

**PERSONALITY DISORDER IN PERPETRATORS OF  
HOMICIDE**

A thesis submitted to the University of Manchester for the degree of

Doctor of Philosophy

in the Faculty of Medical and Human Sciences

**2013**

**DR NICOLA SWINSON**

**SCHOOL OF MEDICINE**

**Faculty of Medical and Human Sciences**

# **Contents**

List of tables.....	7
List of Figures .....	8
Abstract.....	9
Declaration.....	10
Copyright Statement.....	11
Acknowledgements .....	12
Dedication.....	13
The Author .....	14
Overview.....	15
Chapter 1 - Introduction.....	17
1.1 Search strategy.....	17
1.2 Personality .....	18
1.21 The conceptualisation of personality .....	18
1.22 Stability and continuity of personality .....	19
1.23 Personality and Violence .....	22
1.3 Personality Disorder .....	24
1.31 Current Classification of Personality Disorder.....	24
1.32 Classification of Antisocial Personality Disorder .....	28
1.4 Development of Antisocial Personality Disorder .....	32
1.41 Pathways to antisocial behaviour .....	32
1.42 Risk and Protective Factors.....	37

1.5 Personality Disorder and Violence .....	50
1.51 Antisocial Personality Disorder and Violence.....	50
1.52 Other personality disorders and violence .....	53
1.53 Personality Disorder Clusters .....	57
1.54 Psychopathy and Violence .....	58
1.6 Personality Disorder and Homicide .....	61
1.7 Medicolegal aspects .....	67
1.8 Summary of literature review.....	74
Chapter 2 - Background to the current study, Aims and Research Questions .....	76
2.1 Background to the current study.....	76
2.2 Aims.....	78
2.3 Research Questions .....	79
2.4 Ethical Considerations.....	79
Chapter 3 – Methodology .....	80
3.1 Quantitative and qualitative methodologies.....	80
3.2 Mixed Methods .....	82
3.3 Approaches to Mixed Methods Research .....	85
3.4 Rigour within the research process .....	87
Chapter 4 - Quantitative study.....	89
4.1 Quantitative Methods.....	89
4.11 National Confidential Inquiry data collection .....	89
4.12 Measures.....	90

4.13 Sample.....	92
4.14 Data analysis .....	96
4.2 Quantitative Results .....	99
4.21 Prevalence of personality disorder in a national case series of perpetrators of homicide .....	99
4.22 Correlations between domains & dimensions of personality disorder and circumstances of the offence.....	104
4.23 Sociodemographic, Clinical and Criminological factors associated with a diagnosis of personality disorder in reports.....	112
4.24 Trends analysis .....	117
Chapter 5 - Focus Groups.....	118
5.1 Rationale for Focus Groups.....	118
5.2 Focus Group Methods .....	120
5.21 Focus group sample size and composition .....	120
5.22 Focus group recruitment.....	121
5.23 Focus group instrumentation.....	122
5.24 Data collection .....	122
5.25 Data analysis .....	122
5.3 Focus Groups Results .....	125
5.31 Themes.....	125
Chapter 6 - Semi-Structured Interviews .....	135
6.1 Introduction.....	135
6.2 Rationale for Semi-Structured Interviews.....	136

6.3 Semi-Structured Interview Methods .....	138
6.31 Semi-structured interview sample size and composition .....	138
6.32 Semi-structured interview recruitment.....	139
6.33 Semi-structured interview instrumentation .....	139
6.34 Data collection .....	139
6.35 Data analysis .....	141
6.36 Methodological rigour within the qualitative studies .....	143
6.4 Semi-Structured Interview Results .....	149
6.41 Classification of personality disorder .....	149
6.42 Diagnostic process .....	155
6.43 Court process .....	164
6.44 Impact of amendments to the Mental Health Act (1983).....	168
6.45 Recommendations in reports.....	170
6.46 Treatment .....	181
6.47 Training and Experience.....	190
6.48 Stigma.....	194
Chapter 7 - Discussion .....	199
7.1 Methodological Issues and limitations.....	199
7.2 Quantitative results .....	207
7.21 The prevalence of personality disorder .....	207
7.22 Correlations between domains and dimensions of personality disorder and circumstances of the offence.....	209

7.23 Factors associated with a diagnosis of personality disorder in reports .....	211
7.3 Qualitative themes .....	214
7.31 Classification.....	214
7.32 Diagnostic Process.....	217
7.33 Court Process .....	219
7.34 Mental Health Act (1983) amendments.....	221
7.35 Recommendations within reports .....	222
7.36 Treatment .....	225
7.37 Training.....	230
7.38 Stigma.....	231
7.4 Implications and Future Developments .....	233
Bibliography .....	241
Appendices .....	263
Appendix 1: PAS DOC .....	263
Appendix 2: PAS DOC Algorithm .....	307
Appendix 3: Focus group prompts.....	309
Appendix 4: Semi- structured interview schedule .....	311
Appendix 5: Focus Group Participant Information Sheet .....	313
Appendix 6: Semi-structured Interview Participant Information Sheet.....	316
Appendix 7: Consent form .....	319

Final word count: 70,512 words

## **List of tables**

Table 1 : Interrater reliability ratings for PAS-DOC variables .....	100
Table 2: Prevalence of personality disorder and personality disturbance.....	102
Table 3: Frequencies of individual personality domains .....	104
Table 4 Frequencies of severe and complex personality disorder.....	106
Table 5 Univariate analysis for severe personality disorder: sociodemographic and historical variables .....	107
Table 6 Univariate analysis for severe personality disorder: offence related variables .....	108
Table 7 Variables independently associated with severe personality disorder from multivariate analysis .....	109
Table 8 Univariate analysis for complex personality disorder: sociodemographic and historical variables .....	110
Table 9 Univariate analysis for complex personality disorder: offence related variables...	111
Table 10 Sociodemographic and Clinical factors associated with a diagnosis of personality disorder in reports.....	113
Table 11 Criminological factors associated with a diagnosis of personality disorder in reports.....	114
Table 12: Offence related (victim) factors associated with a diagnosis of personality disorder in reports.....	115
Table 13 Offence related (method) factors associated with a diagnosis of personality disorder in reports.....	116
Table 14 Focus group participants: demographic information and experience .....	121
Table 15: Focus groups themes by participants and references .....	124
Table 16: Semi- structured interview participants: demographic information and experience .....	138
Table 17: Semi-structured interview themes by participants and references .....	142
Table 18: Measure of quality in this study .....	145

## ***List of Figures***

Figure 1: DSM IV classification of Antisocial Personality Disorder (American Psychiatric Association 1994) .....	29
Figure 2: ICD10 Classification of Dissocial Personality Disorder (World Health Organisation 1992).....	30
Figure 3: Concurrently conducted mixed methods studies .....	86
Figure 4: Sequentially conducted mixed methods studies .....	86
Figure 5 Degree of overlap between personality domains* .....	105
Figure 6: Reports with diagnosis of personality disorder, year on year .....	117
Figure 7: Focus groups themes.....	126



## **Abstract**

### **Background**

The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has been collecting detailed clinical data since 1996 on a national sample of people who commit homicide, including psychiatric reports prepared for court. From 1996-2006, the Inquiry was notified of 5808 homicides in England and Wales. A diagnosis of personality disorder was made in 16% (406) of cases in psychiatric reports prepared for court. Given prevalence figures of 50-90% for personality disorder in the offender population in general, it seems likely that this is an underestimation in this population.

### **Aims**

Estimate the prevalence of personality disorder in a national case series of homicide perpetrators with court reports. Investigate any variables associated with the diagnosis of personality disorder in court reports, and with specific dimensions of personality disorder. Explore potential reasons for the lack of attribution of a personality disorder diagnosis in reports.

### **Method**

600 court reports were analysed using the PAS-DOC, a document derived version of the Personality Assessment Schedule. Those with a diagnosis of personality disorder in reports were compared with those without on a number of sociodemographic, clinical, and criminological variables. Focus groups and semi structured interviews were conducted with Forensic Psychiatrists with a range of experience to explore attitudes towards personality disorder.

### **Results**

The prevalence of personality disorder in this sample was 56.3% (95% CI 52.3% - 60.3%). Perpetrators with previous violent offences and substance misuse were more likely to be diagnosed with personality disorder by report writers. Severe personality disorder was significantly associated with prior convictions for any violent offences and with a stranger as a victim. Complex personality disorder was associated with a family or spouse as a victim, and negatively associated with a stranger as a victim. A number of themes emerged in the focus groups and semi-structured interviews to explain the discrepancy between the identified prevalence of personality disorder and its diagnosis made by report writers. These included issues surrounding classification, comorbid mental illness, ethical issues regarding court, recommendations for verdict and disposal, treatability, service provision, training and stigma.

### **Conclusions**

Personality disorder is underdiagnosed in psychiatric reports prepared for court. Reasons for this and the implications from both a clinical and ethical perspective are discussed.

## ***Declaration***

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

## ***Copyright Statement***

i. The author of this thesis (including any appendices and schedules to this thesis) owns certain copyright or related rights in it (the “Copyright”) and she has given The University of Manchester certain rights to use such Copyright, including for administrative purposes.

ii. Copies of this thesis, either in full or in extracts and whether in hard or electronic copy, may be made **only** in accordance with the Copyright, Designs and Patents Act 1988 (as amended) and regulations issued under it or, where appropriate, in accordance with licensing agreements which the University has from time to time. This page must form part of any such copies made.

iii. The ownership of certain Copyright, patents, designs, trade marks and other intellectual property (the “Intellectual Property”) and any reproductions of copyright works in the thesis, for example graphs and tables (“Reproductions”), which may be described in this thesis, may not be owned by the author and may be owned by third parties. Such Intellectual Property and Reproductions cannot and must not be made available for use without the prior written permission of the owner(s) of the relevant Intellectual Property and/or Reproductions.

iv. Further information on the conditions under which disclosure, publication and commercialisation of this thesis, the Copyright and any Intellectual Property and/or Reproductions described in it may take place is available in the University IP Policy (see <http://www.campus.manchester.ac.uk/medialibrary/policies/intellectual-property.pdf>), in any relevant Thesis restriction declarations deposited in the University Library, The University Library’s regulations (see <http://www.manchester.ac.uk/library/aboutus/regulations>) and in The University’s policy on presentation of Theses

## ***Acknowledgements***

I would like to thank a number of people, without whose help and support this thesis would not have been possible. In particular I am indebted to my supervisor, Professor Jenny Shaw, for her advice, support and encouragement on both an academic and personal level, occasionally until the early hours of the morning. I would also like to thank my co-supervisor, Dr Dawn Edge, for advice and guidance on the qualitative aspect of the thesis, and my external supervisor, Professor Peter Tyrer, for advice on both the quantitative aspect and on current thinking on personality disorder more broadly. I also greatly appreciate the contribution made by Dr Roger Webb, my advisor, in both giving advice on the statistical analysis and on other aspects of completing the thesis.

I would like to express my sincere gratitude to all of the forensic psychiatrists who very kindly gave up their time to participate in the focus groups and semi-structured interviews and responded with honesty and enthusiasm to my questions; their contribution to this thesis has been invaluable. I am very grateful for the help and patience of Caroline Clements and Ginette Ward in transcribing the interviews, especially for doing this so quickly when time was of the essence. My thanks are also due to Dr Wendy MacDonald for initial advice and guidance on conducting the focus groups.

Thank you to the staff at the National Confidential Inquiry for support and encouragement throughout the thesis, and in particular to Dr David While for advice on statistical issues. I would also like to acknowledge the help of researchers at Imperial College London for agreeing to carry out the reliability ratings on the court reports for the quantitative study, and Dr Douglas Steinke for guidance on STATA analysis.

Finally, I would like to thank my parents, Peter and Annette, and sister Jo for their tireless support and encouragement throughout. I would also like to thank my parents for much babysitting and proofreading.

## ***Dedication***

To Stewart, with love, for everything,

and to Charlotte, for making me realise what really matters.

## ***The Author***

Dr Nicola Swinson is a Consultant Forensic Psychiatrist at The State Hospital, Lanark, Scotland. She qualified from the University of Glasgow in 1999 with an MBChB and from University College London in 1997 with a BSc (Hons). She trained at the Maudsley Hospital, London until becoming a member of the Royal College of Psychiatrists in 2003. She then completed her training in Forensic Psychiatry in the North West of England. She was the Clinical Research Fellow at the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, University of Manchester from 2003 until moving to Scotland in 2012. Her other research interests include homicide, suicide prevention and other aspects of forensic psychiatry.

## **Overview**

This thesis is about personality disorders in the perpetrators of homicide. It focuses on the diagnosis of personality disorder within psychiatric reports prepared for court and reasons for the apparent discrepancy between the likely prevalence in this population, and that given within the court reports.

In order to look at this discrepancy, the introduction will provide a context for the remainder of the thesis by initially outlining current literature on personality, the temporal stability of personality, and the associations between personality and violence. The perennial problem of the classification of personality disorder, including significant limitations with the current categorical system, the lack of a gold standard for assessment and criterion contamination will then be reviewed followed by a more detailed discussion of issues pertaining to the diagnosis of antisocial personality disorder. Given controversy surrounding the construct of antisocial personality disorder, evidence linking childhood personality traits with later antisocial personality disorder will then be described, providing evidence of the longitudinal stability of such traits along with a review of childhood risk factors. Evidence of the association of personality disorder with violence in general and then, more specifically, with homicide will then be detailed. Finally, issues which may influence the diagnosis of personality disorder by clinicians will be discussed. Reasons for giving a diagnosis are inextricably linked to attitudes regarding the diagnosis, and the potential impact, both positive and negative, of giving this diagnosis within a court report. This section will therefore summarise relevant medicolegal issues, including the pejorative nature of the diagnosis and the impact of this in health and custodial settings, along with the therapeutic nihilism engendered by the commonly held view that it is untreatable.

This is a mixed methods study with quantitative and qualitative components. The quantitative study will involve the retrospective assessment of personality disorder using a standardised tool in a random sample of court reports to obtain a precise and valid estimate of the prevalence of personality disorder in this population. Further analysis will be carried out to

establish any correlations between dimensions of personality disorder and offence related variables. Finally, those with and without a diagnosis in reports will be compared on a range of sociodemographic, clinical and criminological variables to ascertain if any individual level factors relating to the perpetrator influence whether a diagnosis is given or not. The qualitative study will consist of focus groups followed by semi-structured interviews; both involving clinicians. The purpose of these is to explore wider attitudes and beliefs about personality disorder held by clinicians which may help to explain the apparent discrepancy in diagnosis. Key findings and associated clinical implications will be examined in the discussion.



