

PAPER FOR NOTA POLICY COMMITTEE

**THE ASSESSMENT, TREATMENT AND
MANAGEMENT OF SEXUAL OFFENDERS WITH
PERSONALITY DISORDERS (INCLUDING
PSYCHOPATHY)**

Dr Rajan Darjee

Consultant Forensic Psychiatrist
NHS Lothian Sex Offender Liaison Service, Royal Edinburgh
Hospital

Dr Katharine Russell

Consultant Forensic Clinical Psychologist
NHS Lothian Sex Offender Liaison Service, Royal Edinburgh
Hospital

Contact details:

The Orchard Clinic,
Royal Edinburgh Hospital,
Morningside Terrace,
Edinburgh EH10 5HF

Tel. 0131 537 5866

Fax 0131 537 5857

Email rajan.darjee@nhs.net or katharine.russell@nhs.net

WHAT IS IT?

Personality describes an individual's characteristic ways of relating to others, experiencing and expressing emotion, thinking about self and others, and behaving. There is no clear defining line between normal and abnormal personality. Personality is best viewed dimensionally (Widiger et al, 2011), where a mild and/or short-lived expression of a trait may be adaptive but an extreme and/or pervasive expression of a trait can be maladaptive. An individual has a personality disorder when they display a lifelong pattern of pervasive problems in personality functioning, which cause difficulties in inter-personal relationships, leading to distress, poor social functioning and/or problems for other people. Various types of personality disorders (e.g. antisocial, borderline, narcissistic, paranoid, schizoid) are currently described in mental disorder classification systems (ICD-10 (World Health Organisation, 1992) and DSM-IV (American Psychiatric Association, 1994)). In practice, individuals rarely fit neatly into such diagnostic categories and often meet criteria spanning different categories. When a clinician is considering personality disorder as a diagnosis they must consider the range of personality traits and not just place an individual into a DSM-IV box. The new approach to personality disorder classification in DSM-5 will include a more dimensional approach.

Psychopathy encompasses a particular set of personality traits characterised by: emotional detachment, coldness and superficiality; an exploitative, domineering and controlling interpersonal style; and antisocial and impulsive behaviour (Patrick, 2006). It is usually assessed and identified using the Psychopathy Check List-Revised (PCL-R; Hare, 1991; 2004). Psychopathy is not equivalent to antisocial personality disorder (ASPD). Many people with psychopathy will also meet criteria for ASPD which essentially describes antisocial attitudes and behaviour. However many people with ASPD lack the grandiosity, callousness and emotional detachment of psychopathy. In addition, psychopathy is not a specific category of personality disorder in ICD-10 or DSM-IV; and people who meet criteria for psychopathy will meet criteria for various ICD-10 or DSM-IV personality disorders. Psychopathy is an important concept in theory, research and practice concerning offender management and recidivism.

Many sexual offenders have personality disorders (Fazel et al., 2007), with research estimates varying from 30-60%, and many more have dysfunctional personality traits. Personality disorders have implications for risk assessment, treatment and management as highlighted in this document.

BACKGROUND AND RESEARCH

Personality disorder and the legal system

The development of the law and services to deal with personality disordered offenders in different jurisdictions can be complicated to understand. The key issue is that personality disordered offenders do not fit comfortably into services or legislation primarily aimed at dealing with offenders with mental illnesses, but they also present difficulties within criminal justice services. Many 'difficult', 'complex' and 'high risk' offenders have personality disorders, and so are overrepresented amongst those who qualify for extended sentences and indeterminate sentences (Coid et al., 2007), and at the higher levels of Multi-Agency Public Protection Arrangements (MAPPA). Some sexual offenders with severe personality disorders are treated in specialist secure hospital and prison units in England and Wales. However the majority of personality disordered sexual offenders are dealt with out with such services, and are found in non-specialist prisons, and on the caseloads of probation officers and police officers who manage registered sex offenders in the community.

