INDIVIDUALS CONVICTED FOR SEXUAL & VIOLENT OFFENSES WHO HAVE PERSONALITY DISORDERS: TREATMENT, CASE MANAGEMENT, AND BEYOND

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An Important Note On Language!

- I am from the UK and will use a few British terms along the way. I will explain these as I go.
- Language and professional differences between the UK and the USA means that some terms, like "psychology" are applied differently across regions and jurisdictions.
- In this presentation, all references to "psychology" and "psychologically" translate to a US audience as "clinical" and "mental health."
- Despite my UK language, **this presentation is designed for clinicians and other professionals working in the mental health field. All are welcome and all can benefit!**
- This applies to social workers, counselors, and others.

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Agenda for the workshop

- Why worry about PD and sexual or violent offences?
- PD from a psychological and a practical perspective
- Linking personality characteristics to types of offending
- Formulation approaches
- Considering the function of behaviour & its link to risk
- The evidence base for treatment (or psychological therapies)
- Taking a psychologically-informed case management approach
  - 4 vignettes to think about

A little bit about me for a N. American audience

- A forensic & clinical psychologist
- 30 years in NHS forensic mental health (including prison healthcare, and community clinic with lifers)
- Overseeing the longest running community sex offender treatment programme in the UK with a focus on PD and high risk.
- Part of the national team leading the development of a pathway for high harm offenders with personality difficulties (OPD pathway).
- Set up partnerships to deliver an amended type of COSA & first community service user forum/peer support model for those with high harm offences.
- Strong advocate of clinically applied research and evaluating impact.

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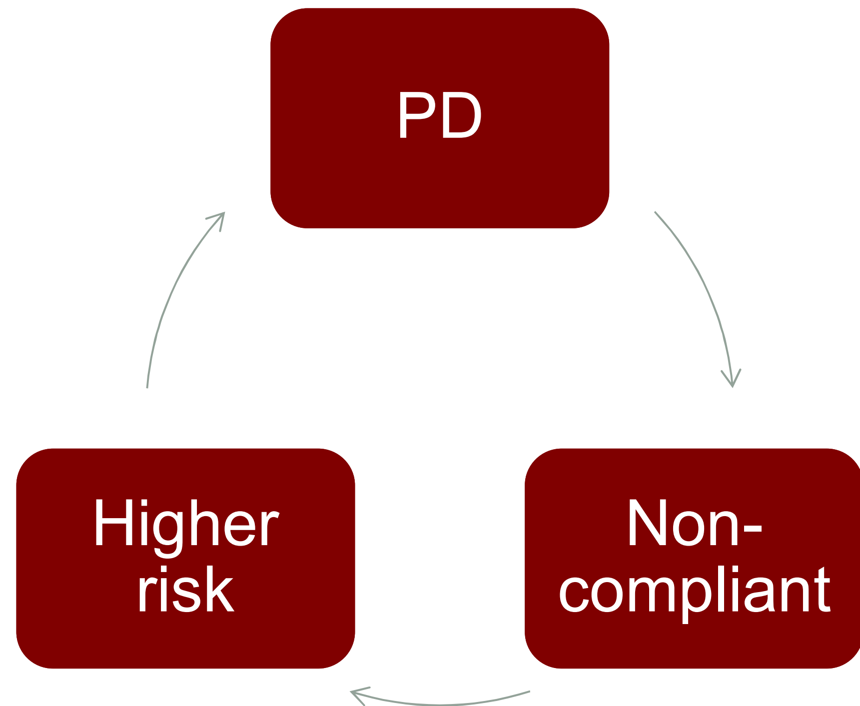
WHY PERSONALITY DISORDER MATTERS IN THOSE WITH HIGH HARM CONVICTIONS

Why PD matters

- More likely to
  - be violent in institutions & on release
  - die prematurely
  - drop out of treatment
  - use lots of services in an unplanned way
  - have a serious negative impact on staff or generate practitioner mistakes
  - have other disorders and less likely to respond to treatment for them
  - Complain or incite disturbance in peers



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THINKING PSYCHOLOGICALLY & PRACTICALLY ABOUT DEFINITION AND LABELS

Why we might want to get away from a diagnostic/medical model

- How does having 2.4 personality disorders sound credible?
- A categorical model strains credulity (you either have it or you don't, personality-wise).
- The label stigmatizes the whole sense of you as a person.
- It engenders a sense of hopelessness, as 'untreatable'.
- And yet, evidence suggests one 'grows out of it' over the course of ten years post diagnosis.