## ***Chapter 1 - Introduction***

This chapter begins with a review of the literature on personality in general; the association of particular traits with violence and their temporal stability. There is then an overview of the current classification of personality disorder and current debates on how this could be improved, followed by a discussion of the classification of antisocial personality disorder in particular. Given controversy over the diagnosis of antisocial personality, and its construct as a psychiatric diagnosis, stability of relevant traits which are evident in childhood and adolescence are explored along with risk factors for developing antisocial personality disorder. Evidence of the correlation of personality disorder with violence, including the association of subtypes and clusters of personality disorder, and of psychopathy, with violence is then discussed. Studies on personality disorder and homicide are then reviewed with a discussion of methodological limitations. The remainder of the introduction covers medicolegal issues which may impact on the diagnosis of personality disorder, both within health services and the criminal justice system.

### ***1.1 Search strategy***

The available literature on personality disorder and violence, on personality disorder and homicide, child and adolescent risk factors, developmental pathways to antisocial personality disorder, classification of personality disorder and medicolegal aspects of the diagnosis was reviewed. Computerised Medline, Embase and PsychINFO searches were performed from 1966 to January 2013 using the terms PERSONALITY DISORDER, VIOLENCE, VIOLENT, HOMICIDE, ANTISOCIAL PERSONALITY DISORDER, PSYCHOPATHY, PSYCHOPATH, PSYCHOPATHIC, CONDUCT DISORDER, RISK, CHILDHOOD, PREDICTORS, AETIOLOGY, AETIOLOGICAL, ETIOLOGY, ETIOLOGICAL, DIAGNOSIS, CLASSIFICATION, STIGMA, STIGMATISE, STIGMATISING, and TREATABILITY. In addition, a series of official reports and book chapter reviews were cross referenced, as were key articles. This was a selective review of the major findings on personality, associations of personality traits with violence, the classification of personality disorder, the development of antisocial personality disorder,

associations of personality disorder with violence and homicide, and medicolegal issues surrounding the diagnosis of personality disorder.

## **1.2 Personality**

### **1.21 The conceptualisation of personality**

The Oxford English Dictionary describes personality as the combination of characteristics or qualities that form an individual's distinctive character: There are two main features of personality; temperament and character. Temperament refers to an innate predisposition to react and behave in a certain way, whereas character represents the aggregation of features and traits acquired through learning and experience which shape behaviour (Lopez-Ibor Jnr 2009).

There are four main structural models of personality. Eysenck's 'Gigantic three' comprising Psychoticism (P), Extroversion (E) and Neuroticism (N) (Eysenck 1985), is scientifically driven and the dimension of 'P' has been linked with antisocial behaviour (Cale 2006). However, this has been criticised for the 'P' dimension being conceptually confusing with psychosis (Egan 2009) and for having poor internal reliability (Caruso 2001). Cloninger's seven factor model (Cloninger 1993)(Cloninger 1993)(Cloninger 1993) initially included four basic dimensions; novelty seeking, harm avoidance, reward dependence and persistence. A further three environmentally acquired dimensions of self-directedness, cooperation and self-transcendence were added later (Cloninger 1993). Derived from psychiatry this model has an apparently robust neurobiological basis, but lacks reliability and validity and fails to capture hostility adequately (Egan 2009). Tellegen (1982) devised a three factor model composed of positive emotionality, negative emotionality and constraint, based on dimensions of positive and negative valence. This has been shown to correlate with the Five Factor Model (Church 1994). The final, and predominant, theory of personality in current practice is the Five Factor Model which constitutes five domains: Neuroticism; Extraversion; Openness; Agreeableness; Conscientiousness (Costa

and Widiger 1994b). This has been shown to exhibit good longitudinal consistency (Roberts and DelVecchio 2000), has utility across different cultures (Schmitt 2007) and is predictive of antisocial behaviour, aggression and violence (Egan 2009). A detailed review of the assessment of personality is beyond the scope of this thesis.

### ***1.22 Stability and continuity of personality***

Psychodynamic theory states that personality structure is determined in childhood (Caspi and Roberts 2001). Freud believed that, by the time of resolution of the oedipal complex (sometimes around age 5 years), the basic personality structures (the id, ego and superego) had developed fully and that socialisation could lead only to minimal change. Erikson, however, broke with Freud, believing that personality development occurred throughout childhood and adolescence, and even into adulthood. The Block Longitudinal Project explored psychodynamic constructs from childhood into adulthood, from age 3 years to 23 years. Focussing on ego development, they found evidence for the 10 year stability of ego control, with a retest correlation of  $r = 0.67$  between 14 and 23 years. They also found moderate consistency for ego resiliency (Westenberg and Block 1993). This study used the Washington University Sentence Completion Test (SCT) of Ego Development for which, although good construct validity has been shown, there is inadequate evidence of identification of sequentiality by the test. It is also solely based on self-report, which may compromise results particularly amongst the adolescent group (Loevinger 1979). Moreover, correlations were only moderate, indicating that ongoing development occurs. By relating ego development to specific dimensions of personality and ensuring, as far as possible, homogeneity of categories, they avoid contamination of dimensions through the inclusion of heterogeneous personality variables as single entities. Moreover, assessment of personality using several observations by independent judges avoids difficulties in sole reliance on self-report measures. However, the use of the California Adult Q-Set at both ages 14 years and 23 years, instead of using the California Adolescent Q-Set (Lorr 1978) at 14 years, is surprising in light of the fact that they used a modified version of the SCT at age 14

years. The study is also limited by the lack of consideration of environmental consistency, which it has been suggested is strongly linked to personality consistency (Roberts and DelVecchio 2000).

There is general agreement that personality is increasingly stable with age, and that psychological, social and cultural factors have diminishing impact, but whether it actually stops changing completely has been questioned (Baltes 1997). Intellectual traits seem to be the most stable, followed by broad personality traits (Caspi and Roberts 2001). A review of longitudinal stability of personality traits showed that people were less likely to change with increasing age, but that change still occurs. , Moderate to large stability coefficients for each of the personality factors from Costa and McCrae's five factor model of personality were demonstrated. Mean population test-retest correlation coefficients showed that trait consistency was 0.31 in childhood; 0.54 during college years; 0.64 at age 30 years; 0.74 between 50-70 years (Roberts and DelVecchio 2000).

The Oxford English Dictionary defines violence as behaviour involving physical force intended to hurt, damage, or kill and aggression as hostile or violent behaviour or attitudes. Human aggression is viewed by Tedeschi as "coercive power", highlighting the interpersonal context of the behaviour (Tedeschi 1983). This can be distinguished from the emotional state of anger, which often, although not invariably, is associated with aggression. Furthermore, there is a necessary distinction between an act of aggression and the presence of an aggressive trait, or tendency to repeatedly engage in aggressive acts. In and of itself, however, an aggressive disposition is insufficient to predict aggression and clearly the commission of an act of violence is multifactorial, encompassing situational factors, interpretation of interpersonal exchanges and others' behaviour, in addition to any predisposition to act aggressively (Blackburn 1998).

Evidence suggests that aggression is stable, and that it predicts later antisocial traits (Olweus 1979; Huesmann, Eron et al. 1984; Black, Baumgard et al. 1995), although it is of note

that not all aggressive children go on to become aggressive in adulthood. Both the continuity of aggression and its expression in violent acts, are dependent on individual personal attributes and coping strategies available to the individual (Blackburn 1998). Within the Dunedin cohort, a longitudinal follow up of a cohort of 1037 children from age 3 to 21 years, both genders were equally likely to exhibit antisocial behaviour when compared with same sex peers across time and in diverse circumstances. Females, however, were less likely to sustain behaviour sufficiently extreme to retain a diagnosis of conduct disorder, therefore males showed increased continuity of disorder (Moffitt 2001).

Livesley suggests that personality crystallises in the late 20s, becoming clearer and more stable and changing little after (Livesley 2003). It has been suggested that around two thirds of variance in traits is stable throughout life (Costa and McCrae 1994a). Continuity of personality can be promoted through person-environment transactions (reactive, evocative and proactive), thus reinforcing the existing personality (Caspi and Roberts 2001). It also appears that continuity of personality is more likely during periods containing novel situations, which contradicts theoretical perspectives on behavioural development which propose that new situations offer opportunity for behaviour modification (Caspi and Moffitt 1993). Individual differences seem to be magnified during disruption of the existing equilibria and people behave in a manner which promotes self-conceptions, unless denied opportunity to resist change. Therefore, promotion of change requires elimination of the circumstances which maintain those processes of continuity (Caspi and Moffitt 1993).

There are methodological difficulties with current evidence. There is a high degree of variability in methods used and a lack of studies looking at adults over 30 years. Moreover, in examining continuity it is important to look at different expressions of the same trait at different ages, and consider in a normative sense whether, although different phenotypically, the trait is actually stable. The greater degree of plasticity of some traits may represent still developing cognitive structures.

### **1.23 Personality and Violence**

One of the first attempts to explore personality differences and their association with violence was the concept of dividing violent offenders into 'overcontrolled' and 'undercontrolled' types. Undercontrolled offenders were seen as those who have low levels of inhibition and therefore were more liable to respond aggressively with greater frequency. They were more likely to be classified as psychopathic. Overcontrolled offenders, on the other hand, had rigid inhibitions against aggression, thus violence ensued with very intense or prolonged provocation. It was proposed that this violence would occur rarely, but with much greater intensity (Megargee 1966). In a study of mentally disordered offenders in high secure care, Blackburn compared perpetrators of "extreme" violence, as defined by an index offence of murder, manslaughter or attempted murder, with those of "moderate" violence, defined by acts of assault. The extreme group were significantly more controlled, inhibited, defensive and less hostile (Blackburn 1968). Such results, however, were not replicated in other studies (Crawford 1977). This hypothesis has also been criticised on the validity of the general premise of 'overcontrolled' (as opposed to merely 'controlled') individuals, and that the difference between "extreme" violence, for instance homicide and "moderate" violence may be solely in the outcome of the interaction, rather than the process or motivation (McGurk and McGurk 1979; Brookman 2005). This would seem to represent an oversimplification of both the complex characteristics and processes underlining aggressive behaviour, and creates a rather arbitrary distinction between different types of violence. The outcome of a violent assault is dependent not only on factors relating to the perpetrator, but also on circumstances, such as location and distance from medical services, whether anyone intervened, levels of intoxication of both the victim and perpetrator and other victim factors such as age and frailty.

Further evidence demonstrated four distinct personality types in a cluster analysis of MMPI (Minnesota Multiphasic Personality Inventory) data in mentally disordered perpetrators of homicide and mentally disordered offenders in general, with further analysis using personality disorder scales of the MCMI (Millon Clinical Multi-Axial Inventory) (Blackburn and Renwick

1996). Primary psychopaths were described as hostile, aggressive, extraverted, impulsive and self-confident with low levels of anxiety. On the personality scale of the MCMI they were predominantly narcissistic, histrionic and antisocial. They were also found to have earlier onset of criminal behaviour and the most convictions for violent crime. They described themselves as more dominant interpersonally. This group has characteristics consistent with the description of the psychopath, originally proposed by Cleckley (Cleckley 1982).

Secondary psychopaths were hostile, aggressive, socially anxious, impulsive, withdrawn and moody with low self-esteem. On the MCMI they were antisocial, avoidant, schizoid, dependent and paranoid. Similarly they showed early onset of criminal career and self-reported as being interpersonally dominant but had more convictions for acquisitive offending. They expressed the highest levels of anger in response to threat (Blackburn and Lee-Evans 1985). This group differs from primary psychopaths in having extreme social anxiety and traits of schizoid and avoidant personality disorders.

The third group were termed the controlled group and were defensive, sociable, controlled and non-anxious. They scored highest on the compulsive scale of the MCMI but there were few with personality disorder.

Finally, the inhibited group were withdrawn, shy, moderately anxious, controlled and had low self-esteem. They were predominantly schizoid, avoidant and schizotypal but had low ratings for antisocial personality disorder. Both of the latter two groups had lower rates of convictions and had later onset criminal behaviour and are seen as corresponding with Megargee's 'overcontrolled' offenders (Megargee 1966), with the former two groups representing 'undercontrolled' offenders (Blackburn 1975). The lack of evidence for measures of control of anger and the confounding factor of comorbid mental illness, given that they were often carried out in in-patient settings, has led to criticism of this typology (D'Silva and Duggan 2010). In a comparison of 51 repeat and single violent offenders within medium and high secure

care in the UK, there was indeed less evidence of anger and antisocial behaviour in the single offence group, but this was thought to reflect the undercontrolled nature of the repeat offence group, rather than a distinctive overcontrolled personality style among those in the other group. The authors do suggest that this has implications for treatment of such individuals, in whom standard treatment approaches focussing on anger management and antisocial behaviour may be less relevant (D'Silva and Duggan 2010). It would appear that there is reasonable evidence that certain offenders have higher degrees of impulsivity and lower levels of inhibition, and also that within the group of psychopathic offenders, they can be differentiated on levels of trait anxiety (Hodgins 2007). However, the limitations outlined above, in particular the possible confounding influence of mental illness, renders further extrapolation from this typology difficult.

## ***1.3 Personality Disorder***

### ***1.31 Current Classification of Personality Disorder***

The two current international classification systems are the ICD-10 (World Health Organisation 1992) and the DSM-IV (American Psychiatric Association 1994). Despite attempts to bring ICD and DSM classification systems closer together, this has not yet been achieved, and it looks unlikely that it will be in the new revisions of both systems. Both take a categorical approach to the diagnosis of personality disorder, with ICD-10 delineating eight personality disorder types and DSM-IV eleven. There are two aspects to diagnosis; initial generic criteria common to all personality disorders followed by specific criteria to identify particular personality disorders (Sarkar and Duggan 2010). There are considerable criticisms of both systems, not least that at a fundamental level they are "atheoretical" (Sarkar and Duggan 2010) and have been construed by the consensus view of expert committees rather than representing an evidence based classification which reflects the aetiology of personality traits (Livesley 2011).

The current categorical systems of classification (ICD10 and DSM IV), although preferable to some within clinical settings given their adherence to a medical model and facilitating easy



communication between clinicians, have considerable problems. The absence of a gold standard to diagnose personality disorder (Loranger 1992; Coid 2003) renders assessment of validity highly problematic. Interrater reliability for the presence of personality disorder generally is reasonable (Zimmerman 1994), but is much poorer when individual categories are concerned, with kappa values shown to range from 0.25 to 0.9 (Tyrer, Coombs et al. 2007). There is a multitude of assessment instruments available for the clinical assessment of personality disorder but the agreement between these is exceptionally low (Clark 1997). DSM-IV defines personality disorder as “pervasive and inflexible” (American Psychiatric Association 1994). However, there is an increasing body of evidence suggesting that this is not the case, either in the short or long term (Shea 2002; Lenzenweger 2004).