Personality disorder in sex offenders

The personality characteristics of sexual offenders are heterogeneous and there is no 'sex offender personality profile' (Craissati et al., 2008). Although personality disorder is common in sex offenders, it is particularly prevalent and severe in serial offenders, those who cause serious harm and those who are 'challenging'. Adult rapists have higher rates of psychopathy, antisocial traits and paranoid traits (e.g., sense of entitlement, hostility and bearing grudges) than child molesters who have higher rates of avoidant and dependent traits (e.g., feelings of inferiority, needy and over-reliant on support from others). Sexual homicide offenders have very high rates of psychopathy and other personality disorders, particularly sexually sadistic and serial offenders (Hill et al., 2007). Among internet offenders are a significant number of individuals with avoidant, obsessive-compulsive, and schizoid personality disorders.

In Hanson and Morton-Bourgon's (2004) meta-analysis psychopathy and personality disorder (grouped with other indicators of 'antisociality') were associated with sexual and violent recidivism in sexual offenders. Psychopathy is one of the strongest predictors of future offending and violence in offenders, including sexual offenders (Hare, 2006). Psychopathy in combination with sexual deviance has been found to be a particularly malignant combination (Olver & Wong, 2006). Sexual deviance is a strong predictor of sexual recidivism, whereas psychopathy is a strong predictor of violent and non-violent recidivism. However where they are both present they interact significantly suggesting that psychopathy enhances the influence of sexual deviance. Olver & Wong suggested that "Psychopathic characteristics, such as callousness, lack of empathy, manipulation, and so forth, would likely make the commission of sexual crimes easier by treating victims and potential victims as objects for self gratification and would, therefore, potentiate sexual recidivism" (p. 79).

Many stable dynamic risk factors (e.g. poor socio-affective functioning, problems with self-regulation, dysfunctional attitudes) are manifestations of dysfunctional personality traits. Indeed, most of the 'psychologically meaningful risk factors' recently identified by Mann et al. (2010) are dysfunctional personality traits. Where

such factors are underpinned by personality disorder they may be particularly difficult to address through treatment

Personality Disorder and psychological treatment

There is evidence that psychological treatment can improve functioning and ameliorate distress in some individuals with personality disorders (Duggan et al 2007). This area has not been as well researched as interventions for some other mental disorders and there has been little rigorous research in offenders. There is evidence that modern CBT programmes reduce re-offending in medium to high risk sex offenders (Hanson et al., 2001; Lösel & Schmucker, 2005; Hanson et al., 2009) and many individuals in these programmes will have personality disorders. However sex offenders with more severe personality disorders (including those who are psychopathic) are harder to engage in treatment, more likely to drop out of treatment, may display difficult behaviour in treatment, can have a marked negative impact on therapists and may not have their needs met by standard programmes (Ministry of Justice, 2011). The application of the responsivity principle (Andrews and Bonta, 2003) is particularly important with individuals with personality disorders. There is little specific research on offending behaviour programmes for sex offenders with personality disorders. Recent systematic reviews have questioned the traditional view that treatment makes psychopaths worse (D'Silva et al., 2004; Salekin, 2002). There is some evidence that appropriately delivered treatment is effective at reducing reoffending in psychopathic offenders, and it has been argued that offenders with psychopathy should be seen as high risk and high needs cases, rather than as automatically unresponsive to any intervention (Skeem et al., 2009). Nevertheless some psychopathic offenders will be unresponsive to interventions and will require incapacitating measures to protect others from serious harm.

Most sexual offenders with less severe personality disorders appear to respond to standard programmes, especially if they are delivered so as to be flexible, responsive and attentive to the therapeutic process. Where personality pathology is more severe suggested adaptations include: greater focus on motivation, engagement, maintaining participation; using more appropriate learning styles; recognising and addressing underlying core beliefs; greater flexibility; emphasis on individual formulation and positive psychology approaches, e.g., good lives approach (Dowsett and Craissati, 2008). Some specialist programmes for personality disordered sex offenders include specific therapeutic approaches developed for the treatment of personality disorder (e.g. dialectical behavioural therapy, schema therapy, cognitive analytic therapy, social problem solving) to address emotional dysregulation, abnormal cognitions, interpersonal problems and difficulties with pro-social coping/problem solving. Suggested adaptations to programmes for offenders with psychopathy include: they need to be intensive and long-term; treatment has to be interesting and exciting; there must be attention to engagement and preventing drop-out; the focus of specific work should not be aimed at addressing empathy / self-centredness, but at understanding the offence cycle or chain, developing self-management skills and achieving needs in pro-social ways; treatment should encourage 'enlightened self-interest'; individual formulation and a 'good-lives' approach are particularly important (Wong and Hare, 2005; Dowsett and Craissati, 2008). Such adaptations for severely personality disordered and psychopathic individuals have been described and recommended by a number of international experts, but there are no published controlled outcome studies of such approaches for personality disordered sexual offenders.