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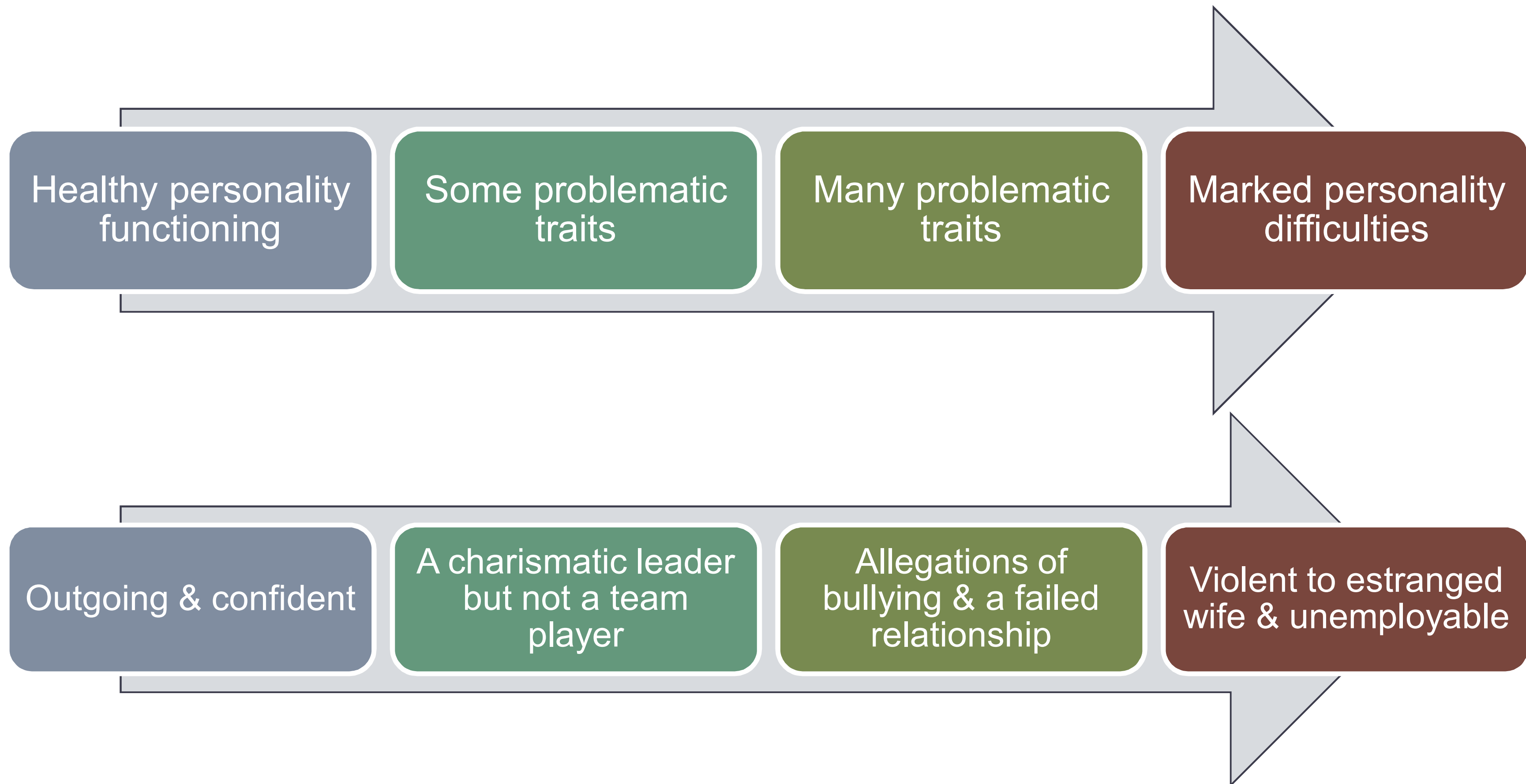
The 3 P's : a good starting point

