

INTRODUCTION

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Chapter 1

PERSONALITY, PERSONALITY DISORDER AND VIOLENCE: AN INTRODUCTION

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INTRODUCTION

Few would argue that interpersonal violence, in its many forms, is a major social problem, causing considerable harm to individuals, families and communities. Indeed, the World Health Organisation (WHO) (2002) has recognised violence as a significant public health issue. The WHO report acknowledges that there are multiple factors that need to be taken into account in explaining violence, including individual, relationship, social, cultural and environmental factors. These are represented in an ecological model (see Figure 1.1). While all levels are clearly important, the focus in this book is on individual-level explanations.

Beginning with the basics, it is useful to define violence. Violence is defined as a range of behaviours intended to harm a living being who is motivated to avoid harm (Baron and Richardson, 1994). This definition is useful in that it excludes harmful acts that are accidental (e.g. a road traffic accident), consensual (e.g. sado-masochism) and ultimately beneficial (e.g. medical procedures). A distinction may be made between violence and aggression: violence is the forceful infliction of physical harm, whereas aggression is behaviour that is less physically harmful (e.g. insults, threats, ignoring), although it is often severely psychologically damaging. Because aggression can be as damaging to the victim as actual physical violence, and sometimes even more so, many mental health and criminal justice practitioners opt to use the term violence to refer to both aggression and physical violence. This avoids appearing to collude with the belief that aggression is not serious or harmful.

There is wide variation between individuals in their proneness to violence, and the agenda in this book is to investigate individual variation in relation to personality and personality disorder. The psychological study of *personality* relates

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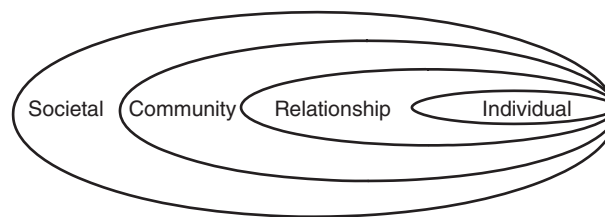


Figure 1.1 An ecological model for understanding violence (World Health Organisation, 2002).

to the understanding of how individual differences (i.e. personality traits) and personality processes (i.e. cognitive, emotional and motivational processes) relate to behaviour (Brody and Ehrlichman, 1998). The study of *personality disorder* relates to a range of clinically important problems with thoughts, feelings and behaviour whose regularities are defined in specific personality pathologies (Livesley, 2001). The term 'personality disorder' references diagnostic categories (see the next section for an elaboration); however, there are mostly no categorical cut-offs for problems in personality traits and personality processes. Hence, in referencing problems in the personality domain, the term 'personality problems' is used here. In this book, both fields of study are represented so that we may best advance our understanding of individual variation in violence.

One of the major reasons for studying personality, personality disorder and violence is to advance psychological and psychiatric treatments. Both criminal justice and mental health professionals play a role in treating and managing people who are violent. Broadly speaking, differing organisational agendas mean that criminal justice personnel see society as the primary client and aim to control crime, whereas mental health professionals view the patient as the client and aim to improve functioning and reduce distress. These days, however, most interventions offered by either group of professionals are designed both to promote individual well-being and reduce risk (Ward, 2002; Ward and Brown, 2004). Nonetheless, the latter aim is still viewed as highly contentious by some mental health professionals (Grounds, 2008).

The contributors to this book, all of whom are internationally renowned researchers and practitioners, will expand on issues related to personality, personality disorder and violence. In this chapter, the aim is to set the scene by addressing some fundamental questions about detention, punishment and treatment of people with personality problems or personality disorders who are violent. Unlike people whose violence is connected with mental illness or developmental disabilities, for whom there is largely agreement on the appropriateness of treatment, the issue of whether or not to treat those with personality disorders or personality problems and an offending history is more controversial. The case for punishment, treatment or a combination of the two requires exploration. If treatment is to be offered, then what should be the treatment goals? Where should treatment be offered: in criminal justice or mental health service locations? However, before embarking on these topics, the scale and nature of the problem needs to be put into perspective.

