HM Prison & Probation Service

NHS

Practitioner Guide

Working with people in the Criminal Justice System showing Personality Difficulties

Third edition – February 2020

Acknowledgements

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Editors:

Jackie Craissati, Independent Clinical Consultant to the OPD programme, Psychological Approaches CIC

Nick Joseph, HMPPS

Sarah Skett, NHS England & HMPPS

Authors:

Abdullah Mia, Northamptonshire Healthcare NHS Foundation Trust

Anna Motz, Central and North West London NHS Foundation Trust

Caroline Logan, Greater Manchester West Mental Health NHS Foundation Trust

Chris Bull, HMPPS

Emma Nicklin, Central and North West London NHS Foundation Trust

Jake Shaw, Oxleas NHS Foundation Trust

Jason Davies, Swansea University

Jenny Tew, HMPPS

Kay Garvey, Birmingham and Solihull NHS Foundation Trust

Kirk Turner, HMPPS

Michelle Chauhan, Avon & Wiltshire Mental Health Partnership NHS Trust

Phil Minoudis, East London NHS Foundation Trust

Rachel O'Rourke, HMPPS

Sarah Paget, Royal College of Psychiatrists

Sarah Simons, Together: Working for Wellbeing

Stuart John Chuan, Simplify Health

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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

The third edition of our Practitioner Guide has been developed in light of new evidence including a survey of practitioner guide users about what is most useful. In this guide, practical advice is given on how to work with people whose behaviour can be extremely challenging; the consequences most apparent from the harm often caused to themselves and others, and the impact on staff and their wellbeing.

Following the public consultation on the joint HMPPS and NHS OPD pathway in 2011 many services are well established and new ones are being commissioned to further develop the pathway. This continues to be a time of innovation as we understand more about developmental pathways, the role of neurobiology, the interaction between the environment or system, and the expressions of complex behaviour.

The OPD pathway is a network of jointly delivered services built on the quality of relationships and designed to instil trust and hope in service users and staff. This guide supports learning by providing pragmatic approaches for any practitioner. Key changes include revisions to the chapter on consultation and formulation, a chapter on strategies for the improved management of individuals, new guidance on staff wellbeing, and the special considerations related to working with women, young adults, people with neurodevelopment difficulties, and ethnic and cultural differences.

Jo Farrar
Chief Executive Officer
HMPPS

John Stewart
Director Specialised Commissioning
NHS

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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: we are concerned with symptoms that are Problematic, Persistent and Pervasive.
2. Look out for: diverse or repetitious offence profiles, persistent non-compliance, rapid community failure, high levels of callousness and instrumental violence. Personality difficulties do not automatically flag 'high risk', but pay attention when these features are present.
3. To understand personality difficulties 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. Personality difficulties comprise 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 person, 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 person.
10. Look after yourself. Seek psychologically informed supervision and support, take time out to reflect, be realistic about change, and celebrate real success.

Contents

Chapter 1: How to spot personality difficulties

The focus of this chapter is the identification and assessment of personality difficulties. This guidance acknowledges the controversial nature of a personality disorder diagnosis and adopts the position that a diagnosis is not necessarily required or helpful in understanding and developing psychologically informed skills when working with individuals. For the interested reader, more information on diagnoses is contained within Appendix I, including brief guidance on when it may be necessary to seek a formal diagnosis.

Throughout this guidance, we refer to the term 'personality difficulties' rather than 'disorder'. It may seem a small change, but it reflects our intention to move away from a rather medicalised and categorical approach to the subject, and a move to emphasise an approach based on psychological principles where personality is considered as a continuum from highly functional to pervasively problematic.

On this continuum we are most concerned with a level of difficulty that might satisfy a diagnosis of 'personality disorder' if such a diagnosis was made. We are also concerned with not labelling people, but rather trying to describe how people feel, how they behave and how they interact with others.

The chapter starts, however, by offering a working definition of personality difficulties, and includes a brief overview of the most commonly used approaches to assessing personality disorder. The chapter concludes with practical advice on how personality difficulties may be identified from a practitioner's perspective.

What do we mean by personality difficulties?

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

- For personality difficulties 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 extreme or severe and these characteristics cause difficulties for themselves or others (problematic).
- Personality difficulties 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 personality difficulties unless the symptoms are…

unusual and causing distress to self or others

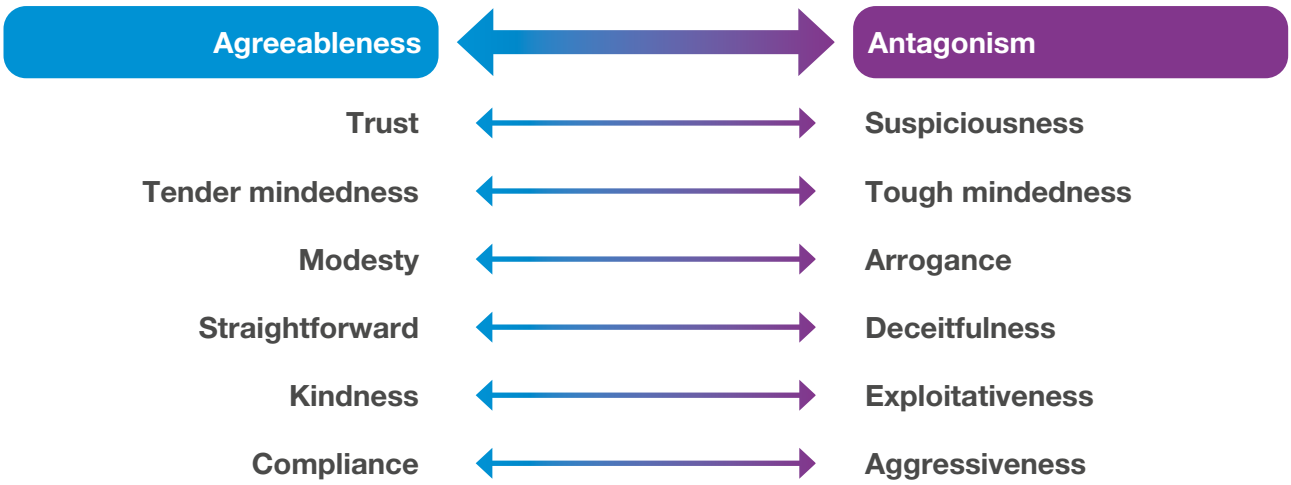
starting in adolescence and continuing into adulthood

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

Personality difficulties as problematic extensions of normal personality traits

Before defining personality difficulties, 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 difficulties are best understood as more unusual or extreme personality types – or a cluster of core characteristics (sometimes referred to as traits) 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 it's 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 difficulties are likely to express higher numbers of problematic personality traits and experience them to more extreme degrees. For example, an individual with personality difficulties of a narcissistic type may be unusually arrogant and exploitative, while an individual with an antisocial personality may be extremely aggressive and deceitful.

Personality disorder diagnoses are categorised into different types of disorder (see Appendix I), 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 show 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. In fact, evidence shows that as the number and complexity of a person's problems increases, the ability to be able to 'diagnose' a particular disorder becomes less likely, as there is so much overlap between symptomology.

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.

A continuum of personality functioning

Although more recent thinking about a framework for understanding human distress and mental health problems – the Power Threat Meaning Framework – has been developed from different philosophical roots, it nevertheless endorses this continuum approach. The framework emphasises the need to understand individuals' personal narratives and subjective experiences, including an understanding of 'what has happened to me?', 'how did it affect me?', 'what sense did I make of it?', and 'what did I have to do to survive?'. The premise is that 'abnormal' behaviour and experience can be understood as an intelligible response to current circumstances, history, belief systems, culture and bodily capacities; humans are fundamentally social beings whose experiences of distress are inseparable from their material, social, environmental, socio-economic and cultural contexts. The framework therefore moves away from ideas of 'pathology' and 'diagnosis'.

What sorts of symptoms should I look out for?

Symptoms of personality difficulties 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 difficulties 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.

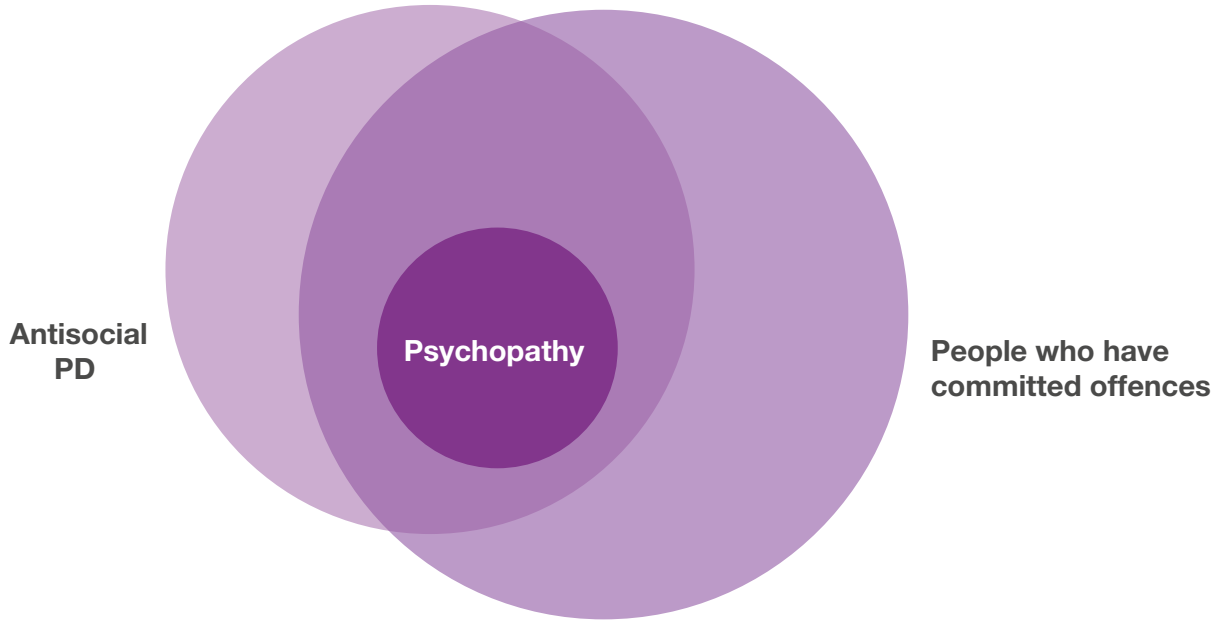
Remember

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

Psychopathy

You will notice that psychopathy is not present among the personality disorders listed in Appendix I, although it is entirely true to say that is a type of personality difficulty. 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 individuals, psychopathy and personality difficulties; see Chapter 5 for top tips for managing people 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 difficulty, 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 people 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.

Distinguishing personality difficulties 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 therapies) 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 difficulties or a diagnosis of personality disorder, form part of the personality system, are therefore chronic and enduring and are generally much less likely to be responsive to medication.
- Despite this distinction, many people assessed as expressing personality difficulties also meet the criteria for mental illnesses such as depression or schizophrenia. It is also suggested that having marked personality difficulties may increase one's risk for developing mental illness.

Learning disability

The distinction between learning disability and personality difficulties 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 difficulty. For example, some individuals showing personality difficulties 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 personality difficulties 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 difficulties 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 difficulties are the most probable cause of the symptoms or concerning behaviours.

Note: there is more detail on neurodevelopmental difficulties and autistic spectrum disorder in Chapters 5 and 6.

Top Tip: Whilst it can be a challenge to decide what is going on for a person, taking time to work with him or her to try and understand their lives, and in the course of doing so, to develop a better working relationship, can be hugely rewarding. Building a shared understanding of the person's history and how their personality has developed over time will help you understand what influences the person's behaviour.

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 difficulties:

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 difficulties 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 a label describing a cluster of core characteristics, Billy's symptoms are most representative of a borderline (emotionally unstable) personality type (instability in a sense of self, relationships and emotions) although he also presents with marked antisocial traits (disregard for and violation of the rights of others). The overlap between these descriptive labels is particularly common among samples of individuals with offending histories. Billy also suffers from episodes of depression and has gone through periods of misusing substances.

A rather different manifestation of personality problems is presented below:

Robert

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

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

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

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

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

- **Problematic**

Robert has demonstrated a number of problematic 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 difficulties 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 might best be described as characteristic of schizoid personality traits (absence of attachments to others, flattened emotions) but he also presents with some paranoid traits (distrust, suspiciousness). He also suffers with an alcohol dependency.

Assessing personality difficulties

There are a number of recognised methods of formally diagnosing, 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 a person who has committed offences with antisocial or psychopathic characteristics. However, if the issue of diagnosis is put to one side, and the focus is on broader approaches to assessment, then the following section highlights the most commonly used methods for assessing personality difficulties.

1. Unstructured clinical interview

Personality difficulties may be identified through the use of an unstructured clinical interview, guided by a diagnostic manual (e.g. DSM-5). To establish a diagnosis of personality disorder, 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. This method can be used to identify difficulties, establish patterns of behaviour and label core characteristics, even though there may be no need to consider a diagnosis.

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 the assessment of personality difficulties 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 disorder 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 recognise personality difficulties

It is usually not essential to have suspected personality disorder diagnosed in a person with whom you are working; qualified professionals may not always be available to you to undertake such an assessment, and it may add little or nothing to your assessment. However, it is possible for you to spot some reliable indicators, which could help you decide whether it would be useful to manage this person as if they have the core characteristics of a personality disorder. The tools in this guide and elsewhere will help you to detect possible personality disorder but they DO NOT diagnose it.

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

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 personality disorder.
- Other reports which may contain relevant information about personality disorder/difficulties 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 personality difficulties more broadly.