- **Persistent** over time
- **Pervasive** across behaviours, thoughts, feelings, relationships, work, home, mates
- **Pathological** because outside the social norm

- Emerges in adolescence, established in 20s, may ameliorate in 30-40s
- Not just a terrible offence, but present pre- and post-offence, in multiple domains
- Strong social & cultural determinants to its expression

The dimensional approach (thinking about narcissistic traits)



Personality disorder is a
disorder of interpersonal
functioning

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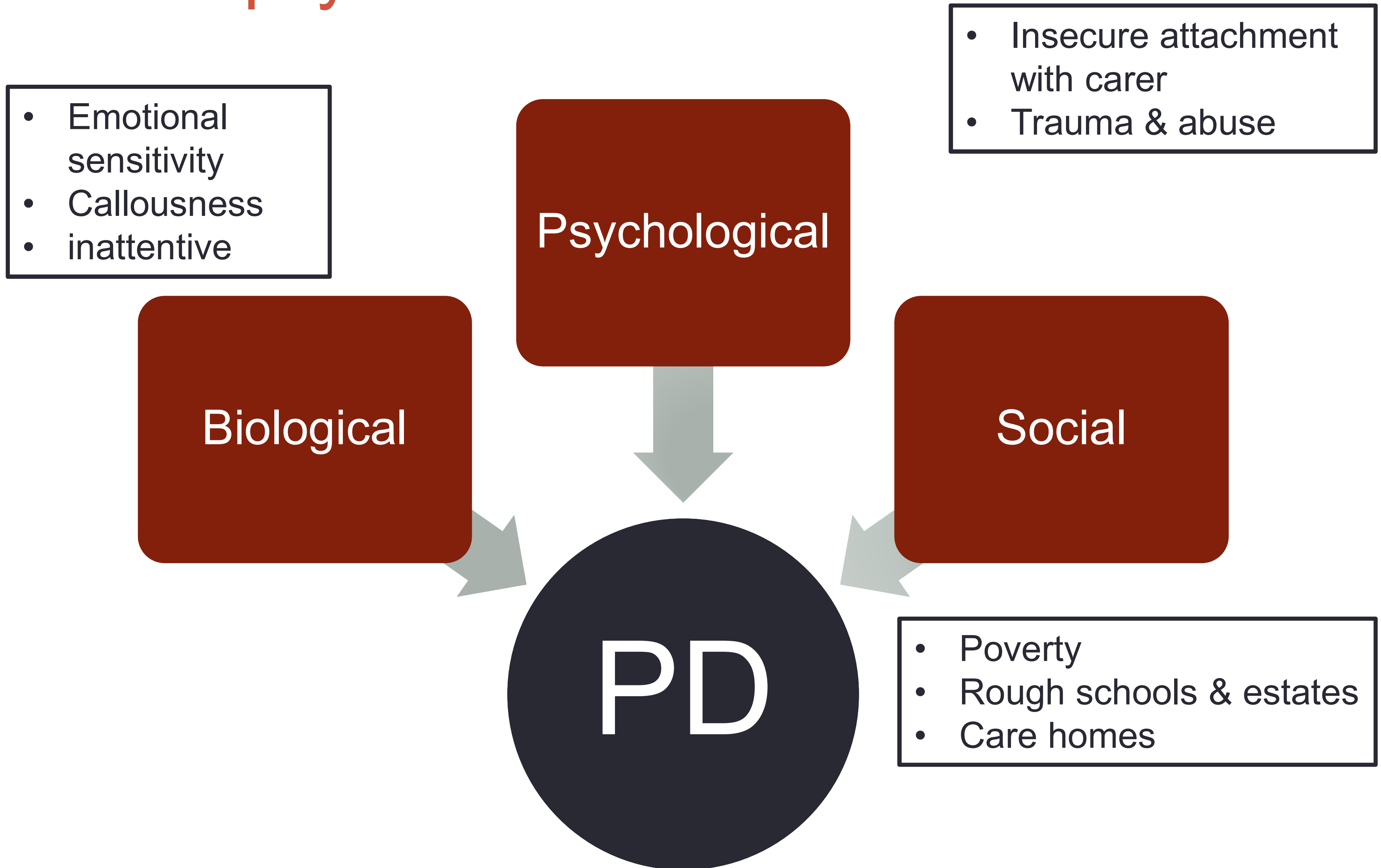
The bio-psycho-social model



