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Working with people with personality disorder

The Peaks unit:

from a pilot for 'untreatable' psychopaths to trauma informed milieu therapy

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--In this paper I will give a very personal account of what I think are the learning points from the dangerous and severe personality disorder (DSPD) pilot and then go on to think about the way forward for hospital based interventions on the offender personality disorder (OPD) pathway. I am a psychologist working on the Peaks unit, one of two former DSPD units set up in high secure hospital settings.

Back in the 1990s psychologist led treatments for people who had offended and who met criteria for a personality disorder diagnosis were virtually unheard of. The only provision specifically targeting the needs of this group, outside of secure hospitals, were therapeutic communities such as HMP Grendon Underwood and the Wormwood Scrubs Annexe — later to be re-named the Max Glatt Centre. The field of personality disorder treatment was a fairly esoteric area and was primarily staffed by medically oriented psychotherapists using a psychoanalytic and group analytic framework. The earliest change from this medical hegemony was in the Max Glatt Centre and was spearheaded by a little known psychologist Margaret Smith who skilfully made the case with the Governor of Wormwood Scrubs at the time for a psychologist to take up the management of the Max Glatt centre. This offered, as early as 1995/96 the opportunity to integrate new evidence based interventions addressing offending behaviour, dialectical behaviour therapy and schema therapy with the older analytic tradition. It also set an important precedent. Therapeutic interventions with this group no longer had to be delivered by medics within a specifically analytic approach; they could be effectively delivered by psychologists working as part of a clinical team.

Soon after this development Gareth Hughes, a psychologist and Ian Keitch, a psychologically minded psychiatrist at Rampton hospital piloted the personality disorder service. This was the first high secure hospital to separate out patients with a personality disorder diagnosis from the other patients and co-locate them in one place. During the Ashworth Fallon enquiry this service caught the eye of commissioners as a model of working that was different and offered solutions to some of the problems identified in the enquiry, and this made it attractive to them. Soon after this the Personality Disorder directorate, now using a clinical model developed by Todd Hogue — a former prison service psychologist — was given 'Beacon status' and commended as a model to be used elsewhere in the prison service and the NHS. The national DSPD service therefore grew out of the pioneering work of the Rampton personality disorder pilot.

In the course of its development a number of key learning points can be identified:

Lesson 1: Do not base policy decisions on evidence that is a) from one study b) where the treatment model is unusual and potentially unethical.

In 1999 when the Rampton hospital PD service was given Beacon status and work began to think about how to extend this model of working nationally there was little understanding of what kinds of intervention might work for this group. Typically at this time people with severe personality disorder or who were rated high on psychopathy measures were excluded from treatment in both hospital and prison settings. The common assumption was that 'psychopaths' were 'untreatable' and they were likely to get worse if gullible or naïve therapists were to engage them in efforts at bringing about change. This belief was largely driven by papers evaluating the therapeutic community at Penetanguishene in Canada and provides a salient lesson in how a single study can have a disproportionate impact on policy, particularly in the absence of other evidence. When this study was eventually re-examined it transpired that it was very unusual and ethically questionable. The regime at Penetanguishine was highly experimental and included 24 hour encounter groups and the use of LSD and Barbiturates in order to 'break down defences' to allow people to talk openly. The weight given to this study however was such that clinicians all over the world were persuaded that treatment would make people worse. The DSPD initiative flew in the face of this assumption and eventually replaced this belief with the proposal that some people who meet the diagnostic criteria for psychopathy could and would respond to intervention.

The learning that emerges from this is that basing new programmes on 'what the literature says' is less

reliable the smaller the literature base and the more eccentric the clinical model in question. Clinician policy makers need to resist the temptation to lean on studies simply because there are no other in the area in the belief that some evidence is better than no evidence.

Lesson 2: Neither the diagnosis of 'personality disorder' nor the construct of 'personality dimensions' are clinically useful.