PERSONALITY DISORDERS AND VIOLENCE

Personality disorders are described in the two major diagnostic classification systems: the Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV; American Psychiatric Association, 1994, 2000) and the International Classification of Diseases 10 (ICD-10; World Health Organisation, 1992). DSM-IV defines personality disorder as

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 (p. 629).

ICD-10 defines personality disorder as

... deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels, and particularly relates to others. Such behaviour patterns tend to be stable and to encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance (p. 200).

The personality disorders are listed in Table 1.1, along with their key features. DSM-IV groups the personality disorders in three clusters: Cluster A – odd or eccentric (paranoid, schizoid and schizotypal); Cluster B – dramatic or flamboyant (antisocial, borderline, histrionic and narcissistic); and Cluster C – anxious or fearful (avoidant, dependent and obsessive-compulsive). Psychopathy, a personality disorder that is covered extensively in later chapters, lacks specific status as a personality disorder in DSM-IV and ICD10, although aspects of it are captured in antisocial and dissocial personality disorders. Extensive research on features of psychopathy over recent years has led to it being considered for inclusion in the forthcoming DSM-V.

In a recent study of a representative sample of the UK general population, using a structured clinical interview, the prevalence of personality disorder was identified as 4.4%, with men more likely to have a personality disorder (5.4%) than women (3.4%) (Coid *et al.*, 2006b). Thus, an estimated three and a quarter million people in the United Kingdom have a personality disorder. Most of these are unlikely to be violent. Indeed, in Coid *et al.*'s study, even among those people diagnosable as having an antisocial personality disorder, about half had not been violent in the previous 5 years (Coid *et al.*, 2006a). Nonetheless, Coid *et al.* (2006a) noted that people with Cluster B disorders, compared to those without, were 10 times more likely to have had a criminal conviction and almost 8 times more likely to have spent time in prison. This elevation of criminal risk was not evident for those with Cluster A and C disorders.

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Table 1.1 DSM-IV and ICD-10 personality disorders

DSM-IV	ICD-10
<i>Cluster A</i>	
Paranoid – distrust; suspiciousness	Paranoid – sensitivity; suspiciousness
Schizoid – socially and emotionally detached	Schizoid – emotionally cold and detached
Schizotypal – social and interpersonal deficits; cognitive or perceptual distortions	No equivalent
<i>Cluster B</i>	
Antisocial – violation of the rights of others	Dissocial – callous disregard of others; irresponsibility; irritability
Borderline – instability of relationships, self-image, and mood	Emotionally unstable
	(a) Borderline – unclear self-image; intense, unstable relationships
	(b) Impulsive – inability to control anger; quarrelsome; unpredictable
Histrionic – excessive emotionality and attention seeking	Histrionic – dramatic; egocentric; manipulative seeking
Narcissistic – grandiose; lack of empathy; need for admiration	No equivalent
<i>Cluster C</i>	
Avoidant – socially inhibited; feelings of inadequacy; hypersensitivity	Anxious – tense; self-conscious; hypersensitive
Dependent – clinging; submissive	Dependent – subordinates personal needs; needs constant reassurance
Obsessive-compulsive – perfectionist; inflexible	Anankastic – indecisive; pedantic; rigid

Compared with mentally ill offenders, personality disordered offenders are more likely to reoffend after discharge from hospital. In their 12-year follow-up of a cohort of 204 patients discharged from UK high security hospitals in 1984, Jamieson and Taylor (2004) found that 38% were reconvicted, 26% of them for a serious offence. The odds of committing a serious offence were seven times higher for personality disordered offenders compared with the mentally ill offenders. However, although personality disordered offenders were more likely to be reconvicted of a serious offence, note that three-quarters of them were *not* reconvicted of a serious offence and 62% were not reconvicted at all.