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Drawing on schemas to help us understand PD

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
Antisocial	Strong/alone	A jungle	Impulsive	Deceive or manipulate
Borderline	Bad or vulnerable	Dangerous	Spasmodic	Attach or attack
Narcissistic	Admirable	Threatening	Haughty	Compete or exploit

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Paranoid and violent

Personality type	Self-schema	World schema	Expressive acts	Interpersonal strategy
paranoid	right/noble	malicious	defensive	suspicious or provocative

High levels of mistrust and suspiciousness. Easily provoked into feeling unfairly treated or attacked, developing grievances and harbouring resentments. Rigid, prickly style.	Angry aggression due to perceiving others as threatening. Morbid jealousy, stalking and related IPV. Post conviction prison-triggered decline into paranoid defences (occasionally frank psychosis).

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Schizoid and violent

Personality type	Self-schema	World schema	Expressive acts	Interpersonal strategy
Schizoid	Self-sufficient	Intrusive or unimportant	Impassive	Isolated or unengaged

<table>
<tr>
<td>Lack of interest in forming relationships with others and a flattened emotional state.
Poor verbal expression.
Withdrawal into an engrossing private fantasy life.
May be a relevant family history.
Rigid & concrete cognitive style, cope poorly with change and experience others as intrusive.</td>
<td>Over-represented in sex offences; particularly child abuse image downloading. Sometimes in rape offences (where sex is easier than emotional connection).

Single catastrophic violent outburst in contexts perceived as highly intrusive.

Some unusual offences, including stalking & extremism. Special interests dominate.</td>
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Antisocial and violent

Personality type	Self-schema	World schema	Expressive acts	Interpersonal strategy
Antisocial	Strong/alone	A jungle	Impulsive	Deceive or manipulate

Childhood conduct disorder (bad behaviour) + impulsivity, irresponsibility, remorselessness & frequent rule breaking. Alliances are antisocial. ‘Attack is the best form of defense’, weakness is despised as are emotionally driven demands for commitment. 50% of the prison population but antisocial burnout by middle age.	One typology of IPV, and one of rape; often when intoxicated. Armed robbery and other violence associated with criminal peers and lifestyle. Violence often instrumental (in relation to acquisition of resources or power). Violence can be expressive (impulsive and/or angry response to perceived humiliation).

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Borderline and violent

Personality type	Self-schema	World schema	Expressive acts	Interpersonal strategy
Borderline	Bad or vulnerable	Dangerous	Spasmodic	Attach or attack

Unstable sense of self, moods and relationships with frequent emotional crises. Self harm and suicide attempts, impulsive & risky behaviours; usually as an attempt to regulate distress. Tendency to idealise then denigrate. Intensely sensitive, particularly to potential rejection. Drawn to others who are vulnerable.	Contexts often relational & enmeshed: eg, intrafamilial child sexual abuse and IPV (dysphoric type) where fear of abandonment drives violence. Offences that emphasise & communicate their ‘dangerousness’ to others (eg, fire setting, bomb hoaxes, threats to kill). Disorganised offending.

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Narcissistic and violent

Personality type	Self-schema	World schema	Expressive acts	Interpersonal strategy
Narcissistic	Admirable	Threatening	Haughty	Compete or exploit

Inflated self worth, self-focus, & exaggerates achievements/abilities. Entitled & expects others to cater to their needs with little reciprocity. 'The rules do not apply to me'. May deal with others contemptuously as perceives them to be inferior. Combined with antisocial traits = psychopathy.	Narcissistic wounds (threats to sense of self) leading to 'vengeance is a dish best served cold'. Fragile narcissists are brittle & erupt with sudden rage. Paedophiles who endorse man-boy lover beliefs.