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 B)
4. Consider interpersonal dynamics
5. Remember the 3 Ps

- Diagnoses given in childhood such as Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD) are often risk factors for developing personality difficulties 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 difficulties 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 personality difficulties 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 antisocial traits 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 difficulties are 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 willful 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 difficulties should be regarded as a vulnerability factor for experiencing other mental health problems. Consequently, individuals showing personality difficulties are heavy users of mental health services. This may be particularly so for individuals expressing borderline personality traits, who may be more treatment seeking than other individuals with personality difficulties. 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.
- **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 difficulties. For example, there is a particularly strong relationship between childhood Conduct Disorder and Attention Deficit Hyperactivity Disorder (ADHD) and antisocial personality difficulties in adulthood.
- **Detention in secure psychiatric facilities** may suggest mental illness, but might also indicate personality difficulties. Obviously, if the person has received treatment in specialist personality disorder facilities (such as the secure OPD Pathway facilities in the NHS or Prison Service), personality difficulties and / or a diagnosis of personality disorder are 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 showing personality difficulties, many such facilities now either explicitly or implicitly provide services to this group. Where someone has spent time in a DTC, either in the NHS, or the Prison Service, personality difficulties and / or a diagnosis of personality disorder may also be present.

d) Childhood difficulties

A range of childhood difficulties are associated with the development of personality difficulties 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 difficulties, individuals expressing personality difficulties 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 personality difficulties

1. **Victimisation:**
   - Sexual abuse
   - Physical abuse
   - Emotional abuse
   - Neglect
   - Being bullied.
2. **Emotional or behavioural problems:**
   - Truanting
   - Bullying others
   - Expelled/suspended
   - Running away from home
   - Deliberate self harm
   - Prolonged periods of misery.

OASys personality difficulties 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.

OASys personality difficulties 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 these OASys items states that if a person scores positively on all or most items (7 or more), this may indicate the presence of marked problematic personality traits associated with serious offending behaviour. However, a number of individuals with personality difficulties (non-antisocial) will score moderately low on these ten items, but will have sexual or violent offending linked to significant histories of childhood adversity, complex trauma, and an increased likelihood of brief periods of contact with mental health services in adulthood.

Some important points to remember about the OASys personality difficulties screen:

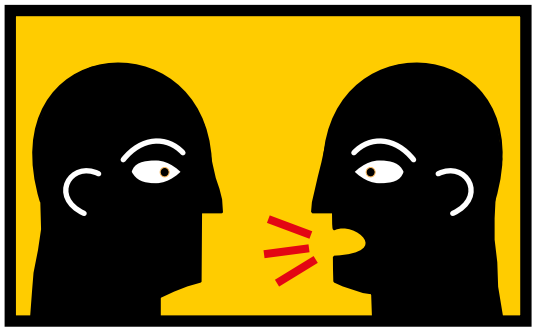
- High numbers of people who have committed offences reach the cut off. It is currently estimated that over 30% of people within the National Probation Service's caseload score at or above a suggested cut off of seven or more of the items endorsed.
- It will only screen for some antisocial, psychopathic and borderline features and will not screen for characteristics of other disorders. So other types of personality difficulties – particularly those with a more introverted profile – may be present even if the OASys personality difficulties scores are not raised.
- Higher overall scores are likely to reflect a more severe antisocial presentation.

A note on the use of screening tools

There are a number available for personality difficulties (often linked to diagnosing personality disorder). Along with the OASys personality difficulties screen there is the International Personality Disorder Examination (IPDE) screen, P-Scan (for psychopathy) and the Standard Assessment of Personality – Abbreviated Scale (SAPAS). 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 showing personality difficulties 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 difficulties. See Chapter 8 for further information on staff wellbeing. Appendix III also outlines briefly the ten Enabling Environment standards which provide a checklist for services against which they can consider how ready they are to be able to manage individuals with personality difficulties.

In later chapters it will become apparent that problematic developmental experiences may lead individuals with personality difficulties 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 rescuer. 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 personality difficulties 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 person's negative expectations of others.

Thus a practitioner's emotional reaction to individuals showing personality difficulties (and the emotional reactions of other practitioners) may be used as a valuable indicator in identifying the possible presence of personality problems. In turn, this can lead to consideration of how to help, understand and manage the individual, 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 personality difficulties

- 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 difficulties are likely to be present.

What next?

If you have identified a case to whom you think this may apply, 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 difficulties among offender groups is very high. It is likely that 30-50% of a probation caseload and 60-70% of a prison population 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 about a formal diagnosis, except in very occasional circumstances.

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 person is highly distressed or emotionally volatile

d) There is something odd or unusual about the person

e) The person 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 do personality difficulties develop?

The biopsychosocial model

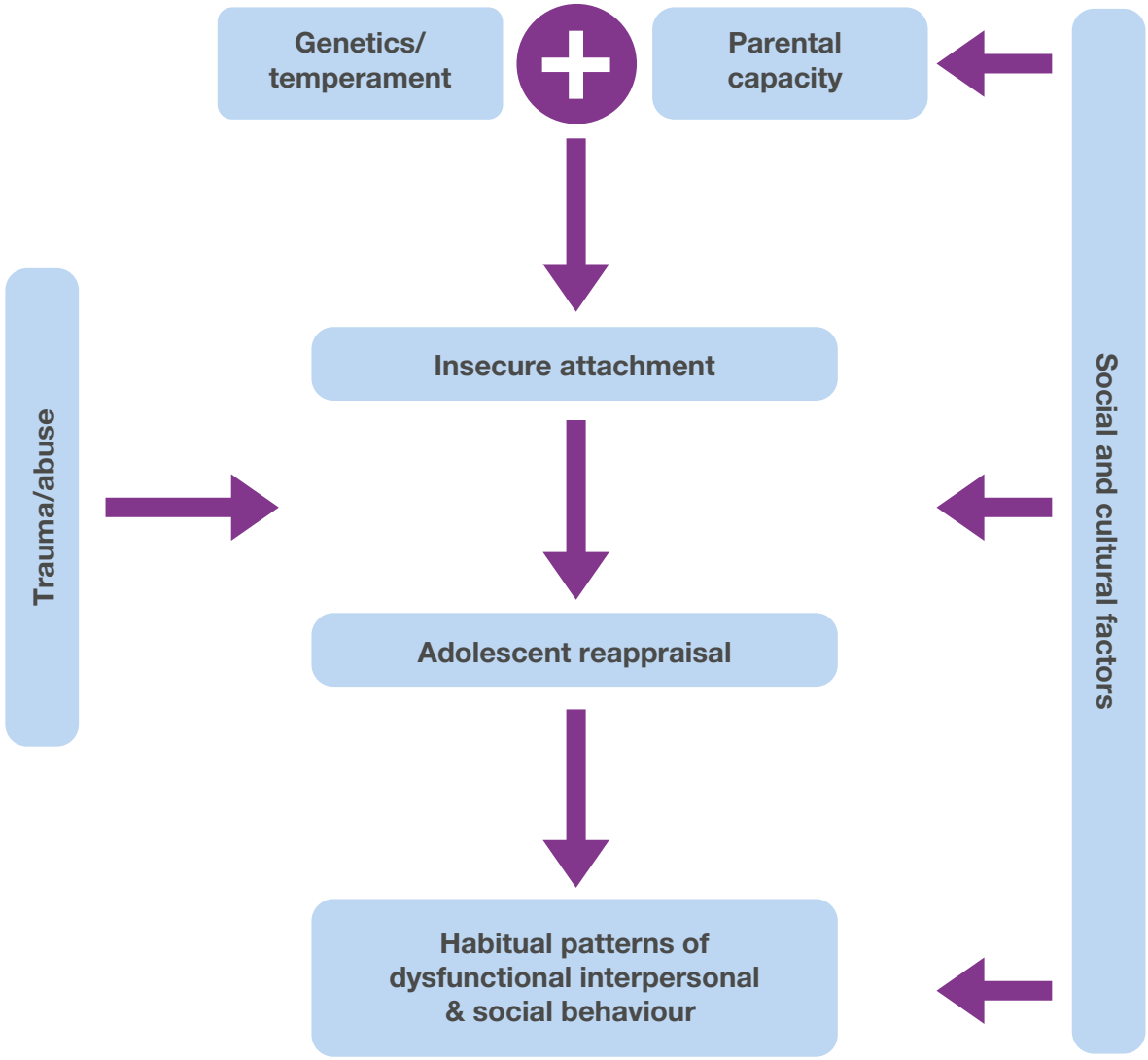
Despite professional disagreements, it would be reasonable to state that currently, most experts in the field subscribe to the **biopsychosocial** model for understanding the development of personality difficulties.

What does this mean? Personality difficulties develop 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.

Figure 2.1



Genetics/temperament

Note that a more comprehensive model for understanding a person's developmental history, and showing how significant interpersonal, psychological and emotional problems may develop can be found in Appendix II. This chapter provides a simplified version of that model.

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 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 difficulties, 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 difficulties during times of war, and also in many Asian cultures, the latter being more liable to develop depressive difficulties and other inward expressions of distress. In both examples, 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 in determining the expression of difficulties.

Our current social context has a strong influence on individuals in terms of the ways in which culture and religion, poverty and lack of opportunity impact our developmental experiences, and the way in which distress is expressed. For those who perceive themselves to be excluded from mainstream social opportunities, alternative and anti-authoritarian social structures may provide a sense of belonging and strong identity. Conversely, access to opportunity and stability (for example housing or employment) is thought to provide a buffering effect, encouraging individuals to conform more readily to socially accepted norms. Social influences are therefore an important moderator of biological and psychological influences.

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.

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.

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 people with personality difficulties. This is partly because it 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 individual. 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 and brain structure at key ages (including adolescence), particularly in the ability to manage emotions and states of stress. The person may not be aware of the influence of such neuroplasticity on their behaviour, and over time, this attachment system remains the key to interpersonal behaviour throughout the life span.

Resilience

However, the pathway to personality difficulties is not always determined by a difficult start in life. Research suggests that the behaviour of securely attached children can deteriorate over time, and likewise, the behaviour of insecurely attached children can improve, both in response to changes in the immediate environment. Furthermore, children differ in the extent to which they demonstrate resilience in the face of adversity, although there is less research in this area than in understanding the impact of trauma on the individual. There is some evidence that an early positive attachment – even if curtailed due to unforeseen events – may be protective. Similarly, intelligence and a 'likeable' warm personality may help buffer the effects of trauma or poor attachment experiences.

Adolescent reappraisal

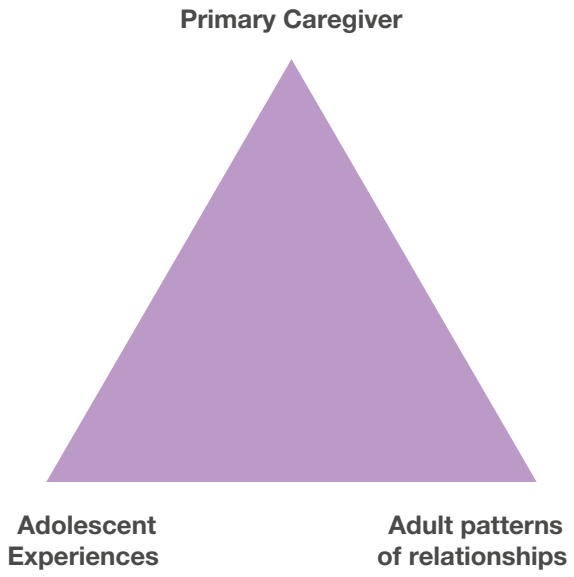
The most important time of change – both in repairing and in aggravating problems – is at **adolescence**. Puberty is the final period of rapid neurological change in the human brain, at a time when the social task is to transfer attachment relationships to peers and wider social institutions outside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

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

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 difficulties 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. 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 difficulties 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 difficulties 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 people. Mark – whose attachment history is summarised earlier in the chapter – was fairly typical of an individual with a cluster of antisocial traits. 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

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.

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.

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.*

Using 'elaboration' for more detail

Mark *She was a good mum.*

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

Mark *What d'you mean?*

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

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

OM *Exhausted?*

Don't challenge, go for detail

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

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

Mark *What d'you mean?*

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

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

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

Use acceptable words, non judgemental

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.

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.

Starts to relive and merge relationships

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?*

Idealises mum, so separates out this fact

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

OM *When did you find out?*

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

OM *What did you know about your father?*

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

High emotion, can't separate self from dad

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 individual (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.

This chapter has focused, thus far, on difficulties that arise as a result of problematic attachment experiences, and traumatic events such as abuse. These are often referred to as **ACEs** (Adverse Childhood Experiences), and there is more information on the internet regarding approaches to the assessment of ACEs, and the development of innovative public health approaches to building resilience and protective factors in vulnerable individuals.

Using attachment theory to make sense of the offence

This guide clearly emphasises the importance of understanding personality difficulties when working with individuals with offending histories: 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 difficulties. 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 can ultimately be exposed. In this way, understanding the development of personality difficulties, 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 antisocial personality traits. 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 difficulties are 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 4), was a high risk paedophile with a number of pubescent male victims. He was thought to show 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 an individual with a domestic violence conviction, 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) 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 individual's offending behaviour 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 difficulties

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

Why might this be?

- First, it is likely that the assessment or diagnosis is rather unreliable under the age of 25; certainly many individuals 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 difficulties represent, 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 difficulties are also relatively risky, 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 individual with personality difficulties who offend.

- However, many individuals with personality difficulties are likely to be responsive, at least in part, to a range of interventions. These are detailed in Chapter 4, 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 problematic personality difficulties 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, individuals expressing antisocial (or psychopathic) traits 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. Individuals expressing borderline traits remain emotionally sensitive, but are less prone to being overwhelmed by intense emotional states, or engaging in repetitive self harming behaviour. Individuals showing narcissistic traits 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 5 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 an individual with personality difficulties. 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.

Chapter 3: Pulling it all together: a model for consultation and case formulation

Introduction

This chapter provides principles and standards to guide practitioners working with people showing personality difficulties, 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 difficulties. Chapter four on psychologically informed management also contains useful information on how to bring a psychological understanding to challenging behaviours.

