

# The treatment and management of personality disordered offenders in the community

Adrian Grounds explores the means of providing for the personality disordered in the community.

**M**y emphasis is going to be on general principles of pragmatic clinical management. Research on the effectiveness of community based treatment for personality disordered offenders is sparse. There is more substantial research in adjoining areas of work, namely the supervision of normal offenders, community based treatment of the mentally ill, and treatment programmes for the personality disordered in hospital and prison settings. In contrast there is relatively little that directly informs management of personality disordered offenders in the community. In view of this I will set out to offer a conceptual framework, and a set of values, perspectives, attitudes and strategies in the hope that it may

be heuristically useful; in effect, a context within which specific treatment approaches and policy initiatives can be evaluated.

There are two other preliminary points. First, I will not be discussing the full range of personality disorders but those that predominate amongst offenders, particularly those within community forensic psychiatry services. Second, in discussing this topic I am drawing from clinical practice, so by habit and convention I will be speaking of 'patients' throughout, rather than 'clients' or 'offenders'. However, I hope what I say will be of general relevance and when I refer to patients you should substitute in your own mind your own preferred term.

## Conceptual issues

Initially some conceptual issues need to be clarified in relation to treatment, diagnosis and responsibility.

### Treatment

In a conference discussion two years ago, Professor Nick Black of the London School of Hygiene and Tropical Medicine, usefully applied from epidemiology and public health medicine the tripartite model of impairment, disability, and handicap to personality disorder. It is a long established taxonomy, and it helps introduce some conceptual clarity to what we mean when we talk about treatment and clinical management in this group. Impairment refers to the underlying clinical disorder or pathology, disability refers to functional status, and handicap refers to quality of life, well being and social dependency. For example, in a case of arthritis the joint disease is the impairment, the inability to walk is a disability and the restriction of activity is a handicap. Professor Black suggested that in the case of personality disorder, abnormal personality traits are the impairment, poor social functioning is the disability and the social consequences of the disorder are the handicaps.

This tripartite model applies to a wide range of medical conditions. It follows that when considering treatment we need to be clear about its objectives. Is the purpose to cure the condition, to

reduce the disability, or to increase independence and quality of life? In personality treatment it is usually most realistically targeted on reducing disability and handicap. In Professor Ron Blackburn's words: 'The goal is to produce more adaptive and constructive ways of dealing with situations and relationships that have been problematic in the person's life'. (Department of Health, 1999a, p.5). The concept of treatment in rehabilitation psychiatry, and in the medical care of other chronic disorders is similar. In the treatment of the elderly with dementia for example, good medical treatment is often not about altering the underlying condition, it is about providing relief of symptoms, maintaining functioning, and provision of support to patients and families. So it is with personality disorders.

### Diagnosis

The second area that needs conceptual clarity is diagnosis. In much mainstream clinical practice the attribution of the diagnosis of personality disorder is very casual. For the personality disordered we should be just as rigorous in applying standard diagnostic criteria (for all their faults) as we are when diagnosing serious mental illness. Generally, evidence of primary personality disorder can be traced from the time of adolescence onwards; primary personality disorders do not develop in mid adult life. We should therefore be particularly sceptical when a patient who previously had a diagnosis of psychotic illness has their diagnosis changed to personality disorder in mid adult life.

### Responsibility

The third topic that requires conceptual clarity is that of responsibility. In clinical work with the personality disordered offenders - when, for example, negotiating boundaries and when assessing criminal and disruptive behaviour - judgements regularly have to be made about the individual's responsibility for his or her actions. Our judgements and thoughts about responsibility for behaviour can be hopelessly muddled conceptually. In a famous essay H.L.A. Hart told a brief story to demonstrate this about a captain of a ship. He was responsible for the safety of his

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passengers but he got very drunk on a voyage and was responsible for the loss of the ship and all aboard:

'... Throughout the voyage he behaved quite irresponsibly and various incidents in his career showed that he was not a responsible person. He had always maintained that the exceptional winter storms were responsible for the loss of the ship, but in legal proceedings brought against him he was found criminally responsible for his negligent conduct, and in separate civil proceedings he was found legally responsible for the loss of life and property. He is still alive and is morally responsible for the deaths of many women and children.' (Hart 1968, p.211).