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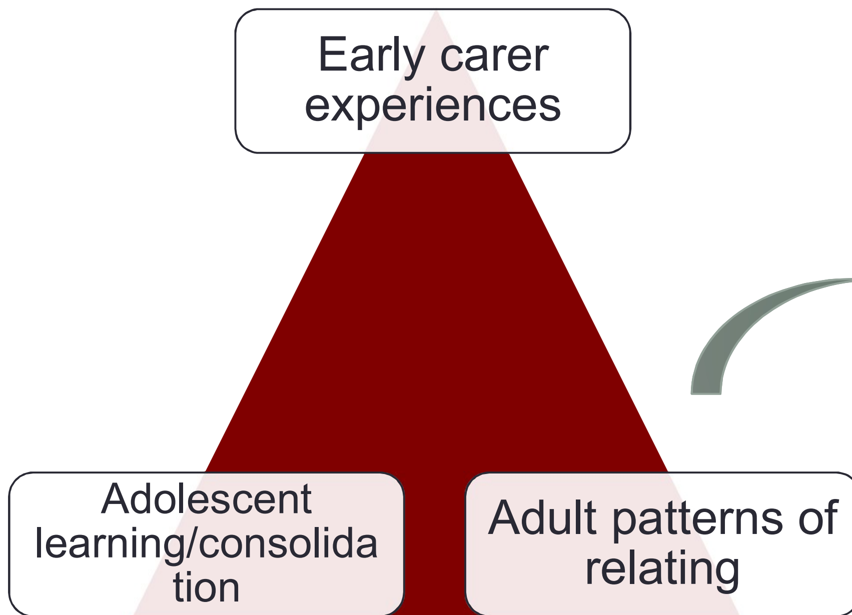
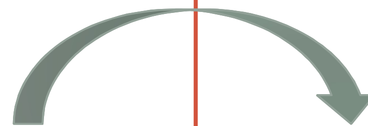
THINKING ABOUT PERSONALITY AND OFFENDING: A FORMULATION APPROACH

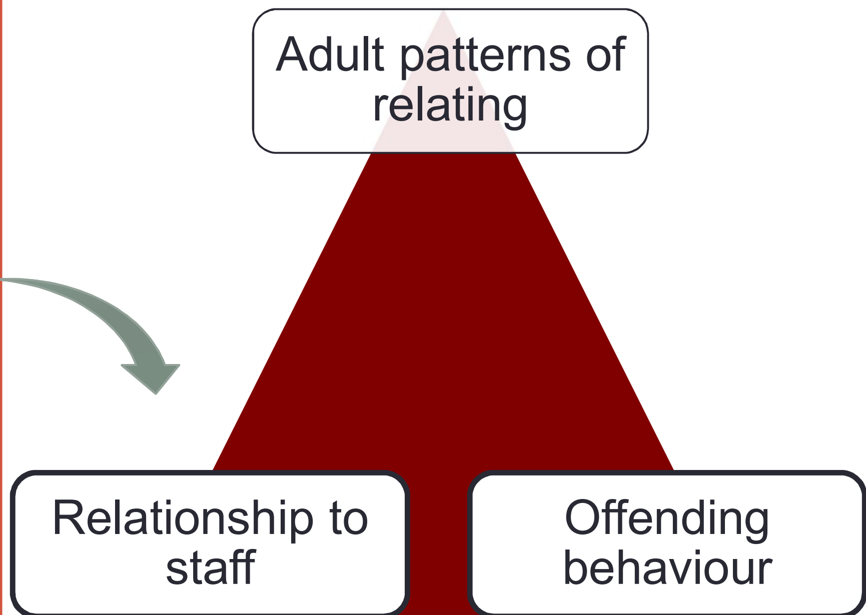
Using the attachment triangle as a framework for formulation

Developmental triangle

Interpersonal triangle







Anticipatory drama (my favourite quote)

"The view is taken that professionals who deal with offenders are not free agents but potential actors who have been assigned roles in the individual offender's own re-enactment of their internal world drama. The professionals have the choice not to perform but they can only make this choice when they have a good idea of what the role is they are trying to avoid. Until they can work this out they are likely to be drawn into the plan.." (Davies)

How trauma underpins PD and offending

- Sexually abused boys are x 10 more likely to acquire a sexual conviction in adulthood than non-sexually abused boys.
  - Think of as many psychological theories as possible to explain the link between being sexually abused as a child and becoming a perpetrator of sexual offences against adults or children.

- Or

  - Think of as many psychological theories as possible to explain the link between being physically abused as a child and becoming a perpetrator of intimate partner violence as an adult.

