

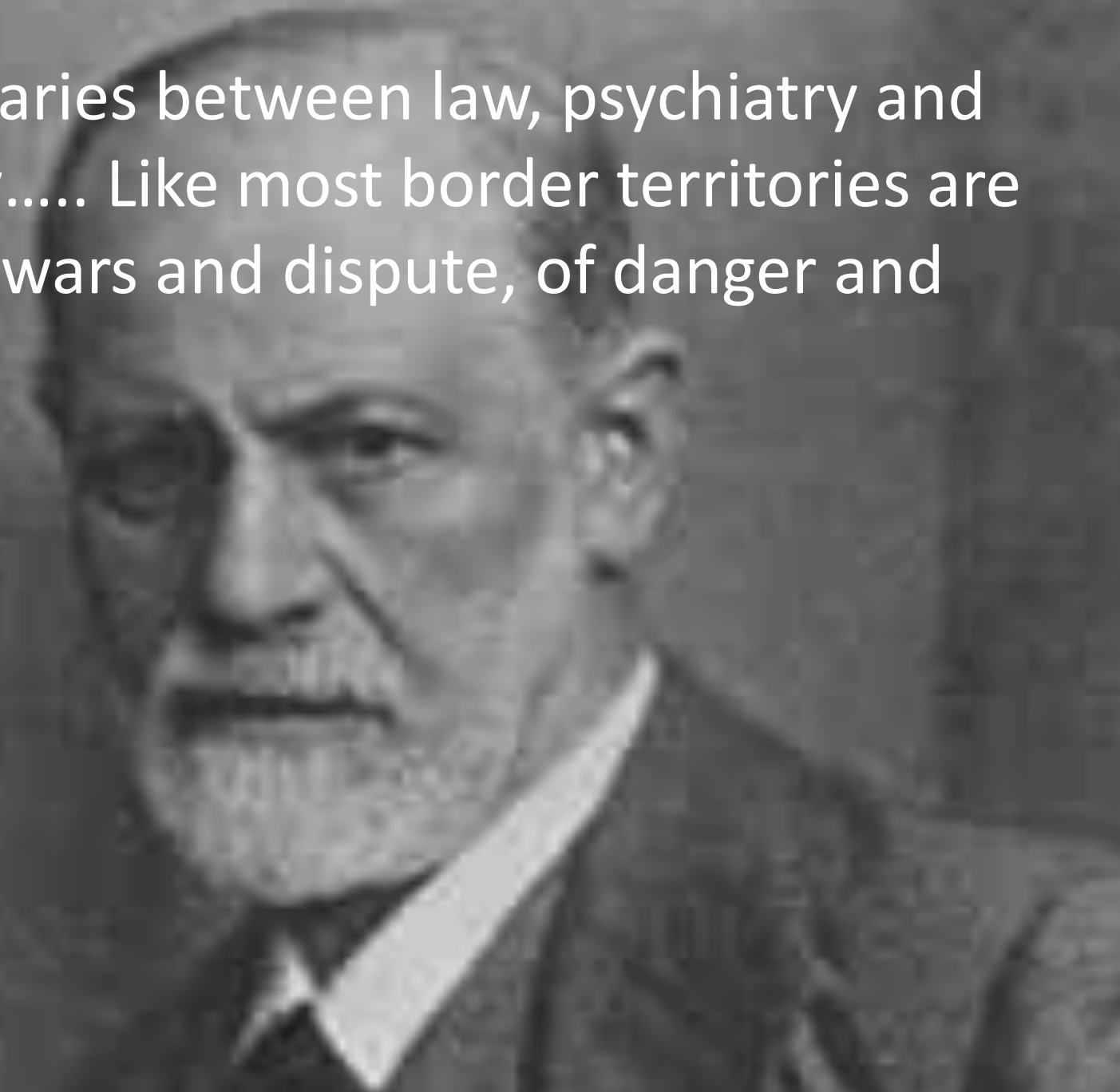
# Personality Disorder and Offending

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The boundaries between law, psychiatry and philosophy..... Like most border territories are matters of wars and dispute, of danger and confusion

Bavidge



- ‘It has been said that each generation of mental health professionals has to discover for itself the importance of personality disorder....Although personality disorder often seems elusive and to defy systematisation, the diagnosis seems to be clinically indispensable’.