Difficulties also arise from a tendency in research to view the diagnosis of personality disorder as a global category, which is seen to lack consideration of the wide heterogeneity of traits involved. For instance, it seems likely that a diagnosis of antisocial personality disorder confers a very different risk of violence, compared with avoidant personality disorder yet there is little consideration of violence in different diagnostic categories (Blackburn 1993b). Such difficulties are compounded further by both the potentially wide variation in characteristics exhibited by individuals within the same category of personality disorder, and also by the substantial overlap seen within the operational criteria for individual diagnoses (Tyrer, Coombs et al. 2007). The conventional manner of terming this comorbidity, suggesting a number of independent diagnoses, has been seen as misleading, and, it is suggested, should be termed “consanguinity” (Tyrer 1996).

Studies examining this indicate significant levels of co-occurrence between different personality disorders: narcissistic with antisocial and histrionic; avoidant with schizotypal and dependent; borderline with histrionic (Oldham, Skodol et al. 1992) paranoid with antisocial; schizoid with schizotypal; borderline with antisocial and dependent personality disorders (Coid 2003). Indeed, although delineating personality disorder by clusters (see 1.53 Personality

Disorder Clusters) has been seen as more fundamentally sound (Oldham, Skodol et al. 1992), there is still significant comorbidity between clusters A, B and C (Coid, Yang et al. 2006a). This has resulted in the diagnosis 'Personality Disorder – Not Otherwise Specified' being increasingly used in clinical practice and in research (Zimmerman 1994; Tyrer 2007). The high rates of comorbidity with axis 1 disorders, such as antisocial with substance misuse and borderline with depression (Sarkar and Duggan 2010), together with the view that certain personality disorders are on a spectrum with Axis 1 disorders, such as avoidant personality disorder and social phobia, schizotypal personality disorder with schizophrenia (which is classified with schizophrenia in ICD 10), has led to calls to relocate personality disorders back into Axis I (Livesley 2008; Kotov 2011). It is argued though, that a more comprehensive conceptualisation of personality, with consideration of personality as a diathesis with examination of its core components; function, traits and organization, may obviate the need to amalgamate it with other mental disorders in Axis 1. This would continue to facilitate the valuable contribution to clinical practice and management of mental illness which examining personality separately confers (Tyrer 2010).

Another potential solution to address these difficulties is a dimensional approach. One of the dominant theories of personality is the Five Factor Model which constitutes five domains: Neuroticism; Extraversion; Openness; Agreeableness; Conscientiousness (Costa and Widiger 1994b) and is a dimensional measure of personality. Although shown to predict antisocial behaviour, violence and aggression, it does not correlate with DSM-IV categories of personality disorder (Egan 2009). Given that personality and symptoms of personality disorder are continuously distributed, the arbitrary diagnostic threshold threatens validity of the construct (Sarkar and Duggan 2010). It would seem more empirically sound to assess individuals on personality dimensions; this approach is supported by several authors (Tyrer 1996; Haslam, Holland et al. 2011; Livesley 2011), and dimensional measures of normal and abnormal traits, as identified by the SNAP (The Schedule for Nonadaptive and Adaptive Personality; Clark and

Harrison 2001), have been shown to demonstrate high levels of robustness across different samples (Eaton, Krueger et al. 2011).

A classification of personality disorder which is based on evidence on the phenotypic structure and genetic basis of personality disorder has been proposed (Livesley 2011). This is an attempt to address many of the current difficulties and controversies surrounding the current classification. The suggested system has two parts. Firstly, personality disorder generally is defined, in order to differentiate it from normal but, at times, significant variation in personality. This includes deficits in the sense of self and in social and interpersonal behaviour. Secondly, different forms are identified. Given the repeated inability to replicate DSM-IV and ICD 10 diagnoses within analyses of personality disorder traits and criteria, Livesley has identified four dimensions of personality disorder which are continuous with normal personality. These are emotional dysregulation, dissocial, social avoidance and compulsivity. He proposes 30 primary traits organised into these domains, which also function as descriptors for those individuals who do not fit into one of the four "higher-order" domains. Thirdly, the assessment of severity differentiates between personality disorder and severe personality disorder. Severity is conferred by both self and interpersonal pathology, and more extreme expression of traits. Although DSM-IV categories cannot map directly onto this classification, it is argued that the domains are similar to the most prevalent and valid diagnoses: antisocial; borderline; schizoid and avoidant; obsessive-compulsive personality disorders (Livesley 2011).

In looking at the severity of personality disorder, if the impact of dysfunction on an individual is considered, then borderline, schizotypal and paranoid personality disorders could be seen as most severe, given the impact on social functioning (Millon 2011). However, if the impact on society is considered, antisocial and narcissistic personality disorders would be deemed most severe (Adshead and Sarkar 2012). In a review of papers referring to severity of personality disorder certain themes were identified. Cluster A and B disorders were seen as more severe than Cluster C disorders, severity increased with both the number of features of a specific

disorder and with the number of specific disorders, and severity was seen as being associated with levels of social impairment and risk of harm to self or others (Crawford, Koldobsky et al. 2011). A dimensional rating of severity has been proposed which correlates with levels of clinical pathology and social functioning. The ratings of severity are 0 'no personality disorder'; 1 'personality difficulty' (sub threshold); 2 'simple personality disorder' (one or more personality disorders within the same cluster); 3 'complex personality disorder' (personality disorders spanning clusters); 4 'severe personality disorder' (two or more personality disorders in over one cluster, one being antisocial personality disorder) (Tyrer 1996). Evidence indicates that those with more severe pathology in a community sample tend to be those in contact with specialist services (Yang, Coid et al. 2010).

### **1.32 Classification of Antisocial Personality Disorder**

Given the clear link between antisocial personality disorder and violence, it is important to examine, in more detail, the classification within different systems, and the limitations of this.

*“These reveal a preoccupation with the nosological status of the concept...its forensic implications, its subdivisions, limits [and] the propriety of identifying psychopathic personality with antisocial behaviour. The effect of reading solid blocks of literature is disheartening; there is so much fine-spun theorising, repetitive argument, and therapeutic gloom.” (Lewis 1974)*

In his review of the previous 50 years literature on psychopathic personality, Sir Aubrey Lewis raises issues which remain contentious over three decades later. A syndrome of antisocial behaviour exists which is characterised by a cluster of antisocial symptoms. This has a variety of definitions in different countries, different settings and within different classification systems: Antisocial Personality Disorder in DSM-IV (American Psychiatric Association 1994); Dissocial Personality Disorder in ICD-10 (World Health Organisation 1992); Psychopathy (Hare, Hart et al. 1991), as operationalised in the PCL-R, and the legal definition of psychopathic disorder in the Mental Health Act (1983) prior to recent amendments. There are difficulties with

regard to both diagnostic heterogeneity of antisocial personality disorder, and childhood conduct disorder, as well as historical heterogeneity (Lynam 2002).

The relative importance of both behavioural and personality symptoms in definitions is worthy of consideration. The DSM classification of Antisocial Personality Disorder, originally introduced into DSM-III based on data from a classic follow up study of children referred to a conduct problems clinic in the United States (Robins 1966), is outlined in Figure 1.

**Figure 1: DSM IV classification of Antisocial Personality Disorder (American Psychiatric Association 1994)**

<p><b>A pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:</b></p> <ul style="list-style-type: none"><li>(1) failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest</li><li>(2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure</li><li>(3) impulsivity or failure to plan ahead</li><li>(4) irritability and aggressiveness, as indicated by repeated physical fights or assaults</li><li>(5) reckless disregard for safety of self or others</li><li>(6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations</li><li>(7) lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another</li></ul> <p>The individual is at least age 18 years</p> <p>There is evidence of Conduct Disorder with onset before age 15 years</p> <p>The occurrence of antisocial behaviour is not exclusively during the course of Schizophrenia or a Manic Episode</p>
--

This has been criticised for being too behavioural (Hare, Hart et al. 1991) and for lacking specificity, therefore limiting investigation of more specific causal factors (Hill 2002).

ICD10 classification of Dissocial Personality Disorder (World Health Organisation 1992) shares many features of Antisocial Personality Disorder and psychopathy, although differs in having a greater emphasis on interpersonal and affective characteristics than the DSM IV classification of Antisocial Personality Disorder. It is outlined in Figure 2.

**Figure 2: ICD10 Classification of Dissocial Personality Disorder (World Health Organisation 1992)**

Personality disorder usually coming to attention because of a gross disparity between behaviour and prevailing social norms characterised by

- callous unconcern for the feelings of others
- gross and persistent attitude of irresponsibility and disregard for social norms, rules and obligations:
- incapacity to maintain enduring relationships, though having no difficulty in establishing them
- very low tolerance to frustration and a low threshold for discharge of aggression, including violence
- incapacity to experience guilt or to profit from experience, particularly punishment
- marked proneness to blame others, or to offer plausible rationalisations, for the behaviour that has brought the patient into conflict with society

There may also be persistent irritability as an associated feature. Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis.

Despite some discrepancies in specific criteria, the concept of antisocial personality disorder, defined either by DSM or ICD represents a clear syndrome of adult antisocial behaviour and it is this cluster of symptoms that I will refer to as antisocial personality disorder (ASPD) from now on.

The concept of psychopathy (Hare, Hart et al. 1991), was originally described by Cleckley in *The Mask of Sanity* (Cleckley 1982) and later operationalized in the Psychopathy Checklist – Revised (PCL-R) (Hare 2003). Psychopathy is not contained within either major classification system and can be construed as a higher order personality construct (Dolan and Doyle 2007). It was initially based on a two factor structure of an interpersonal/ affective component and social deviance factor. Other evidence suggests that a three factor structure, encompassing a deceitful, arrogant interpersonal style which involves dishonesty, manipulation and grandiosity; defective affective experience characterised by a lack of remorse, lack of empathy and shallow emotions and behavioural elements such as impulsiveness, irresponsibility and sensation seeking may be more valid (Cooke and Michie 2001). This has been criticised by Hare and replaced by a four factor structure (Hare 2003). This encompasses an *Interpersonal* factor (glib/superficial; grandiose self-worth; pathological lying; conning, manipulative), an *Affective* factor (lack remorse or guilt; shallow affect; callous, lack empathy; fail to accept responsibility), a *Lifestyle* factor (stimulation seeking; impulsivity; irresponsible; parasitic orientation; lack of realistic goals) and an *Antisocial* factor (poor behaviour controls; early behaviour problems; juvenile delinquency; revocation of conditional release; criminal versatility). This has been shown to have a higher degree of validity in predicting external manifestations of psychopathy and have utility in longitudinal research (Neumann, Vitacco et al. 2005).

The predominant value inherent in the diagnosis of psychopathy is the well documented association with early onset offending, both violent and nonviolent offending and recidivism (Dolan and Doyle 2000). However, in assessing any association between personality disorder or psychopathy and violence, criterion contamination is problematic. If social deviance itself leads to a diagnosis of personality disorder, it is therefore impossible to independently analyse the contribution of the deviation itself (Blackburn 1988). Aggressive behaviour is a defining feature of antisocial and borderline personality disorder and hostile, antagonistic traits are contained within the criteria for eight different categories of personality disorder: paranoid; schizoid;

antisocial; borderline; narcissistic; histrionic and obsessive compulsive (American Psychiatric Association 1994). This issue is critical to current problems with the classification of antisocial personality disorder, and dissociative personality disorder, and is at the centre of the current controversy over core traits of psychopathy. Some authors have therefore urged that social deviance should be seen as a “secondary symptom or consequence of psychopathy”, rather than a core construct (Cooke, Michie et al. 2004).

## ***1.4 Development of Antisocial Personality Disorder***

Personality disorder is conceived of by some as medicalisation of violent behaviour (Eldergill 2006). Patients with personality disorder are often seen as not truly ‘ill’ and it remains a contentious and pejorative diagnosis (Bowers 2002). This is compounded by the lack of robust evidence for effective treatment interventions for both antisocial personality disorder and for psychopathy (Duggan, Huband et al. 2007).

However, there is clear evidence, as detailed below, of a developmental trajectory from antisocial behaviour in childhood to antisocial personality disorder in adulthood. Childhood risk factors have been consistently shown to predict future antisocial behaviour and there is evidence of heritability of personality disorder. The longitudinal stability of personality traits evident in childhood resulting in the development of antisocial personality disorder in later years is well documented.

### ***1.41 Pathways to antisocial behaviour***

Various theories have demonstrated a pathway from childhood antisocial behaviour to antisocial personality in adulthood. In the Cambridge Study in Delinquent Development 411 males, born in 1953 and from South London, were followed up at regular intervals from age 8 years to 32 years. Eight face to face interviews were conducted over 24 years, with ‘antisocial personality’ measures carried out at ages 10, 14, 18 and 32 years. The most significant predictors of antisocial personality at 18 years were: convicted parent; large family size; nervous



mother; high neuroticism; poor child-rearing; low junior school attainment. The best independent predictors of antisocial personality at 32 years were: convicted parent; large family size; young mother; low nonverbal IQ. 50% of those with convictions were antisocial at 18 years, 57% at 32 years (Farrington 1995).

Farrington also looked at vulnerable children at 8-10 years who did not develop antisocial personality. These children, although not delinquents in later life, were often unsuccessful with poor living conditions and low status jobs and were often unmarried. Parental interest in education was a protective factor against delinquency but quality of parenting and family harmony only exerted an effect if parenting was poor or there was a lack of family harmony, in which cases they increased risk (Farrington 2000). It is, however, difficult to disentangle this from other family factors.

Farrington proposed a theory of stages for development of antisocial tendency. The 'energising stage' is characterised by the desire for material goods, status and excitement, facilitated by frustration, boredom and alcohol and drug misuse. In those from disadvantaged backgrounds the opportunity for achieving such desires legitimately is less. The 'directing stage' then involves motivations to antisocial tendency, especially if socially disapproved methods for achieving goals have habitually been chosen. In such children, low IQ often leads to failure in school and less capacity for legal achievement of goals. The 'inhibiting stage' serves to decrease antisocial tendencies by social learning leading to internalised beliefs and attitudes. Prosocial parents, close supervision and love-oriented discipline with empathy facilitate this whereas poor parenting, disharmony and a criminal family lead to internalised procriminal and anti-establishment attitudes. This can be compounded by impulsivity and low IQ which may decrease the ability to build up internal inhibitions against offending. Finally the 'decision making stage' depends on opportunities and a cost-benefit analysis of outcomes. It is suggested that those who are impulsive, or have difficulty manipulating abstract concepts may give insufficient consideration to consequences of offending. It is, therefore, a self-perpetuating pathway with

poverty, low intelligence and school failure leading to truancy and then a lack of qualifications resulting in low status jobs or unemployment which renders legitimate achievement of goals very difficult, thus increasing antisocial tendencies (Farrington 2000).