For a long time the literature in this field argued about the merits of diagnosis versus dimensional models of personality disorder. In the event neither of these models have proven clinically useful; what clinicians actually use with this population are case formulations and personal narratives linking chronically traumatic pasts with distressing and 'criminogenic' biopsychosocial processes. A danger of relying on diagnostic categories is that other contributing factors from other domains are overlooked. There are also consequences for the evidence base. If diagnostic categories do not correspond with substantive and homogenous groups of disorders then it is unlikely that interventions will work reliably for these groups.

Increasingly practitioners have recognised the pervasive and significant impact of chronic histories of sexual, violent, emotional and neglecting abuse as the core problem for many of those accessing the PD service, to the extent that consideration has been given to renaming the Rampton unit a Chronic Trauma Service for people who have offended seriously, as opposed to a Severe Personality Disorder service. Whilst this change of name is unlikely to happen it reflects the culture and perspective amongst many clinicians working with this group.

Lesson 3: People with personality disorder diagnoses were being excluded from services everywhere, not just in hospital settings.

The final abandonment of the strategy of excluding people with personality disorder diagnoses from services on the ground that they were untreatable is perhaps one of the biggest achievements of the DSPD pilot. Once the assumption of 'untreatability' was challenged a significant population of people who had previously been excluded from services were at last able to access treatment.

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Those meeting PD diagnoses typically come from the most disenfranchised, disempowered and impoverished social backgrounds, often characterised by chronic experiences of adversity and abuse. Prior to the DSPD pilot they were very poorly catered for in terms of health services; now, ten years after the pilot began they are being offered services — whether from an offending background or not. Mortality rates for this population and their consumption of health services such as AandE are high. Treating this group therefore has the potential to offset other costs to the health and criminal justice systems.

Lesson 4: Service user involvement and strength based approaches offer substantially neglected but promising avenues of intervention for building social capital and reducing re-offending.

There is an increasing recognition that involving service users in the delivery and planning of interventions can be a more effective model for change. This was to some extent recognised in the therapeutic community model where the idea of the 'community as doctor' enlisted the strengths of the peer group to achieve change for its members. A similar approach has more recently been adopted by health services in the 'recovery approach', which dovetails well with strength based models of rehabilitation (or habilitation) such as the 'Good Lives' model that argues that a lifestyle in which the individual meets universal needs without offending displaces the need to offend.[1] This is very much part of the contribution of Occupational Therapists to the 'hospital model' who actively integrate a 'Good Lives' approach into their model of working.

Whilst this remains work in progress there is clearly a learning point here about patient involvement, non-prescriptive labelling and not investing 'programmes' and 'therapy' as being the main or even the central vehicle for change.

Lesson 5: Neither hospitals nor prisons are the best settings for meeting the needs of people with diagnoses of personality disorder.

Both prison and hospital cultures have their own long standing narratives that label and stigmatise their

1. Ward, T. and S. Maruna (2007) *Rehabilitation*. London: Routledge.

clients. If we were to develop services from scratch for those with these kinds of problems — in a context where resources were not an issue — we would avoid stigmatising and/or medicalising their problems or giving the label 'patient' or 'offender'.

In any other context we would not put people who have been sexually abused in the same environment as perpetrators of sexual abuse; or put victims of violence in the same settings as those who have perpetrated serious violence. The thought of suggesting to victims of offending that they share their accommodation and therapy groups with perpetrators would make us wince. Nor would we put those who the literature tells us are most likely to re-offend if they have an 'antisocial peer group' in settings where they are living cheek by jowl with other people who have offended. We would also be hard pressed to justify putting people who are suffering from the ravages of institutionalisation in highly routinized conditions of confinement for long periods of time.

The ideal solution would be to intervene in contexts where people are separated from others who have offended altogether and are offered the opportunity to live with non-offenders. The 'circle of friends' model attempts to achieve this to some extent with those who have been released.

What this thought experiment serves to highlight is the often unacknowledged impact of confinement on individuals attempting to change their lives. This creates two tasks: firstly to bring about change in offending behaviour and the ability to manage distress and secondly to develop skills and competencies in surviving confinement. Often these two agendas overlap but at times they do not. When people are doing particularly sensitive pieces of work on offending or trauma it is important that they are protected from some of the more invidious aspects of confinement to prevent escalating patterns of disengagement and reciprocal hostility.