In this book, the focus is specifically on those personality dimensions and disorders that are associated with violence. Nestor (2002) suggested that four fundamental personality dimensions operate as clinical risk factors for violence: (1) impulse control, (2) affect regulation, (3) narcissism and (4) paranoid cognitive personality style. These traits, he says, distinguish those who act violently from the majority who do not. Through the identification of the specific personality dimensions that are associated with high risk for violence, we may contribute to the elimination of the stigmatising generalisation that *all* personality disordered people are violent. It is important to remind ourselves that not all people with personality problems or personality disorders are violent. Those we see in forensic psychiatric hospitals

and prisons are there because they present a risk and are not representative of all people with personality problems or personality disorders.

The relationship between the type of personality disorder and violence is apparently strongest for antisocial personality disorder (Hiscoke *et al.*, 2003), which is unsurprising since aggressive behaviour is one of the defining criteria of the disorder. There is a clear circularity of reasoning here: if violence is part of the definition of antisocial personality disorder, then the incidence of violence among people diagnosed as having antisocial personality disorder is going to be higher than for those with diagnoses that do not feature violence. Skeem and Cooke (in press) have commented upon this problem of conflating measures and constructs in relation to psychopathy, as measured by Hare's (1991, 2003) Psychopathy Checklist – Revised (PCL-R). Psychopathy is measured by the PCL-R in terms of traits (grandiosity, selfishness and callousness) and behaviours (antisocial, irresponsible and parasitic lifestyle). The PCL-R has been shown to be a good predictor of future violence in convicted offenders (Hare *et al.*, 2000; Hemphill, Hare and Wong, 1998). However, the PCL-R includes items relating to criminality, leading to an unhelpful mix of the behaviours that we are trying to explain (crime, violence) and the explanatory variables (traits). More recent analyses by Cooke and Michie (2001) indicated that seven items relating to criminality and disapproved behaviours could be removed to leave a purer personality model of psychopathy. They found a superordinate construct of psychopathy, with three constituent factors: (1) arrogant and deceitful interpersonal style; (2) deficient affective experience; and (3) impulsive and irresponsible behavioural style. These features may well be the core of psychopathy and the variables that explain crime and violence. Or, as Skeem and Cooke point out, these factors may have no explanatory value at all! Given that research into psychopathy has used a measure that conflates traits and criminal behaviour, it is possible that the observed relationship between psychopathy and violence is the result of the inclusion of the behaviour under study within the measure itself.

What is the likely relationship between personality, personality disorder and violence? Some basic personality characteristics are associated with an increase in the risk of violence whereas others are associated with a decrease in the risk of violence. Studies of the development of antisocial behaviour, for example, find that impulsiveness in children is associated with later antisocial behaviour and aggression, while inhibition is associated with a lower likelihood of later antisocial behaviour and aggression (Farrington, 2005). It is easy to imagine how impulsiveness (acting without thinking) can lead to antisocial behaviour and aggression and how inhibition (fearfulness and shyness) may protect against antisocial behaviour and aggression. However, characteristics such as these are neither necessary nor sufficient to explain the behaviour of interest. Over the person's lifespan, there are continuous reciprocal interactions between the individual and social and environmental variables that account for the development of the complex personality of the adult. That is, biological, psychological, social and contextual variables, singly and through their interaction, all contribute their share to the explanation of a person's propensity for violence. It is unlikely that any one factor alone will contribute sufficiently to warrant designation as the sole causal agent of violence. Of particular interest in this book are the mechanisms whereby basic personality

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characteristics promote the development of and increase the risk of aggression and violence. These mechanisms include emotional experiences and emotion regulation, perception of and responses to social cues and beliefs about the self and the world. These mechanisms are, at least in theory, open to the possibility of change, with the potential to reduce the likelihood of violent behaviour.

