PERSONALITY, PERSONALITY DISORDER AND VIOLENCE

Edited by

Mary McMurran
University of Nottingham, UK

and

Richard C. Howard
University of Nottingham and Rampton Hospital, UK
PERSONALITY, PERSONALITY DISORDER AND VIOLENCE
WILEY SERIES IN
FORENSIC CLINICAL PSYCHOLOGY

Edited by

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and

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SERIES EDITORS’ PREFACE

ABOUT THE SERIES

At the time of writing, it is clear that we live in a time, certainly in the United Kingdom and other parts of Europe, if perhaps less so in areas of the world, when there is renewed enthusiasm for constructive approaches to working with offenders to prevent crime. What do we mean by this statement and what basis do we have for making it?

First, by ‘constructive approaches to working with offenders’, we mean bringing the use of effective methods and techniques of behaviour change into work with offenders. Indeed, this view might pass as a definition of forensic clinical psychology. Thus, our focus is the application of theory and research in order to develop practice aimed at bringing about a change in the offender’s functioning. The word constructive is important and can be set against approaches to behaviour change that seek to operate by destructive means. Such destructive approaches are typically based on the principles of deterrence and punishment, seeking to suppress the offender’s actions through fear and intimidation. A constructive approach, on the other hand, seeks to bring about changes in an offender’s functioning that will produce, say, enhanced possibilities of employment, greater levels of self-control, better family functioning or increased awareness of the pain of victims.

A constructive approach faces the criticism of being a ‘soft’ response to the damage caused by offenders, neither inflicting pain and punishment nor delivering retribution. This point raises a serious question for those involved in working with offenders. Should advocates of constructive approaches oppose retribution as a goal of the criminal justice system as a process that is incompatible with treatment and rehabilitation? Alternatively, should constructive work with offenders take place within a system given to retribution? We believe that this issue merits serious informed debate.

However, to return to our starting point, history shows that criminal justice systems are littered with many attempts at constructive work with offenders, not all of which have been successful. In raising the spectre of success, the second part of our opening sentence now merits attention, that is, ‘constructive approaches to working with offenders to prevent crime’. In order to achieve the goal of preventing crime, interventions must focus on the right targets for behaviour change. In addressing this crucial point, Andrews and Bonta (1994) have formulated the need principle:
“Many offenders, especially high-risk offenders, have a variety of needs. They need places to live and work and/or they need to stop taking drugs. Some have poor self-esteem, chronic headaches or cavities in their teeth. These are all ‘needs’.

The need principle draws our attention to the distinction between criminogenic and noncriminogenic needs. Criminogenic needs are a subset of an offender’s risk level. They are dynamic attributes of an offender that, when changed, are associated with changes in the probability of recidivism. Non-criminogenic needs are also dynamic and changeable, but these changes are not necessarily associated with the probability of recidivism” (p. 176).

Thus, successful work with offenders can be judged in terms of bringing about change in noncriminogenic need or in terms of bringing about change in criminogenic need. While the former is important and, indeed, may on occasion be a necessary precursor to offence-focused work, it is changing criminogenic need that, we argue, should be the touchstone in working with offenders.

While, as noted above, the history of work with offenders is not replete with success, the research base developed since the early 1990s, particularly the meta-analyses (e.g. Lösel, 1995), now strongly supports the position that effective work with offenders to prevent further offending is possible. The parameters of such evidence-based practice have become well established and widely disseminated under the banner of “What Works” (McGuire, 1995, 2002).

It is important to state that we are not advocating that there is only one approach to preventing crime. Clearly, there are many approaches, with different theoretical underpinnings, that can be applied to the task. Nonetheless, a tangible momentum has grown in the wake of the “What Works” movement as academics, practitioners and policy makers seek to capitalise on the possibilities that this research raises for preventing crime. The task that many service agencies grapple with lies in turning the research evidence into effective practice.

Our aim in developing this Series in Forensic Clinical Psychology is to produce texts that review research and draw on clinical expertise to advance effective work with offenders. We are both committed to the ideal of evidence-based practice and we encourage contributors to the Series to follow this approach. Thus, the books published in the Series will not be practice manuals or “cook books”: they will offer readers authoritative and critical information through which forensic clinical practice can develop. We both continue to be enthusiastic about the contribution to effective practice that this Series can make and look forward to continuing to develop it yet further in the years to come.

ABOUT THIS BOOK

Crimes and the people who commit them come in many guises: crimes range from the relatively trivial to the highly serious; criminals from the naïve to the professional. Crimes of violence are clearly at the serious end of the offence spectrum: violent crimes may injure victims, both physically and psychologically, and they can spread fear through communities, particularly among those individuals who perceive themselves as vulnerable. Similarly, the people who commit violent acts range from those individuals who perpetrate acts of ‘low-level aggression’
(Goldstein, 2002) to serious offenders at the extremes of premeditated violence. One particular group of people who commit crimes, including violent crimes, are those people with mental disorders (Hodgins and Müller-Isberner, 2000). The broad category of ‘mentally disordered offender’ includes people with a personality disorder, a group that has caused some recent concern, exemplified by the advent of the notion of ‘Dangerous and Severe Personality Disorder (DSPD)’.

It is abundantly clear that the inter-relationship of personality disorder and antisocial and criminal behaviour stretches our thinking at conceptual, theoretical, legal and clinical levels. In this timely text, Mary McMurran and Richard Howard have drawn together an impressive list of contributors to address these complex issues. The resulting text is a welcome addition to the Series which will be of undoubted interest to those engaged in forensic clinical psychology.