Although clearly a seminal study, there are certain limitations, some of which are unavoidable in a prospective longitudinal study with this duration of follow up. The objectivity and validity of some of the measures used, such as parenting measured by social workers interviewing parents, may have introduced bias into the results. Further, testing effects were not controlled for. Finally, the measure of 'antisocial personality' was based on deviant behaviour alone and personality and interpersonal characteristics such as egocentricity, empathy and guilt were not considered.

In the Dunedin cohort a taxonomy of 'life course persistent' antisocial behaviour was developed, as against that which was restricted to adolescence (Moffitt 1993a). The 'life course persistent' (LCP) group was characterised by early onset of 'difficult' behaviour of high risk young children, triggered and maintained by an adverse social environment. Cognitive deficits, a difficult temperament or hyperactivity were early, but identifiable, indicators of neuropsychological abnormalities, either genetic or acquired. They displayed restlessness, inattention and negativism at 3 and 5 years, and social alienation at 18 years. Environmental risks including inconsistent parenting, poor family attachments and poverty expanded to include poor peer and teacher relations in later years. They also had higher rates of comorbid diagnoses such as conduct disorder, ADHD and low IQ. During childhood and adolescence maladaptive child and environment interactions increased, resulting in maladaptive personality traits, characterised by aggressive and antisocial behaviour which is maintained throughout adulthood. Uncontrolled behaviour at 3 years was shown to be associated with the development of antisocial personality disorder, violent offences at 21 years and increased levels of recidivism (Caspi, Moffitt et al. 1996).

The 'adolescence-limited' (AL) group displayed antisocial behaviour which emerges with puberty during a time of dysphoria and the 'maturity gap' between biological and social maturity. A delinquent style can be seen as mimicking antisocial behaviour in order to exert independence from parents and reinforce peer group affiliation. Most desist with adulthood, moving into a more conventional lifestyle although this can be prevented by 'snares' along the way, such as a criminal record or addiction. 'Adolescence-limited' (AL) antisocial behaviour is common, representing 22% of the Dunedin cohort, near normative and temporary. 'Life course persistent' (LCP) antisocial behaviour is present in far fewer, 6% of the cohort, and is persistent and pathological (Caspi, Moffitt et al. 1996).

This pattern has been supported by evidence from several countries, and by follow up within the Dunedin cohort (Moffitt, Caspi et al. 2002). It has also been shown that the aggressive behaviour of LCP individuals is highly stable, whereas those in the AL group have increased rule breaking predominantly between 10 and 17 years (Stanger, Achenbach et al. 1997). LCP behaviour shows a high degree of heritability but AL does not (Edelbrock, Rende et al. 1995). Family and environmental factors seem more important for LCP, with association with deviant peers exerting more influence in AL.

The gender difference is also substantial, with the male: female ratio around 10: 1 for LCP, but being almost the same for AL, at 1.5: 1. Such gender differences have also been evident in the Christchurch sample (Fergusson, Horwood et al. 2000), showing ratios of 4: 1 for early onset antisocial behaviour, and 2:1 for late onset antisocial behaviour. Kratzer and Hodgins, in a Swedish cohort of 13000, showed a male predominance in the LCP group of 15:1, and 4:1 for later onset antisocial behaviour (Kratzer and Hodgins 1999).

Outcomes for the LCP group were much poorer, with half showing signs of difficulty such as a criminal record, long term unemployment, major mental illness or lack of qualifications. They scored much more highly on psychopathic traits, particularly callousness and impulsivity, and

also showed weaker bonds to family and were likelier to leave school early. The AL group had high rates of delinquent peer associates in adolescence, unconventional values and non-violent delinquent offences. Despite having a better prognosis they often attracted harmful consequences such as absence of qualifications, teenage parenting, substance misuse, a criminal record and incarceration, therefore, this pathway can also carry a cumulative disadvantage (Moffitt 2001).

This is clearly a very important study of a large, unselected birth cohort with regular assessments until 21 years, with an attrition rate of less than 3%. Assessment at each stage was comprehensive, involving both self-report measures and reports from parents, teachers, peers, partners and official police records. Furthermore, consideration has been given to measuring age appropriate behaviours at different stages. However, use of structured diagnostic instruments in much of the research may generate results of questionable accuracy and possibly overestimate the prevalence of cases. Indeed, the DIS (Diagnostic Interview Schedule) has been shown to yield inadequate concordance with clinician administered DSM-III checklists in general population surveys (Helzer, Robins et al. 1985).

Given the low base rate of more serious, persistent antisocial behaviour in the general population only 6 females (1%) and 47 males (10%) were on the LCP path which clearly limits findings, particularly for females. Further research focussing on trends in antisocial behaviour and on such behaviour in females would clearly be beneficial.

Vizard proposes a developmental trajectory for the development of later severe personality disorder, starting in childhood. Children, already vulnerable due to genetic and perinatal risk factors alongside early developmental risk factors are likely to have serious attachment problems, potentially compounded by abuse and neglect. They therefore are increasingly likely to develop comorbid axis 1 disorders, and encounter adverse life events leading to a pathway through the care system, with probable criminal justice system involvement. This model

incorporates causal and maintaining factors and allows for resilient children to leave the pathway and vulnerable children to join it at various stages of development. Vizard highlights the need for a robust definition of early onset severe personality disorder, and the development of a conceptual model allowing identification of those at risk and the development of appropriate preventative interventions (Vizard, French et al. 2004).

### **1.42 Risk and Protective Factors**

Knowledge of the origins of personality disorder remains rudimentary and fragmented (Livesley 2003). Effects of adversity are modified by factors influencing vulnerability and resilience. There is an impressive body of evidence regarding risk factors for childhood and adult antisocial behaviour and it is clear that the longer duration of time of exposure to a risk factor, the more dramatic its effect on behaviour (Cohen and Brook 1987). It has been argued that most known protective factors are the inverse of risk factors but this only holds if the relationship is linear. The absence of some risk factors, such as attention deficit and hyperactivity disorder (ADHD), does not constitute a protective factor (Loeber, Wung et al. 1993). Another question is the ability of protective factors to 'buffer' risk factors, such as the protective effect of a child's exposure to adequate discipline even with an antisocial father (Robins 1966). It follows therefore, that it should be possible to interrupt the chain reaction of accumulation of risk at different stages and in different areas.

### **Social Factors**

#### **Parenting**

Rejecting, aggressive, inconsistent and lax parenting is an important risk factor for persistent antisociality (Patterson 1991). Conversely, high levels of affection and positive role models in parents increase resilience (Werner and Smith 1992), with rules and duties fostering responsibility and autonomy in adolescence. In an extensive follow up of 15000 children, nonauthoritarian attitudes, child-centred parenting and strong positive attitudes to education

outweighed other negative contextual effects (Osborn 1990). It seems that emotional acceptance of the child, alongside supervision, control and clear behavioural rules is more important for development in a difficult social environment.

Maternal factors such as a young mother or low maternal IQ and reading skills (Maynard 1997) increase risk, perhaps via economic stress, poorer quality parenting and compromising assistance of children with schoolwork. Poor parental mental health (Rutter, Quinton et al. 1990) and parental criminality (Farrington 1995) confer a poorer prognosis, likely through the compromise of parenting skills and perhaps as a proxy for other social disadvantage. Evidence from the Dunedin cohort echoes these findings with a young mother, low maternal IQ and parental mental health problems and criminality all exerting significant risks. Moreover, family factors such as harsh, inconsistent discipline, family conflict, excessive criticism of the child, frequent moving, multiple caregivers, more time with a single parent and low SES (socioeconomic status) increased the risk of antisocial behaviour. In adolescence a poor relationship with parents also increased risk (Moffitt 2001).

In Robins study (1966), children with conduct disorder were significantly more likely to have parents of low occupational status, only one third lived with both parents and one third had spent time in institutional care. They were also more likely to have a father who drank alcohol excessively or was absent and were also behind at school. At 30 years they had a 1 in 5 chance of developing a sociopathic personality and over half had been arrested for major crimes. The most significant predictors of persisting antisocial behaviour were antisocial behaviour (drinking heavily, arrests, desertion) in the father and a lack of adequate discipline in the family home (Robins 1966).

Other family factors can act as protective factors against these risks: strict or adequate discipline can buffer against an antisocial father (Robins 1966), a good relationship with an adult external to the family buffers against a poor marital relationship (Jenkins and Smith 1990) and

family stability has been shown to be protective against conduct disorder (Quinton, Pickles et al. 1993).

The issue of cause and effect is a matter of some debate. The coercive behaviour of children shapes the responses of adults to them (Lytton 1990). The process is transactional, in that parents and children react back and forth, contributing to the maintenance of dispositional characters by leading to a mutually congruent response. Therefore, positive behaviour from the child leads to positive reinforcement which leads to positive representations of others, and the converse is also true. These reinforcements, however, seem to have less impact on some conduct disordered children who respond less to social reinforcement and punishment. There is evidence of a connection between a “difficult” rating in preschool and adolescent delinquency which is independent of the quality of child rearing (Lytton 1990).

### ***Social and Community Factors***

There is substantial evidence linking social factors to the promulgation of antisocial behaviour. Farrington demonstrated increased antisocial behaviour associated with neighbourhoods with high levels of families in economic deprivation; community disorganisation and low neighbourhood attachment; high levels of crime and violence and availability of drugs; new immigrants and racial discrimination and prejudice. This leads to a stressful environment, deviant role models and directly impacts on antisocial behaviour. There is also an indirect effect through interactions with family, school and peers (Farrington 1998).

Broader cultural factors may also be important, based on the concept that cultural transmission leads to the development of behavioural similarities within cultures, and differences across cultures (Cooke 2003). For instance, cultures vary in socialisation processes in the extent to which children are permitted to express aggression. A cross-cultural comparison of Sweden and China showed substantial differences in both rate of expression of aggressive behaviour, but also in parental responses to this (Ekblad 1988). Attempts to explain this have centred on the “individualistic-collectivist” dimension. Individualistic cultures, such as North

America, emphasise competitiveness, self-confidence and independence. Collectivist cultures, such as China, emphasise individual contribution and subservience to the group along with acceptance of authority (Cooke 2003). It has been argued that within individualistic societies cultural transmission enhances grandiosity, glibness and superficiality and that the inherent competitiveness promotes Machiavellian behaviour, particularly deceptive, manipulative and parasitic behaviour (Wilson and Herrnstein 1985). Hare has expressed concerns that North American society is “moving in the direction of permitting, reinforcing, and, in some instances actually valuing some of the traits listed in the Psychopathy Checklist – traits such as impulsivity, irresponsibility, lack of remorse and so on” (Hare 1993) pp177. Lasch proposed that the logical end-point of individualistic societies is “a narcissistic preoccupation with the self” (Lasch 1979) pp21. The Epidemiological Catchment Area study was a seminal five site study of the prevalence of mental disorder and the use of mental health services in the United States in the 1980’s (Robins 1991). Using data from this study it has been estimated that the prevalence of ASPD will increase from 3.7% to 6.4% within the next 20-30 years (Robins, Tipp et al. 1991).

### ***School and Peer Influence***

High achievement, motivation and education further than high school typifies resilient individuals. Good achievement and reading skills seem more important than IQ in determining psychosocial adjustment in adulthood (Werner 1993). Similarly low levels of behavioural problems, high self-esteem and achievement were associated with a prosocial atmosphere, structured teaching, incentives, control and supervision and delegation of responsibility to students at school (Rutter, Maughan et al. 1979). This may lead to self-affirmation and represent acceptance by society. In the Dunedin study (Moffitt 2001), conduct disordered children were more likely to have been rejected by other children, have delinquent peers and feel marginalised by conventional children and from school. They were also significantly more likely to leave school before 16 years and this has been shown to predict ASPD better than poor educational performance (Robins, Tipp et al. 1991). It may be possible, however, that positive



work behaviour and job stability might represent a turning point for some young delinquents (Losel and Bender 2003).

## ***Personal Factors***

### ***Conduct Problems***

Problems of conduct are the commonest form of childhood psychiatric problem, with a prevalence of 5-10% in developed countries, and constitute the commonest reason for referral to child and adolescent psychiatric clinics (Hill 2002). They are characterised by difficulties in social interaction, with aggression, oppositional behaviour, bullying and lying, and therefore exert a considerable impact, on the individual and also on family, peer, educational and wider social relationships.

Current classification systems are similar in that they both specify behaviour necessary for a diagnosis. In DSM-IV (American Psychiatric Association 1994), however, oppositional defiant disorder and conduct disorder are separated. In ICD-10 (World Health Organisation 1992) conduct disorder criteria are similar to a combination of both oppositional defiant disorder and conduct disorder in DSM-IV. The significant extent of comorbidity of oppositional defiant disorder and conduct disorder with attention deficit hyperactivity disorder has led to doubts regarding their distinctiveness as separate diagnostic entities, or whether they may represent different severities along a dimension of the same disorder (Hill 2002). It is clear that children with a combination of oppositional/conduct problems and hyperactivity/attentional deficits have a poorer prognosis with more varied, severe and stable behaviour (Lynam 1998).

Robins' seminal follow up of 524 patients attending a child guidance clinic in St Louis in the 1920s demonstrated that severe antisocial behaviour in adulthood was a syndrome, closely connected with severe antisocial behaviour in childhood, with over 90% of adults with antisocial personality disorder (ASPD) having some antisocial behaviour in childhood. However, only half of the children with antisocial behaviour went on to develop adult ASPD. A range of childhood

antisocial behaviours predicted ASPD better than any specific behaviour. A child's own behaviour was also a better predictor than socioeconomic status (which was unimportant once behaviour was controlled for) or family variables (Robins 1966). These results were subsequently replicated in a comparison of four male cohorts, differing in historical periods of childhood, geography and age at follow up (Robins 1978). However, the focus was predominantly on antisocial behaviour, rather than other personality variables and the retrospective assessment, despite the impressively low attrition rate at 30 year follow up, may result in some diagnostic inaccuracies with underestimation of cases.