Lesson 6: Clinically, single case methodology is the most useful approach to evaluation.

The relative lack of outcome studies for the DSPD pilot is puzzling. Whilst long term outcomes are a long way away in that few of those going through services have been discharged into the community, it would have been easier to make decisions about the future of the service if there had been more up to date and clinically meaningful data available to policy makers. Those studies that there were conducted heralded from the first five years of the pilot and did not necessarily reflect the perceptions of those involved in the services, or indeed the kinds of services that developed over time.[2] Clinically, moreover, there was a lot of learning that was not captured and could still be passed on if there was a more active approach to sharing learning from single case studies.[3]

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The future role of hospital based interventions

The differing needs presented by those with severe personality disorder highlights the importance of offering a hospital placement for those with co-morbid mental illness. In the model proposed here individuals with mental health problems would be allocated to hospital settings and individuals with 'pure' personality disorder to prison settings. Putting aside the problems associated with separating diagnoses into mental health and non-mental health categories, or indeed the problems of using a diagnostic framework in a service that is essentially formulation or case conceptualisation driven, it is proposed that several criteria be used for allocation to an enhanced high secure hospital setting:

a) Evidence that individuals have a presentation linked with complex trauma and re-traumatisation for whom it would be counter-productive and unethical to deliver interventions in a prison setting

b) Evidence that individuals have reacted badly to psychological interventions in the past, for example who have responded by offending or self -harming in the context of trauma or offence focussed work

c) Evidence of a disorder that significantly impairs an individual's capacity to engage in treatment as usual (TAU) as delivered elsewhere in the pathway

2. Howells K, Jones L, Harris M, Wong S, et al. (2011). The baby, the bathwater and the bath itself: a response to Tyrer et al.'s review of the successes and failures of dangerous and severe personality disorder. *Medicine, Science and the Law 51*(3):129-33.
3. Davies, J., Howells, K. & Jones, L. (2007). Using single case approaches in personality disorder and forensic services. *Journal of Forensic Psychiatry and Psychology*. 18(3), 353-367.

d) Those for whom there has not been an adequate formulation or case conceptualisation — or for whom there have been significant problems in making a diagnosis.

This paper will not examine criteria c and d. Here it is proposed that the core business of a high secure hospital setting for people who have offended and who have a personality disorder diagnosis is to work with the problems linked with chronic trauma when these cannot be addressed in a prison setting.

The ubiquitous theme of trauma in those with personality disorder diagnoses who have offended.

A recent review of case formulations for patients on the Peaks Unit identified chronic histories of trauma causally related to the offence in most of the population. Furthermore this study identified that clinicians were formulating offending behaviour as being largely underpinned by the cognitive, emotional and behavioural sequelae of repeated experiences of trauma. Indeed trauma was identified as a common factor in the development of both personality disorder and offending behaviour.

Much of the recent literature on personality disorder highlights its association with different kinds of trauma history. A number have identified clear links between different types of 'maltreatment' and different personality disorders. Similarly researchers are linking different kinds of offending with different kinds of trauma history. Whilst it is not the only causal factor it is proving to be a significant one that has been relatively neglected by practitioners in the past. Possibly this neglect has been driven by a reluctance to risk the possibility of people using their own abuse histories as an exculpatory narrative that allows them to avoid taking responsibility for their offending.

The traumatising and re-traumatising impact of imprisonment.

Therapy addressing trauma can be delivered in prison settings but there is much more chance of people being exposed to re-traumatising experiences due to the aspect of imprisonment that is about 'punishment'. A number of writers have highlighted the traumatising aspects of custodial settings and others have identified ways in which the justice system can consolidated and exacerbate 'delinquency'. The following have been identified:

a) Deprivation of opportunity to be exposed to 'normative experiences' promoting a sense of mastery and competence, providing experiences of prosocial relationships or fostering a positive identity.

b) Incarceration leads to development being 'arrested'.

c) Involvement with the CJS may be a 'traumatic stressor' particularly for those already suffering from some form of PTSD. A number of researchers have provided evidence to support the contention that abuse is prevalent within adult prisons; inmates may experience significant levels of victimisation involving verbal, physical, sexual, and/or emotional abuse.

d) Behavioural or psychological dysregulation in reaction to memories and experiences linked with trauma that may provoke overbearing limit setting measures from the institution (punishment) that further exacerbate distress and/or offending behaviour.

e) People may also become newly traumatized whilst in detention through being victims of or witnesses of violence, gang-fights, sexual assaults and/or peer suicide attempts.