Personality disorder and supervision/management

Personality disordered sexual offenders can be difficult to manage as they may relate in problematic ways to staff involved in treatment and supervision; they may display problematic behaviours, such as deliberate self-harm, aggression and substance misuse; they may be unco-operative with supervision; they may cause different staff and agencies to be polarised and work dysfunctionally; and they may cause staff to become anxious, stressed and burnt out (see www.justice.gov.uk; Working with PD offenders: A practitioners guide. Ministry of Justice, 2011). Understanding the personality dysfunction of the sexual offender and being “psychologically aware” when planning management can help minimise such difficulties. Thinking reflectively about cases, having support from colleagues and recognising difficult feelings when working with personality disordered sex offenders are all essential, but are often overlooked or squeezed out when practitioners have busy case loads and are managed in a way that is task focussed and emphasises getting actions completed. Staff selection, support, training and supervision are important.

CURRENT PRACTICE

Most personality disordered sex offenders in the UK are managed in the criminal justice system. A small number of personality disordered sex offenders are dealt with in the forensic mental health system. Legislation and practice vary across the UK. In England and Wales, the only jurisdiction in the British Isles where significant numbers of such individuals are treated in secure hospitals, the majority of cases are still dealt with in prison and in the community. The government in England and Wales has just published a consultation on personality disordered offenders (Department of Health, 2011), highlighting that hospital based treatment is expensive, slow and lacks evidence of effectiveness, and favouring putting resources in place to treat and manage personality disordered offenders primarily in the criminal justice system (in prison and in the community). The presumption of this approach is against hospital treatment unless there is a good justification for this (e.g. comorbid mental illness) and promotes the development of a pathway from assessment for sentencing, through treatment and management in specialist units in prison, to management in the community under supervision by the probation service. The role of mental health services in such a pathway is primarily to provide consultation, assessment, management advice and treatment to support criminal justice agencies.

In England and Wales the OASys PD screen may be used by offender managers to identify offenders who are likely to have severe personality disorder (particularly antisocial personality disorder and psychopathy). If most of the items, i.e. eight or more, are present then the offender should be referred for specialist assessment and intervention. A high score is associated with ‘failures’ of various sorts, i.e. reoffending, breaking conditions of parole, dropping out of treatment etc). Another approach to identifying personality disorder is for practitioners to identify those cases they work with who have evidence of pervasive and persistent problems with interpersonal relationships, emotional functioning and/or behaviour (usually from childhood). A further way is for practitioners to be able to consult specialists where they have cases which are unusual, troubling, concerning, or causing agencies or staff to fall-out. Whatever the approach to screening and identifying cases, it is important that there is access to specialist consultation or assessment for offenders who have the most severe personality pathology (Russell and Darjee, 2012).

The actuarial risk assessment tools used by criminal justice agencies in the UK do not explicitly include personality disorder as a risk factor (e.g. RM2000), but dynamic assessment tools (such as Stable and Acute 2007 (SA07; Hanson et al., 2007) and Structured Assessment of Risk and Needs (SARN; Webster et al., 2006)) include factors which are manifestations of personality traits (e.g. lack of concern for others, intimacy deficits, emotional dysregulation). An actuarial tool used more in North America, the Sex Offender Risk Appraisal Guide (SORAG; Quinsey et al., 1998), includes psychopathy and personality disorder as risk factors. Structured professional judgement risk assessment tools (such as Sexual Violence Risk-20 (SVR-20; Boer et al., 1997) and Risk for Sexual Violence Protocol (RSVP; Hart et al., 2003)) include psychopathy as a risk factor.