Hart uses this story to illustrate that this single word, responsibility, is used in a range of different senses that need to be carefully distinguished. For example, one needs to distinguish: role responsibility: (the captain was responsible for running his ship); causal responsibility (for example, A was responsible for causing an injury to B); liability responsibility, which includes culpability; and capacity responsibility, which is a distinctively psychological notion that generally refers to capacity for self-control. (Hart 1968). In the clinical management of offenders, we typically tend to conflate clinical judgements about capacity for self-control with moral judgements about culpability.

In relation to people with personality disorder there is a further important distinction. Personality disordered offenders may repeatedly behave in destructive ways for which we want to blame them, but we should distinguish between a person's responsibility for what they are, and their responsibility for what they do. We may quite often tell our patients that they are responsible for their behaviour, but we do not hold them responsible for their conditions. We know

something about the aetiology of the severe personality disorders - the contributions of genetics, temperament, childhood antecedents and family factors. A man with an anti-social, explosive personality disorder is not responsible for his genetic inheritance or the coercive and cruel upbringing that left him with a life long tendency to mis-perceive threat and provocation from others; nor is a woman with a borderline personality disorder who repeatedly injures herself responsible for her history of abuse and victimisation, any more than the patient with schizophrenia is responsible for the aetiology of his condition.

In summary, when we attribute responsibility and blame in our work with personality disordered offenders, we should always think carefully and critically about the nature and validity of our judgements.

### **Clinical perspectives**

What general perspectives should we have in relation to the treatment and clinical management of offenders with personality disorders?

First we need to recognise how disabling these conditions can be. The disorders can have a severity and morbidity similar to that of severe mental illness. People with personality disorders can be just as disabled as people with chronic schizophrenia, and we should therefore apply our conceptual models of disability and rehabilitation to the personality disordered as well as to the mentally ill. This involves carefully determining both the person's current and their best possible levels of functioning, and the aim in management should be to help the person achieve and maintain their optimal level of functioning.

Secondly, management needs to be seen on a long time scale. Some people with personality disorders will need contact,

support and help over their life times, continually or intermittently. Structures of care should be designed to enable this.

Thirdly, there is a need for realism and realistic objectives. This is particularly important in the context of management in the community. In the clinical treatment and management of people with personality disorder, changing the person's basic characteristics may not be a feasible or appropriate treatment objective, although in the long term, with ageing, the characteristic features of antisocial and emotionally unstable personality disorders may ameliorate. More realistic objectives may involve trying to reduce secondary damage, and the targeting of specific symptoms and problem areas.

We need to be clear about what we can and cannot do, particularly in relation to the supervision of dangerous people. Clinically the personality disordered are a very heterogeneous group. What we can do varies with the individual case. For some it will be nothing, for some it will be intermittent help, for some the clinical relationship will be of fundamental importance, and for a few clinical help can turn their lives around.

What can be done depends fundamentally on the kind of relationship and working partnership that can be established with the patient. This is a key point to bear in mind in current debates about the Government's proposals to increase statutory supervision of dangerous personality disordered offenders in the community. At first sight it is tempting to assume that more extensive supervisory powers and more skilled supervisors with better training are the keys to delivering public safety, but supervision is not a community equivalent to institutional detention and observation. You cannot supervise someone who refuses to be supervised. I will return to this later.