What is formulation? Formulation can provoke extremely diverse – and often anxious - responses in practitioners: prison officers or probation officers may be very new to the concept and initially rather bemused; psychologically trained practitioners 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. The formal nature of the term, formulation, belies the fact that anyone who is curious about the meaning of human behaviour is intuitively formulating all the time. For example, if you ever find yourself thinking along the lines of these examples, you are formulating in a psychologically informed manner:

'all that macho posturing, I think he's compensating in some way for his insecurities'

'his victims are all vulnerable, I suppose it's something about needing to be in control'

'we had a terrible session, she's so angry about everything, I think she just wanted to dump it all on me'

The aim here is therefore to provide a model for formulation which builds on these existing skills; and is sufficiently versatile to be accessible to a wide range of professions, generalisable across diverse services, and easily understood by, and useful to, service users.

The chapter approaches the subject in three steps.

a) **Consultation,** the **process** by which a formulation is developed

b) **Formulation,** the **product** of a consultation, and which forms the basis of future actions

c) **Recording** the formulation; good practice standards

Consultation: presenting a case for discussion

If case formulation is the product, then case consultation or case discussion is the event or process by which the product can be achieved. It can be defined as the verbal interaction or discussion between a consultant (a practitioner with some subject expertise and the requisite skills) and a consultee (in this case, another practitioner with a complex case). Consultation can include advice-giving and signposting, but is likely to encompass more than this, as detailed in the section on formulation below. Consultation 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 difficulties, it is important to seek feedback and support (see Chapter 7 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 person.

Why bother with case consultation?

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 person, 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.

Research to date on the OPD pathway tasks suggests that consultation is a highly valued experience by the recipients, probably more useful than the formulation itself.

Tips for presenting (from the point of view of the consultee) (the order can be varied):

1. Read the file even if you know the individual, you'd be surprised what facts you had forgotten
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 relevant elements of the individual's life, preferably in chronological order. Depending on the purpose of the consultation, 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

Tips for leading a consultation (from the point of view of the consultant)

Every practitioner develops their own style and structure for consultation over time; there is no one right way of leading a discussion on a complex case. For some, their preference is for a clear structure, for others a more free-ranging discussion; some use diagrams and flipcharts, others prefer a narrative approach. Regardless of preference, the consultant role within a case consultation must attend to the following two aims:

a) the consultation must be responsive to the needs of the consultee (rather than the wishes of the consultant), and in order to achieve this, the consultant needs to be flexible and adaptive, encouraging a collaborative approach to formulation, that is psychologically informed rather than psychologically led.

b) The consultee should leave the consultation feeling more hopeful than at the start of the consultation. Hopeful can mean many things: it may be that the consultee's anxieties are more contained, he/she feels more confident, or that there is greater clarity regarding the case, with clear and achievable goals that provide a sense of purpose.

To reiterate, everyone finds their preferred approach to consultation; however, here are a few tips (in no particular order) that may be helpful, given that the task can be daunting, even for the most experienced of practitioners:

- Set the goal for the consultation from the outset, by making sure everyone understands what the presenting concern is.
- Consider dividing up the available time into sections: you might want to ensure there is a balance between sharing impressions of the individual and his/her working relationship with staff in the here and now; gathering historical information; and developing a formulation and action plan.
- The consultee often knows more than they think they do; ask elaboration questions – 'tell me more about that' in response to any facts, and build their confidence.
- Be disciplined with yourself and limit the number of questions asked of the consultee; a difficult case does not become simpler just by asking more and more!
- Don't underestimate the importance of simply helping the consultee to put their knowledge into chronological order, tidy up their understanding of the triggers to problematic behaviours, and prioritise their risk concerns. Turning a complex and chaotic case, into an orderly sequence of psychological facts can lead to great clarity of mind.
- Try to develop a good balance between fact finding and free ranging thought; some speculation within a consultation is a creative process, but you need to return to the known 'facts' in due course.
- Don't forget to empathise with the consultee's frustrations and failures, share your own disasters, and allow laughter to creep into the consultation.
- If a case feels overwhelming in its complexity, think in terms of simplifying. For example, work backwards from the offence (or presenting problem), and just focus on those elements of the developmental pathway that lead to the behaviour of concern; think of risk in terms of the one or two factors that are most likely to precipitate a re-offence; try and identify just one action that will make the most difference. Less is more.
- Bring some props: you might have a formulation diagram you like to fill in, or a checklist of trauma symptoms; you may want to refer to the items on a risk tool, bring a copy of the PCL-R items, or the miniature version of DSM 5! Don't be afraid to check something out in the room. Always carry this guidance in your work bag!
- Slipping into teaching mode can often be helpful; talking for ten minutes in the middle of a consultation, on a particular issue of relevance is often experienced by others as very useful.
- If your formulation includes more than five sentences, it is probably too long.
- If your recommendations amount to more than five, there are definitely too many.

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.

Despite recent attempts at evaluation and building of the evidence base, there remains some uncertainty regarding the impact of formulation on treatment and management outcomes for people with personality difficulties. That is, practitioners believe it to be a useful tool, but there is limited 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 using formulation in the OPD Pathway

The following principles 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) A formulation-based approach is likely to be a priority when:

   i. We struggle to establish a strong working relationship with an individual

   ii. We are perplexed as to how to manage behaviours that seem to us to be irrational, self-destructive or perplexing

   iii. An individual is failing to progress as we might have hoped and seems to be ‘stuck in the system’

   iv. We lack confidence in our understanding of a particularly serious offence, and feel anxious about the sentence plan as a result.

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.

Formulation level

In the OPD pathway, we have organised formulations into three levels of complexity. The reason for this is that it is crucial to be highly responsive to the needs of the recipient (or beneficiary) of the formulation. In many cases, the primary beneficiary is the staff member working with the individual; in other cases, the individual him/herself is the primary beneficiary (or, of course, both may be). In responding to the beneficiary's needs, formulations needs to be highly accessible, meaningful, and 'owned' by the recipient.

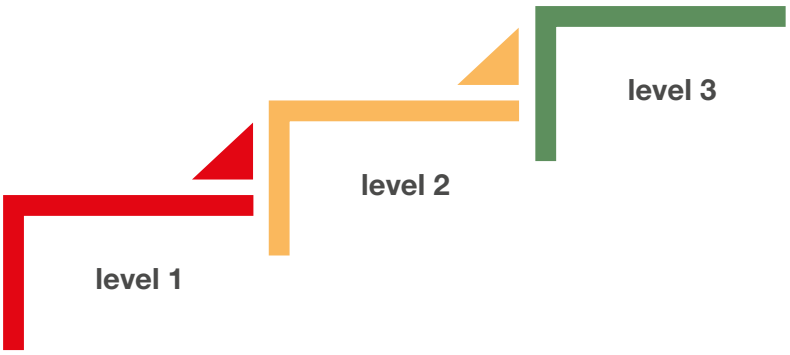
Level 1 formulations:

- to be used in contexts where the service user is largely progressing according to the sentence plan but may be presenting with a particular problem or issue currently;
- to be used to build the skills of staff without prior psychologically-oriented training, in order to help them to make sense of difficult behaviours
- to be used when seeking advice from other services (that is, it could comprise an email or letter regarding suitability for a particular intervention).
- to be used when writing a substantive note in the individual's electronic record system, following a psychologically informed discussion.

Figure 3.1 outlines the nature of a level one formulation which, in essence, poses the following three questions:

- What behaviour/offending is worrying me?
- If I read the file, can I see if a pattern emerges?
- So how should this inform my practice?

Figure 3.1



a level 1 formulation will:

a) give an indication of the pattern of behaviour
b) it'll attempt to organise the most important information
c) it'll connect some of those pieces of information with one another in a psychological explanation
d) it'll provide a basis for decision-making in terms of risk management of other interventions
e) it'll be easy to understand and relevant to those for whom it is intended – and short (a paragraph)

Drawing on the case vignettes for Billy and Mark, whose backgrounds are described in other chapters of this guidance, the following table aims to clarify the goal of a level 1 formulation, by providing problematic formulation examples.

Table 3.1

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.

Level 2 formulations:

- Likely to be used when there is uncertainty regarding the relationship between risk concerns and personality difficulties that require disentangling.
- to be used in contexts where there is impasse in terms of the sentence plan and/or progression;
- to be used to develop treatment plans in specialist OPD interventions in prison and in the community

Figure 3.2 outlines the nature of a level two formulation which, in essence, poses the following three questions:

- What behaviour/offending is worrying me?
- If I read the file, can I see if a pattern emerges?
- What are the clues from childhood which shape the emerging behaviours?
- Can I create a credible story line, which builds a picture of how and why the behaviour/offending might have occurred?
- So how should this inform my practice?

Figure 3.2

a level 2 formulation will:

a) state clearly what it is seeking to explain

b) give an indication of the information relied upon

c) try to account for the developmental history of the case or problem and patterns in presentation

d) attempt a psychological explanation of the problem (i.e. it'll connect important pieces of information), be based on an active collaboration with the SU, and discuss the activation and maintenance of the SU's problem(s)

e) offer several options for action

f) be easy to understand and relevant to those for whom it is intended – and quite short (2–3 paragraphs)

Table 3.2 below provides two (rather brief) examples of formulations for John and Stephen that try to demonstrate the way in which a level 2 formulation provides a more complete formulation than a level 1, largely because of the introduction of key elements of a psychologically meaningful developmental narrative.

Table 3.2

	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 formulations:

- To be compiled by those with substantial experience and/or specialist expertise, and likely to comprise a full case formulation. Includes, for example, psychological reports written for the purposes of parole board hearings.
- To be developed by the completion of intensive treatment interventions (such as therapeutic communities or secure hospital treatment), equivalent to a 'discharge' report.

With training and support, it is expected that all staff can develop Level 1 formulations as a minimum, and many will acquire the confidence and competence to develop level 2 formulations. Level 3 formulations are likely to be restricted to those with higher level specialist formulation training. **However, these guidelines should be interpreted flexibly in the light of service context and practitioner confidence and competence**.

This chapter has focused on two of the three levels of formulation, largely because these are the approaches most likely to be used. Level 3 formulations are subject to separate and comprehensive professional guidelines for report writing (and risk assessments) as produced, for example, by the British Psychological Society or the Royal College of Psychiatrists.

Recording the formulation: good practice standards

Making a written note of the formulation – showing your thinking – is the final step in this process, and often one that causes more angst and takes more time than it should. The purpose of the written note is (in no particular order of priority):

- To evidence reflection and consultation/supervision on the case.
- To provide a set of prompts to the formulation recipient (whether written by themselves or the consultant), should they return to the formulation some time later, which facilitates recall of the key points of the consultation.
- To enable a new key worker/service to take over the case and understand the essential elements of the current formulation.
- To support the recipient (either practitioner of individual service user, as appropriate) to be able to explain the formulation to a third party, with confidence and understanding.

It is important to remember that a written note is not an absolutely confidential component of any documentation system; whether working in the Criminal Justice System, the NHS or a third sector organisation, service user records are 'owned' by the relevant overarching organisational body. Furthermore, all records are – in principle – open to data information requests. It is therefore important that written notes on the formulation are always written as though they may be read by a wider audience than that intended by the writer of the note. Most particularly, even if the consultation recipient was a practitioner and the note written for their benefit, it is good practice for the individual who was the focus of the consultation to become aware of the discussion (and the contents of the note) at a time that seems right.

Holding these parameters in mind, the likelihood is that a Level 1 formulation can be written as a single paragraph note, perhaps half a page at most of writing. A level 2 formulation will require some additional narrative within the note, and might stretch to a one full page. Although the consultation may well have been free-ranging, including personal observations and speculation in order to arrive at a formulation, the record should reflect the conclusions of the discussion, not the discussion itself. Some examples of brief written formulations are outlined – rather sketchily – throughout this chapter, and other chapters in relation to the case vignettes.

Although the written note of the formulation should be succinct, there are still some quality guidelines that can facilitate best practice. These are as follows:

Clarity as to the purpose of the consultation

For example: 'X sought advice as to how to improve her engagement with Y during supervision sessions' or 'X was concerned that Y had reached an impasse in his sentence, and was seeking fresh ideas in order to progress the situation'.

Noting the information on which the formulation is based

For example: 'on the basis of a brief discussion' or 'I have read the OASys report and had a one hour discussion with the key worker'.

Clarity and precision in describing the presenting problem/offending, linked – as appropriate – to key relevant developmental experiences

Examples of this core task are provided throughout this chapter, both in terms of level 1 and 2 formulations. The key quality indicator here is that the formulation is presented in explanatory and narrative form. This means that approaches such as drawing up lists that are not sequentially linked represent poor practice.

The written note is succinct and easily understood by all

Be careful not to write a note that demonstrates your psychological skills at the expense of being useful to the recipient! Complex ideas should be expressed in jargon-free language that could make sense to the individual service user, and/or a non-specialist practitioner.

Recommendations for action should be clearly articulated

There is a skill to developing recommendations that are closely linked to the formulation, and that are easily achievable and likely to have an impact in terms of resolving the presenting problem. However, the key good practice element in terms of recording is clarity – who will do what and when?

Summary

Consultation and formulation provide the mechanism by which all the preceding work – the correct identification of the individual 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 crucial areas.

Chapter 4: Psychologically informed management approaches

Aim

Now that it has become clearer how to identify personality difficulties, and how to make sense of it in terms of individual development, this chapter focuses on what to do next: considering the potential benefit of interventions and understanding the impact of psychologically informed management approaches. Treatment interventions have developed over the past two decades, although the established evidence-base remains limited in relation to individuals with high harm offending behaviour associated with complex personality difficulties.

We know that many individuals exhibiting personality difficulties are unlikely to consider or experience treatment services as meeting their needs: services often exclude such individuals on account of presenting behaviours that disrupt traditional treatment approaches; individuals often find the expectations regarding attendance and participation overwhelming. However, treatment interventions are not the only option for reducing risk and achieving progression, and you should not despair if an individual refuses to engage or is found to be unsuitable for programmes of therapy.