Follow up of another clinic sample from Pennsylvania and Georgia in 1987 in the Developmental Trends Study (Loeber, Burke et al. 2002) showed that whereas oppositional defiant disorder predicted conduct disorder, attention deficit hyperactivity disorder did not and earlier onset conferred a faster progression to more serious problems. In a meta-analysis of five studies, Loeber et al showed that 28.5% with conduct disorder developed ASPD, compared with 1.7% without a history of conduct disorder. In their subsequent study, 52% with adolescent conduct disorder, and 90% with a lifetime diagnosis met criteria for a diagnosis of ASPD, compared with 17.2% and 10% respectively. They used modified diagnostic criteria for ASPD, without the requisite childhood conduct disorder. Clearly this was of value in this study but limits comparisons with other samples. The presence of adolescent conduct disorder and of callous unemotional traits was independent predictors of future ASPD. Callous unemotional traits include lack of guilt, absence of empathy, shallow and constricted emotions; the hallmarks of the conceptualisation of adult psychopathy (Cleckley 1982).

Early onset of conduct problems increases the likelihood of persistence of antisocial behaviour (Farrington 1995). In a retrospective study of a prison population, 94.7% of early starters (arrest before 14 years) compared with 73.1% late starters fulfilled criteria for a diagnosis of ASPD (Vitelli 1997). Oppositional defiant disorder, low socioeconomic status (SES) and parental substance abuse have been shown to be the best predictors of new onset conduct

disorder, and physical fighting the most predictive of the onset of conduct disorder and of all conduct disorder symptoms (Lahey, Hart et al. 1993).

In the sample from the Dunedin cohort (Moffitt 2001, p141) 90% of those with conduct disorder had comorbid diagnoses, predominantly anxiety disorders, depression, substance abuse and attention deficit hyperactivity disorder, which is consistent with the ECA rates of comorbid diagnoses with ASPD (Robins 1991).

It would seem that a diagnosis of conduct disorder can be a self-fulfilling prophecy, with children identified early as aggressive and obnoxious and therefore dealt with in a manner which leads to further resentment which, in turn, leads to added rejection by others.

### ***Temperament***

The Dunedin Multidisciplinary Health and Development Study is a longitudinal follow up of a cohort of 1037 children from age 3 to 21 years (Caspi, Moffitt et al. 1996). They have suggested that a difficult temperament sets in motion person-environment transactions with parents, teachers and peers, at home and at school which sustains early emerging difficulties and elaborates them into antisocial outcomes (Caspi, Moffitt et al. 1996). Children who were 'undercontrolled' (irritable, impulsive, impersistent, rough and uncontrolled in behaviour and emotionally labile) in temperament at 3 years were significantly more likely at 18 years to describe themselves as "danger seeking" and "impulsive", were prone to respond with negative emotions to everyday events and to be enmeshed in an adversarial relationship. At 21 years they were 2.9 times more likely to have ASPD, 2.2 times likelier to be recidivist offenders and 4.5 times more likely to have been convicted of violent offences (Caspi, Moffitt et al. 1996). Effect sizes, however were small and the authors themselves advise treating the results with caution. Additionally the use of structured instruments may lead to overestimation of prevalence rates (Helzer, Robins et al. 1985). Despite the impressive continuity shown between temperament at 3 years and adult ASPD, assessment at 3 years is likely to be substantially influenced by environmental and parenting factors, which were not controlled for.

It is questionable as to whether temperament at age 3 years can reliably be attributed to constitutional features of the child when parenting in early years exerts such an influence on the character of infants. This difficulty is exacerbated by frequent reliance on parental report, which is inevitably subjective and does not therefore necessarily reflect solely the disposition of the child. A study of temperament, using behaviourally based measures, during the first year of life did not show any association with subsequent conduct problems (Belsky, Hsieh et al. 1998). The authors suggest that infant temperament moderates the impact of parenting, particularly if temperament is negative, but state that the findings do not support the view that negative infants evoke harsher parenting. This study, however, is restricted to first born sons from maritally intact families, thus limiting its generalisability.

### ***Attachment and childhood victimisation***

An important risk factor for the development of future antisocial behaviour is the lack of secure bonds in childhood (Bowlby 1982). Insecure attachment is a predictor of externalising and problem behaviour, and secure attachment can be protective against family conflict (Jenkins and Smith 1990), child abuse and mentally unwell parents (Losel and Bender 2003). In the Newcastle study mother-child involvement and daily stimulation by mothers decreased both hyperactivity and conduct disorder in elementary school children (Kolvin, Miller et al. 1988) and a positive relationship with the mother was protective against punishing and rejecting behaviour of fathers (Elder, Caspi et al. 1986). Parents who were emotionally attentive and supportive were also significantly associated with the development of social competence in children from deprived social backgrounds (Osborn 1990). It does seem that insecurity of attachment is related to antisocial tendencies, especially if extreme. Dismissing attachment, derived from the Adult Attachment Interview, describes individuals who use a minimising attachment style, either dismissing how important of attachment is to them, or its influence. Negative experiences with attachment figures, especially rejection, can be minimised through normalisation, idealisation of parents, or poor childhood memories. In a study of 60 adolescents admitted to a private psychiatric hospital a dismissing attachment style was associated with conduct disorder and

antisocial and narcissistic personality traits in males, but not in females owing to inadequate sample size. This is limited by sample size and questionable generalisability given the patient population (Rosenstein and Horowitz 1996). Childhood victimisation is a significant predictor of a diagnosis of ASPD and of the number of lifetime symptoms (Luntz and Widom 1994). Johnson et al showed that neglect and physical abuse predicted future ASPD but relied on retrospective assessments, involving only one question concerning this (Johnson, Cohen et al. 1999).

### ***Genetic Influences***

There is well documented evidence that conduct problems, whether assessed categorically or dimensionally, are substantially heritable with the majority of estimates of heritability between 0.4 and 0.7 (Simonoff 2001). Furthermore, a follow up study of 600 subjects showed that stability of an individual's aggressive behaviour between 8 and 30 years was exceeded by stability across generations (Huesmann, Eron et al. 1984). There is a strong genetic component to all personality disorders, the heritability of dissocial personality disorder being 50%, with unique environmental effects accounting for the remaining effect (Livesley, Jang et al. 1993). This has led to the suggestion that it may be possible to distinguish between temperament (genetic component) and character (influenced by experience) but it is clear that characterological traits have a heritable component, such as openness and cooperativeness (Livesley 2001). It seems apparent that all aspects of personality are shaped by a gene-environment interaction. Social experience can affect the developmental fate of inherited cognitive and behavioural characteristics through modification of gene expression (Reiss and Neiderhiser 2000). Interesting evidence from a Swedish adoption study showed that adoptees without antisocial biological parents had an adult risk of adult criminality of 3% if raised in a low risk family, which increased to 6% in a high risk family. Those with antisocial biological parents had a corresponding risk of 12% in a low risk family, and 40% if both biological and environmental risk factors were present (Bohman 1996).

Ground-breaking evidence of a functional polymorphism in the gene encoding the neurotransmitter metabolising enzyme monoamine oxidase A was found to moderate the effect of child maltreatment and children were less likely to develop antisocial problems. Results showed an attributable risk fraction of 11% for violent convictions and 85% of the cohort with a low MAO-A genotype and severe maltreatment had a history of antisocial behaviour (Caspi, McClay et al. 2002).

### ***Childhood Psychopathy***

“Psychopathy is stable across time, in part, because we currently fail to recognise its presence early and adequately and fail to intervene effectively” (Lynam 2002).

Although almost all individuals with ASPD have a history of childhood antisocial behaviour, antisocial behaviour in childhood is common and therefore a weak predictor so it is necessary to try and identify the minority of children whose antisocial behaviour will persist. There is evidence that the concept of psychopathy, primarily applied to adults, may be important in understanding severe conduct disorder in children and adolescents. Psychopathy in adulthood is the strongest predictor of violent offending and recidivism (Quinsey 1995).

Bowlby (1951) argued that persistent maternal deprivation until the age of 5 years resulted in irreversible detrimental effects such as becoming a cold “affectionless” character and a delinquent (Bowlby 1951). Farrington has recently demonstrated that physical neglect; poor parental supervision; a disrupted family; large family size; a convicted parent; depressed mother or low family income at 8-10 years predicted high PCL-SV (Psychopathy checklist – screening version) scores at 48 years (Farrington 2006). It has also been shown that physical abuse and separation from a parent were more common in delinquents scoring high on the PCL-YV (youth version) (Campbell, Porter et al. 2004).

It is clear that, within those severely antisocial and aggressive children, subgroups exist differing on severity and stability of behaviour (Frick, Stickle et al. 2005). Attempts to delineate

this have focussed on severity or type of antisocial behaviour, timing of onset and on the construct of psychopathy –looking at affective, interpersonal, self-referential and behaviour style (Moffitt 1993a).

In a sample of children with comorbid attention deficit hyperactivity disorder and conduct disorder, aged 6-13 years, 57% showed high rates of callous unemotional traits, as measured by the Antisocial Process Screening Device (Barry, Frick et al. 2000). This subgroup showed a preference for exciting and dangerous behaviour, fearlessness, lower sensitivity to cues of punishment with a reward-dominant response style. This is seen as being significant in many theories of psychopathy. This may represent deficient early development of guilt and empathy leading to an underlying deficit in behavioural inhibition. They were also less reactive to stimuli which were emotionally distressing or hostile and showed a low level of distress regarding their antisocial behaviour and associated negative consequences. This is consistent with adult psychopathic individuals who score lower on negative affectivity. The coexistence of attention deficit hyperactivity disorder, conduct disorder and callous unemotional traits can be seen to correlate highly with the construction of psychopathy (Barry, Frick et al. 2000).

Gillstrom et al note that emotion can be seen as being like a second language to psychopaths (Gillstrom and Hare 1988), with a lack of appreciation of the underlying affect of language which has been analogised as “knowing the words but not the music” (Johns and Quay 1962). ASPD is associated with mild impairment in theory of mind tasks, largely reflecting difficulty in empathic understanding (Dolan and Fullam 2003). The inability to distinguish between emotionally charged and neutral words, along with similar deficits which seem to occur at the level of attention and memory may seriously impair the capacity to empathise, thus contributing to callousness and, potentially, to ego development.

Moreover, risk factors associated with conduct disordered children with callous unemotional traits appear to be distinct from children without. Wootton et al showed that the association

between ineffective parenting and conduct disorder was moderated by the presence of callous unemotional traits, with callous unemotional traits leading to high levels of conduct problems, irrespective of the quality of parenting and the association was not additive (Wootton, Frick et al. 1997). These children also show fewer verbal deficits than purely conduct disordered children, particularly in verbal reasoning ability (Loney, Frick et al. 1998). It would seem that the presence of callous unemotional traits indicates particular affective traits and motivation which may be less responsive to normal socialisation, and also that the absence of such traits may delineate a group with different aetiological factors who may be more amenable to intervention (Wootton, Frick et al. 1997). Recent evidence linking impairments in eye contact with their mothers, of children with a high level of callous unemotional traits, lends weight to this argument, and the authors suggest that this impairs higher-order processing required in developing theory of mind and empathy (Dadds, Allen et al. 2012)

It is clear, however, that, given the predominance of cross sectional studies, and lack of current evidence of the proportion of children with this developmental precursor who go on to meet criteria for psychopathy, the predictive utility remains, at present, somewhat limited.

There are emerging attempts to address this difficulty. In a sample of 1136 children, Frick showed that conduct disorder with psychopathic features was associated with more severe and instrumental aggression and higher self-reported delinquency one year later. Callous unemotional traits, not impulsivity, predicted increased aggression, especially instrumental, at follow up. At 2-4 years within informant stability of callous unemotional traits was 0.9, and between informant 0.67-0.8 (Frick, Kimonis et al. 2003). Other evidence indicates that early onset, aggressive, violent or pervasive conduct disorder is associated with adult psychopathy (Rogers, Johansen et al. 1997).

A 4 year follow up study of 98 children with conduct problems demonstrated the highest rates of conduct problems; self-reported delinquency; police contacts (as reported by parents)



and highest actual or threatened violence in those with conduct disorder and callous unemotional traits. Those with conduct disorder only had similar rates of self-reported delinquency as controls, but higher rates of reactive aggression. Those with only callous unemotional traits had high rates of self-reported delinquency, predominantly for non-violent offences. Overall, impulsivity-hyperactivity problems were associated with increased conduct problems. It does seem that conduct disorder with callous unemotional traits, but without impulsivity-hyperactivity may represent a more severe and chronic pattern of antisocial behaviour. Controlling for impulsivity-hyperactivity did not influence different trajectories of delinquent behaviour so, although impulsivity may be part of psychopathy, it is possibly broadly associated with early onset conduct problems, rather than being specific to psychopathy (Frick, Stickle et al. 2005). This also suggests that callous unemotional traits may identify a severe and violent subgroup of conduct disorder (Andershed, Kerr et al. 2002).

Emerging evidence suggests a distinction between callous unemotional traits and conduct disorder, that is apparent at a young age although, given conceptual difficulties and a lack of evidence regarding reliable and valid clinical assessment of psychopathy, caution is advocated regarding formalising this within a classification system (Rutter 2012). Callous unemotional traits in the absence of antisocial behaviour have been shown to confer an increased risk of future psychopathology and psychosocial difficulties. It is proposed that further research on these individual may shed light on protective factors against the development of antisocial behaviour, such as consistent and good parenting (Viding and McCrory 2012).

Notwithstanding this, the lack of prospective longitudinal studies of sufficient duration, linking childhood and adult psychopathic traits, means that any predictive validity of these traits is limited and needs to be interpreted cautiously. There is, therefore, a need for new longitudinal studies investigating the development of risk and protective factors, and causes of adolescent psychopathy with repeated measurements at various ages to improve reliability (Farrington 2005).

It is clear that there is ample evidence of some childhood individual differences predicting important outcomes in adulthood and that certain traits, such as aggression, have a high degree of stability. There has long been an assumption that a high degree of stability is present in the temperaments and personality features of children and adolescents but this could be viewed as being inconsistent with a developmental perspective on psychopathology. Moreover, there is increasing evidence of the lack of temporal stability of personality dysfunction (Yang, Coid et al. 2010). Perhaps the static notion of personality traits needs to be abandoned for a more dynamic conceptualisation addressing why some traits are consistent and why some change. If traits are less stable and therefore more changeable early on, then the prospect of effective interventions seems more likely (Frick 2002) and, along with this, may come a shift in relatively entrenched views of personality disorder and disturbance as being untreatable and a move away from the stigma surrounding the diagnosis.