The theoretical framework that informs the management of personality disordered offenders should be based on an understanding of the aetiology and nature of these conditions. They are developmental disorders, disorders of the psychological development of personality. For example, in the aetiology of

antisocial personality disorder we know quite a lot now about the genetic contributions; the childhood antecedents of conduct disorder, hyperactivity and under-controlled temperament; and the experiential factors of delinquency, coercive child rearing and childhood victimisation. In order to maintain a sympathetic stance, and in order to orientate clinical work properly, the childhood antecedents have to be constantly kept in mind. Based on this framework, the approach to management will often have three key features. First there should be provision of psychological support or supportive psychotherapy. Secondly, the person's strengths need to be recognised and built upon because they are protective and help maintain stability. Thirdly, management often involves manipulating a person's social environment - thinking about the influences in the social environment that are helpful, alongside those that are stressful and trying to alter the latter.

If we view the antisocial and emotionally unstable personality disorders as developmental disorders, in which childhood antecedents of victimisation and damaging relationships are important, it is clear that the attitudes with which professionals regard these patients are important.

### **Clinical attitudes**

The starting point should be an attitude of commitment and interest rather than avoidance. These patients may have repeated experiences of rejection and inconsistent care, and may therefore be mistrustful and hypersensitive to rejection - covert and explicit. Commitment and interest are also important because the task of the clinician or supervisor often involves trying to convey to other people an understanding of the patient. In trying to link patients up with services, the interest and sympathy of other agencies has to be engaged by explaining the disabilities and transmitting the right attitudes. The avoidance of hypocrisy is important. Generally when putting unpalatable proposals to patients we try to present them as being in the patient's interests and for their own good. When for example, we have to refuse a patient's request we may try and present the

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decision as a disguised benefit. The patient knows that our arguments are spurious. It is better to be honest about what we can and cannot do and why.

We also need to recognise what our patients can and cannot cope with and what they need. We should retain common sense. Thus we should endeavour to be accepting but not credulous; to meet reasonable requests; and to keep our professional behaviour within conventional boundaries. Some years ago the late Michael Shepherd, used the term 'professional friendship' to describe the right clinical relationship with patients (Shepherd 1989). It is a good term and accurately captures what we should try to establish, a relationship that is akin to friendship but also different from normal friendship in that it has a professional purpose, character and limits.

## Clinical strategies

Some of the discussion below is drawn from an earlier review (Grounds 1995).

### *Therapeutic alliance*

Establishing a therapeutic alliance is of primary importance. The medium through which care and treatment are provided is the relationship with the patient and attention must be given to how the relationship is established and maintained. From the outset efforts should be made to ensure that the patient feels understood and that there is shared agreement about realistic treatment objectives and mutual expectations. Offenders with diagnoses of antisocial or psychopathic personality disorders are particularly likely to have

childhood histories of deprivation, cruelty and rejection. In adult life they may therefore be morbidly sensitive to perceived provocation or rejection, and particular vigilance and care is required at the outset in handling the first interview. The objective of a first interview may be no more than to achieve the goal that at the end the patient will come back.

### *Long term support*

The supportive relationship needs to be consistent, tolerant and potentially long term. Patients with disorganised and unstable lifestyles may have difficulty in maintaining regular outpatient attendance, and may best be managed by an open ended commitment to see them again on request at times of crisis. Contact may therefore be intermittent over a long period, and there will be a need to make a fresh assessment and to work on new problems that have arisen on each occasion. For some patients the relationship with the clinician may be the only long term confiding relationship that they have, and its importance should not be underestimated. Progress may need to be measured over long time scales; over the short and medium term no benefit from community support may be observable, but over years the emotional and social stability of some people can show unexpected improvement.

The continuing clinical or supervisory relationship is a negotiated partnership. There need to be pragmatic discussions about presenting problems and possible strategies for dealing with them. When things break down or cannot be established, there should be a willingness to try again.