This chapter therefore predominantly focuses on psychologically informed management approaches, but commences with a consideration of treatment.

In the section below on Interventions, some basic principles are covered. For detailed information regarding the current availability of custodial and community programmes associated with the OPD Pathway and with Offending Behaviour Programmes in England & Wales, please approach an OPD practitioner or HMPPS staff who can access up to date brochures from the relevant teams.

Interventions

Pathways for people with personality difficulties can be difficult to plan, challenging to implement, and often require coordination across a range of service providers. These individuals can:

- Make significant demands on and for services, but be 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 experience such difficulties;
- 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 individual showing personality difficulties.

Some general conclusions about effective psychological interventions for individuals showing offending behaviour and personality difficulties

In general, effective psychological therapies for personality difficulties tend to emphasise the need for a clear and shared model of care, understood by both the practitioners and the individuals in receipt of the therapy; such therapies attend carefully to the relational aspects of care, and ensure that consistency, safety and boundaries are held in mind throughout the programme. That is, there is an emphasis on an attachment based formulation of the individual'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 focused therapy (SFT), cognitive analytic therapy (CAT), transference-focused psychotherapy and therapeutic communities (both forensic and non- forensic). This list is not exhaustive, and there may also be occasion to draw on trauma-specific therapies such as EMDR (Eye Movement Desensitisation & Reprocessing) or other behavioural therapies for specific difficulties.

Treatment targeting different areas

When you are considering someone for treatment, it is worth highlighting 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 difficulties. The four areas are:

- the underlying core personality characteristics themselves
- treating symptoms and behaviours associated with the difficulties (for example, impulsivity and aggression)
- treating problems which commonly co-exist with the difficulties (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 clusters of personality traits - borderline and antisocial - 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 Criminal Justice System manages a high number of individuals who would meet criteria for a diagnosis of antisocial personality disorder. 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.

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 difficulties, including individuals who offend. As a general guideline, treatment effectiveness can be subdivided according to the level of risk. Interventions for low risk cases may make people worse (although exactly why this is the case is not fully understood); for medium to high risk cases the evidence for effectiveness is better.

Treatment completion is important, and there are consistent findings that those people 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 difficulties are linked to a greater likelihood of treatment non-completion, you will need to pay particular attention to this issue.

Individuals showing personality difficulties are likely to respond to encouragement, contact outside treatment sessions, help with attending, reminders about failed appointments, and so on. In other words, such individuals may need more not less attention when they are attending a programme.

Are individuals with psychopathy treatable? Research would generally suggest that there are some grounds for optimism in thinking about interventions for such individuals. 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 individual 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 Chapter 5.

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 a service user and are a useful indicator of what is likely to be helpful in effective case management.

a) The evidence-base suggests effective treatment for people exhibiting personality difficulties includes:

- A strong, but boundaried attachment relationship between the therapist/practitioner and service user
- 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 service user.

b) Good practice in delivering treatment for people with personality difficulties 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 service user
- Shared and agreed goals
- Using creative and flexible approaches, especially, to motivate and engage the service user, and overcome blocks to progress A well-trained therapist for the approach being used and the provision of high quality clinical supervision

How can planned environments help?

The nature and quality of the therapeutic environment and the relationships within services are a key component of their effectiveness. As mentioned earlier, relationships lie at the heart of successful interventions. An explicit reference, and attention to, the psychologically informed 'relational environment' helps all involved to 'make meaning' from their experiences and interactions with each other, alongside a consideration of the impact of both the physical surroundings, the institutional context (whether that is a probation office or a prison wing), and the wider system. Initiatives such as the Enabling Environments standards (see Annex III), the HMPPS Rehabilitative Culture handbook, Psychologically Informed Environments (PIES), and Psychologically Informed Planned Environments (PIPES - see appendix IV) all attend to creating a living learning 'environment' and supportive 'relating' conditions.

Intervention options

The following is a schematic representation of the options for an individual with offences associated with personality difficulties, showing the increasing intensity of interventions.

Constructive waiting relationship

- Consider psychologically informed management approaches that focus on relationship building, motivation and risk management – see below

Local services in CMHTS or prison in-reach

- Consider degree of risk and current behavioural crises, for example, self harm or suicidal behaviour

Symptom or behaviour specific programmes (for example, AOBPs)

- Consider, if in denial of index offence and whether admits a problem behaviour
- Length of sentence and what is available, risk level, and accessibility
- Whether they have successfully completed such a programme before

Treatment-intensive day programmes (for example, community day programmes)

- Consider, if sufficiently motivated or high risk
- If previously failed in a behaviour specific programme
- If their needs are sufficiently complex

Psychologically informed relational environments For example, Enabling Environments (EE), Psychologically Informed Environments (PIEs), Psychologically Informed Planned Environments (PIPEs)

- Consider these environments in order to increase preparedness and/or motivation for the next phase of a pathway
- Or if the person requires consolidation of learning from other interventions
- Can also support transition between services

Residential programmes (for example, therapeutic communities, OPD intervention services in secure prison or health settings)

- Consider, if failed in previous two types of programmes
- Consider motivation and at least 18 months available to attend

Psychologically Informed Management Approaches

It is estimated that perhaps only 10% of individuals successfully complete bespoke treatment programmes for individuals with personality difficulties. The rest of this chapter is devoted to building practitioner understanding and confidence in applying theoretically sound psychological principles to the successful management of individuals; this section should be read in conjunction with Chapter 5 on 'Top Tips'.

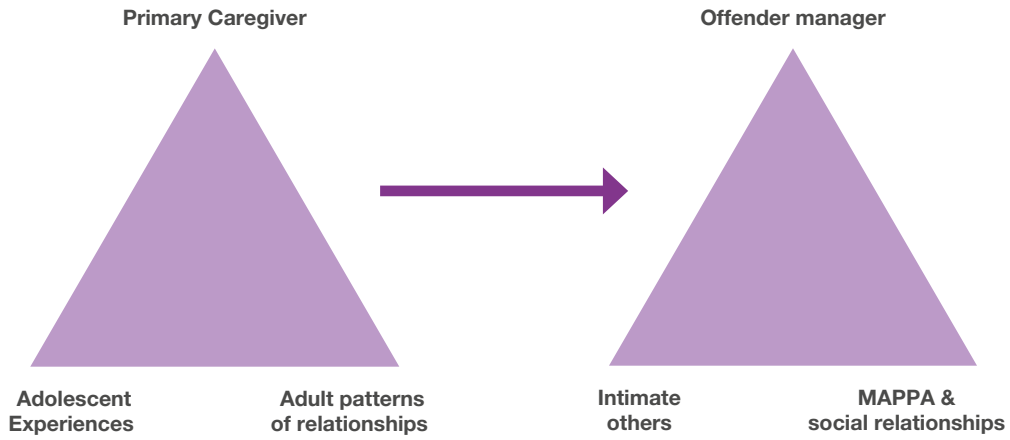
The attachment triangles

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 service user.

In the first instance, we should return to the attachment triangle in chapter two, which described the developmental pathway of the individual showing personality difficulties. Figure 4.1 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 MAPPA (in custody, substitute prison staff for MAPPA).

Figure 4.1



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 prison keyworker, offender manager, the hostel, offender supervisor, MAPPA 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 Billy'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 4.1 outlines the core beliefs, and interpersonal styles of each of the diagnosable personality disorders (as defined by DSM-5). These ideas are drawn from Millon and Padesky, and link closely to cognitive behavioural theories of personality difficulties.

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 showing personality difficulties, the observable behaviours.

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

Table 4.1

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	Wild. 'Dog eat Dog'	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

Consider Peter again. In chapter two he was identified as demonstrating a cluster of largely narcissistic traits – with a few antisocial features - 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 less likely to result in harmful behaviour to others.

Basic principles

There are some principles to the psychologically informed management of people with personality difficulties, which apply to most types of personality traits. 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, drug testing 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 an individual with paranoid traits in his own flat rather than approved premises because there is less to be paranoid about in his flat; or by giving an individual with narcissistic traits an esteemed job in prison that paradoxically reduces his need to demonstrate his sense superiority over others.

Second, many individuals showing personality difficulties – particularly groups of traits that would fit with the DSM 5 clusters A ('odd'), and 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 people with personality difficulties tend to be longer than most. Unfortunately, the drive to break rules is too ingrained, too compelling, and 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 rigor. However, it is still important to try and build in some kind of goal system – positively oriented -

which allows for encouragement and a sense of progress. As with all behavioural approaches, make sure these goals and the indications of progress are thought out in advance, clear, consistent and easy to achieve.

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

Basic principles

1. Consider three aspects of management
   - Capacity for personal change and control
   - Likely response to externally imposed controls
   - Options to alter the environment to complement traits.
2. Generally individuals in the CJS showing personality difficulties 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 individuals
   - The characteristics or aspects more likely to lead to failure
   - The characteristics or aspects which most worry the individual.

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 individuals with personality difficulties. 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 difficulties 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 – and 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 man with paranoid traits in approved premises, or Peter provoking his prison keyworker 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 individual, 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 who believes that s/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 individual.

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 their 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 individual showing personality difficulties, the practitioner can do three things:

- Maximise the chances of a successful parole hearing; or of successful completion of statutory supervision, which in turn reduces the risk profile
- Focuses the risk management plan on those areas of an individual'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 7).

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 two 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 individual 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 presents predominantly with narcissistic traits, and 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: his perception was that 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 rather than imminently risky to others. A compromise was reached, when it was agreed that the police would concentrate on pursuing the option of a SHPO (Sexual Harm 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.

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 described as 'weird', he was bright but a poor achiever, and worked for years in the Civil Service (athough 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 presents with the cluster of core schizoid characteristics and some paranoid features. If thought of in terms of core and secondary traits (see Table 4.1), he has a self concept of being selfsufficient 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.

Prison staff – notably the offender manager in custody and the local psychologist – liaised closely with the offender manager in the community, and developed a shared formulation that disentangled Robert's personality difficulties from his risk to others; this formulation was incorporated into the offender managers' reports to the parole board panel, who were impressed by the depth of understanding shown by practitioners, and assured of the robust nature of the release plan.

Robert was granted release, and the new probation officer managing the life licence brought Robert to consultation with the community psychologist. The officer had tried to develop an enhanced 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 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 an 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 enhanced the risk management plan by confronting Robert's core traits and exacerbating 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 group work 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 local 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 the reader to greater confidence and creativity in the management of this group of people.

Chapter 5: Top tips for management

In previous editions of this guidance, this section has proved to be extremely popular in building the confidence of practitioners to develop simple strategies for the improved management of individuals, often overcoming obstacles to progression as a result. The aim of this 'Top tips' for Management section is not to undermine the importance of careful history taking and the development of meaningful formulations when time and circumstances allow. However, it is undoubtedly the case that sometimes relatively simple responses to relatively complex presentations can be very helpful.

In this chapter, we use labelling terms (such as 'schizoid') not to denote a diagnosis of a particular personality disorder, but as a descriptive term for a cluster of core characteristics that can have meaning for both practitioners and – if sensitively explored and explained – for individual service users. In reality of course, individuals showing personality difficulties are more likely to struggle with traits that are fairly diverse and are included in more than one descriptive label.

It is also important to hold in mind that it is necessary to consider the **function** of a particular trait or problematic behaviour in order to be sure which set of management strategies to consider. Take, for example, the commonly occurring problem of rule breaking behaviour; too often this is assumed to be an antisocial characteristic. However, individuals with paranoid traits often break rules if imposed by authority figures who they believe to have malevolent intent; individuals with schizoid traits may break rules which they believe to be irrational in nature or inconsistently applied. Similarly, intense but fleeting emotional expression is undoubtedly one of the features of an individual exhibiting borderline traits; however, individuals with predominantly narcissistic characteristics may sometimes erupt unexpectedly into a rage when they feel that their sense of self has been excessively challenged; or an individual with paranoid traits may become angry when they feel their concerns have been dismissed.

In the first part of this chapter, tips in relation to personality 'types' or core characteristics are provided. In the second part of the chapter, we provide some 'do's and don'ts' in relation to particular behaviours that are challenging for services and practitioners to manage.

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

a) these personality characteristics are less commonly encountered in an offending population

b) experienced clinicians sometimes struggle to differentiate schizotypal from schizoid personality difficulties; or to differentiate histrionic from borderline personality difficulties.

Furthermore, in terms of the section on schizoid personality characteristics, this is likely to be equally relevant to individuals who present with traits of autistic spectrum disorder (ASD, high functioning individuals, sometimes referred to as having Aspergers). Whether or not schizoid personality and ASD are truly overlapping constructs is a controversial topic; but for practical purposes for the non-specialist practitioner, the management approach is broadly the same.

Details on psychopathic characteristics (as measured by the PCL-R) are included here, after the section on antisocial personality traits. Psychopathy is defined in line with the Psychopathy Checklist; this requires specialist training and additional experience to administer, and practitioners should be careful not to comment on psychopathic traits unless they have the requisite expertise. Nevertheless, PCL-R assessments are sometimes commented on within documentation and reports pertaining to an individual, and this section provides information which may be helpful to the practitioner (and the individual service user) to better understand the concept.

Finally, always remember that individuals mature with age, and with the benefit of interventions that facilitate understanding and change. The secondary characteristics – most commonly behavioural difficulties – of personality traits ameliorate with age. Therefore, it is crucial to consider characteristics in terms of evidence for change over time, thereby instilling a more future-oriented and hopeful approach to considering the management of residual traits.

1. Schizoid personality traits

Quick reference

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

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

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

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

Profile of the schizoid personality

The central features of the schizoid personality are an apparent lack of interest in relating to others and a marked emotional detachment. Such individuals often see themselves as loners or misfits, have a strong need for autonomy and perceive other people as intrusive. They may have difficulty experiencing strong emotions and struggle either to reflect on or express their emotional needs. They may have a monotonous quality to their speech and appear reserved, inexpressive, humourless and emotionally flat.