In most cases in the UK, no personality disorder assessment is done. The availability of clinical assessment of personality disorder for criminal justice agencies varies across the UK. Some specialist forensic mental health services (e.g. in South East London, South London, North West London, Newcastle, Liverpool and Edinburgh) provide such input directly to criminal justice agencies, but in most areas of the country there is little or nothing provided. Psychologists employed by probation services provide such input in some areas. The Ministry of Justice and Department of Health personality disorder document suggests that psychologists should work closely with probation officers to advise on complex risk issues so that the high risk cases can be prioritised and resources can be used in the most appropriate way. If necessary the psychologist can undertake a more thorough specialist risk assessment to look at all aspects of risk, i.e., nature, likelihood, frequency, imminence and severity of harm; suitability for treatment; and style of management/supervision required.

CONCLUSION AND NOTA POLICY

- All staff working with sexual offenders should have general awareness of personality disorder and how it may present in order that appropriate specialist assessment and advice can be sought where necessary. All staff should be aware of the DoH/NOMS Personality Disorder guide (Department of Health, 2011). There are straightforward ways for non-clinicians (such as social workers, probation officers and police offender management officers) to recognise cases where personality disorder may be causing problems.
- There should be direct access to specialist consultation, assessment and advice by appropriately qualified, trained and experienced practitioners (psychologists or psychiatrists) who should be competent in personality disorder, risk assessment and management of sexual offenders.
- At each stage of assessment, treatment, and management of sex offenders, staff should have access to specialist advice and consultation and possibly a full specialist risk assessment provided by clinicians, e.g. psychologists or psychiatrists who have expertise in risk assessment and personality disorder.
- When treating personality disordered sexual offenders, programmes need to be flexible and responsive, with special attention to engagement, motivation, interpersonal processes and addressing relevant dynamic factors. Not all personality disordered sex offenders need a specialist programme, but where personality dysfunction is severe it will be particularly important to ensure that any programme is responsive to needs.

REFERENCES

American Psychiatric Association. (1994) Diagnostic and statistical manual of mental disorders (4th edition). American Psychiatric Association, Washington DC.

Andrews D. A., & Bonta, J. (2003). The psychology of criminal conduct (3rd ed.). Anderson, Cincinnati.

Boer DP, Hart SJ, Kropp, PR, Webster, CD (1997). Manual for the Sexual Violence Risk - 20: Professional Guidelines for Assessing Risk of Sexual Violence. The Institute Against Family Violence, Vancouver, B.C.

Coid J, Yang M, Ullrich S, Zhang T, Roberts A, Roberts C, Rogers R & Farrington D (2007) Predicting and understanding risk of re-offending: the Prisoner Cohort Study. Research Summary 6. Ministry of Justice, London.

Craissati J, Webb L, Keen S (2008) The relationship between developmental variables, personality disorder, and risk in sex offenders. *Sexual abuse: a journal of research and treatment* 20, 119-138.

Department of Health (2011) Consultation on the Offender Personality Disorder Pathway Implementation Plan. Department of Health / NOMS Offender Personality Disorder Team. Department of Health, London.

Dowsett J, Craissati J (2008) Managing personality disordered offenders in the community. A psychological approach. Routledge, London.

D'Silva K, Duggan C, McCarthy L. (2004) Does Treatment Really Make Psychopaths Worse? A Review of the Evidence. *Journal of Personality Disorder* 18:163-177

Duggan C, Huband N, Smailagic N, et al. (2007) The use of psychological treatments for people with personality disorder: a systematic review of randomized controlled trials. *Personality and Mental Health* 1:95-125.

Fazel S, Sjostedt G, Langstrom N, et al. (2007) Severe mental illness and risk of sexual offending in men: a case-control study based on Swedish national registers. *Journal of Clinical Psychiatry*, 68, 588–596.

Hanson RK, Morton-Bourgon K. (2004) Predictors of sexual recidivism. An updated meta-analysis. Public Works and Governmental Services Canada.

Hanson, K., Gordon, A., Harris, A., Marques, J., Murphy, W., Quinsey, V. et al. (2002) First report of the collaborative outcome data project on the effectiveness of psychological treatment. *Sexual Abuse: A Journal of Research and Treatment*, 14, 169-194.