One further question that arises is how can one tell if a violent person has a personality disorder or not? Serious violence contravenes not only the law but also society's moral and ethical codes to such a degree that some people would say that serious violence *must* reflect an underlying personality disorder. One consideration is the degree of choice a person exercises in the use of violence. For some offenders, violence is their chosen means of operating in the world and there is no moral conflict, loss of control or distress. Such people would not normally be described as personality disordered, although our growing knowledge about psychopathy may herald changes to this perspective, with major implications for the legal process (Fine and Kennett, 2004). A second consideration relates to the criteria for diagnosis. As for any other behaviour, serious violence can be explained by reference to an individual's traits, social history, current thoughts and feelings and the context the person is in. Whether these characteristics amount to a personality disorder depends upon the criteria set forth in the classification systems and the cut-offs applied for diagnosis. A person may have problems to some degree but that degree may be insufficient to meet the level for a diagnosis. This situation of having personality problems but not meeting the cut-off for diagnosis is one disadvantage of a categorical model of personality disorders, and it is likely that the next version of the Diagnostic and Statistical Manual of Mental Disorders, DSM-V, will move towards a dimensional model (Widiger and Simonsen, 2005).

PUNISHMENT OR TREATMENT OR BOTH?

Broadly speaking, the aims of punishment are to signal to society what is acceptable and what is not, and to prevent and reduce crime. By applying sanctions for socially proscribed behaviours, members of society in general will be deterred from crime, and the individual offender will be deterred from committing crime again. Additionally, where the crime has been grave, an offender can be incapacitated through long-term detention or even, in some countries, death. Hollin (2002) noted that, if this logic works, we would expect punishment to reduce crime. The truth is that, overall, it does not. Reconviction rates for prisoners in the 2-year period after release run at around 55% to 60% (Cunliffe and Shepherd, 2007). Furthermore, meta-analyses of what is effective in reducing crime by individuals indicate that punitive measures, such as the 'short sharp shock', fines, surveillance and drug monitoring, are not effective in reducing crime, whereas cognitive-behavioural treatments are effective, reducing reoffending by 30% to 40% in adults and as much as 60% in young offenders (McGuire, 2001, 2002). So, as for other types of offenders, there is a utilitarian case for treating offenders with personality problems or personality disorders: treatment works better than punishment.

Personality Problems and Personality Disorder as Mitigation

In mitigating antisocial behaviour and violence, a psychological explanation or psychiatric diagnosis needs to identify specific deficiencies that impair the agency of the person diagnosed. The deficiency may affect the capacity of a person to make rational decisions, impair the control a person has over his or her behaviour and/or impair the degree of awareness of the harm caused by the act.

People with personality problems or personality disorders are usually viewed as being responsible for their behaviour and not warranting excuse or mitigation in the same way as those with mental illness or learning disabilities. The basis of this view lies in the perceived normality of people with personality disorders. They face the same challenges in the same way as the rest of us in relation to controlling their emotions and impulses. We all, at times, have to control anger and aggression under provocation and express our anger appropriately. We all have to practise negotiation, compromise and fair play to achieve what we want without bullying, intimidating or abusing others. The truth is, we all come to these challenges with different personal resources and some are better equipped than others to control their emotions, relate well to other people, and act in non-violent ways. Indeed, a dimensional approach to personality disorders, as mentioned earlier, would likely place people with personality problems and personality disorders at the far end of a continuum that includes the normal range of experiences and behaviours.

A disorder may excuse or mitigate antisocial and violent behaviour because the individual is not fully aware of the legal or moral imperative to refrain from this behaviour or because that person does not fully understand the harmful consequences of that act. Intellectual disability and dementia are examples of such disorders. In any caring society, people who are seriously mentally impaired are unlikely to be punished for violent acts. In relation to people with antisocial personality disorder, there is an assumption of knowing the consequences but nonetheless being unable to exercise control over behaviour. In relation to psychopathy, the case has been made that psychopathic individuals' lack of emotional capacities reduces their responsibility for their actions in that they do not really understand the implications of their antisocial and aggressive acts, either for others or for themselves (Benn, 1999). This has far-reaching implications for the administration of criminal justice.