Clive Hollin
Mary McMurran

REFERENCES

PREFACE

Serious violent behaviour is a matter of grave concern for most members of society. In some cases, the causes of the eruption of violence seem self-evident, for instance, where a mentally ill person in a distressed and deluded state harms someone that is perceived to be a threat. In other cases, the violence may be the consequence of an emotional charge so great that we suspect that we might act in the same way ourselves should we find ourselves in similar circumstances. There are cases, however, where we do not fully understand violence or do not understand it at all. We may understand the effects of influences that impair judgement and disinhibit behaviour, such as drink or drugs, but nonetheless we may wonder what kind of personality it is that is violent under the influence of intoxicating substances. In cases where people appear to be wantonly or uncontrollably violent and there is no obvious, satisfactory explanation, we respond with complete incomprehension.

Personality disorder is often invoked to account for apparently wanton or uncontrollable violence. When this happens, care must be taken to avoid circular reasoning: Q. What is the cause of this person’s violence? A. Personality disorder. Q. How do you know this person has a personality disorder? A. Because this person is violent. Circularity is not uncommon when using diagnostic criteria, where adverse behaviours are listed along with traits in the descriptions of disorders. However, when we start to scratch the surface of some of these personality disorders, we begin to see how temperament and basic dispositions can affect an individual’s development across the lifespan. In particular, we can see how personality can influence the development of thinking, learning, emotion control and interactions with other people. In some cases, this developmental trajectory, which is a reciprocal interaction between an individual’s basic dispositions and influences of the social environment over time, will produce an individual with a propensity for violence.

The purpose of this book is to elucidate the personality factors that are implicated in the development of violent behaviour and the mechanisms whereby these increase the likelihood of violence. To this end, a number of internationally renowned researchers and clinicians present their latest theories and research in a number of domains: Traits, including impulsivity, the Big 5, and psychopathic traits; Disorders, including anti-social personality disorder and narcissism; Affect, including affective dyscontrol, the processing of emotional expression, anger, attachment difficulties and empathy deficits; and Cognition, including attention, problem solving and criminal thinking styles. The chapters that follow provide cogent descriptions
of each of these specific topics, highlighting the relevance of research to clinical practice.

Services for treating people with personality disorders generally and specifically offenders with personality disorders have developed exponentially in the United Kingdom over the past decade. This surge was prompted first by the joint Department of Health and Home Office development of services for dangerous offenders with severe personality disorders (Department of Health/Home Office 1999, 2000). Subsequently, the National Institute of Mental Health for England (NIMHE; 2003) issued a directive, *Personality Disorder: No Longer a Diagnosis of Exclusion*. In this general mental health service personnel were instructed not to exclude people with personality disorders from treatment but rather to develop services for this particular group. These services should base their work on current evidence of what is known about personality disorder and its treatment. There is a burning need, therefore, to disseminate up-to-date information.

This book plays a part in the dissemination of information, with particular reference to personality disorder and violence. We hope that this will stimulate thought, influence research and practice, and ultimately improve services. It is our ambition that, by influencing researchers and practitioners, this book will contribute in a modest way to reducing aggression and violence. We offer our thanks to all of the eminent contributors to this book, and we look forward to keeping up with their thinking as their research programmes progress.

Mary McMurran
Richard C Howard

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INTRODUCTION
Chapter 1

PERSONALITY, PERSONALITY DISORDER AND VIOLENCE: AN INTRODUCTION

MARY MCMURRAN
University of Nottingham, UK

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. sadomasochism) 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
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.
6 PERSONALITY, PERSONALITY DISORDER AND VIOLENCE

Table 1.1 DSM-IV and ICD-10 personality disorders

<table>
<thead>
<tr>
<th>Cluster A</th>
<th>DSM-IV</th>
<th>ICD-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paranoid – distrust; suspiciousness</td>
<td>Paranoid – sensitivity; suspiciousness</td>
<td>Schizoid – emotionally cold and detached</td>
</tr>
<tr>
<td>Schizoid – socially and emotionally detached</td>
<td>Schizoid – emotionally cold and detached</td>
<td>Schizoid – emotionally cold and detached</td>
</tr>
<tr>
<td>Schizotypal – social and interpersonal deficits; cognitive or perceptual distortions</td>
<td>No equivalent</td>
<td></td>
</tr>
</tbody>
</table>

Cluster B

<table>
<thead>
<tr>
<th>Antisocial – violation of the rights of others</th>
<th>Dissocial – callous disregard of others; irresponsibility; irritability</th>
<th>Emotionally unstable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borderline – instability of relationships, self-image, and mood</td>
<td>(a) Borderline – unclear self-image; intense, unstable relationships (b) Impulsive – inability to control anger; quarrelsome; unpredictable</td>
<td>Histrionic – dramatic; egocentric; manipulative seeking</td>
</tr>
</tbody>
</table>

Histrionic – excessive emotionality and attention seeking

Narcissistic – grandiose; lack of empathy; need for admiration

Cluster C

<table>
<thead>
<tr>
<th>Avoidant – socially inhibited; feelings of inadequacy; hypersensitivity</th>
<th>Anxious – tense; self-conscious; hypersensitive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent – clinging; submissive</td>
<td>Dependent – subordinates personal needs; needs constant reassurance</td>
</tr>
<tr>
<td>Obsessive-compulsive – perfectionist; inflexible</td>
<td>Anankastic – indecisive; pedantic; rigid</td>
</tr>
</tbody>
</table>

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
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.
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.