Researchers have identified increased exposure to antisocial peers and disruption to community contact in prisons as a problem for prisoners. They argue that this limits the opportunity for reinforcing societal norms and expectations through exposure to adaptive and prosocial interactions, in contrast with hospital based settings.

Lambie and Randell (2013) write *'Although it is possible that positive rehabilitative effects can be achieved in a confinement setting, the nature of confinement, as well as the negative impacts that it may have, can greatly limit the rehabilitative potential of such placements. Incarceration environments are often characterized by victimization, social isolation, and unaddressed or exacerbated mental health, educational, and health needs. These factors may limit rehabilitation and have damaging effects that contribute to recidivism and other unfavourable outcomes'*. [4]

Whilst it can be argued that a number of these factors are also present in hospital settings, the underlying philosophy of care focussing on rehabilitation, recovery and treatment is potentially less likely to trigger these reactions than the prison setting that has a more or less explicit model of retribution and punishment as well as rehabilitation.

According to Ward and Maruna (see ref 1), the aim of rehabilitative interventions in conditions of confinement should be to develop a prefiguring 'good life' **in their place of confinement** where the individual is offered the opportunity, as far as is possible, to develop skills in meeting all their needs in a non-offending manner. Hospital based treatment models are aimed at a more comprehensive attempt to provide such 'normative experiences'.

Having worked in a prison based therapeutic community within a larger prison setting I am all too aware of the ways in which the external prison culture

4. Lambie, I. & Randell, I. (2013) The impact of incarceration on juvenile offenders. *Clinical Psychology Review* 33 (2013) 448–459.

intrudes — even if there is a strong and genuine commitment amongst staff and inmates on the unit to a therapeutic culture. There are inevitable rubbing points like visits, gym, weekends when non-unit staff are brought on to the unit due to low staffing, senior managers who are not 'onside' or simply do not understand or agree with the treatment model. Maintaining a 'psychologically informed environment' consistently in this setting presents a real challenge. Often these kinds of incursions into the treatment milieu can be used as 'grist for the mill' for therapeutic work but, for the least engaged and most vulnerable to trauma related anti-authority reactions these incursions can be the *'straw that breaks the camel's back'*.

The need for specialist trauma focussed, trauma aware, non-custodial settings for people who have failed to respond to treatment as usual.

There is no evidence base yet for the treatment of chronic trauma/re-traumatised individuals and consequently there is a need for trauma focussed interventions for this group to be developed. The evidence underpinning the NICE guidelines for working with PTSD are based on single event traumas, for example people struggling with flashbacks and intrusive memories associated with an accident or an episode experienced in the context of military combat. Most of the Peaks population have experienced multiple traumatic experiences and might be better described as re-traumatised or experiencing chronic trauma. They differ also in that they have also experienced 'treatment as usual' and have not responded to this or dropped out so that they were not able to show whether or not TAU would work for them.

Whilst some interventions focussing on trauma and its impacts on beliefs and patterns of relating — using a Cognitive Analytic Therapy, EMDR or Schema focussed model — have been used to some effect, there are also some who have responded poorly and have responded by acting out or self-harming. There is room still for interventions that address the fragile mental state of those suffering from chronic trauma. These need to target both chronic personality traits and offending behaviour.[5]

The psychological mechanisms linking trauma with offending of different kinds is beginning to be clarified.

The psychological mechanisms linking trauma with offending of different kinds is beginning to be clarified. Waxman e al (2014) identify links between different kinds of abuse and different kinds of personality disorders; however they do not describe any putative psychological mechanisms underpinning this.[6] They do propose however that *'borderline and schizotypal PDs were most strongly predicted by sexual abuse, antisocial by physical abuse and avoidant and schizoid by emotional neglect'*. To the extent that there is a direct association between the kind of abuse experienced and the diagnostic criteria for the disorders they claim resulted from it (borderline PDs are prone to sexual acting out, antisocial PDs to violent behaviour and avoidant and schizoid PDs to emotional detachment) there are some implicit suggestions as to what kinds of mechanisms might be at play.