If we hold people responsible for their actions, then a proportionate punishment is a reasonable option; yet, a final consideration to be taken into account is the effect of punishment on the individual (Benn, 1999). Punishment can lead to behaviour change when it is immediate and inevitable (note that neither of these is typical of punishments in relation to crime) (Hollin, 2002). If the individual can understand the punishment in relation to the deed, and if punishment is likely to lead to a change in attitude or behaviour, then perhaps punishment proportionate to the deed is warranted. An analogy is reprimanding a child for a misdeed. The child may not fully understand why the misdeed transgresses social or moral rules, but through the reprimand he or she begins to learn appropriate behaviour. Concerning people with antisocial personality disorder, violent behaviour may be explicable in terms of biopsychosocial disadvantage; hence there is mitigation of culpability, yet that individual may nevertheless be able to learn from punishment.

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Concerning people with psychopathy, biopsychosocial disadvantage may again mitigate culpability, but the nature of the disorder may mean that the individual will not learn from punishment. Hence, to punish is purely for society to signal its disapproval. Some philosophers believe that punishment should be only a just desert and should not be administered to effect behaviour change (Ciocchetti, 2003). Indeed, it was noted earlier that punishment is not the most effective way to reduce recidivism overall (Hollin, 2002); hence, while punishment may be a necessary signal of society's disapproval and a means of exacting retribution for a crime, it is through treatment that behaviour change is most likely to occur.

For offenders with personality problems or personality disorders, treatment takes place within either a criminal justice context or a forensic mental health setting or, most probably, a combination of both of these over time. Thus, there is usually a combination of punishment and treatment. However, not all offenders with personality problems or personality disorders are considered treatable. Issues that need to be considered in making the decision to offer treatment or not are: Can appropriate treatment targets be identified? If they can, do treatments that have a positive effect on these treatment targets exist? An understanding of personality problems, personality disorder and violence is required to identify and address the treatment needs of these offenders.

IDENTIFYING TREATMENT TARGETS

If violence is seen as driven by emotions, primarily anger, and if the person claims an inability to control his or her behaviour in the face of strong emotions, then treatment may be an option, especially if the individual concerned wishes to experience less anger and have greater self-control. In the absence of a major mental illness, people who fit this description may be diagnosed as suffering from an intermittent explosive disorder, defined as aggression disproportionate to the degree of provocation (American Psychiatric Association, 1994), or a personality disorder, particularly antisocial or borderline personality disorders. It is worth noting here that there is no category for disorders of anger or aggression in either of the current psychiatric classification systems, DSM-IV (American Psychiatric Association, 1994) or ICD-10 (World Health Organisation, 1992). Effective treatments for anger problems are available and may be tailored specifically to suit people with personality problems (see Chapter 10).

If violence is driven by what the perpetrator stands to gain from violence, including control over another person and material benefits, this may be seen as less deserving of treatment and more deserving of punishment. This response is even more likely where there is no expressed desire to change or where a desire to change is expressed apparently only for pragmatic reasons, such as avoiding punishment. But what if people with this presentation also have emotional and cognitive deficits that contribute to an explanation of their violent behaviour? Some people do not recognise fear, cannot empathise with another's suffering or cannot use information about another person's feelings to alter their behaviour. This, of course, describes psychopathy, a disorder comprehensively described later in this volume by several eminent researchers in this field.

In both the cases described above, violence may be explained at least partly by behavioural, emotional or cognitive deficits that are evident early on in life and which persist into adulthood. How do these deficits or differences come to express themselves in the form of adult personality disorder? Only an adult can be given a diagnosis of personality disorder, in the belief that personality is still in formation in childhood and adolescence. So, what might be happening over the years that results in adult personality disorder?