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.

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; many individuals cope poorly with change, although others find the predictability of prison rules helpful. They may drink heavily in an attempt to 'fit in'. There is also considerable overlap with Avoidant and Schizotypal personality traits and Asperger's Syndrome (Autistic Spectrum Disorder).

Relationship to offending

- Schizoid characteristics have 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 men who have violent and sexual convictions; including a subgroup of men who have committed murder with sexual elements to it.
- Schizoid personality features may be linked to offending in a number of ways:
  - People showing schizoid traits often feel little empathy for others, which might otherwise inhibit aggressive acts.
  - Violence committed by people showing schizoid traits 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 people showing schizoid traits 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 individuals with schizoid characteristics

Tips for one-to-one working

Respect their need for space

It will be recalled that individuals with schizoid traits 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 individuals with schizoid traits, 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 individual 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 individual. 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 traits

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 recipriocity.

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

Profile of a narcissistic personality

Narcissistic personality difficulties suggest 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 difficulties, the traits are excessive and destructive, so that an individual's potential is never achieved.

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 unimpressionability)
- Deficient social conscience (e.g. flouts social conventions, a disregard for personal integrity and the rights of others).

Relationship to offending

Narcissistic personality difficulties alone are 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 individuals who lash out in response to perceived slights, and in a subgroup of high risk individuals with paedophilic offences who believe themselves to be attractive to pubescent boys.

Tips for working with narcissism

The core theme of narcissistic characteristics 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

Entitlement, specialness & arrogance

These core traits of narcissistic personality 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 individual is better read, more educated, has more sophisticated tastes than you, then acknowledge it in a neutral way. If the individual 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 idealisation/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 individual with narcissistic traits 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 individual 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 individual. 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. Antisocial personality traits

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 individuals 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 those who have been convicted of rape than convicted of child sexual offences).

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.

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 showing antisocial traits 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 antisocial traits are only one element - albeit an important element - of psychopathy. At one end of the antisocial spectrum are highly psychopathic individuals 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 – individuals 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.

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 anti-social personality disorder (ASPD). It is associated with an increased likelihood of general recidivism, violence and, to a lesser extent, sexual offending. It is far more common for those convicted of rape than those convicted of child sexual offences.

ASPD may be linked to offending in a number of ways:

- People diagnosed with ASPD 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 personality disorder 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 antisocial traits

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 individuals 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 person 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 antisocial 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 antisocial traits with more complex presentations. These individuals may present with mood disorders, may be highly psychopathic, or also meet the criteria for other personality core traits (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

Antisocial individuals 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 person knows and understands the consequences in specific, not general, terms.

4. Psychopathy

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.

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 anti-social personality disorder, psychopathy also encompasses traits from a range of other personality disorders including; Narcissistic, Histrionic, and Paranoid. 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.

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 behaviour 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
- Antisocial 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 secondaryto 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.

Individuals with a high level of psychopathic traits 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 individuals with psychopathic characteristics

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 business-like 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 the individuals themselves. 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 people who have committed offences 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 person 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.

5. Paranoid personality traits

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.

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

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 individuals tend to see themselves as righteous and noble. They may feel incorruptible in a corrupt and manipulating world. Their stance becomes rigid, inflexible and closed off. They may feel the need for assistance, but doubt the sincerity of that help when it is offered, and just reject it.

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.

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 individuals with paranoid characteristics

Tips for one-to-one working

Respecting the core traits and interpersonal style:

- Expect and ignore demeaning comments and hostility. The individual is defending themselves.
- 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 individual 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 line manager'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.

6. Cluster ‘C’ personality traits (avoidant, dependent and obsessive compulsive)

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 traits may be associated with domestic violence and avoidant and dependent traits are commonly seen from those convicted of child sexual offences.

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
Obsessive compulsive	Responsible, competent	Irresponsible, incompetent	“I know what’s best” “Details are crucial” “People should do better”	Control

Profile of the Cluster ‘C’ personalities

Cluster ‘C’ personalities 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 personality disorders making them easy to miss.

Avoidant personality is characterised by high levels of social anxiety, which stems from an underlying sense of defectiveness and inadequacy. Individuals with avoidant characteristics 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 personality 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 personality 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 personality characteristics.

Relationship to offending

Cluster C personality characteristics 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 traits may facilitate offending behaviour in a number of ways:

- Dependent personality features are characteristic of an established typology of men who perpetrate domestic abuse. 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 personality traits are some of the most frequently identified personality difficulties among those convicted of child sexual abuse (and those convicted of internet sexual offences) and may be associated with difficulties establishing rewarding intimate relationships with adults, social withdrawal and loneliness.

Tips for working with Cluster 'C' personality traits

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 individuals with Cluster 'C' traits 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.

7. Borderline personality traits (sometimes referred to as emotionally unstable)

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.

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

Profile of a borderline personality

A disorder of emotion regulation, including unstablemoods, 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 idealisation (highly positive regard) and devaluation (intensely negative feelings). They may quickly form intense and tempestuous attachments to significant others. Individuals showing borderline traits 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).

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 characterised by alternating between extremes of idealisation 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 behaviour, gestures, threats or self-injuring behaviour
- 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.

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 borderline personality traits

Tips for one-to-one working

Alternating idealisation 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 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. However, 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 an individual with borderline traits 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.

Managing behaviours that challenge

This section overlaps with many of the tips scattered throughout the previous section of this chapter, but it is organised in terms of presenting behaviours that challenge practitioners and services, and which may be linked to more than one cluster of personality traits. It is designed to be helpful to the practitioner who needs to think quickly about the best way in which to handle a situation in the 'here and now'. It may also be helpful for those who are looked to for advice 'on the hoof' and who want to be responsive to the help-seeker. As with the previous section, the following tips do not supplant the need for more thorough consideration of an individual's complex needs, as and when time and circumstances allow.

This approach suggests three steps to approaching a presenting problem:

1. Developing clarity about the behaviour causing concerns
2. Creating a quick provisional hypothesis about the function of a particular behaviour
3. Providing some standard 'do's and don't's' to support the practitioner

Step one is drawn from functional analysis - the term used to describe an approach to understanding the function of behaviours in terms of their triggers and their consequences for the individual and the 'system' with which s/he is surrounded. However, it takes practice to be able to describe a behaviour with precision; staff from various backgrounds often refer, for example, to 'threatening behaviour' or 's/he was inappropriate', not appreciating that these statements are vague and can be misunderstood. For example, a more behavioural description of 'threatening behaviour' might state 'makes a verbal threat to physically hurt X'; 'inappropriate' might be more precisely described as 'made sexually explicit remarks about X's choice of clothing'. Taking a curious approach to eliciting more precise information from the concerned individual then facilitates precision in describing an emerging pattern of behaviour.

Step two draws on our understanding about interpersonal relating, core beliefs and behavioural theories; it postulates that if we can understand the triggers to repeated behaviours, and the consequences that ensue, we can develop an understanding of the meaning and purpose of the behaviours. This understanding almost certainly needs to be reviewed and revised as we learn more about the individual, but in the short term, this understanding informs our immediate response.

Step three describes the recommended responses to an individual presenting with behaviours that are challenging to manage; although not individualised in approach, it provides advice that is theoretically based, and linked to ideas that some responses can be unhelpful by increasing the likelihood of an unwanted or distressing behaviour reoccurring, and some responses can be helpful in reducing the likelihood of such behaviours.

This approach is outlined below in relation to three types of presenting difficulty:

1. Responding to self harm
2. Responding to suspiciousness
3. Responding to aggression

The suggested responses are outlined below very briefly, and the experienced practitioner will undoubtedly augment the model with additional criteria. These approaches should be considered alongside adherence the existing policies and procedures for the management of concerning behaviours (such as violence and self harm) within the setting where the practitioner works.

Responding to self harm

Provisional hypothesis (for example)

- Communicating distress to others
- Trying to make other people help or notice you
- Trying to regain control of intense emotions or difficult interpersonal situations
- Soothing intense feelings or distracting from them
- Seeking a 'buzz' (including releasing a biological 'natural high' from a surge of endorphins in the brain)
- Striving to feel 'real', and in touch with the world
- Looking for a temporary escape from problems (rather than the permanent escape of suicide)
- Punishing oneself in response to feelings of guilt or shame, however irrational

Do's and don'ts'

DO	DON'T
Make sure the service user receives the necessary medical help	Fuss over the injury or the service user
Take an interest in the reasons for self harming	Let any sense of judgement or disapproval enter into your enquiries
Talk to the service user when s/he is calm	Talk to the service user straight after the incident
Focus on the service user's emotional distress, and empathise	Comment on whether self harm was the right or wrong response to distress
Start working on a crisis plan for next time	Assume everything is resolved because the service user has stopped self harming
Aim to reduce the frequency and seriousness of self harm	Set yourself (and the service user) up for failure by aiming for abstinence
Explore a range of explanations for the behaviour	Dismiss the service user's stated wish to die
Stick with it despite setbacks	Give up at the first disappointing hurdle
Be confident that talking about self harm is helpful to the service user	Worry that talking about self harm will prompt a service user to hurt him/herself

Responding to suspiciousness

Provisional hypothesis (for example)

- A difficulty (biological) in reading other people's states of mind
- Dealing with anxiety by locating the problem outside of yourself – avoiding humiliation and shame
- Gives permission for never having to feel weak by relying on others – 'life is a jungle'
- A belief that others will always exploit personal information about you
- Understandable vigilance in light of life experiences

Do's and don't's

DO	DON'T
Focus on the distressing feelings which the incident provokes	Focus on the explanation
Let the service user give his side of the story	Imply disbelief or disagreement in your manner
Explore a range of explanations for the incident	Dismiss the service user's explanation for the motivation
Aim to soothe the service user	Expect a paranoid style to change
Focus on possible courses of action or ways forward	Focus on the service user relinquishing his explanation
Stick with it despite setbacks	Give up at the first disappointing hurdle
Focus on the triggers in the environment, and try to reduce these	Focus on therapy as the primary means of improving the situation

Responding to aggression

Provisional hypothesis (for example)

- Communicating distress to others
- Trying to make other people feel vulnerable instead of you
- Avoiding exposure of feelings of shame
- Self defence
- Trying to regain control by dominating interpersonal situations
- Seeking a 'buzz' (including releasing a biological 'natural high' from a surge of endorphins in the brain)
- Striving to feel 'real', and in touch with the world
- To get what you need (material goods)

Do's and don't's

DO	DON'T
Take an interest in the reasons for the violence	Let any sense of judgement or disapproval enter into your enquiries
Focus on thoughts and feelings	Focus on the behaviour
Let the service user give his side of the story	Ignore the fact the behaviour has consequences for others
Explore a range of explanations for the violence	Dismiss the service user's explanation for the motivation
Aim to reduce the frequency and seriousness of the aggression	Set yourself (and the service user) up for failure by aiming for no further incidents
Focus on personally meaningful immediate consequences	Focus on longer term moral standards
Stick with it despite setbacks	Give up at the first disappointing hurdle
Have a shared plan with clear goals and limits	Try to extinguish the behaviour through controls and restrictions

Summary

This chapter provides a range of 'top tips' for management that can be drawn on at the discretion of the practitioner in response to the settings and circumstances in which he/she is operating. It is greatly enhanced by an understanding of personality, its development, and our approaches to formulation that are laid out in preceding chapters.

Chapter 6: Special considerations

The experience of the OPD pathway is that fundamental concepts considering the nature and development of personality difficulties, their link to risk, and the tools required to implement psychologically informed approaches to the management of such individuals, are generalisable to most situations and contexts. That is, the preceding chapters of this guidance are pertinent to all. However, this chapter recognises that there are special considerations which, if taken into account, can greatly enhance our understanding of individuals' difficulties and shape our approach to management. There are probably numerous areas to consider, and not all can be considered here. For example, individuals with personality difficulties who identify as transgender, and/or who are pursuing a transgender pathway, are often responded to with a degree of anxiety by services that are uncertain how to meet their needs. As with others areas of 'difference', practitioners working with transgender individuals and personality difficulties need to keep an open mind and be responsive: consider – with staff and with the individual him/herself – how the transgender issues may be separate to, or interact with any problematic personality traits or any history of offending behaviour.

In this chapter, we focus on the four main areas that regularly arise in our formulations and our case discussions. These four areas are:

- Working with young adults
- Working with women
- Working with individuals with neurodevelopmental difficulties
- Working with ethnic and cultural differences

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 compelling at this developmental stage leading to further problems depending on the criminogenic nature of those peers.

The challenge for services, 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 (the recognition of a person's moods and emotions and responding accordingly), co-regulation (the interaction between people to regulate the behaviour of the other) and repair, to seek to maximise the window of opportunity offered at

this time. This section is written with the young adult male in mind, in particular, but there will be significant overlaps with young females too. It highlights those areas of difference that are important to consider when working with individuals in late adolescence/young adulthood.

There is consensus now that cognitive development and emotional regulation is not fully developed until at least the mid-20s. During this early adult period, the brain is pruning, building and thickening the various branches of neurons that underpin all aspects of cognitive, emotional and physical functioning. The following table outlines the challenges associated with maturation and development in the young person.