As mentioned above, there

should be a broadly accepting rather than punitive attitude to the patients demands. We should adopt a willingness to help without getting too hung up about reinforcing dependency. This is often a theoretical fear that is really a rationalisation of avoidance. The more clinical work I do the more I think that basically we should try and give patients what they ask for, unless the requests are unreasonable or inappropriate; so one will not, for example, accede to requests that will result in improper prescribing. Being willing to take seriously what patients are asking for entails being alert to their states of genuine despair and hopelessness.

### *Practical befriending*

Some need support that is best described as practical befriending. One project established recently in Cambridge by the charity Turning Point provides a good example of this. The project consists of a small team led by an experienced ex-probation officer. They work with high risk patients in the community who have histories of poor engagement with statutory services. The team provides practical help, transport, company and ordinary social activities. They are successful by virtue of being a non-statutory agency and by virtue of not being constrained by conventional definitions of professional tasks. Strategically, a practical befriending approach may also be the best means of implementing supervision. With one of our restricted patients in the community, for example, the statutory supervision is implemented by members of the clinical team taking him out to do his weekly shopping. In this particular man's case it is the best means of maintaining effective clinical relationships and the monitoring of his condition.

### *Advocacy*

Good clinical management may also involve an element of explicit advocacy. People with disabling personality disorders can engender fear and avoidance in other people and this can result in their entitlements not being met. For example, recently a patient who tends to be intimidating because of his low frustration tolerance, anger and large size, but who is also of borderline intelligence, articulate and functionally illiterate, received

letters from his housing office saying that because of his aggressive manner with staff he was banned from the premises and in the future would have to communicate in writing. It is on such occasions that professional weight needs to be exercised with the person's permission to reframe attitudes, explain the disability and calm the worries. However, explicit advocacy has to be used in the context of not losing objectivity, and maintaining vigilance about the danger of splitting among professionals.

### *Crisis intervention*

Services and forms of support for personality disordered offenders need to be able to provide intervention quickly at moments of crisis. This may involve early contact in relation to urgent new referrals, and a pragmatic approach to crisis admissions to hospital. At times of crisis when a brief admission is needed, it is irrelevant to ask first whether the patient is mentally ill. Of more immediate importance is the person's current risk to themselves or others and their capacity to manage safely. Within the community residential sector there needs to be the same possibility of emergency admission, to staffed residential accommodation, for example, as there is to hospital.

### *Psychodynamic understanding*

Clinical management needs to be informed by psychodynamic understanding of the patient. Whilst most offenders with personality disorders are not suitable for individual psychoanalytic psychotherapy of a conventional kind, the clinician should retain an awareness of psychodynamic issues for three reasons. First, psychodynamic theories may be necessary in order to develop a proper psychological understanding of the patient's behaviour, and the organisation of his or her emotional life. Secondly, because the relationship with the patient is the medium through which the clinician works, the dynamics of that relationship need to be recognised and understood. The emotions and attributions exhibited by the patient towards the clinician and vice versa, should be considered in terms of what they reveal about the patient's history and emotional life. Not uncommonly, patients who in early

life have been subjected to cruelty or rejection develop similar pathological patterns of relating in adult life, and these may begin to feature in the clinical relationship. Care needs to be taken to recognise this and to avoid re-enacting rejection or punitiveness in professional behaviour and attitudes towards the patient.

Thirdly, offenders with personality disorders may sometimes present with a genuine desire for insight and self-understanding. They may be perplexed and distressed by their destructive behaviour, the chaos of their lives and their inability to change. In taking the initial psychiatric history, the clinician is likely to see links and continuities between patients' early life experiences and their problems as adults. Spending time over a limited number of sessions, taking the patient in detail through his or her life history, may help them see for the first time parallels between past and present. In reconstructing their biographies patients can experience relief and illumination through recognising the experiences that shaped their adult expectations and views of their social world. For example, suspiciousness and paranoid sensitivity in adult life with a tendency to perceive threat and provocation in others and to react explosively, may have understandable links with childhood experiences of living in an early environment of genuine fear and threat of unpredictable violence. As one such man observed: 'I wasn't allowed to grow up normally; fear was put into me all the time. Now I keep feeling I've got to defend myself'. Patients can be helped to see the parallels between the way they view other people in their adult lives, and the way they experience significant others as children, and thus how their distorted attributions and inappropriate responses arise. Although from a psychoanalytic perspective this work is superficial, it may nonetheless be safe and useful: it can be carried out over a limited period of time, it need not involve the development of difficult or dependent transference relationships, and its limited nature means that it may not be too psychologically demanding of the patient.