Following through the two examples given above, one being violence driven by emotional dysregulation and the other being violence driven by instrumental gain in the absence of empathy or fear, we can trace the genesis of violent behaviour for people with antisocial personality disorder and psychopathy. Individual differences that are present from birth may confer high risk for violence, but the expression of violence additionally depends upon the person's experiences over his or her lifespan. As we shall see, this life-course developmental model helps identify many facets of the person that are likely to be useful to focus upon in treatment. If we accept that the overarching goal of treatment is to reduce violence, for the benefit of the individual, potential victims and society as a whole, then we need an understanding of how people come to be violent.

Antisocial Personality Disorder

Perhaps the best traced developmental sequence is that which identifies early impulsivity, especially where it flourishes into childhood conduct problems, as a direct risk for adult antisocial personality disorder. This developmental pathway traced from early impulsivity and measuring the effects of additional risks accrued along the way has been researched in a number of high-quality longitudinal studies, whose findings are cogently summarised by Farrington (2005). Impulsiveness, particularly in association with low intelligence, may be linked to deficits in the executive functions of the brain, and may indicate an impairment in the abilities necessary for forward planning and goal-directed behaviour, including attention, abstract reasoning and behavioural inhibition. This initial risk for antisocial behaviour and violence is inflated where parental management of the child is harsh and inconsistent, such that the child is seldom rewarded for good behaviour but often punished for bad behaviour. In psychological terms, the child's experience is that being good is unrewarded and that the world is hostile. Furthermore, the child may become desensitised to punishment. Of course, the child's difficult behaviour and the carers' management practices influence each other in a reciprocal relationship, often creating a vicious cycle of adverse effects.

Recent evidence from a longitudinal study has identified a potential genetic and neurobiological mechanism underpinning the differential effects of maltreatment (Caspi *et al.*, 2002). In boys, those who have the variant of a gene that determines low monoamine oxidase A (MAOA) enzyme activity, which leads to low metabolism of neurotransmitters, differ in their response to childhood maltreatment compared with boys who have the variant of that gene that determines high MAOA enzyme activity. Those with low MAOA activity who are maltreated bear threefold greater odds of developing conduct disorder, and nearly 10-fold greater odds of being

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convicted of a violent crime in adulthood. Hence, certain genetic factors appear to make some people more sensitive to stress, and this may affect the development of the neurotransmitter system, which may translate into antisocial behaviour and violence later in life.

Conflict and antisocial behaviour in families also add to the risk of antisocial personality disorder, possibly because, via parental modelling, the child learns to confront, fight and commit crime. Furthermore, there is an absence of learning the skills of negotiation and prosocial behaviour. Where difficult behaviours occur in the classroom, the child may fail academically, thus decreasing future job prospects and increasing the likelihood of crime as a career. School truancy and mixing with delinquent peers provides opportunities for taking up disapproved behaviours, such as smoking, drinking and drug taking, and antisocial behaviours, such as damaging property, stealing and fighting. The end result of this developmental route is a poorly educated adult, with little or no work experience, who uses violence and aggression as a means of resolving interpersonal problems, may have a criminal record and likely drinks heavily and uses illicit drugs. This person is the product of an interaction between his or her personality, social experiences and current opportunities. All of the violence-exacerbating challenges that he or she has faced in life are more likely when families are economically strained and live in high-crime neighbourhoods.

The pathway of interacting personality traits, personality processes and experiences described above may result in antisocial behaviour and aggression to such a degree that it may be classified as antisocial personality disorder. This is described in detail by DeBrito and Hodgins in Chapter 7. However, understanding the pathway to antisocial personality disorder reveals the specific risk factors, which may also be construed as appropriate targets for prevention or treatment to minimise risk. The pathway described above indicates that antisocial behaviour and violence may be prevented by family support, parent training and school inclusion programmes (Hawkins and Herrenkohl, 2003; Tremblay and Japel, 2003; Utting, 2003). In treating adult antisocial behaviour and violence, the intermediate targets suggested by the pathway include improving people's interpersonal problem solving, conflict resolution and emotion control, and changing the antisocial biases, beliefs and attitudes that support antisocial behaviour, aggression and violence (McGuire, 2006).