Cognitive development Moving from concrete thinking and simple ideas to abstract thinking with deeper meaning and contradictory ideas	The young person is developing the capacity to work through abstract ideas and to be able to think about opposing views with some depth; they are learning how think about the future and how to plan. Their views on themselves are developing, in terms of their strengths, opinions and changing beliefs. Thinking ahead of possible consequences is particularly difficult for a period.
Emotional development Moving from emotional responses to rational or future thinking	Changing hormones contribute to emotional changes in the young person, and as the use of language and thought matures in a deeper and more nuanced way, so the young person changes their instinctively emotional response to a situation. The young person may find it difficult to sustain engagement in interventions that are experienced as boring, and rapid fluctuations in mood and motivation result.
Behaviour development Moving from risk taking to a greater knowledge of risk and danger	Everyone takes some risk as it is necessary for healthy functioning. However the young person takes more risks than average (perhaps in order to achieve the same level of the pleasure chemical dopamine as adults, and/or because of beliefs that they are indestructible), and bases their decisions on feelings rather than a consideration of consequences. Impulsive behaviour is likely to be higher in the young person, and may be associated with self-management through substance misuse.
Relationships Moving from difficulties expressing themselves and language problems to better social skills and emotional awareness	Relationships require social skills, language and emotional intelligence; but until development is mature, the young person finds it difficult to judge the right level of reaction to difficulties, to hold back from arguments, to take others' perspectives and to judge what is the right thing to say. These difficulties may be enacted in intimate relationships, but are also likely to draw them into dysfunctional attachments such as gang affiliation.
Childhood trauma Trauma as a more recent event, influenced by lack of neurological maturity	The young person may struggle to process and express their difficulties at a time when neurological development is not yet mature. Frequently talking about violence, fantasising about, drawing pictures of, writing about, rapping about violence, could all be ways of acting out or communicating trauma. Risk assessments suggest that vivid sexual and physical fantasy lives in young person are less predictive of future risk than might be the case in mature adults.

There is a broad agreement that personality disorder itself should not be diagnosed in adolescents or young adults because personality development is not complete, and symptomatic traits may not persist into adulthood. We should also exercise caution in talking about personality difficulties during this period; practitioners tend to use more cautious terms such as 'emerging traits' during these early adult years. Given how many individuals mature in their behaviour, as well as their emotional and cognitive functioning after the age of 25 ('growing out of personality difficulties'), this caution is justified. However, many are in agreement that a formal assessment – including the use of questionnaires or semi-structured interviews - if carefully used, can support the development of a formulation and an appropriate intervention plan. Adopting strategies to identify high risk individuals early on, particularly in adolescence may be helpful.

Working with women

This section focuses on the characteristics and needs of women with personality difficulties where these differ to those of men.

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 6.1 below.

Table 6.1: Some of the important ways in which men and women differ in their experience and expression of personality difficulties

Social circumstances	• 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 • Women are more likely than men to be involved in exploitative relationships with others, which can make them vulnerable to further exploitation by others, 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	• More likely to have experienced childhood abuse (emotional, physical, sexual and neglect)
Offending	• 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 Criminal Justice System and in their pathways in and through custody. The practitioner working with women with personality difficulties 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.

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 personality difficulties 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. A 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.

Working with neurodevelopmental disorder

Neurodevelopmental disorder refers to individuals who have experienced disturbed brain development or problems with the central nervous system (including brain damage) at an early age. It includes difficulties with attention deficit and hyperactivity, dyslexia and autistic spectrum disorder.

Increasing evidence is emerging to suggest that neurodevelopmental characteristics may play a significant role in the development of personality difficulties. Precise estimates of the relative contribution of developmental and environmental factors is, as yet, difficult to establish, and is likely to vary between individuals.

An important issue to understand is that personality features influenced by neurodevelopmental characteristics can be manageable and potentially treatable. Again further research will be required but with awareness and support there may be good reason for optimism in many cases. Whilst it may seem intimidating to begin working with cases where a neurodevelopmental difficulty is identified, spending some additional time to develop an understanding of the person and their difficulties is frequently rewarding.

Characteristics suggestive of a potential neurodevelopmental factor might include:

- Persistent, repetitive difficulties
- Unusual volatility
- Little evidence of material, social or instrumental gain from problem behaviour
- Perceived by peers to be different or require additional support
- Struggling to adapt to change
- High levels of impulsivity
- Atypical eye contact
- Dependence on others for support

On taking a more detailed history further suggestive characteristics may be found potentially including: birth complications, delayed development, head injury, a period of hypoxia (lack of oxygen), or delayed development compared to siblings.

Whilst full neurological and/or neuropsychological assessment may be required in some cases, many cases can benefit from a relatively brief screening to consider a potential neurodevelopmental influence. This may provide an important addition to the formulation process and inform care pathway planning. Potential screening assessments could include:

- Drawing tests such as the Rey or Taylor complex figure tests – it is easy to over-estimate skills and abilities based on a verbal account. Some practical visuo-spatial tests can quickly illustrate perceptual difficulties or problems with 'central coherence'.
- Search or planning tests (such as the Key Search Test or "Can you tell me how to make [favourite meal]?) – this may help to identify practical planning difficulties.
- Qualitative tests of basic reading, writing, mathematical ability and memory
- Qualitative tests of geographical / spatial understanding ("Can you describe to me how I might get to [a specific location]?")

Any screening tests should be supplemented by interviews, staff feedback and wider assessment (e.g. observation of the person's living space). When a good rapport has been developed the person may disclose many of their own strategies to overcome their difficulties, and these may be a good starting point for further development.

Understanding an individual's wider difficulties may help to make sense of their 'adaptive lifestyle strategies'. In many cases these will help to preserve the person's identity and sense of self, but on occasion they can be a contributory factor to their social difficulties.

The relationship between neurodevelopmental difficulties and trauma is also complex. People with neurodevelopmental difficulties may be more vulnerable to experiencing both acute (abuse or victimisation) and persistent (bullying or humiliation) trauma; however they may also find coping and resolving traumatic experiences more difficult.

In terms of care pathway planning for people with a potential neurodevelopmental the following issues might be considered:

- Shorter, structured sessions – tiredness can be a factor when an individual may be using alternative, possibly more effortful cognitive strategies.
- Clear, concise guidance provided in a manner consistent with their learning strengths – social rules can be complex and some people may find intuitive understanding a persistent challenge.
- Reducing distraction in learning environment – a more relaxed, natural environment may facilitate learning.
- Peer support (potentially with some further training) – where an appropriately motivated peer group can be found some additional training may help develop a peer support network.
- An emphasis on 'Show-Me' rather than 'Tell-Me' learning – many skills are easier to learn when shown rather than told. Occupational therapy support (when available) can be particularly helpful in some cases.

- Mentalisation Based Therapy (MBT) – The MBT model is consistent with a neurodevelopmental model of personality difficulties and may enhance a person's ability to take alternative perspectives under stress.

Realistically in some cases complete compensation for a significant neurodevelopmental difficulty may not be possible. Whilst diversity should be celebrated, life can be tough for an individual with a neurodevelopmental difficulty; however investing a little time with the individual, listening to their narrative and validating their emotional experiences can still be a helpful and positive experience.

Working with ethnic and cultural differences

The development of our personalities tells us something about ethnic and cultural differences, and how these have affected our experiences of the world. This section discusses some of the issues faced and offers some possible tips on how to approach these.

Terminology is important when thinking about difference; it frames how and what we think, and feelings in relation to actions. This section looks at what services and professionals need to consider when thinking about working with difference, specifically ethnic minority community members. When discussing 'race',[1] ethnicity or other forms of difference, people often monitor language for fear of 'getting it wrong'. This in turn can impact on relationships with whom we wish to work. Often our reactions to being racist is one of horror, which can shutdown conversation and exploration. The reaction to other forms of discrimination is often not as strong, or obvious, but it is potentially equally as painful. This section uses 'race' and ethnicity as a vehicle to explore how to work with difference, however the tips can and do apply to other characteristics protected under the Equalities Act, extending out to social class.

TIP 1: Be brave. Be courageous. We learn most about each on the edges of discomfort, and talking about discrimination is uncomfortable, but necessary.

Intersectionality

Audre Lorde states "there is no such thing as a single issue struggle, because we do not live single issue lives". Human lives are complex, and our personalities embody this complexity. The concept of *intersectionality* can help us understand this. For example, issues affecting women are different depending on what other social groups women belonged to, whether they are black, disabled, transgender, or have an offending history. No one 'issue' defines a person.

TIP 2: Resist simplicity. Hold in mind different aspects of an individual's identity, they may overlap and provide different experiences of oppression, power dynamics, and discrimination.

Difference neutral services

Professionals often state they 'treat everyone the same' based on an idea of shared humanity, in relation to 'race' this means 'colour blind' approaches. Whilst this is noble in intent, the implicit message, can be a denial of the oppression that people experience e.g. racism, sexism, heteronormativity (ie the assumption that everyone is heterosexual). Furthermore, in denying differences, we also deny the very factors that contribute to an individual's identity and self-esteem, (which is often the focus of individual

1 It is widely recognised and understood now that 'race' is a social construct (hence inverted commas), with no specific gene associated with all Black or all White people. The use of 'race' continues to have social and political connotations and no scientific validity.

and group work). In taking a colour-blind approach, services spare themselves the pain of reflecting on institutional practices that reinforce experiences of prejudice, both intentional and unintentional. It excludes any discussion examining the cultural and colonial base on which the judicial and mental health system is built and for people who have offended, sometimes engaging with these institutions of power can be retraumatising; recreating the experiences and pain they are seeking to avoid.

TIP 3: This is about what you represent, not just what you do. Staff may not be *personally* racist, but we do represent structures and institutions that are *institutionally* racist. Acknowledging this explicitly creates a space to keep in mind the need for adapted service delivery.

Unconscious bias

Our systems perpetuate the idea that some people are more likely to change than others. These people are seen as having 'psychological mindedness' however it has also been regularly (and falsely) stated that people from particular communities (ethnic minorities, and men) do not have the same level of psychological mindedness and are 'hard to reach'. These biases also operate in the diagnosing of psychological distress, with sexism, racism and homophobia having historical foundations in the psychiatric and psychological professions.

For example, across the system we tend to see a greater number of referrals from white men to *therapeutic* services for people who have committed violent offences, but a greater number of referrals for black men for Challenge, Support and Intervention Plans (CSIP) as part of violence reduction. One interpretation may be that violence for black men is seen as something that can only be managed (via treatment programmes or medication), and not therapeutically treated; likely this has foundations in ethnic stereotypes and slavery.

Discussing this can be anxiety provoking, for individuals, teams and organisations. People and systems do not like to be seen as prejudicial. The resulting defensiveness can often act as a barrier to people and teams discussing how their practice may exclude and prevent people from specific communities being able to make use of the services they provide.

TIP 4: Be aware of our defensiveness and our biases. Actively reflect on referral and treatment pathways, and who we deem suitable as able to engage with therapeutic services.

Power

For people from minority communities the impact of cultural histories (e.g. slavery, colonisation, medicalisation of homosexuality) also impact on an individual's ability to build relationships. Services often represent institutions that have a history of misusing power against minority communities. For example, a greater use of 'stop and search' on young Black men by police, the longer stays in secure hospitals, the greater use of medication and the higher number of restraints and deaths in police custody. The knowledge or experience of these involve a misuse of power, and lead to a mistrust of services.

Power is more available to those who reflect society's hierarchy of power, privilege and advantage. For some this may be remote, and recreate patterns of exclusion, oppression or a sense of inadequacy, that can trigger coping strategies that involve offending behaviours. Taking a formulation based approach to understanding an individual's needs requires discussion of interpersonal and structural trauma, of which racism is one part, as this is relevant to developing sound understanding of an individual's life history and how this impacts upon offending and ability to relate pro-socially.

It is also key to challenge the notion that offences can be justified within certain cultures; this requires the practitioner to hold a difficult balance between acknowledging the role of oppression and cultural belief systems, but not providing a space to justify the use of violence.

TIP 5: Create spaces to discuss oppression. Using your power, acknowledge that there are differences in experience, include these in your collaborative formulations.

Language and communication

Due to issues of oppression power and bias, it is important to consider the adaptation of the language we use when working with people from minority communities. When we speak, we think about what we try to communicate, in that moment for that situation. We know from linguistics research that there are also moments where we convey something deeper (like when there is a 'slip of the tongue' moment). Similarly, there are times where what is said has a different deeper meaning to the listener, based on their life experiences. The meanings associated with words are often linked to concepts that have particular significance to different communities.

Ethnic minority communities often hold *collectivist* cultures, that value inter-dependence in comparison to *individualist* cultures that value independence. In inter-dependent cultures, hierarchies are often set by concepts of 'honour' and 'respect'. When working with people who have experienced long histories of discrimination and deprivation, 'honour' and 'respect' are values that cannot be removed from an individual, therefore in developing relationships it is important to understand these ideas. Similarly, when working with LGBTQ+ communities, it is useful to hold in mind concepts of 'pride' and 'safety' as part of the process of combating heteronormativity.

Services need to acknowledge that psychological concepts do not always translate directly, and need to be interpreted to incorporate cultural understanding. Co-constructing formulations, where possible, helps us both understand, and tackle problems, and places us alongside the person, emphasising togetherness.

TIP 6: Adapt language and communication to build trust and shared awareness of life histories. Acknowledge that the service may not understand how relationships are built in different communities.

Summary

This chapter has provided some additional guidance and practical tips for practitioners who are working with specific groups of individuals with commonly encountered characteristics, enhancing the wider guidance provided in the preceding chapters.

Chapter 7: Staff wellbeing

The aim of this chapter is to focus on staff – the vital heart of any service for individuals with personality difficulties. The skills and resilience of practitioners impacts the efficient and effective working of the service and the wellbeing of the workforce. The chapter will focus on the challenges practitioners face when working in this area, the impacts these can have (personal reactions, burnout and boundary issues) and the role of supervision and support in maintaining wellbeing and a healthy approach to work.

Challenges

Practitioners working with individuals who have offended and have significant personality difficulties face substantial challenges in their day-to-day work. Given that personality difficulties are characterised by an ingrained pattern of problematic behaviours that are damaging to the individual or others around them, working with these individuals can raise very strong opinions and high emotions in individual practitioners and staff teams. Furthermore, unexpected behaviours, re-offending and drop out can be very demoralising. Examples might include the individual who:

- functions well in the prison environment and does well in prison offending behaviour programmes, but reacts very differently 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 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.