## ***1.5 Personality Disorder and Violence***

### ***1.51 Antisocial Personality Disorder and Violence***

Antisocial personality disorder has a well-established association with criminality (Farrington 1995; Rasmussen and Levander 1996). Indeed, evidence indicates that less than 5% of males in the general population perpetrate 50-70% of violent offences (Moffitt 1993a; Hodgins 1994). These are men who, as children, fulfil criteria for conduct disorder and, as adults, exhibit antisocial personality disorder and psychopathy. Hodgins (2007) classifies them as life course persistent offenders and divides them into those with and without comorbid anxiety disorders. The non-anxious group is further subdivided into those with established PCL-R psychopathy and those who have elevated scores yet do not cross the threshold. The PCL-R group have been shown to perpetrate a greater number of violent offences, instrumental and reactive in nature and they are seen to rapidly reoffend on release (Hodgins 2007), which is of utility in assessing and managing risk on discharge or release.

In a study of personality disorder within the general population, community prevalence rates of any personality disorder of 4.4% and 0.6% for antisocial personality disorder were found using clinical interviews (Coid, Yang et al. 2006a). The presence of any personality disorder was shown to significantly increase the risk of several violent incidents, violence when intoxicated, victim injury and several victim types. Antisocial personality disordered individuals exhibited very high degrees of versatility of violence with a strong association with victim injury, repetitive violence and variety of victim types and locations, in addition to independently increasing risk of violence when intoxicated. The population attributable risk for victim injury and over five violent incidents accorded to antisocial personality disorder were 24% and 20.9% respectively, clearly lending support to the view that a small proportion of individuals are responsible for a large proportion of crimes. It is interesting, however, that half of those with antisocial personality disorder in this community sample did not report any violent incidents (Coid, Yang et al. 2006b). However, both violence and diagnosis in this study were established by self-report, with diagnosis by a screening tool. This is likely to overestimate the prevalence of mental disorder and underestimate the frequency of violence.

Prevalence rates for antisocial personality disorder of 63% for male remand prisoners and 31% for female prisoners were found in the UK prison population, which are broadly similar to rates found in the prison system in the United States (Singleton, Meltzer et al. 1998). Offenders have been shown to have a tenfold increased risk of having antisocial personality disorder (Fazel and Danesh 2002) compared with the general population. The relative risks of a violent conviction of 7.2 (males) and 12.1 (females) have been demonstrated in those with antisocial personality disorder (Hodgins, Mednick et al. 1996), compared with the general population. Antisocial personality disorder is also associated with a greater degree of criminal versatility (Coid, Kahtan et al. 1999).

The risk of antisocial behaviour in antisocial personality disorder may be further increased by comorbidity with schizophrenia-spectrum personality disorders (paranoid, schizoid and

schizotypal subtypes) (Moran and Hodgins 2004). A community study of 101 adults indicated significant levels of comorbidity of antisocial and schizophrenia-spectrum personality disorders that the comorbid group had significantly higher rates of self-reported criminal behaviour than either group alone (Schug, Raine et al. 2007). Unfortunately the authors do not differentiate between violent and non-violent offending, assessment of criminal behaviour is by self-report alone, rather than combined with official records, and the sample size is relatively small, with only 31 of the sample of 101 adults having either an antisocial or schizophrenia-spectrum personality disorder, or both.

A recent meta-analysis of the correlations between personality disorder, violence and antisocial behaviour showed an overall fixed effects pooled odds ratio of 10.4 for violence in antisocial personality disorder. There was a similarly increased risk of reoffending for those with any personality disorder, with or without a comorbid mental illness and a population attributable risk fraction for personality disorder for violence of 18.8%. However, given the significant confounding influence of substance misuse, there was no indication of rates of offending behaviour with or without substance misuse (Yu, Geddes et al. 2012).

As a diagnosis, antisocial personality disorder has been shown to have some stability over time with kappa values of 0.68 for broad definitions, and 0.31 for more restrictive (Dinwiddie and Daw 1998). Some authors, however, suggest that “antisocial burnout” occurs over several decades of follow up (Arboleda-Florez and Holley 1991). More recent evidence indicates that, throughout adulthood, there is a decreasing prevalence of antisocial personality disorder and other cluster B disorders with increasing age, in particular over 35 years (Yang, Coid et al. 2010) and that, compared with other clusters, cluster B disorders have been shown to be significantly less pronounced at 12 year follow up (Seivewright 2002).

### **1.52 Other personality disorders and violence**

Epidemiological data on personality disorder other than antisocial personality disorder are limited as often antisocial personality disorder is the only discrete category included in studies of adequate size. Some evidence, predominantly from the United States, includes prevalence rates of other categories but are often hampered by methodological limitations, including variable and unreliable assessment procedures, inadequate sample size and selection bias (Coid, Yang et al. 2006a). Moreover, when associated risk of violence is considered, much research in criminology focuses on sociodemographic and 'criminogenic' risk factors, rather than psychopathology (Burke and Hart 2000).

#### ***Borderline Personality Disorder***

Borderline personality disorder is defined as a pervasive pattern of instability of interpersonal relationships, self-image and affect and marked impulsivity beginning in early adulthood and present in a variety of contexts (American Psychiatric Association 1994). In community surveys using interviews to establish diagnosis the prevalence is 0.7 -2.0% of the general population (Coid 2003). In their systematic review of serious mental disorder in prisoners, Fazel and Danesh found prevalence rates of 25% in female offenders (Fazel and Danesh 2002), and rates of 23% and 20% were found in male remand and female prisoners respectively (Singleton, Meltzer et al. 1998). It is often comorbid with antisocial personality disorder in forensic populations (Coid 2003).

In a sample of 260 male and female serious offenders in maximum security settings 69% (n=178) were noted to have borderline personality disorder and this was associated with offences of arson and criminal damage, as well as with self-harming behaviour. Offending behaviour in borderline personality disorder was seen to have several motivating factors, including compulsive homicidal urges, urges to harm, relief of tension, revenge, displaced anger and dysphoria (Coid 1998). Borderline personality disorder is also correlated with early age of onset of offending in forensic settings (Blackburn, Logan et al. 2005).

Given the symptom cluster which constitutes borderline personality disorder, it is unclear whether it is the borderline personality disorder itself which is associated with violence, or traits, such as impulsivity or antagonism, which are common in borderline personality disorder but not specific to it, and are themselves associated with violence. Furthermore, there are questions as to whether aggressive behaviour is a consequence of borderline personality disorder, or whether aggressive behaviour itself leads to the attribution of such a diagnosis. Alternatively there may be another factor, such as impulsivity, which independently leads to both aggression and to a diagnosis of borderline personality disorder (Burke and Hart 2000).

This problem underlines the issue of circularity which is common to many personality disorders when exploring the association with violence. Given that aggression, impulsivity and hostility are within the diagnostic criteria for several subtypes of personality disorder, it is impossible to independently analyse the association of the personality disorder with aggressive and impulsive behaviour as often aggressive behaviour has led to the diagnosis. This is exacerbated by the lack of a temporal relationship between violence and personality disorder as, in the current classification, personality disorder cannot be diagnosed before 18 years and the violence has generally predated this, resulting in an earlier diagnosis of conduct disorder. Frequently this is further complicated by comorbid substance abuse and Axis I disorders such as PTSD (Duggan and Howard 2009).

### ***Narcissistic Personality Disorder***

Narcissistic personality disorder is defined as a pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration and lack of empathy, beginning by early adulthood and present in a variety of contexts (American Psychiatric Association 1994). Narcissistic personality disorder has been shown to have community prevalence rates of 0.4-0.8% (Coid 2003) and it is prevalent in prisoner populations, with rates of 8% in male remand and 6% in female prisoners (Singleton, Meltzer et al. 1998). It is also particularly common in forensic populations (Hare 1983), often comorbid with antisocial personality disorder (Coid 2003). Prevalence rates of 21%

were seen in all admissions to secure psychiatric services between 1988 and 1994 (Coid, Kahtan et al. 1999). Diagnosis, however, was based on records, not structured assessments. An association of narcissistic personality disorder with homicide was demonstrated in this study and a previous study of patients in maximum security hospitals and prisons (Coid 1998). Such offending is viewed as being motivated by a need for power, control and domination over victims following perceived slights to the self-esteem of perpetrators (Coid 1998; Coid, Kahtan et al. 1999). However, comorbidity and behavioural problems were associated with admission of these patients to hospital and the authors state that personality disordered patients were “highly selected”. It therefore seems possible that there were different thresholds for admission by admitting psychiatrists, with those with personality disorder requiring higher levels of violent and aggressive behaviour to be considered, than those with mental illness.

### ***Histrionic Personality Disorder***

Histrionic personality disorder is defined as a pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts (American Psychiatric Association 1994). Community prevalence rates of 2.1% have been demonstrated (Coid 2003). It has been shown to be associated with acquisitive offending, motivated by financial gain and a desire to resist arrest (Coid 1998), but not apparently with violent offences. Moderate correlations for young age at first conviction have been demonstrated in forensic populations (Blackburn, Logan et al. 2005).

### ***Paranoid Personality Disorder***

Paranoid personality disorder is characterised by a pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, beginning in early adulthood and present in a variety of contexts (American Psychiatric Association 1994). Rates within community samples have been estimated at 0.7 – 2.4% (Coid 2003). Paranoid personality disorder is frequently comorbid with antisocial personality disorder and associated with violent crime (Coid 2003). Singleton et al found rates of 29% and 16% for male remand and female

prisoners (Singleton, Meltzer et al. 1998). In forensic populations prevalence rates of 7% have been demonstrated, and a correlation with serious violence (including attempted murder and wounding). This violence is seen as being characterised by undercontrolled aggression, often provoked by misinterpreting the intentions of others or fairly minimal provocation and often motivated by revenge (Coid 1998; Coid, Kahtan et al. 1999). Further analysis of data from the national survey of psychiatric morbidity in prisoners in England and Wales, based on structured clinical interviews using the SCID II (Structured Clinical Interview for DSM-IV Axis II Personality Disorders) (First 1997) on 391 males, indicated an association with robbery and blackmail. Although this study controlled for substance abuse and schizophrenia which some such studies do not, there was limited collateral evidence on previous offences, and the authors concede that some of the offence categories are too heterogeneous (Roberts and Coid 2009).

### ***Schizoid Personality Disorder***

Schizoid personality disorder involves a pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning in early adulthood and present in a variety of contexts (American Psychiatric Association 1994). Schizoid personality disorder has a community prevalence of 0.4 – 1.7%, is frequently comorbid with schizotypal personality disorder (Coid 2003) and is prevalent in offender populations, with rates of 8% in male remand and 4% in female prisoners (Singleton, Meltzer et al. 1998). Prevalence rates of 6% have been seen in forensic populations and an association with attempted murder or wounding demonstrated (Coid 2003). Studies have shown an independent association with kidnapping, with offence characterised by expressive anger and accompanied by excitement or exhilaration (Coid 1998; Caspi and Roberts 2001; Roberts and Coid 2009). Other authors, however, suggest that schizoid personality disorder may actually lower the risk of offending behaviour (Muller-Isberner and Hodgins 2000).



### **1.53 Personality Disorder Clusters**

Personality disorders are grouped into clusters by DSM IV, based on similarities in characteristics: Cluster A, the odd/eccentric cluster includes paranoid, schizoid and schizotypal personality disorders; Cluster B, the dramatic/emotional /erratic cluster includes antisocial, borderline, narcissistic and histrionic; Cluster C, the anxious/fearful cluster includes avoidant, dependent and obsessive compulsive personality disorders. It is noted in DSM IV that the cluster model of classification has not been consistently validated and has limitations (American Psychiatric Association 1994). Nonetheless, this appears to be increasingly used for research purposes (Skeem and Mulvey 2001; Moran, Coffey et al. 2006) owing to greater simplification of overlap between characteristics in categories of personality disorder and adherence to basic personality structure (Tyrer, Coombs et al. 2007). There is some evidence that this improves reliability, particularly if cluster D (inhibited/obsessional) with obsessive compulsive disorder, is seen as a separate category from cluster C (Tyrer, Cooper et al. 2005).

The World Health Organisation World Mental Health Surveys indicated prevalence rates of 3.6% for cluster A disorders, 1.5% for cluster B and 2.7% cluster C in the general population (Huang, Kotov et al. 2009). Cluster B disorders are strongly associated with violent criminal behaviour, and there are suggestions that cluster C disorder may reduce the risk of offending (Muller-Isberner and Hodgins 2000). In a cohort study of 800 children followed up during adolescence and adulthood, a strong correlation was found for cluster B disorders with interpersonal aggression, with a more modest correlation for cluster A (Crawford, Shaver et al. 2006). A further longitudinal community study demonstrated increased violence in the presence of both cluster A and B symptoms (Johnson, Cohen et al. 2000). In an epidemiological study, Coid (2006) found odds ratios (adjusted for sociodemographic factors and mental illness) for a criminal conviction of 0.61 for cluster A and 10.6 for cluster B. Odds ratios for serving a custodial sentence were 1.37 for cluster A and 7.57 for cluster B. Cluster C individuals had odds ratios of 0.56 (for a criminal conviction) and 0.24 (for serving a custodial sentence) (Coid, Yang et al. 2006a). Further examination of the ONS (Office for National Statistics) data on the UK

prison population, allowing for co-morbidity within clusters, indicates rates from 20-25% for cluster A disorders; 49-72% for cluster B; 7-8% for cluster C and 10% for cluster D in male sentenced prisoners. Rates for female prisoners were 6-24% for cluster A; 31-61% for cluster B; 11-16% for cluster C and 10% for cluster D (Singleton, Meltzer et al. 1998).

As detailed above, there is substantial overlap between different personality types which broadly, although not exclusively, occurs within clusters, with some overlap occurring between different clusters (Oldham, Skodol et al. 1992). Furthermore, current categories within diagnostic systems have disparate theoretical derivations, from empirical longitudinal research (antisocial), psychoanalysis (borderline, narcissistic) to clinical observations (obsessive compulsive and dependent) (Coid 2003). Thus, attributing specific personality types becomes of limited clinical utility and the cluster model, with some evidence of improved reliability (Tyrer, Cooper et al. 2005), seems to offer a more clinically intuitive and useful basis of classification. The degree of overlap of traits from different subtypes is indicated by the frequent use of the diagnosis 'Personality Disorder – Not Otherwise Specified' (Verheul and Widiger 2004), which calls into question the utility of the current classification systems from a clinical perspective, as well as theoretical. Although the cluster model is preferable in this regard, overlap between clusters does occur, particularly as when personality disorder increases in severity it also tends to span more than one personality cluster, or domain (Tyrer 2013).