Psychopathy

Developmental approaches to understanding psychopathy are gaining currency. In childhood, a significant number of aggressive children show only reactive forms of aggression; yet, there is a subgroup that shows both instrumental and reactive aggression. Callous and unemotional traits in children are associated with especially severe aggression and persistent conduct problems, and there is evidence for high levels of heritability of these traits (Viding *et al.*, 2005). Blair and colleagues (Blair *et al.*, 2006; see also Chapter 9) suggest that this emotional dysfunction is at the heart of psychopathy. While research is as yet inconclusive regarding the genetic and molecular neurobiological factors underpinning low emotional

responsiveness, these appear to affect the functioning of the amygdala and the orbital/ventrolateral frontal cortex. Impairment in aversive conditioning circuits manifests as lack of fear and empathy deficits. Indifference to the experience of punishment and to the perception of others' distress (i.e. low empathy, see Chapters 9 and 12) interferes with socialisation, and permits the development of instrumental violence. People with psychopathic traits also show lack of flexibility in altering responses to a stimulus (see Chapter 13), so that when contingencies change (e.g. to signal punishment or non-reward instead of reward), they persevere with previously rewarded behaviour. The lack of reward then causes frustration, which putatively leads to reactive aggression (see Chapter 8).

These neurobiological risk factors pose a risk for violence, but social and environmental influences have an additional role to play over the lifespan. Callous and unemotional traits in children may interfere with early attachment relationships with caregivers, which may exacerbate the absence of concern for others and may also affect the carer's affection for and attention to the child (Saltaris, 2002; see also Chapter 11). Good parenting may have less impact on children with emotional deficits than on those without in terms of teaching the child to be attentive to the feelings of others, but there may be more scope for influence through modelling acceptable means of attaining goals. Thus, prosocial role models have the potential to divert the child from antisocial means of goal attainment.

In terms of prevention and treatment of problems, there has been no real suggestion that the treatment targets should differ for psychopaths. Rather, what has been suggested is that the mode of intervention needs to take psychopathic traits into account, harnessing the need for control, status and success to beneficial effect (Hemphill and Hart, 2002).

TREATMENTS FOR OFFENDERS WITH PERSONALITY DISORDERS

If, in explaining violence, a profile of the individual's biological and psychological functioning may be presented to a legal body in mitigation, then the nature and degree of dysfunction should inform the disposal, whether punishment, treatment or a combination of the two. However, in reality, the decision is made partly in terms of the treatments and services available. People with psychosis have access to mental health professionals willing to take responsibility for their treatment, provide hospital beds and community supervision arrangements, and implement a range of pharmacological, psychosocial and management interventions. Hence, it is relatively easy for a judge to direct a person with psychosis into treatment.

People with personality disorders, until recently, have had fewer mental health professionals willing to take responsibility for their treatment and a dearth of services available to them. The directive encapsulated in the title of the National Institute for Mental Health in England's (2003) document, *Personality disorder: No longer a diagnosis of exclusion*, has prompted a change in service provision. Over the past 5 years, there has been support for the development of specialist community-based treatment services (Crawford and Rutter, 2007). These augment provision in

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forensic mental health services and the joint Department of Health and Prison Service in England and Wales provision for dangerous people with severe personality disorders (Department of Health/Home Office, 1999, 2000).

To flourish, these services need to have effective treatments available to them. Meta-analyses of outcomes of psychological treatments for people with personality disorders show a strong positive effect of treatment (Cohen's d^1 0.80 to 1.39), with both cognitive-behavioural and psychodynamic approaches showing good effects (Liechsenring, Rabung and Liebing, 2004; Perry, Banon and Ianni, 1999). However, good quality research is scarce and this body of treatment research is strongly biased toward borderline personality disorder (Binks *et al.*, 2006; Duggan *et al.*, 2007).