Potential impacts on staff

Working with individuals with personality difficulties can impact on staff in multiple ways. Whilst the work can be very rewarding, intellectually demanding and satisfying, it is likely that all staff will experience some negative impacts during their career - whether that be emotional reactions, a lack of motivation, feeling stuck, feeling exhausted or experiencing burnt out.

Personal reactions

When faced with such polarised behaviours in the above examples, it is very often the case that practitioners will automatically and 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.

In addition, practitioners might experience:

- problems in getting much needed input from other mental health and social care services
- inconsistent inter-agency working
- having to work within narrow and rigid organisational protocols when managing risk and highly challenging cases
- high levels of personal responsibility for individual outcomes.

The cumulative effect of such individual and organisational factors 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 challenging, extreme and sometimes risky behaviours we may begin to feel exhausted, personalise things that are said to us, feel critical towards our colleagues or the individual service users and lose our capacity to empathise. We then risk automatically reacting by:

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

As a result, practitioners are at increased risk of burnout.

The above are common occurrences, experienced by many if not all staff. If left unchecked, this can lead to unexpected outbursts of extreme hostility or rigidity, or entangled or overly involved alliances with individuals.

Remember

Working with an individual who has offended and presents with personality difficulties can elicit feelings of anger, rejection, anxiety, fear and unfairness.

In a small minority of staff, working with individuals with personality difficulties will exacerbate problems or vulnerabilities related to their own background and personality. When working with these individuals it is essential that a team approach is fostered and support and supervision systems are in place for all staff. Being alert to your own emotional reactions and behaviours and those of your colleagues is important and any concerns should act as a ‘red flag’ to raise your concerns with a colleague, or a senior member of staff. Engaging in regular peer discussions and support, individual or group supervision and reflective practice are ways of noticing and responding to such reactions as well as enhancing your practice through developing your knowledge and skills.

Staff burnout

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. This can be also be impacted by job and organisational changes / uncertainty, and a lack of participation in decision-making. In working with individuals with personality difficulties it is important that all staff to be alert to the warning signs of burnout in themselves or their colleagues.

So what are the signs of burnout? Described below are the three main components to look out for. The box on the right provides a summary of the 3 aspects of burnout.

a) The development of negative, cynical attitudes and feelings about individuals who offend. 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 people with whom they work that leads them to take the view that individuals are deserving of their troubles and that change is not possible.

b) Experiencing set-backs or feeling hampered in your ability to 'do what might work' (by yourself, colleagues or the organisation) can lead to feeling ineffective. This can lead to feelings of inadequacy and failure which leaves the practitioner unhappy about themselves and dissatisfied with their accomplishments at work.

Key aspects of burnout

Research by Maslach and colleagues suggest three key aspects of staff burnout:

- **Depersonalisation and cynicism** – Negative and cynical attitudes and feelings about work.
- **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.

c) Emotional exhaustion is experienced 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. It is important to recognise that work is only one aspect of our lives and thus stresses and difficulties in other areas of our lives draw on the same emotional resources and resilience as do work demands. Therefore a wide range of life events (e.g. financial pressures, relationship difficulties, long term caring responsibilities) can contribute to us being more susceptible to emotional exhaustion (and to boundary difficulties – see later in this section).

Risks of burnout

The unfortunate consequences of burnout can be a deterioration in the quality of care or service that practitioners provide, high staff turnover, staff absenteeism, low morale, an increase in mistakes made, personal distress, problems with sleep, increased alcohol use, marital and family problems, and developing a feeling that 'nothing works'. There is also growing recognition of presenteeism where staff are in work but don't engage fully in their job role. This can show itself in various ways such as excessive working (because tasks take longer than they should or normally would) or spending many hours at work without the usual level of productivity. It can also show itself through avoidance and distraction behaviours (eg attending but not contributing to meetings; doing 'helpful' tasks such as running errands for others rather than seeing clients).

The personal risks for staff of burnout include:

Physical	Mental
• Increased blood pressure • Coronary heart disease • Poor immune system • Recurring illnesses • Physical exhaustion.	• 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**
• Emotional exhaustion or detachment • Irritable and impatient towards others • Depersonalisation of service users	• Feeling isolated from colleagues • Rude towards service users • No time for colleagues or activities • Unwillingness to help service users

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 www.stress.org.uk website helpfully separates the causes into three categories: Job factors, lifestyle factors and psychological factors. Some of these are summarised below. Why not have a read and consider which ones might be relevant for you personally.

Job factors
Unclear Requirements
High-Stress Times with No “Down” Times
Big Consequences of Failure
Lack of Personal Control
Lack of Recognition
Poor Leadership
Lifestyle factors
Too Much Work With Little Work / Home Balance
No Help or Supportive Resources
Too Little Social Support
Too Little Sleep
Too Little Time Off (e.g. not using full annual leave entitlement)
Psychological factors
Perfectionist Tendencies
Pessimism and proneness to worry
Excitability and proneness to stress
Tendency to be impatient and hostile
Lack of Belief in What You Do

Practitioner self-care and resilience

Attending to your own wellbeing is one part of building resilience and minimising the likelihood of burnout. As noted in the list of burnout factors above, ensuring you take adequate time off and access support and supervision are important for your own welfare and the effectiveness of your work. There are a range of other factors you should also build into your approach to work:

- **Training**

Develop a good understanding about why individuals with personality difficulties present with such challenging behaviours, and have a set of clear and helpful management strategies for responding to different personality difficulties presentations. Other sections of this guide are designed to help with this.

- **Expectations**

It can help to maintain realistic expectations about the work, such as not expecting to like the individuals you work with or be liked by them, 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

- **Maintain a healthy work/life balance**

It is important to 'have a life outside work' and to engage with things that contrast with the requirements of work. This might include spending time with family and friends, engaging in a hobby, travelling or doing anything you enjoy. The key is to ensure you spend sufficient time doing these things without thinking about or engaging in work.

- **Learn to relax**

Practice regular stress management (see https://www.nhs.uk/conditions/stress-anxiety-depression/understanding-stress/ for some ideas), take regular holiday breaks and get enough sleep and rest. Paying attention to your diet and adhering to guidelines on alcohol consumption (see www.drinkaware.co.uk for current advice) are also important.

Monitoring and maintaining boundaries

Boundaries are an essential part of safe and effective practice however there are multiple ways in which these can be threatened and challenged. Under certain conditions any member of staff can be susceptible to boundary problems such as becoming punitive or overly caring in their interactions. Maintaining a balance between these two positions - described as the 'boundary seesaw' is vital for safe and effective practice.

Boundary problems can come in many forms from 'boundary inattention' (eg not sitting near the alarm button in a room when seeing a particular individual because you 'know them well') to boundary violations – which at the extremes can involve befriending an individual or developing personal (and even sexual) relationships with them.

For boundary issues to take place there are at least 3 factors at play:

1. the service user – especially their motives and behaviour e.g. confusing care and interest for friendship; creating and exploiting weaknesses
2. the context – both the physical surroundings and the procedures in place e.g. staff isolation; unstructured or unclear purpose and tasks; lack of or inadequate staff supervision
3. the practitioner (potentially you!) – especially their motives and behaviour e.g. being too involved or detached (carer versus enforcer); currently stressed or emotionally vulnerable; service user reminds you of…

Of central importance to monitoring and maintaining boundaries is to do this explicitly and with the expectations that we are all susceptible to boundary problems. What this means is that discussions of our boundaries with different individuals should be expected, open and a common part of our review of our practice. Those providing individual or group supervision to others should actively consider burnout and boundary issues regularly in supervision. Beware of anyone (including yourself) saying "that could never happen to me". It is essential that boundary problems are identified and addressed quickly to ensure that the seriousness of the issue doesn't escalate.

There are a number of ways to support boundary maintenance including:

- the organisation ensuring there are appropriate policies, training and supervision for staff in respect of this
- staff reviewing their boundaries, discussing these in supervision and proactively reviewing the boundaries adopted with each client
- supervisors monitoring for boundary changes, discussing practitioner feelings and actions towards individuals, reinforcing appropriate boundary setting and addressing boundary inattention and violations
- teams recognising and actively addressing potential splitting (e.g. staff having polarised views) as left unchecked this can lead to boundary problems

Practitioner supervision

Supervision is a central part of working effectively and safely with this group of individuals and in maintaining your own wellbeing. We would suggest that it should be a priority in this type of work, and not optional. There are various forms of practitioner supervision such as coaching; peer supervision; reflective practice and supervision from a more senior colleague. Staff should ensure they have regular time set aside to engage in at least one form of practitioner supervision. In addition to practitioner supervision,

staff will need to engage in management supervision where the focus is on the 'pragmatics' of your work (caseload allocation, service expectations, performance review, formal wellbeing checks). While it is possible for practitioner supervision and management supervision to be provided by the same person (e.g. a senior member of your team) sufficient time must be allocated to BOTH the management AND practitioner elements.

Core features of practitioner supervision

Supervision should be a regular activity planned into your working time. Practitioners with different levels of skills and experience are likely to have different needs within supervision, however supervision typically has 3 core functions:

- Formative / educative – supervision is a place to learn and reflect on your practice. It should provide space to problem solve, reflect and where you can develop skills and ideas.
- Restorative / supporting – supervision should be a validating experience where you feel safe and supported to examine the emotional demands of your work and how you respond to this.
- Normative / managing – supervision provides a forum to benchmark your practice and to ensure that your work meets the necessary ethical and best practice standards.

There are several models designed to guide supervision and reflective practice, however it is important that supervision focuses on what is going well in addition to concerns, issues and development needs. As a supervisee it is important to give thought to what you need from supervision / reflective practice before each session. For those in supervisory roles using models and frameworks can be helpful to guide and inform supervision.

Being a reflective practitioner

Supervision and group based reflective practice sessions are designed to enhance individual practice and to support practitioner wellbeing. In addition, practitioners should regularly take a few moments to review their work. Try to get into the habit of asking yourself after every individual contact - "what went well"; "what could be improved"; "are we meeting our goals"; "how was / am I feeling" and "what could I take from that to apply elsewhere". In summary, being a reflective practitioner means:

- Taking regular thinking time on your own and with a supervisor to review your practice
- Chatting informally with peers about cases
- Presenting cases to your supervisor and exploring the person'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.

There are a number of reflective guides to help with structuring reflection. Two of the easiest to use (and remember are):

- Driscoll's[2] 'what?' model of structured reflection. When examining practice 3 questions are asked
  - What – providing a description e.g. what happened, what did I do, how did I react
  - So what – analysing what took place e.g. what were the effects of my actions
  - Now what – actions to take based on the reflection e.g. what might I do differently next time
- Gibbs'[3] experiential learning cycle. Reflection is guided through six steps:
  - Description (what happened)
  - Feelings (what were your reactions / feelings)
  - Evaluation (what worked / didn't work)
  - Analysis (what sense can you make of the situation, what would happen if . . .)
  - Conclusions (what can be learned from this situation)
  - Action (what are you going to do as a result of the reflection)

Resources

Burnout – in addition to the resources in the text above, there are a number of free tests on commercial websites, if you search for 'burnout tests':

Boundary checklists – there are boundary checklists from therapy and forensic mental health specialists that provide some very useful ideas in relation to boundary problem identification. In addition, the following markers should be monitored and used an potential warning signs:

- Strong feelings (positive or negative) about a client
- Extended sessions
- Overdoing, overprotecting and over-identifying
- Unplanned / out-of-hours telephone contact
- Gift giving / accepting
- Touching / comforting
- Practitioner self disclosure
- Departures from normal practice

Working in a relational way lies at the heart of good quality and psychologically informed management of individuals with personality difficulties. We expect a good deal of ourselves and our colleagues, and it is crucial that we make well being a priority, with careful attention to supervision, burnout and boundary management as important components of a healthy workforce.

2 Driscoll, J. (ed.) (2007) Practising Clinical Supervision: A Reflective Approach for Healthcare Professionals, 2nd edn. Edinburgh: Baillière Tindall

3 Gibb, G. (1988) Learning by Doing: A Guide to Teaching and Learning Methods. Oxford: Further Education Unit.

Appendix I: Personality disorder diagnosis

The different personality disorder diagnoses

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.

> 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.

- 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 personality difficulties, 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 personality difficulties 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. In addition, many service users feel that the labelling process belies the fact that the behaviour can be an understandable response to a set of events that have happened to the person (such as abuse), and that to locate the problem within the person (ie that they are 'disordered') is not acceptable or accurate.

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.

An official definition of personality disorder, as taken from the American Psychiatric Association's Diagnostic and Statistical Manual – 5 is presented below.

Table A1.1: DSM-5 Personality Disorders

DSM – 5 Disorders	Primary presenting features
Cluster A	Distrust, suspiciousness
Paranoid	Absence of attachments to others, flattened emotions
Schizoid	Eccentric behaviour, discomfort with close relationships, unusual perceptual experiences
Schizotypal	
Cluster B	Disregard for and violation of the rights of others.
Antisocial	Attention seeking and excessive emotionality
Histrionic	Grandiosity, need for admiration, lack of empathy.
Narcissistic	Unstable relationships, self image, emotions, and impulsivity.
Borderline	
Cluster C	Submissive behaviour, excessive need to be taken care of.
Dependent	Oversensitive to negative evaluation, feelings of inadequacy, social inhibition.
Avoidant	Pre-occupation with orderliness, perfection and control.
Obsessive-Compulsive	

Different classification systems are used for diagnosis. Table A1.1 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).

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.

The proposed approach to personality diagnosis within the next iteration of the International Classification of Diseases (ICD-11) - due to be implemented in 2022 - has adopted a rather different approach to that of DSM 5. ICD-11 will move away from the ten types of personality disorder, and will have five trait domains as follows:

- negative affectivity
- detachment
- dissociality
- disinhibition
- anankastia

Furthermore, personality can then be rated in terms of severity - mild, moderate, severe - which then avoids the problems associated with multiple co-morbid personality types. ICD-11 will also introduce the option for a sub-threshold personality difficulty, further endorsing the continuum approach to assessing personality problems.