Explaining the link (sexual victim to perpetrator)

- Behavioural
  - Classical conditioning
  - Operant conditioning
  - Social modelling
- Cognitive
  - It must be my fault, I never said no
  - Am I gay, why did he pick me
  - Schemas
- Biological
  - Early, strong sexual drive
  - Poor self-soothing skills
- Mentalising theory
- Psychodynamic
  - Identification with the aggressor
  - The core complex

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The function of a behaviour: rule breaking

Personality characteristics	Rule-breaking
Paranoid	The rules are being manipulated to make sure I can/can't do something
Schizoid	The rules are illogical, and I will take the logical path.
Antisocial	Rules are there to be broken; only a fools worries about them.
Borderline	In the moment, I didn't think about the rules
Narcissistic	Rules are for others, I make my own rules.

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Is rule-breaking a risk concern?

- John
  - Committed a series of armed robberies during a time when he was both using and dealing crack cocaine.
  - As a child, he was often in trouble at school and started thieving from an early age.
  - Currently he gets into occasional trouble for breaking rules when influenced by his peers.
  - He reflects that he used charm to get away with his behaviour, to some extent, and used to think that he was invincible.
- Peter
  - Committed a series of armed robberies during a time when he was both using and dealing crack cocaine.
  - This offending spree took place after his mother's death, and with his wife's highly criminal family members.
  - Currently he gets into trouble for breaking rules that he says are illogical or inconsistently held.
  - He abhors his offending past, but maintains his current stance is justified.

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DOES THERAPY WORK WITH PD OFFENDERS?

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The main evidence based therapies

- Non-criminal justice PD settings
  - Schema
  - Dialectical behaviour
  - Transference focused
  - Mentalisation based
  - Therapeutic community

- Criminal justice PD settings
  - Therapeutic community (for high risk men staying > 18 months) and with a link through to the community
  - Substance abuse interventions in those with antisocial PD

What do we already know about PD therapies?

- Conclusion = nothing works brilliantly but everything works quite well, if...
  - Core philosophy of care
  - Whole team approach
  - Explicitly explained to client
  - Associated with key therapeutic characteristics (not necessarily ‘expertise’) : *empathic, warm, flexible, secure in own relationships*
  - Attention to crisis management and skills development.

What do we already know about PD therapies?

- Conclusion = can make people worse (about 10%?)
  - If already low risk offender
  - If overly challenging and critical
  - If overly rigid (about who's right)
  - If admitted to hospital for more than 72 hours
  - If too much talking about past abuse

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Why bother with the evidence base?

- We know (a snapshot of my favourite findings)
  - Therapists are very poor at predicting outcomes in terms of risk
  - Actually patients/offenders are better at doing it
  - Static risk (+ score for PD/adversity) is a stronger predictor of outcome than completing therapy, unfortunately
  - Emotional abuse in childhood + one other childhood problem = easy & very robust red flag for re-offending/non completion as an adult
  - Self report measures don't predict anything, don't bother (except maybe locus of control)
  - Badly behaved psychopathic offenders have better outcomes after interventions than well behaved ones
  - Do not deploy resources on low risk offenders, they do badly in treatment (even though there are other reasons for therapy)
  - Everyone gives up offending eventually, it's about timing

What goes wrong in the community: some observations ?

- Substance misuse interventions poor; excluded or based on self-report
- Rule-breaking not tolerated
- Unlikeability leading to low tolerance of professionals
- ‘well treated’ individuals complaining about everyone’s lack of insight, but still failing!
- NO SOCIAL CAPITAL; life in the community is a series of exclusions and humiliations

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Mentalising modes

Theory

- Pretend mode
  - intellectualising
- Psychic equivalence
  - I think it, therefore it is true and real
- Teleological mode
  - You are what you do, not what you say (words are not enough)

Practice

- 'You're only interested in me saying the right thing, not what I really think'.
- 'My probation officer failed to sign my form on purpose, she's deliberately wanting me to lose my temper'.
- Session content is irrelevant, it's everything else that matters (text, fares, letters, believing in someone, sticking with…)

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WHAT IS PSYCHOLOGICALLY-INFORMED CASE MANAGEMENT?