- Livesley (2001)

# Cluster B dramatic/emotional/erratic (high novelty seeking

- Very common in forensic population
- Antisocial/ Dissocial: Disregard for and violation of the rights of others
- Histrionic: Attention seeking and excessive emotionality
- Narcissistic: Grandiosity, need for admiration, lack of empathy
- Borderline/Emotionally Unstable Personality Disorder: Unstable relationships, self image, emotions, and impulsivity

# Characteristics of the patients

- Range of personality disorder: antisocial, borderline, narcissistic, paranoid, schizoid, obsessional.....
- Range of other problems: institutionalisation, eating disorder, atypical Aspergers, physical problems, somatisation, mood disorders .....
- Age: 19-50
- Adult sex offenders, but not child

- IQ cut off at 80
- Prison transfers
- Hospital Orders
- Transfer has to be voluntary
- Disclosure expected
- Cost: £200,000 pa

# Model

- Adapted TC
- Derives from Northfield Experiment WW2
- Cassel, Henderson, Grendon Underwood
- Patient participation
- Based on: reality confrontation, communalism, permissiveness and democratisation

# Program

- 3 community meetings at 1.5 hours/week
- 2 small groups and orientation to therapy
- Adapted ward round
- Patient input ie CPA, ward round and peer reports
- Self Change Programme, substance misuse, CBT,
- Art and other psychotherapies
- OT-meaningful occupation



# Aspects of treatment

- Psycho education
- Personal scientist
- Meaningful involvement in treatment
- Development of formulation (narrative)
- Meaningful occupation
- Attendance to boundaries
- Address criminogenic needs

# Findings and Tips

- Empathy and insight not linked to decreased risk
- Externalisation of blame associated with increased risk
- Motivation vital
- Level of resistance

# Findings and Tips 2

- Rule breakers so provide fewer not more rules
- Anticipate rather than react
- Do not placate
- Be straightforward
- Expect reaction to 'authority' even if working in their best interests ie irrational
- Choose battles

- Personality Disorder associated with increased risk in offenders of all kinds
- Dynamics reflected in the institution
- Can be destructive of treatment
- Resistant to Treatment
- 'Staggering capacity to remain the same'

# Cleo's Rule of Institutions

- The dynamics of the patient group will ALWAYS be reflected in the staff group and institution to a lesser or greater extent

## Antisocial PD/Psychopathy

Increased aggression and violence

Impulsivity

Lack of empathy and tolerance

Sense of entitlement

Cynicism

Acute sense of justice/injustice

Broken relationships

Other PCLR factors

Psychodynamic or psychoanalytic view

Destructiveness

Corruption

Perversion-sadism and masochism but also  
perversion of the truth and unwillingness to face  
reality

Delinquency

Tyrannical superego

Corruption

# Response (countertransference) problems:-

Cruelty in the name of confrontation

Hatred

Pathological excitement

Distancing



b) Inability to confront/seduction

Collusion

Corruption of staff

Destructive relationships

Hopelessness

## Misconceptions in treatment

Preoccupation with history (especially abuse) so treatment is far back and far away

‘Remains as they exist today’

Ignorance of multiple aetiology e.g. genetic (innate –v- reactive)

# The Criminal Act

- Legal definitions
- Voluntary, intentional, reckless
- Responsibility

# Criminal Act 2

- Psycho-analytic viewpoint:
- Consequence of a state of mind
- Cs and ucs processes
- What is the meaning of the act?
- Affective as well as cognitive understanding
- (Cordess and Cox)

# Implications in General

- Concretisation of fantasy into action
- Concretisation of responses; society via legal system; attitudes of people in society including mental health, social services and therapists
- Collaboration essential which can be more difficult than being with the patient

# Implications for Technique

- Safety for patient and therapist
- Containment v holding
- Setting
- Inpatient and outpatient
- Advantages and disadvantages

# Dangers

- Over and under-involvement
- Identification with patient v institutions real and societal
- Hope versus despair
- Acting out of countertransference- hate, revulsion, erotic
- Lack of proper supervision
- Location of responsibility

# My views re Aims

- Helping patient to be able to form their own narrative, not ours
- Avoidance of 'being the detective' and tolerating the unknown
- Expand freedom to think allowing for patients to make decisions we may not think wise
- Avoid omnipotence