For further information: https://icd.who.int/en

When a formal personality diagnosis might be necessary

There are times when an individual with whom you are working requests a formal diagnosis; some individuals 'want to know' or find that a more medical approach to their difficulties is reassuring. Clearly, a referral for formal diagnosis cannot simply be expedited 'on a whim' but it may be appropriate to try and facilitate this in some circumstances. There may also be occasions when an individual presents with particularly complex difficulties and it is unclear whether or not that individual is suffering from a psychotic illness; psychiatrists may well prefer to take a diagnostic approach to assessing an individual's difficulties in such a situation.

Much more commonly, formal personality disorder diagnoses will be required for medico-legal purposes. This may be in order to consider an individual for possible detention under the Mental Health Act (1983), or when presenting a case for release (or continued detention) to a Mental Health Tribunal. The diagnosis may also be important at the time of trial, when particular pleas are being considered such as Diminished Responsibility (for an offence of homicide). However, these are very specialist situations; in most cases, the guidance provided in chapters one and two suffice for the practitioner to be able to work effectively with individuals in a range of situations.

Appendix II: A unifying model of how developmental history can be understood

This model gives a way to think of the relationships required to give a whole-person, whole-life perspective in the field of human relations; it can provide a framework for a detailed understanding of an individual, or it could be used to develop an entire service, or strategy.

The OPD pathway uses a biological / physical, psychological and sociocultural model, viewed across the life span, to help us understand individual development and change – crucially, we need a birth to death perspective.

In the development of individual and social life, the whole terrain is called the 'Relational Field' - and it is depicted it across the coloured background in the diagram. It involves both conscious and unconscious processes to different degrees in different areas. It establishes the centrality of the interface between each individual and their world, both internal and external as a complex, interactive matrix.

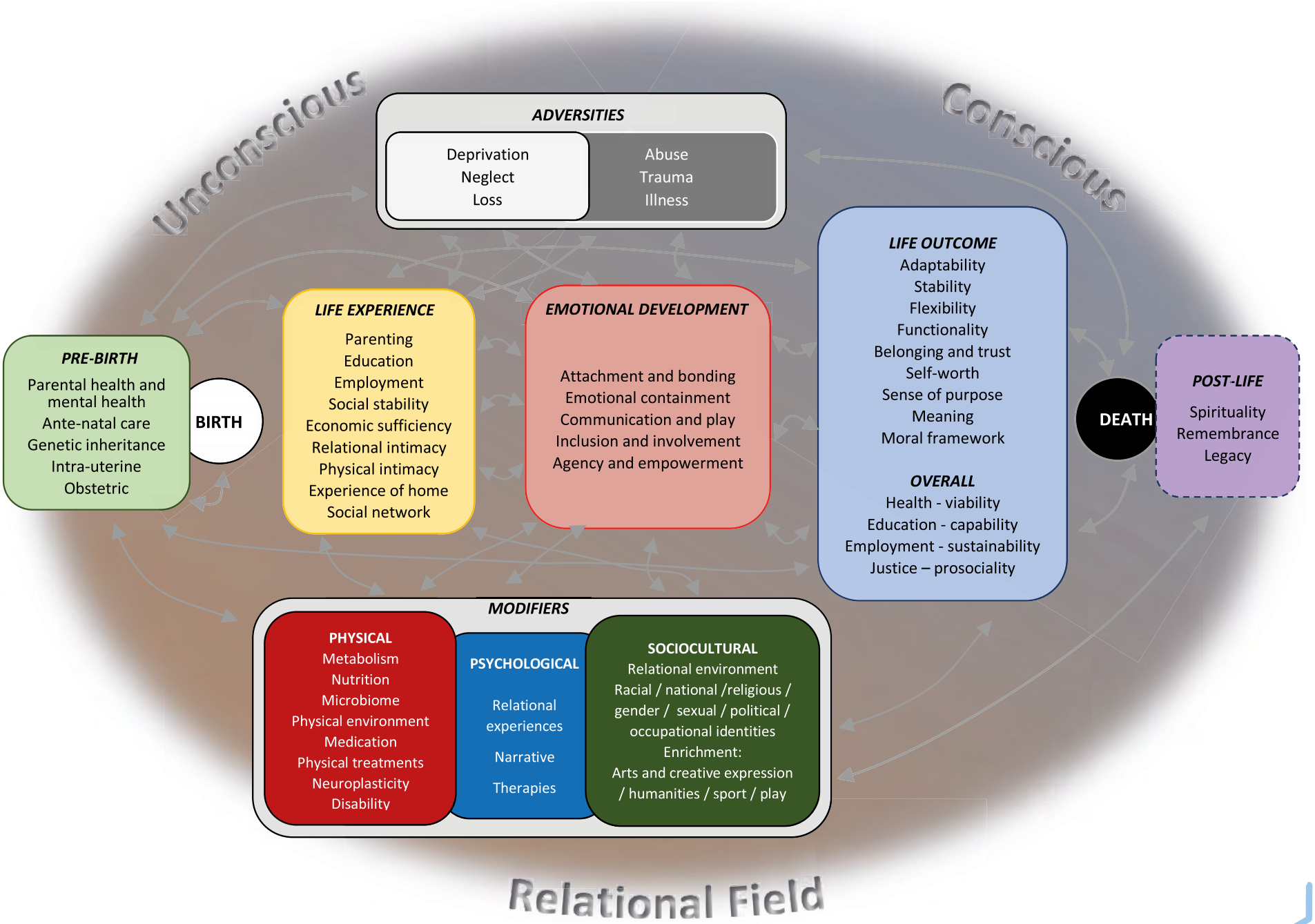
The three main areas before 'outcome' are presented as discrete areas: pre-birth, emotional development and life experience; all contain numerous elements. 'Pre-birth' covers genetic heritability, parental health and antenatal and birth factors. 'Emotional developmental' stages assert the importance of a maturing and stable sense of identity and contribute directly to the development of cognitive capability. 'Life experiences' cover the range of individual and social relational experiences that provide the optimal external support for emotional development and stability. Central to this is the role of attachment and the importance of a consistent relational environment.

Adverse factors have direct effects on physical, cognitive and emotional development. This by omission (such as deprivation or poverty) or commission (such as trauma or abuse): they are shown in the 'adversities' area in the diagram.

The other main 'biopsychosocial' factors, which can be positive or negative, are grouped in another area – called 'modifiers'. The relationship between these three fields of modifying influences involves a complex interrelationship involving a constant process of feedback, progression and regression. Sociocultural inheritance and expectations will have a variable impact on emotional development. Aspects of emotional development will continue to be strengthened or undermined by the quality and timing of life experiences and the opportunity for experiential provision and learning.

'Life Outcome' is a moving target (therefore, itself also subject to and providing dynamic feedback in the system) and is depicted as another area containing a list of qualities, all of which are dimensional in nature, spanning negative to positive outcomes, with most people existing somewhere between the extreme points. The positive words in the upper section are chosen so that outcomes are aligned to indicate the optimal expected results of a satisfactory combination of pre-birth factors, emotional development and life experience. The 'overall' paired words below can be considered as levels of individual capacity and capability and, in the societal sense, show how the individual responds across the four domains of health, education, employment and prosocial life.

'Post Life' recognises the significance of individuals' spiritual or religious life with its expectations of remembrance and legacy, how they may influence the way their life is led, and their acceptance or rejection of life experience. The model also acknowledges the interconnected ways in which bereavement and legacy can have significant effects on the life courses of others in the wider relational community.


Unconscious
Conscious
ADVERSITIES
Deprivation
Neglect
Loss
Abuse
Trauma
Illness
PRE-BIRTH
Parental health and mental health
Ante-natal care
Genetic inheritance
Intra-uterine
Obstetric
BIRTH
LIFE EXPERIENCE
Parenting
Education
Employment
Social stability
Economic sufficiency
Relational intimacy
Physical intimacy
Experience of home
Social network
EMOTIONAL DEVELOPMENT
Attachment and bonding
Emotional containment
Communication and play
Inclusion and involvement
Agency and empowerment
LIFE OUTCOME
Adaptability
Stability
Flexibility
Functionality
Belonging and trust
Self-worth
Sense of purpose
Meaning
Moral framework
OVERALL
Health - viability
Education - capability
Employment - sustainability
Justice – prosociality
DEATH
POST-LIFE
Spirituality
Remembrance
Legacy
MODIFIERS
PHYSICAL
Metabolism
Nutrition
Microbiome
Physical environment
Medication
Physical treatments
Neuroplasticity
Disability
PSYCHOLOGICAL
Relational experiences
Narrative
Therapies
SOCIOCULTURAL
Relational environment
Racial / national /religious / gender / sexual / political / occupational identities
Enrichment:
Arts and creative expression / humanities / sport / play
Relational Field

Appendix III: Enabling Environments

What is an Enabling Environment?

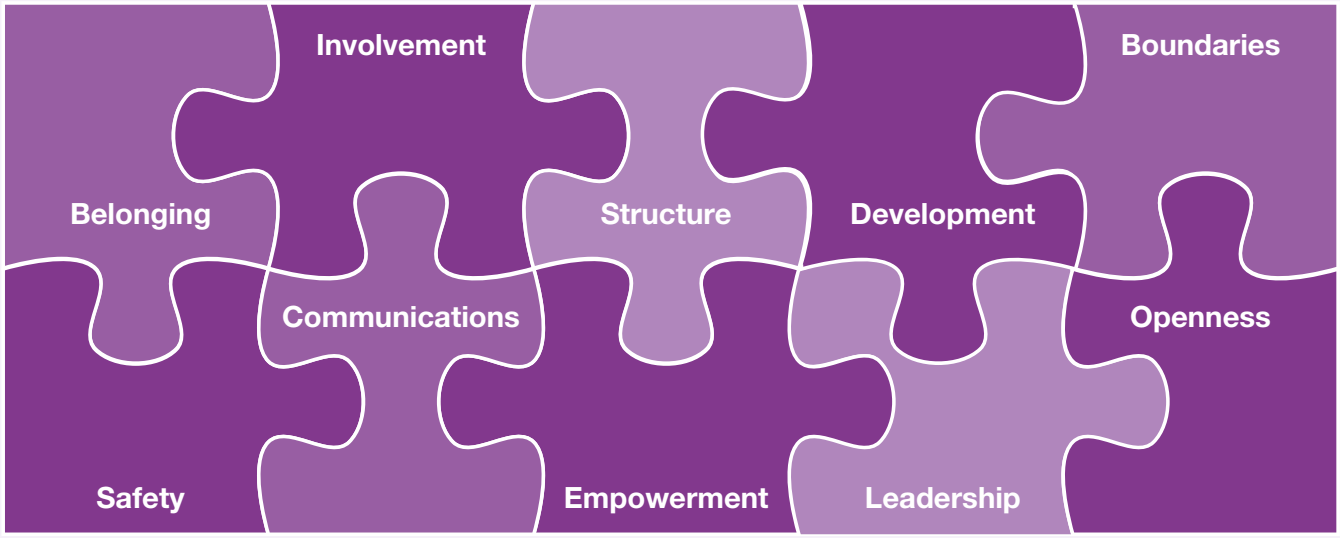
Enabling Environments are places that promote well-being through relationships and a sense of belonging, provides opportunities for growth, and values the contributions of all parties. They foster an organisational culture that supports all participants to develop, flourish and thrive.

An Enabling Environment is the foundation for healthy, more effective services and work places and there is evidence that they produce happier, more productive staff; better outcomes; and improved engagement.

> **"Staff and residents collaborate more and recognise the many shared goals. The environment is calmer, safer."**
>
> – Approved Premises Staff Member

Enabling Environment principles and standards

The Enabling Environments project has identified a set of key principles which are necessary to identify, develop and sustain an enabling culture in any setting. Taken individually, each principle will enhance the enabling qualities of an environment, but it is when they are all present that they form an integrated matrix which forms an Enabling Environment.



Each of the ten principles are defined by a standard, and each standard has an associated set of criteria. The criteria describe what we might expect to see in a place that meets the standard.

Enabling Environments Standards	
Belonging	The nature and quality of relationships are of primary importance
Boundaries	There are expectations of behaviour and processes to maintain and review them
Communication	Everyone is supported to communicate in ways that enable them to be listened to and heard
Development	There are opportunities and support for self-development and growth
Involvement	Everyone shares responsibility for the environment
Safety	There is support in place to help everyone feel emotionally safe
Structure	Engagement and purposeful activity is actively encouraged
Empowerment	Everyone is encouraged to develop their personal authority
Leadership	Leadership takes responsibility for developing and maintaining an enabling culture
Openness	The environment is outward-looking and open to learning

The Enabling Environments network

The Enabling Environments network is an evidence-based quality improvement and award project that invites applicants to consider whether they are achieving the ten standards in their own organisation. Using tools, advice, training and support provided by the network, the process takes participants on a journey, where they are encouraged to pay attention to their environment in relation to the ten standards. Each standard applies equally to all participants whether they be providers of a service or recipients. Places need to demonstrate that they have involved everyone in the award process and it is through working with each other to achieve a common goal that places often become more enabling.

> **It made people question best practise and challenges assumptions about how things are or should be done. Provided an opportunity to introduce change and evaluate the status quo.**
>
> – Forensic Inpatient Ward Staff Member

The assessment process requires places to provide evidence that they are not only meeting the standard, but that the principles are embedded in organisational practice and that there are processes in place to support and sustain the enabling culture.

Our expert team of Assessors are trained to assess a wide range of environments including prisons, children's homes, inpatient wards, approved premises and universities. Places will typically undergo a one-day assessment and the Assessors will either recommend a Development Report, Certificate of Achievement or an Enabling Environment Award.

For more information contact the Enabling Environments Team at *eeadmin@rcpsych.ac.uk* or visit *www.enablingenvironments.com*

Appendix IV: Psychologically Informed Planned Environments

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 difficulties.

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 people with an offending history and 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).
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 people 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.