Here, we are particularly interested in treatments for people with antisocial personality disorder and psychopathic individuals. Duggan *et al.* (2007), in their systematic review of psychological treatments for people with personality disorders, identified only two treatment trials specifically for antisocial personality disorder. These focused on reducing drug use, comparing combinations of contingency management, methadone prescription and cognitive-behavioural therapy. While positive effects were observed for contingency management, this is a very narrow treatment for antisocial personality disorder. Clearly, treatment for antisocial personality disorder is a subject requiring a considerable amount of further research. D'Silva, Duggan and McCarthy (2004) addressed the question of the treatability of psychopaths in a systematic review. They identified 24 studies, most of which were of poor methodological quality. Overall, as many indicated improvement as indicated deterioration; hence, no firm conclusions can yet be drawn about the treatability of those with high psychopathy traits. Again, treatment for psychopathic personality disorder is a subject requiring a considerable amount of further research.

It is imperative to research the effectiveness of treatments so that services can be developed on the basis of empirical evidence, thus giving mental health professionals the confidence to work with people with personality disorder, the judiciary the confidence to direct people with personality disorder into treatment, and the client the confidence to work therapeutically on his or her problem to effect lasting change. With an infrastructure and a knowledge base in place, professionals may begin to have confidence in deciding that, while people with personality disorder need to be held responsible for their behaviour, they may also benefit from treatment.

OFFENDERS WITHOUT PERSONALITY PROBLEMS OR PERSONALITY DISORDERS

Of course, Prison and Probation Services have for years been treating offenders with personality disorders, although they have not been diagnosed as such. In a review of 28 prison surveys worldwide, representing a total of 12 844 prisoners, 65% of men were diagnosable with any personality disorder and 47% with antisocial personality disorder, with the figures for women being 42% and 21% respectively

(Fazel and Danesh, 2002). Treatment programmes for offenders in correctional services are almost certain to be offered to a high proportion of people with personality disorders, although in recent years those scoring high on psychopathic traits have been excluded from treatment.

As mentioned earlier, meta-analyses of treatment outcome studies in correctional services indicate that treatments do reduce recidivism (McGuire, 2001, 2002). Finer-grained meta-analyses of treatment outcome studies have enabled the identification of principles of effective practice (Andrews, 2001). These principles are that treatment should (a) be targeted at high-risk offenders, (b) focus upon major empirically identified risk factors for criminal recidivism and (c) be delivered in ways that are responsive to offenders' learning styles and abilities. Effective treatments focus on changing antisocial cognitions and adverse cognitive-emotional states (e.g. resentment), building self-management, self-regulation and problem-solving skills, decreasing associations with antisocial others and increase anti-criminal networks and reducing substance use.

The fact that treatments work for prison and probation populations raises a number of issues for offenders with personality problems or personality disorders. If treatments that address thinking skills, values, emotion management, self-regulation and substance use work with prisoners and offenders on probation, amongst which groups there is a high proportion of personality disordered offenders, can we extrapolate from this that effective treatments for personality disordered offenders have been developed, albeit incidentally? Or, do personality disordered offenders require additional treatment components that add value to mainstream interventions? If personality disordered offenders can be effectively treated in criminal justice settings, why not treat them in prisons and probation services, rather than in mental health settings, since the cost to the public purse would be much less? There are no simple and straightforward answers to these questions.

CONCLUSION

The purpose of this chapter was to set the scene for the chapters that follow. Some basic definitions have been provided for the topics of the book, namely personality, personality disorder and violence. Apart from these simple clarifications, more questions have been raised than answered with regard to which aspects of personality are relevant to violence, how personality and personality disorder relate to violence and the implications of their relationship for clinical practice. With the spirit of enquiry raised, the subsequent chapters are the rocks that will pave the path to enlightenment.

NOTE

1. Cohen's d is an effect size statistic calculated by subtracting the post-treatment mean from the pre-treatment mean and dividing by the pooled standard deviations. An effect size of 0.20 is considered small, 0.50 medium, and 0.80 large.

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