Psychodynamic awareness entails being aware of counter-transference issues too. When a team is involved in the care of personality disordered offenders, there is a need to guard against the danger of splitting. This was well described in the classic paper *The Ailment* by Tom Main (Main 1957). He observed the way in which particularly demanding and difficult patients could engender a split between an 'in group' of staff who felt they had a particularly good understanding and sensitivity towards the patient, and an 'out group' of staff who considered their colleagues in the 'in-group' to be collusive, unrealistic and over indulgent. Such splitting can be destructive, and needs to be recognised and understood in terms of the patient's psychopathology.

Cognitive and behavioural treatment programmes may have a useful part to play in community management. They are likely to be of limited duration and to focus on specific symptoms or problem behaviours, such as repeated aggression, sexual offending, social anxiety and paranoid sensitivity. Such programmes are likely to be an adjunct rather than an alternative to long term support.

There will also be circumstances when no specific treatment approaches appear to be feasible, and there is a professional feeling of hopelessness. At such times it is useful to remember the question that the late Murray Cox, Consultant Psychotherapist at Broadmoor Hospital, was fond of repeating: what do you do when there's nothing you can do? The point being that when there is nothing you can do, you and the patient are still there and something constructive has to be done.

Much of what I have described is implicitly about containing and managing risk. This topic will be discussed in other contributions, and so I will only make a few brief

and general remarks about it.

## Risk management

In assessing risk a combination of actuarial and clinical approaches is generally advocated (Kemshall 1996). In the individual case, risk assessment has to be based on a detailed knowledge of the person's history. The level of risk a person poses may change over time and in different contexts. Again it is important that we, our patients, third parties and other agencies involved in an individual case have realistic expectations about what can and cannot be done in terms of risk containment. In clinical work our practice should not be defensive but it should be defensible. The standard is not accurate prediction but defensible decision making. In other words I may not always be able to foresee a disaster tomorrow; but if it occurs, will my practice today be seen to be up to standard? Were decisions carefully made, alternatives considered and were there sound reasons for the judgements that were made? Risk assessments need to be based on good evidence, principally historical knowledge about the case. Risk needs to be distinguished from worry. Sometimes worry is excessive in relation to the risk and there is professional over-reaction. Conversely, sometimes there is too little worry in relation to the risk and there is professional under-reaction.

## Mental health policy and the structure of mental health services

This review of community based management needs to be placed in the wider context of public expectations, mental health policy and the structure of mental health services. The publicity and debate that can follow notorious and grave

offences by mentally disordered people show that such events are perceived by the public and politicians to imply a massive failure by psychiatric services to provide public protection. The long awaited proposals for policy development from the Home Office and Department of Health in relation to dangerous people with severe personality disorder have now been issued for consultation (Home Office / Department of Health 1999) and in discussing them it is important to keep a perspective about the current structure and ethos of mental health services, and the NHS more generally.

Contemporary mental health services are not primarily designed to prevent harm and protect the public. The central feature of the reform of psychiatric institutions that took place in the post war decades was not the reduction in hospital beds but a change in ideology and culture. The task of reform involved the replacement of the ethos of security with an ethos of therapy and liberalisation. This was a huge achievement. Thus contemporary services are based on policies and values that emphasise community based care wherever possible, care in the least restrictive alternative setting, minimal use of hospital beds and compulsory powers, and respect for patients' autonomy. Acute general mental health services see their core role as providing treatment for illness, and concepts of need may be defined in terms of capacity to benefit, i.e. the capacity of a patient to benefit from the service available, and the capacity of a service to benefit the patient. This is consistent with the general principles that structure the commissioning and provision of NHS health services. Contemporary principles of health commissioning give priority to the purchasing of health care rather than social care, treatments of proven effectiveness, and the delivery of measurable health gain. General mental health services are not primarily custodial with purposes of security, control and preventive detention. Public safety and crime prevention are important aims of social and criminal justice policy; but it is questionable whether crime prevention is in any primary sense a health service

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objective.