### ***1.54 Psychopathy and Violence***

Psychopathy is a clinical construct of personality involving key affective, interpersonal and behavioural characteristics. These include callousness and lack of empathy; egocentricity; impulsivity; shallow emotions; irresponsibility; manipulativeness and violation of social norms (Hare 1998). There is a lack of robust evidence regarding UK prevalence rates, with a wealth of evidence emanating from North America and Canada. There are indications that levels of psychopathy within the offender population in the UK are lower, if North American cut-off scores are used (Dolan and Doyle 2007), with evidence from Canada indicating rates of 15-25% in the

federal offender population (Woodworth and Porter 2002). It is associated with early onset of criminal behaviour and criminal versatility, involving a range of both violent and non-violent offences (Dolan and Doyle 2000). It is associated with sexual violence (Brown and Forth 1997) and it is suggested that psychopaths may perpetrate more instrumental, goal driven violence which is associated with the expression of callous unemotional traits (Woodworth and Porter 2002; Dolan and Doyle 2007). Psychopathy is predictive of institutional aggression and violence in forensic settings (Hill, Rogers et al. 1996). It is strongly associated with violent recidivism on release (Hart, Kropp et al. 1988; Serin and Amos 1995) and it appears that levels of reoffending on release worsen with age, as opposed to non-psychopaths (Woodworth and Porter 2002). Indeed, studies indicate a sharp decrease in non-violent offending in psychopaths after 40 years of age, not paralleled by decreasing violent offending (Hare, McPherson et al. 1988; Harris 1991). This suggests a more stable, persistent capacity for violence, rather than for other types of criminality. Moreover, it appears that, in contrast to other personality disorders which 'burn-out' after 40 years, scores on factor 2 (social deviant factor of the PCL-R) have been shown to decrease with age but factor 1 (interpersonal/affective) features persist. This lends support to the theory of continuity and stability of 'core traits' of psychopathy such as callousness, even if behaviour changes (Harpur and Hare 1994).

There is clear evidence of extensive overlap of traits of psychopathy with DSM IV personality disorders, particularly cluster B disorders. This has been documented in antisocial personality disorder, with evidence that only 25% of those with antisocial personality disorder have psychopathy yet 90% of psychopathic offenders fulfil criteria for antisocial personality disorder (Dolan and Doyle 2007). Traits associated with psychopathy, however, are also present in other personality disorders which has led to the view that psychopathy may be better construed as a higher order (superordinate) category (Blackburn 1993c). Overlapping traits include mistrust in paranoid personality disorder; impulsivity in borderline personality disorder; insincerity, egocentricity and superficial charm in histrionic personality disorder and

exploitativeness, grandiosity and lack of empathy in narcissistic personality disorder. The overlap with narcissistic personality disorder has led some authors to contend that psychopathic personalities are on a continuum with narcissistic personalities, merely representing a more extreme expression of the same trait (Leaff 1978).

Psychopathy, as measured by total PCL-R score, has been shown to be significantly associated with all cluster B disorders, particularly antisocial personality disorder, and significantly correlated with paranoid personality disorder. Examining this relationship further, interpersonal and affective facets are most strongly associated with narcissistic and histrionic personality disorders, and behavioural and antisocial facets with antisocial and borderline personality disorders (Blackburn 1998; Blackburn, Logan et al. 2005). The antisocial behaviour factor of the PCL-SV (Psychopathy checklist – screening version) has been shown to be a better predictor of violent recidivism than the emotional detachment factor in a study using data on a community sample from the MacArthur Violence Risk Assessment Study (Skeem and Mulvey 2001). The antisocial behaviour factor was associated with cluster B personality disorders. The emotional detachment factor failed to meaningfully predict future violence. This contrasts with other evidence indicating total PCL scores better predict violent recidivism than the antisocial behaviour factor alone (Salekin, Rogers et al. 1996).

Despite controversy over the factor structure of psychopathy and conflicting evidence regarding the contribution of specific factors, it remains clear that there is a well-documented association with violence and recidivism, alongside greater stability of the construct over time, compared with personality disorders. The assessment of psychopathy, therefore, has a high degree of clinical utility in assessment of risk of future violence and in management of both offenders and patients, who may respond differently to certain treatment interventions. Thus, Blackburn's suggestion that psychopathy is better construed as a higher order category, rather than another subtype of personality disorder, is one which merits further exploration (Blackburn 1993c).

The different classification systems and models available for diagnosing personality disorder, with clinicians commonly using either ICD10 or DSMIV classification systems, sometimes the cluster model, and additional measures of psychopathy, creates further confusion around the diagnosis, both within mental health services and, critically, by the courts. Although the cluster model has better reliability than the subtypes in DSM IV and ICD10 (Tyrer, Cooper et al. 2005), it tends to be predominantly used for research purposes, with clinicians continuing to use the standard categorical classification systems (Skeem and Mulvey 2001). The current assessment of psychopathy by the PCL-R is hampered by criterion contamination and given the importance often placed on this measure by the courts; this limitation has significant ethical implications.

## ***1.6 Personality Disorder and Homicide***

Given the well documented increased risk of violence in personality disorder, it should follow that those with personality disorder will have an increased risk of homicide. The available evidence on personality disorder and homicide, though, is severely hampered by methodological limitations. Most studies consider personality disorder as a homogenous entity, only distinguishing antisocial personality disorder, if at all. Assessment procedures vary markedly, from the use of pre-existing records to informant information and diagnosis is often merely taken from psychiatric reports, without further analysis. Sample sizes are generally small, particularly in studies which investigate characteristics of the homicide which range from 19-182 cases. Thus, numbers of perpetrators with any personality disorder in these groups is even less, often under 50 cases. Evidence for the prevalence of particular subtypes of personality disorder amongst perpetrators of homicide, as highlighted above, is therefore insufficient and inadequate to draw any robust conclusions. There is also a lack of consistent evidence concerning method, type of violence and victim type. There is, therefore, a lack of any robust evidence which uses an adequate sample size, standardised assessment of personality

disorder and explores associations of types of personality disorder with specific offence variables in homicide.

In a comprehensive analysis of a subgroup of 1091 offenders from all individuals convicted of homicide or attempted homicide from 1988 to 2001 in Sweden, the prevalence of personality disorder as a primary or secondary diagnosis was 54%. Diagnosis was ascertained in these cases by examination of standardised psychiatric assessments (Fazel and Grann 2004). Prevalence rates of personality disorder in homicide offenders in Iceland, from 1900-1979, were 21.3% (Petursson and Gudjonsson 1981), although this is a descriptive study which relies upon psychiatric assessments carried out over 50 years ago. (Petursson and Gudjonsson 1981). Another study, although looking only at matricide in Scotland from 1957 to 1997, found a prevalence of 19% for personality disorders based on similar records (Clark 1993). Within England and Wales, of the 2670 homicide perpetrators between 1999 and 2003, 5% (n = 146) had a primary diagnosis of personality disorder, determined either by mental health services or in court reports (Appleby 2006).

Rates of antisocial personality disorder in homicide perpetrators have been shown to vary widely, with estimates ranging from 13% to 55.2% and, when solely offenders with major mental illness are considered, comorbid antisocial personality disorder prevalence rates range from 8 to 64% (Cote and Hodgins 1992; Erb, Hodgins et al. 2001; Putkonen, Kotilainen et al. 2004)

There is an association between narcissistic personality disorder and homicide (Coid 1998; Coid, Kahtan et al. 1999). Coid (1998) highlighted that a number of such homicides occurred when in a state of "narcissistic rage", which is seen to result from a blow to self-esteem resulting in an extreme reaction of anger and need for revenge (Kohut 1973). It is suggested that the all-consuming quest for revenge and accompanying irritability leads to extreme acts, carried out without thought of consequence or remorse (Coid 1998). Other evidence indicates higher rates of borderline personality disorder in perpetrators of homicide, compared with

nonviolent offenders, and this may specifically involve affective instability and intense relationships (Raine 1993).

In a review of nearly 300 biographies of murderers, Stone (1998) has developed descriptions of key characteristics of homicides by different personality disorders. Stone views spousal homicides as being of two types: triggered by jealousy and perpetrated by those with paranoid personality disorder, or homicides involving “getting rid of a burdensome spouse”, tending to involve psychopathic offenders. He views other homicides committed by paranoid personality disordered offenders as often triggered by righteous indignation, or grudges, leading to an explosive attack. He notes that offences characterised by detachment of method, such as mail bombs or poisoning, are likely to involve individuals with schizoid personality disorder, often with accompanying paranoid traits. He finally observes that, in borderline personality disorder, although violence to self and others is common, in females homicide is rare but, when it does occur, is often flamboyant in nature (Stone 1998). Although such observations are of interest, this is a case series and thus provides no robust empirical data. Moreover this is a sample which, by its nature, contains a large proportion of dramatic and sensational homicides and therefore cannot be seen to be representative of a UK population of homicide offenders.

There are a number of Scandinavian studies looking at homicide perpetrators, and different characteristics of both the perpetrator and offence. They are based on national databases, thus constitute national samples. There are, however, methodological limitations which include diagnoses based on records of psychiatric assessments, not standardised assessments and, given the rarity of homicide, sample sizes tend to be small when subgroups are analysed. Moreover, there are questions over the statistical analysis in the studies from Finland, with relative rates being presented as odds ratios and incorrect confidence intervals (Woodward 2000). One of these studies showed a tenfold increased risk of homicide in personality disorder, increasing to 12 times and 54 times increased risk for men and women respectively, for antisocial personality disorder (Eronen et al 1996b).

Other data from Finland examining 50 homicide perpetrators showed that personality disordered offenders of either gender were significantly more likely to kill an acquaintance, and less likely to kill a relative (than those with schizophrenia or no mental illness). Similarly, these were also homicides which tended to be preceded by a quarrel. Although guns, blunt weapons and sharp weapons were frequently used, personality disorder predicted the victim being kicked or hit, as well as injury occurring to the victim's face. They were also more likely to steal from the victim (Hakkanen and Laajasalo 2006).

Another study from Finland looking specifically at homicide by ligature strangulation, demonstrated that 89% (17 of 19 offenders) were diagnosed with a personality disorder, using psychiatric assessments. This was compared with data on Finnish homicide offenders (also who had had psychiatric assessments) using all methods of homicide which showed a prevalence of 51% with personality disorder (Tiihonen, Eronen et al. 1993). The authors suggested that ligature strangulation may be associated with personality disorder (Hakkanen 2005).

Further evidence is described in a study of all Swedish perpetrators of homicide diagnosed with antisocial personality disorder or autistic spectrum disorder between 1996 and 2001. Those with antisocial personality disorder were further divided into impulsive (14 cases) and controlled (13 cases) on the basis of the nature of violence in the homicide. Those who perpetrated impulsive violence were significantly more likely to use knives/sharp objects as a method of homicide (71% versus 11%), whereas the controlled group were more likely to use firearms (50% versus 14%) (Wahlund and Kristiansson 2006). This study is hampered by assessment of personality features such as impulsivity or self-control, based on the nature of violence at a single point in time.

It has been proposed that homicides by psychopathic individuals are less likely to be triggered by domestic disputes or emotional arousal, and that victims are more likely to be male and strangers (Dowson and Grounds 1995). Given the emotional deficit, lack of empathy and



predilection for violence, instrumental goal driven homicidal violence may be prevalent in crimes of psychopathic offenders. However, associations with poor behavioural controls and impulsivity might suggest that reactive violence would be expected (Woodworth and Porter 2002). Some evidence indicates that instrumental violence is associated with psychopathic offenders and stranger homicides (Williamson, Hare et al. 1987; Cornell, Warren et al. 1996). There is, however, increasing support for predominantly instrumental homicides having a reactive component, and vice versa, although it still seems that when compared with non-psychopaths, psychopaths are more likely to perpetrate homicides that are more instrumental in nature. It seems that instrumental violence is associated with factor 1 (affective/interpersonal) scores on the PCL-R, but not with factor 2 (Woodworth and Porter 2002). There is a suggestion that the antisocial behaviour factor of the PCL-SV is associated with reactive violence, and the emotional detachment factor with more instrumental violence (Hart and Dempster 1997).

Furthermore, analysis of official reports indicated that psychopaths were more likely to perpetrate predominantly instrumental homicides but when self-report data was examined, this difference disappeared. Thus, the authors suggest that psychopaths seem to exaggerate the reactive nature of the offence to a greater degree, and were also seen to omit important details of the offence more commonly (Porter and Woodworth 2007). There are also suggestions that psychopaths are more likely to perpetrate sexual homicides and more likely to use greater degrees of sadistic and gratuitous violence during the commission of the offence (Porter, Woodworth et al. 2003).

In an interesting examination of the cognitive associations about violence in psychopathic murderers, compared with non-psychopathic murderers, abnormal social beliefs were demonstrated. Psychopathic murderers had diminished negative reactions to violence and the authors suggest that it is this, rather than poor impulse control or problem solving, which is critical in their offending and may have important implications for future assessment of risk (Gray, MacCulloch et al. 2003).

A study of serial killers demonstrated that all 68 fulfilled criteria for antisocial personality disorder (Geberth and Turco 1997). Cases for this study were acquired through searching media databases, and through personal knowledge as a result of the author's clinical post as a homicide consultant. Serial killers were defined as individuals perpetrating at least two homicides with unknown victims, at different times, often in different locations and where there was no connection between the homicides. Records were examined, such as police reports and records and crime scene photographs, and DSMIV criteria applied (Geberth and Turco 1997). Such methods of data collection and analysis would appear to introduce substantial levels of bias into these results. Rates of psychopathy have been shown to be as high as 31.4% in homicide offenders (Laurell and Daderman 2007), although these were retrospective ratings using psychiatric files.

Personality disorder is also overrepresented in studies of homicide recidivists, with a prevalence of 64% in a sample of 36 homicide recidivists in Finland (Eronen 1996a), although this study is clearly hampered by small sample size and some statistical flaws in the representation of relative rates as odds ratios.

Female homicide offenders have been shown in one study, which compared them with the general population, to be ten times more likely to have any personality disorder, and 70 times as likely to have antisocial personality disorder (Eronen 1995). In another Finnish study Putkonen et al (2001) examined all female homicide perpetrators, who had a psychiatric assessment (75% of the total) between 1982 and 1992. Seventy per cent had a primary diagnosis of a personality disorder and a further 9% a secondary diagnosis. Of the 77 women with personality disorder, 42 had cluster B, 7 had cluster A and 15 had cluster C disorders. When compared with psychotic offenders there were significant differences in features of the homicide. Those with personality disorder were significantly more likely to kill adults and current or former partners, to use stabbing as a method and be intoxicated at the time of the offence. Antecedents to the homicide were more frequently quarrels or long term violence by the victim (Putkonen,

Collander et al. 2001). The rarity of female homicide perpetrators inevitably means that studies examining this in particular are hampered by small sample sizes. It is of note that, in the study detailed above, the nature of the homicides in females with personality disorder (Putkonen, Collander et al. 2001) seems to have been reactive whereas in both male and female offenders (Hakkanen and Laajasalo 2006) it appeared to be a combination, often triggered by a quarrel yet involving financial gain. This would lend support to the theory above, that homicides are rarely exclusively instrumental or reactive. Secondly, it highlights the problems of heterogeneity within personality disorder, and the methodological limitations inherent in subsuming all personality disorders under a global category.