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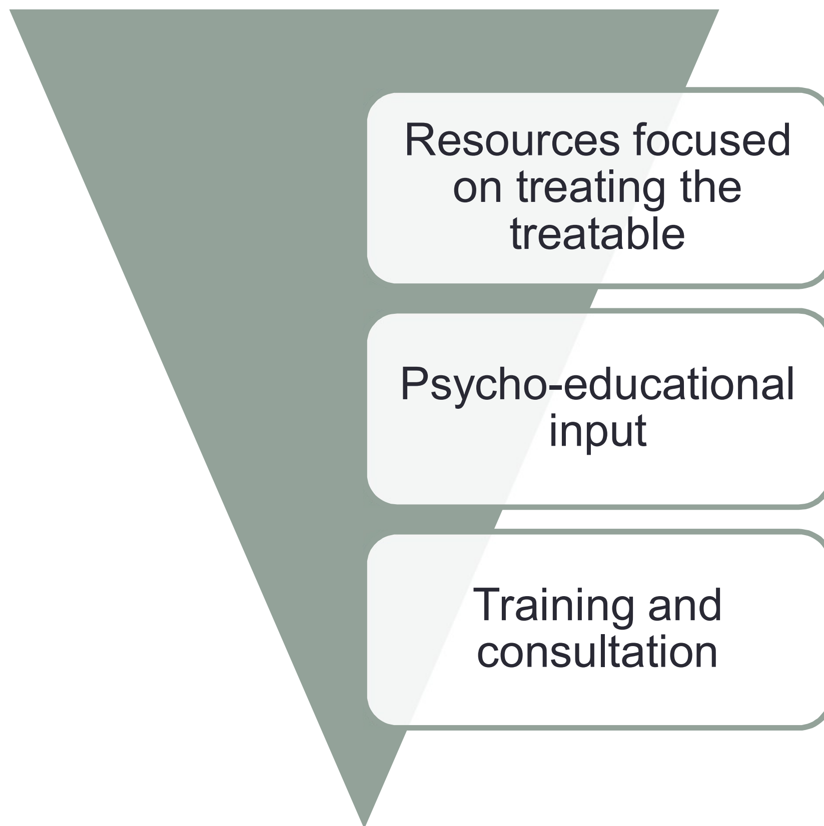
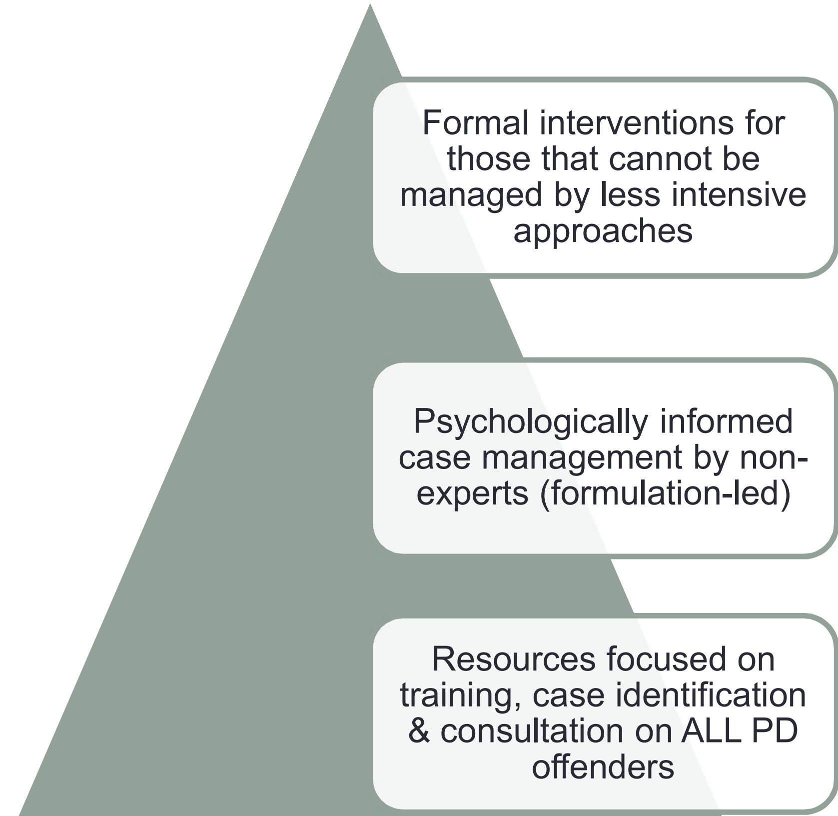
The offender personality disorder (OPD) pathway

