getting what they want out of a situation, sometimes creating believable but totally fabricated accounts of themselves and their lives. They may be highly treatment resistant or may give the appearance of engagement without having any genuine desire to change.

Quick Reference

Overview: A varied group of individuals who’s characteristics can include being cold and detached, grandiose, manipulative, charming and selfish. Behaviourally they can be impulsive and irresponsible, live life day to day and break rules without any concern for the consequences.

Link to Offending: Strongly associated with an increased likelihood of general and violent offending.

Tips: Peer working and support is essential. Target normal criminogenic variables but try and identify what the individual really wants and cares about to make things relevant to this. Be wary of their attempts to control and manipulate through charm or aggression. Do not spend time trying to build empathy and rapport.

Psychopathy is a personality type, but not found in classificatory systems like DSM-5. As defined by the **Psychopathy Checklist Revised (PCL-R)**, psychopathy comprises 20 characteristics which are scored as two factors.

- Factor 1 : affective and interpersonal traits
- Factor 2 : chronic antisocial traits

Strictly speaking, an individual needs to score on most items in order to be correctly labeled as 'psychopathic'. However, rather than an overall 'score', it is much more helpful to think about their actual traits and the impact these may have on their behavior and offending; people with the same score can have different combinations of traits. Consider these four areas:

- Interpersonal traits: Glib and superficial, grandiose, pathological lying, conning and manipulative
- Affective traits: Lacking any remorse or guilt, having no emotions or shallow emotions, callous and lacking empathy, and not taking responsibility for things
- Lifestyle aspects: A need for stimulation and a proneness to boredom, parasitic, lacking long term goals, impulsive, and irresponsible
- Anti-social aspects: Having poor behavioural controls (being hot headed), having early behavioural problems, juvenile delinquency, having violations of conditional release and being a versatile offender (NOTE: there is a debate as to whether offending is a primary feature of psychopathy, or whether it is secondary to traits such as impulsivity and callousness)

An individual's intimate relationships and sexual attitudes and behaviours are also considered.

Relationship to offending

Around 7% of UK prisoners are considered to have high levels of psychopathic traits. Psychopathy is associated with an increased likelihood of general and violent recidivism, along with problematic institutional behaviour and difficulties engaging in and benefiting from interventions to address risk.

Psychopathic individuals may offend in a number of ways:

- They may be highly impulsive, which is likely to get them into trouble.
- They generally do not care about rules and so sanctions will have little impact in guiding self regulation.
- While they can be hot headed they may also be likely to use instrumental violence to achieve their aims.
- They have little or no concern for the impact of their behaviour on others and so do not try and avoid harming others when pursuing their own interests.
- Factor 2 traits are much more strongly linked to risk; these Factor 2 traits are also the ones that may be more likely to change over time.
- Factor 1 traits are probably not linked to risk but they lead to problems engaging someone in sentence plans or treatment to try and manage or reduce their risk.

Tips for working with Psychopathy

Tips for one-to-one working:

Don't assume you know what they think and feel:

They may have very different emotional reactions to you, or experience punishment and reward quite differently.

Don't invest in developing a therapeutic alliance:

Rather than seeking an emotional connection, taking a businesslike approach to working together towards shared goals is likely to be more constructive and helps to avoid some potential opportunities for manipulation.

Be transparent:

Be frank, transparent, collaborative (if you can) and consistent to help reduce game playing. Raising the potential of manipulation and how you may both deal with this when it happens may be helpful; as can working together to try and understand the purpose of any deceitfulness when it is spotted.

Co-working and peer support is essential:

Work openly with others, discuss feelings and concerns, and be on the lookout for attempts to con you or seduce you into breaching boundaries. **Look after yourself!**

Tips for general offender management:

The label 'psychopath' can cause much anxiety and raise many misconceptions both for staff and offenders. Remember to still focus on the individual and their particular traits and needs.

Consider criminogenic needs and responsivity issues:

Highly psychopathic individuals are likely to have similar criminogenic needs to other offenders but they will have more of them and they may be more entrenched. This is not to say they cannot be worked with. They are likely to require long term interventions and particularly creative approaches to sentence management. Manage interpersonal and affective traits and intervene with Factor 2 traits

Make things meaningful for them:

Highly psychopathic individuals may have little insight into what behaviours they need to change from society's point of view, and so see no reason to engage in sentence management. Try to understand what drives them, and what they want in order to try and make things relevant. 'Enlightened self interest' is when the offender agrees a pro-social goal with the practitioner, re-directing drives and interests which were previously fuelling antisocial behaviour. Positively reinforce this at every opportunity.

Hold the line but be clear about their choices:

Avoid confrontations over who is in charge. They are likely to want to feel in control. Clearly outlining their choices and the consequences of those choices can help to give them control while still managing their behaviour when required. Ensure you follow through with any consequences when they make their choice.

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