Hanson, R.K., Harris, A.J.R., Scott, T. & Helmus, L. (2007). Assessing the risk of sexual offenders on community supervision: The Dynamic Supervision Project; User report 2007-05. Ottawa: Department of the Solicitor General Of Canada.

Hanson, R.K., Bourgon, G., Helmus, L, Hodgson, S. (2009). The principles of effective correctional treatment also apply to sexual offenders: A meta-analysis. *Criminal Justice and Behavior* 36(9), pp. 865-891

Hare RD.(1991) *The Hare Psychopathy Checklist-Revised Manual*. Toronto: Multi-Health Systems.

Hare RD. (2004) *The Hare Psychopathy Checklist-Revised Manual* 2nd edn. Toronto: Multi-Health Systems.

Hare RD. (2006) Psychopathy: a clinical and forensic overview. *Psychiatric Clinics of North America*: 29: 709-24.

Hart SD, Kropp PR, Laws DR, Klaver J, Logan C, Watt KA (2003) Risk for Sexual Violence Protocol (RSVP). Mental Health, Law and Policy Institute, Simon Fraser University.

Hill A, Habermann N, Berner W, Briken P. (2007) Psychiatric disorders in single and multiple sexual murderers. *Psychopathology*, 40, 22-28.

Loranger AW (1999) *International Personality Disorders Examination Manual*. Psychological Assessment Resources, Odessa, Florida.

Lösel, F., & Schmucker, M. (2005). The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*, 1, 1-29.

Mann RE, Hanson RK, Thornton D (2010) Assessing risk for sexual recidivism: some proposals on the nature of psychologically meaningful risk factors. *Sexual Abuse: a journal of research and treatment* 22(2) 191-217.

Marshall, W. L., Marshall, L. E., Serran, G. A. & Fernandez, Y. M. (2006) *Treating sexual offenders. An integrated approach*. Routledge, New York.

Ministry of Justice (2011) *Working with offenders with personality disorders: a practitioners guide*. National Offender Management Service, Ministry of Justice, London.

Olver ME & Wong SCP (2006) Psychopathy, Sexual Deviance, and Recidivism Among Sex Offenders. *Sexual Abuse: a journal of research and treatment*. 18(1), 65-82

O'Shaughnessy RJ (2009) The role of personality disorder in sexual offending. In Saleh FM Grudzinskas AJ (eds) *Sex Offenders: Identification, Risk Assessment, Treatment, and Legal Issues*. Oxford University Press.

Patrick CJ (2006). Editor. *Handbook of Psychopathy*. Guilford Press, New York.

Quinsey V L, Harris G T, Rice M E, Cormier C A. (1998). *Violent offenders, appraising and managing risk*. Washington, D.C, American Psychological

Association.

Russell, K. & Darjee, R. (2012) Managing the risk posed by personality disordered sex offenders in the community: A model for providing structured clinical guidance to support criminal justice services. In, *Managing Clinical Risk: A Guide to Effective Practice* (edited by Logan, C. & Johnstone, L.). Routledge.

Salekin RT (2002) Psychopathy and therapeutic pessimism. Clinical lore or clinical reality? *Clinical Psychology Review* 22, 79-112.

Skeem J, Polascheck D, Manchak S. (2009) Appropriate treatment works, but how? Rehabilitating general, psychopathic, and high risk offenders. In Skeem LJ, Douglas KS, Lilienfeld SL eds. *Psychological science in the courtroom: consensus and controversies*. New York: Guilford.

Widiger TA, Huprich S, Clarkin J (2011) Proposals for DSM-5: Introduction to Special Section of *Journal of Personality Disorders*. *Journal of Personality Disorders*, 2: 135.

Webster SD, Mann RE, Carter AJ, Long J, Milner RJ, O'Brein MD, Wakeling HC & Ray NL (2006) Inter-rater reliability of dynamic risk assessment with sexual offenders. *Psychology, Crime and Law* 12, 439-452.

Wong, S. & Hare, R. D. (2005) *Guidelines for a Psychopathy Treatment Program*. Multi health systems, Toronto.

World Health Organization (1992) *The tenth revision of the International Classification of Diseases and Related Disorders (ICD-10)*. World Health Organization, Geneva.