In the context of contemporary general mental health services, personality disordered offenders are problematic because structurally and ideologically mental health services are not designed to manage them. Such patients stress services because they challenge entry criteria in relation to diagnosis, violence, anti-social behaviour and the intractability of their problems. Although the thrust of Government policy for mental health services in recent years has been to give increasing prominence to public safety (Department of Health 1999b) there are difficulties in implementing this. Current knowledge and techniques of risk assessment and management are still not sufficiently discriminating or powerful to identify and contain reliably those who may offend seriously. Supervision is not a form of community incapacitation. There are limits to it: it is contingent on a relationship of partnership, co-operation and disclosure between supervisor and supervisee. You cannot supervise people who are unsupervisable.

Despite the policy initiatives to emphasise to better risk management, supervision and the

delivery of public safety, general mental health services may not be able to operate in this way. Usually, patients are not kept in psychiatric beds when their symptoms of acute illness have improved under treatment but they remain at risk of offending in the community. In practice, serious violence amongst the mentally disordered can make hospital admission not quicker, but slower and more difficult to achieve. The factors known to be associated with increased risk of offending, namely substance abuse and previous violence, constitute barriers rather than priorities for admission. In the community, social care agencies and residential facilities make autonomous decisions to reject patients with offending histories, or who are thought to pose a risk to others, and there is no authority that will exert countervailing pressure. This is a difficult context in which to provide seamless care for personality disordered offenders. These problems are deep seated and structural and will not be solved by imagining some model service or set of services that are simply grafted on to what is already in place. Although the risk management and public protection policy agenda is important, it is in conflict rather than consistent with the prevailing ideology of mental health services.

We need a new realism about what current services and treatment approaches can and cannot do for different categories of patient. We particularly need realism about those with personality disorders. At the same time mental health services should be trying to do more rather than less for this group. In

part, it is the disowning of this group by psychiatrists that has created the window of opportunity through which the Government has launched its new proposals for the preventive detention of the minority who are dangerous offenders. If mental health services were perceived as having more of an interest and sense of ownership towards the personality disordered, we would be in a stronger position to argue against inappropriate compulsory measures and forms of psychiatric involvement.

A disparity has opened up in recent years. On the one hand, heightened public concern and expectations that mental health services should contain the dangerous, but on the other hand the disengagement of those services from involvement with personality disordered offenders. This state of affairs needs to be reversed. Thus, public expectations should become more realistic and consistent with our limited abilities to deliver safety; whilst at the same time mental health services should engage more actively with these patients.

In thinking about ways forward in the management of personality disordered offenders, we should examine what might be learnt from the most innovative community services for the chronically mentally ill. For example, we might focus on identifying successful styles of community based support. We might give more consideration to psycho-educational work, both for patient groups and for relatives and carer groups, about the nature of the disorders. There is also the challenge of providing employment and therapeutic work so that patients can gain experiences of achievement and self-esteem, including engagement in appropriate work that involves them in looking after others.

Finally, there is the need to keep the long term perspective, the aim of helping patients get to old age in safety. Some years ago Michael Craft described a man who after being in special hospitals continuously for 30 years was discharged to the community. He wrote: '... At 74 there were still a few happy years to be spent walking along a seaside promenade with his boarding house landlady...' (Craft 1984, p. 443). At our most difficult

moments with personality disordered offenders it is an image to remember.

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