In contrast a wide range of mechanisms linking trauma to delinquency have been identified in the literature. Kerig et al highlight many of these:[7] At a biological level there is increasing evidence that there is often a long term impact on brain neurochemistry, structure and function following the experience of a range of different kinds of trauma. These can mean that an individual is less able to inhibit behaviour and finds it harder to curb impulsive urges. Biological stress systems can also be left in a state of high reactivity that can create a context where some kinds of offending are more easily triggered.

Trauma can also impact on the emotional processes linked with offending. Repeated experiences of trauma can leave an individual either more prone to affect dysregulation or to emotional numbing, acquired callousness and experiential avoidance. Another impact can be a significant difficulty in recognising and responding to emotional states in other people.

This interpersonal insensitivity can be reflected in thinking processes also. Trauma related cognitive processes linked with offending identified in the research include: interpersonal processing deficits, rejection sensitivity, alienation, moral disengagement, stigmatization associated with shame and self-blame, cognitive immaturity, deficits in recognition and

5. Moore, E., Evershed, S., Kilkoyne, J. & Jones, L. (2013) *A Clinical Model for Working With Personality Disorder in High Security Hospitals*. Unpublished internal document.
6. Waxman, R.,Fenton, M.C., Skodol, A.E.,, Grant, B.F. and Hasin, D. (2014) Childhood maltreatment and personality disorder in the USA: Specificity of effects and the impact of gender.Personality and Mental Health; 8(2): 30-41.
7. Kerig P.K. and Becker S.P. (2010) From Internalizing To Externalizing: Theoretical Models Of The Processes Linking PTSD To Juvenile Delinquency. In Sylvia J. Egan (Ed.), Post-Traumatic Stress Disorder.

response to risk, 'futurelessness' and delinquency as adaptations.

Interpersonal processes linked with trauma that have been shown to impact on propensity to offend include: disrupted parent-child relationships, friendships, disrupted peer relations and disrupted romantic attachments, suggesting that it is the impact of trauma on attachment that mediates the relationship between trauma and offending. Attachment experiences when abusive or severely disrupted often result in people not being able to care about or understand what other people are feeling or thinking. The ability to understand other people's minds is developed in the context of a secure attachment; not having this experience results in a diminished capacity to think about one's own mind — and other people's minds.

Chronic trauma and their sequelae associated with developmental abuse present differently in the context of different personality traits and influence significantly the way in which trauma and attachment problems are played out. Research suggests that serious antisocial behaviour can be the result of a combination of a genetically determined 'fearless temperament', abuse, loss and disorganised attachment. The case for trauma awareness in therapeutic regimes is thus overwhelming.

Work on trauma and offending behaviour amongst people with personality disorder diagnoses can result in a process of 'getting worse before getting better'. A common reaction to trauma work and to offence focussed work is to engage in self-harm or offending behaviour that ranges from substance misuse (as a strategy to cope with difficult emotions) to serious violence (assaulting peers because they remind them of people who have abused them for instance). In the absence of new coping skills — or during the process of acquiring them — people can resort to previous ways of coping. In order to contain this process and prevent it from early discharge from treatment specialist settings need to be able to offer the following:

a) A 'trauma aware' staff team who know how to work with and understand the manifestations of trauma as they are played out on the ward

b) Clinical practitioners who are able to conceptualise case material in such a way as to make sense of chronic trauma in the context of offending and self-harm

c) A setting that actively avoids triggering trauma related memories in the way that people work.

The case for psychologically informed prisoner environments

The key task in working out what kinds of treatment pathway might be best suited to an individual is to identify potential 'traumagenic' responses to specific regime components in different settings. This should enable us to identify what kinds of regime are most appropriate for which individuals. There is evidence that certain toxic responses to regimes are linked with specific reactions to trauma elicited by these regimes. Consequently we need a typology of trauma-triggering regime features to help think about what location is best suited for a particular individual. The following table outlines some of these regime features.