Illness model



Public health model



OPD pathway goals

- 4 high level outcomes
  - Reduce sexual and violent re-offending
  - Improve psychological well-being
  - Improve workforce competence & confidence
  - Deploy limited resources efficiently

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Reviewing the OPD pathway

Advantages

- Huge influx of staff into specialist PD skills/services
- Almost completely uniform delivery of the model across England & Wales
- Pathway focus
- Accessibility for the 90% who don't get through therapy

Disadvantages

- Political change can overwhelm in one fell swoop
- Has the sharing of a limited resource led to a loss of impact?
- The constant pull back to a residential/treatment focus
- Believing in something can be dangerous….

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Psychologically-informed case management

- ‘Psychologically informed’ means that the key worker/case manager/prison officer/probation officer approaches engagement with the individual offender with the formulation held in mind, taking into account personality style, relational issues and possible risk triggers when working with the individual.

Task: 4 vignettes moving to the community

- Use the schema table and/or the triangles to arrive at a tentative formulation
- What is the one trait/behaviour most likely to lead to failure in the community
- What is the one thing you (as the probation officer) could do that is most likely to help the person succeed/remain in the community.
-

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Ms Brown – borderline & antisocial traits

- 29 year old serving 8 years for a serious assault on male partner with broken bottle when both drunk. Suspicious of partner's infidelity.
- Early in sentence, self harmed frequently, but improved.
- Several previous convictions for thieving + alcohol-related violence on men & women.
- Stormy relationships with men, pimped when money tight.
- Father & step-mother both had alcohol problems; father unpredictable – loving but also violent when provoked by minor misdemeanours. Sexually abused by uncle for 2 years, but hit by mum when disclosed this ('slut'). Suspected dad sanctioned abuse.

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Mr Blond – 'pathological narcissism'

- 60 year old serving 8 years for 6 counts of sexual assault on a 12 year old he'd met in the park that day. Befriended the boy with drinks and food. Denies any sexual touching, & refuses to participate in treatment. Behaviour excellent & helpful to illiterate prisoners. But contemptuous to prison staff, frequent complaints to governor, resulting in negative feedback.
- In early 20s, convictions for burglary & shoplifting. Three previous court appearances for sexual offences (every 10 years), pubescent male stranger victims (+ 1 girl victim).
- Intelligent, but no work record. Moderate PCL-R score. Two close friends – both sex offenders.
- Mum loving, overprotective single parent; grandparents paid for private boarding school where lots of peer sex – 'best time of my life'.

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Mr Pink – antisocial traits + some borderline

- 37 year old serving 8 years for a serious assault on wife (4 years married). Pleaded not guilty to allegation of rape made by her; controlling & threatening behaviour. All incidents during 6 month period in which his previously stable relationship was deteriorating. Completed IPV programme adequately; struggles with feelings of dependency/fear of abandonment.
- Prolific offender aged 16-26 (general non-violent), then stopped. This sentence, 15 adjudications for disobeying orders & threats (officer speaking 'disrespectfully'); prickly with female officers.
- As child, witnessed dad's repeated IPV & was hit trying to intervene. Dad left when 7; at 11 went into care until adult (mum a sex worker & neglected him).

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Mr Orange – schizoid (or ASD) traits

- 26 year old serving 8 years for harassment (stalking) & possession of an explosive substance with intent (planting a home made bomb under a female colleague's work desk). Victim was friendly – interpreted by him as wishing to share her life with him. Eventually sacked; 1 month later planted the bomb which failed. Explanation was that he intended to kill himself with her 'joining me in death'. Excellent behaviour in prison.
- No previous convictions. De-selected from prison therapeutic community after 2 months as became depressed and lost temper at having to attend groups ('too much'). No other treatment offered.
- Settled & secure family background, mum cold/undemonstrative & father shy/avoidant. Loner at school & as adult. Tried dating sites as wanted a girlfriend 'like other people'.

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IT'S BEEN A PLEASURE

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