VULNERABILITY (ABUSE IN CHILDHOOD, ABUSE IN CUSTODY)	TRAUMA TRIGGERING REGIME FEATURE	PRISON	HOSPITAL	REACTIONS
Traumatic memories of being secluded / restrained / assaulted / by people in uniform; Some trauma acquired in military context	People wearing uniforms	Prisons typically require staff to wear uniforms and follow quasi-military model of discipline	No longer require staff to wear uniforms but do increasingly require things like ID badges	Mistrust and assaults on staff particularly those wearing uniforms
History of being sexually abused sometimes with ongoing urges to take revenge	Being non-sex offender located with Sex Offenders	Generally, but not always, sex offenders separated from other offenders	Sex offenders located with non-sex offenders	Assaults / urges to assault sex offenders. Use self-harm to keep abuse away. Use self-harm as alternative to being violent
History of being assaulted, scalded, attacked by non-sex offenders for being a sex offender	Being a sex offender located with non-sex offenders	Generally, but not always, sex offenders separated from other offenders	Sex offenders located with non-sex offenders	Panic and fear of engagement Deception and concealment of offending from fellow residents
Abused in groups by groups of people. Being locked away alone. So only feel safe — alone	Being required to attend groups	Context specific but little individual work available	Context specific but individual work generally available	Panic in groups — act out to avoid group context. Act out to evidence 'indomitability'
Abuse involving a range of 'discipline' narratives (physical and psychological)	Being subject to 'discipline'	Explicit discipline agenda within a punitive narrative	More a 'boundary' model within a clinical narrative	Attacks on people 'imposing discipline'

Witnessing violence • Being violently abused • Being preoccupied with violent urges and wanting to join in violence	Being witness to violence	Violent incidents high in some settings	Fewer violent incidents in most settings	Panic, self-harm to get away, self-harm to show dominance, self-harm to keep abusers away
Attachment difficulties abandonment / rejection	Changing care teams a lot	Range of contexts involving significant change in care team	Some focus on continuity of care as part of clinical model	Mistrust, stuck in phase of testing relationships
History of abuse	Having to disclose abuse to police	Imperative to do this implemented rigorously	Imperative to do this implemented rigorously	Violence, self-harm
Neglectful care leading to poor boundary maintenance and acting out	Low levels of staffing and observation	Staff resident ratios lower	Staff resident ratios higher	Acting out to elicit care
Being 'in care', repeated changes in carers, imprisonment as young person, deprivation of opportunity to be exposed to 'normative experiences	Deprivation of opportunity to be exposed to 'normative' experiences	Limited regime resources impedes this	Regimes focussing on building whole lifestyle through multi-disciplinary team model	Delays in emotional, social and educational development. Low self-esteem and poor definition of future possible self outside
Neglectful care. Being locked in room for long periods of time as a child	Social isolation	Range of contexts leading to different levels of isolation, including segregation as punishment	Isolation for short periods with close monitoring	Pattern of increasing withdrawal

Conclusions

This analysis and discussion suggests a need for specialist trauma focussed interventions in high secure settings. Whilst there are some locations in the prison service where excellent work of this type is being delivered — I am thinking particularly here of the DSPD units and, in a different way, prison therapeutic communities — there are some people for whom prison based interventions are going to be very difficult simply because of the nature of the environment. There are also some people who don't manage well in hospital settings (anecdotally there is a high representation of people who have been sexually abused returning to CSCs from hospital setting as a consequence of not being able to cope with being co-located with people who have offended sexually). Colleagues at Whitemoor Fens Unit have indicated that people with borderline and histrionic personality disorder traits who are at risk of self-harm and/or suicidal ideation might be better placed in secure hospital settings.

Rather than waiting to see if trauma interventions can be delivered in prison settings and then only moving them to hospital if things don't work out it might be useful to identify those for whom a hospital placement would be the most appropriate and useful drawing on the findings of research into PD and from the experience of clinicians who have been delivering treatment to those with PD diagnoses over the last ten plus years. Hopefully this paper has suggested some ways of thinking about these issues.