An association between antisocial personality disorder and type II alcoholism (characterised by repeated violent behaviour when intoxicated and serotonergic malfunction) has been demonstrated in homicide perpetrators, perhaps supporting the link between serotonin dysfunction and impulsive aggression (Coccaro, Siever et al. 1989; Tiihonen, Eronen et al. 1993).

### ***1.7 Medicolegal aspects***

The construct of personality disorder is steeped in controversy, not least with its conceptualisation as a psychiatric diagnosis. Defining personality disorder continues to present problems, with the classification systems of ICD 10 and DSM IV remaining disparate in their categorisation and there is ongoing lack of agreement regarding diagnostic methods, with clinical assessment showing poor reliability (Coid 2003). Furthermore, there are concerns amongst some clinicians that it should not be a psychiatric diagnosis, viewing it as merely medicalisation of violent behaviour or social deviance, with medical intervention as an attempt to alleviate societal suffering, rather than that of the individual (Eldergill 2006). Management within mental health services is particularly contentious, exacerbated by the difficulties outlined above and a lack of consensus about effective treatment.

Personality disorder can be seen as a pejorative diagnosis, a label for “patients psychiatrists dislike” and an excuse to deny patients appropriate treatment (Lewis and Appleby 1988). The controversial Dangerous and Severe Personality Disorder (DSPD) programme was launched in 2001 subsequent to a number of high profile homicides and a perceived need for more intensive management of individuals with a severe personality disorder linked to offending behaviour. This included services both within the criminal justice system (HMP Frankland and HMP Whitemoor) and within the NHS. NHS services included those in high secure hospitals (Rampton and Broadmoor hospitals) and additional services within medium secure settings and the community. Following an evaluation of the DSPD programme in 2009, alongside the completion of research into the effectiveness of services to engage with these individuals, some DSPD sites have been decommissioned and the next phase of development of services for managing offenders with severe personality disorder has begun (Joseph and Benefield 2012). Stigmatising views of these individuals are not particular to psychiatrists; a qualitative study of interviews with nursing staff on a DSPD unit in a high secure hospital demonstrated common stigmatising views of patients held by nursing staff, with descriptions of patients as “monstrous” and “evil”. Qualities associated with a negative view of patients with personality disorder included planning the offence; torture or serious violence as part of the offence, especially if the victim was vulnerable; lack of remorse; the lack of a history of childhood sexual abuse and appearing “nice” (Bowers 2002).

Patients with personality disorder are viewed as different from other patients, as not being truly ‘ill’, and therefore not meriting the same access to health services, care and tolerance afforded to patients with, for instance, schizophrenia. Thus they are also seen as culpable and responsible for actions so, when behaviourally disturbed, are often rejected by services (Gunn 2000). In some ways this is unsurprising: these are difficult patients who often reject treatment and improve slowly, if at all. Offenders with personality disorder have poorer outcomes than other mentally disordered offenders or offenders without personality disorder. Compared with

patients with mental illness, recidivism rates in personality disordered patients discharged from high secure settings are two to three times greater (Bailey and MacCulloch 1992). A study of violent female offenders in Finland indicated that one third of those with personality disorder reoffended and that 81% of all repeat offenders had personality disorder (Putkonen, Collander et al. 2001). Patients with personality disorder also have significantly higher rates of previous convictions for both violent and non-violent offending and previous custodial sentences than those with mental illness (Coid, Kahtan et al. 1999). However, although higher rates of violent recidivism were seen in a study of those admitted to special hospitals under the legal category of psychopathic disorder than those under mental illness, any significant difference disappeared when previous offending was controlled for. It was suggested that previous criminal behaviour may impact on the likelihood of being detained under the category of psychopathic disorder (Black and Spinks 1985).

The implicit meaning conveyed in the diagnosis is that they are less deserving of care and treatment, the diagnosis itself being a derogatory label. Some authors point out, however, that this is a criticism of the manner in which the diagnosis is used by clinicians, not of the concept or classification itself (Dowson and Grounds 1995). Notwithstanding this, it is clear that the impact of the diagnosis of personality disorder, and in particular those who are diagnosed as psychopathic, is stigmatising in a wider context than merely among mental health professionals.

The treatability of personality disorder continues to be a controversial issue within psychiatry, although there is emerging evidence for effective treatment for personality disorders other than solely for borderline personality disorder (Clarke, Thomas et al 2013), including evidence for antisocial personality disorder (Doyle 2013). Nonetheless, there continues to be an insufficient evidence base regarding effective treatment, particularly within secure services, but this all too often becomes confused as meaning evidence of absence of any effective treatment. The lack of clarity regarding assessment, diagnosis and management can lead to therapeutic nihilism. Furthermore, given the high prevalence of personality disorder among patients in both

general adult and, particularly, forensic mental health services, many patients with personality disorder are not receiving the structured interventions which they need, and recent evidence indicates that treatment as usual may make some patients worse (Clarke, Thomas et al. 2013). Given that treatment modality has been shown to be less important than the “seriousness and commitment of professionals” involved, this is especially concerning (Bateman and Fonagy 2001).

Furthermore, the apparent necessity of finding one treatment to manage these patients, rather than combining psychological, social and pharmacological approaches in individual patients seems somewhat short-sighted. There are also questions as to why the aim of treatment in personality disorder is often seen as being a cure for the disorder, whereas this is not the case in other disorders, such as schizophrenia and many medical conditions (Taylor 2006).

Concerns have also been raised about the potentially harmful effects of certain treatment settings. The prison environment is often harsh, with sometimes inconsistent discipline, which often mirrors childhood experiences of those with personality disorder, thus reinforcing adverse reactions and the potentially damaging psychological effects of imprisonment have been demonstrated (Andersen, Sestoft et al. 2000). It is necessary to ensure that treatment in hospital avoids exacerbating current disorders (Taylor 2006). There does appear to be emerging evidence supporting a variety of treatments for personality disorder (Bateman and Fonagy 2000; Bateman and Fonagy 2004; Taylor 2006). It seems that, rather than being untreatable, many patients with personality disorder are, instead, inadequately or inappropriately treated. Despite evidence of effectiveness of some interventions, only 54% of Forensic Psychiatrists in a UK survey felt that personality disorder is treatable (Haddock, Snowden et al. 2001). Furthermore, a qualitative study of lead clinicians in medium secure units in England and Wales demonstrated that, not only was a primary diagnosis of personality disorder a reason to refuse admission, it was also seen as a more difficult decision to admit a

patient with comorbid personality disorder owing to concerns about lack of response to treatment and the detrimental impact on both staff and other patients (Grounds, Gelsthorpe et al. 2004). It seems, therefore, that whether or not treatment within mental health services is appropriate for these patients remains a highly contentious issue both within Forensic Psychiatry, and within mental health services more broadly.

It is necessary to acknowledge that, despite the problems inherent in provision of treatment, the cost of untreated personality disorder is substantial, involving further custodial sentences, criminal justice costs, costs to the economy of the loss of the offender and potentially the victim, along with victim costs in health and social services. If wider services are to be provided to these patients there is a need to comprehensively address the health economics, in both the costs of treating and of the failure to treat these individuals (Taylor, Newirth et al. 2006).

The impact of how mental health professionals frame personality disorder, and perhaps more crucially psychopathy, has a potentially crucial impact on how the legal system deals with such offenders. A qualitative study of barristers in England showed that the most important factor to them in relation to psychiatrists giving evidence was clarity of language, followed by a clear prognosis and firm conclusions and recommendations (Leslie, Young et al. 2007). This highlights the difficult juxtaposition between the very clear and definitive views of psychiatrists required within the context of a court, and the difficulties in assuming this position with regard to individuals with personality disorder, exacerbated by the limitations of current classification and insufficient evidence regarding effective interventions. Issues surrounding the diagnosis of psychopathy exemplify these problems. The ability of the PCL-R to predict violence is accorded significant importance within the criminal justice system (Seagrave and Grisso 2002) and evidence from the legal system in the United States showed that the presence of psychopathy was associated with views of greater degrees of culpability, lower treatability and more support for the death penalty in murder cases, even in juveniles (Edens, Guy et al. 2003).

This has clear moral and ethical implications for adults who score highly on the PCL-R but, given that research into early signs of psychopathy remains in its relative infancy, the dilemma in cases concerning adolescents is even more significant. The prediction of psychopathy early, as outlined above, can potentially enable early intervention, commensurate with needs and risks. Concerns have been raised, however, regarding the inevitable use of the prediction of future risk of violence in the criminal justice system, given the respect accorded to the concept of psychopathy and the predictive value of the PCL-R (Seagrave and Grisso 2002). Moreover, the current political climate and public perception means that harsh sentencing would be likely, from a safety conscious court. Finally, the increasing emphasis on prediction of persistence of violence and risk would result in undoubtedly extensive use in delinquency cases. It is therefore necessary that any such measure be reliable and valid. There are issues with regard to personality development that may call the accuracy of such predictions into question. As Cleckley states:

*“Confused manifestations of revolt or self-expression are, as everyone knows, more likely to produce unacceptable behaviour during childhood and adolescence than in adult life. Sometimes persistent traits and tendencies of this sort and inadequate emotional responses indicate the picture of the psychopath early in his career. Sometimes, however, the child or the adolescent will for a while behave in a way that would scarcely seem possible to anyone but the true psychopath and later change, becoming a normal and useful member of society”*(Cleckley 1982) p154.

There is, therefore, a risk that transient features of a developmental process, rather than a persistent trait are being observed. For instance, empathic understanding and abstract thinking do not fully develop until mid-adolescence and are preceded by egocentricity, which may manifest as being ‘grandiose’, ‘unempathic’ and ‘remorseless’, not necessarily enduring characteristics. Additionally, in developing autonomy and an adult - like identity, impulsive, sensation-seeking and risk taking behaviour is normatively present. Moreover, evidence is



inconsistent with some studies finding that the relationship between psychopathy and violent recidivism is eliminated when conduct disorder before 15 years and young age at first conviction are controlled for (Langstrom and Grann 2002).

It seems crucial therefore, despite some encouraging results, to exercise caution in the use of psychopathy in the prediction of recidivism in children and adolescents and it should not be used exclusively in this. The consequences of false positive errors within the criminal justice system adds weight to the argument that the false positive rate in identifying psychopathic traits is possibly unacceptable and that there is a clear need for further longitudinal studies examining callous unemotional traits as a potential developmental precursor of adult psychopathy.

In addition to emerging evidence regarding the possibility of effective interventions, there is also increasing recognition of the lack of temporal stability of personality disorder (Tyrer 2013). Recent evidence demonstrates a decreasing prevalence of antisocial personality disorder and other cluster B disorders with increasing age, in particular over 35 years (Yang, Coid et al. 2010) and that, compared with other clusters, cluster B disorders have been shown to be significantly less pronounced at 12 year follow up (Seivewright 2002). Thus, personality disorder may not be the immutable, unchangeable diagnosis it is often assumed to be, by both mental health professionals and the courts.

Another effect of the current political climate, with the development in 2001, and more recent demise (of those based in high secure hospitals), of specialist Dangerous and Severe Personality Disorder units is an increasing political interest in the problem of personality disorder. This began a decade ago with the publication of the document "Personality Disorder: No longer a diagnosis of exclusion"(National Institute for Mental Health in England 2003), regarding development of services for those with personality disorder. It was hoped that this, alongside increasing professional interest in personality disorder would allow progress through the provision of resources for the development of research and services. A comprehensive

review of empirical research on the DSPD programme indicated an absence of high quality trials of particular environments or treatments. Concerns raised about the programme included a longer admission process than anticipated, staff and patient frustration at delays, a lack of attention to clear criteria for moving on from the units, and to step down facilities (Völlm and Konappa 2012) alongside inadequate access to psychological interventions (Burns, Yiend et al. 2011).

From an economic perspective the funding required is significant. A review of the cost-effectiveness of the DSPD programme, which has revenue costs of £60 million annually, showed lower than predicted patient numbers, higher costs compared to prison not reflected in improved outcomes and no clear advantage to the markedly more expensive hospital based programmes (Barrett and Tyrer 2012). Economic considerations also include wider health and social service implications in addition to multiagency involvement, such as the MAPPP (Multi-agency public protection panels) process.

## ***1.8 Summary of literature review***

Personality disorder remains a highly contentious diagnosis within psychiatry, with some questioning whether it truly represents a mental disorder or not (Vizard, French et al. 2004; Eldergill 2006). With regard to personality, there is evidence of increasing trait consistency with age, but ongoing personality change does occur (Roberts and DelVecchio 2000). There is clear evidence from longitudinal studies of a developmental trajectory from antisocial behaviour in childhood to antisocial personality disorder in adulthood (Caspi, Moffitt et al. 1996). Childhood risk factors have been consistently shown to predict future antisocial behaviour (Farrington 1995) and there is evidence of heritability of personality disorder (Livesley, Jang et al. 1993).

Current categorical classification systems are significantly flawed. They are based on clinical consensus, not empirical evidence, and exhibit poor interrater reliability for subtypes with wide variation of characteristics within subtypes. There is significant overlap between subtypes

and even between clusters. In assessing personality disorder, there is a lack of a gold standard and poor agreement between different assessment tools.

Although the evidence of an association of personality disorder, in particular antisocial personality disorder, with violence is well-documented, current research is hampered by problems of criterion contamination given that violence and aggression are often used to diagnose personality disorder, thus the association becomes somewhat circular. Although it is clear that personality disorder, especially antisocial personality disorder, increases the risk of homicide, the literature on personality disorder in homicide perpetrators has additional methodological limitations with a lack of use of standardised assessment tools, with frequent reliance on diagnoses from psychiatric reports or assessments for court. This evidence is further compounded by the rarity of homicide, inevitably leading to difficulties with small sample sizes. It continues to represent a stigmatising and pejorative diagnosis and there is a lack of robust evidence for effective treatment interventions, resulting in therapeutic nihilism regarding the diagnosis within mental health services. It seems likely that these issues contribute to a demonstrated reluctance among clinicians to attribute the diagnosis (Zimmerman 2010).

These issues provide the context for the development of this study, which will be described in detail in Section 2.1.

## ***Chapter 2 - Background to the current study, Aims and Research Questions***

This chapter outlines the rationale for conducting this study arising from the review of the literature and current data available from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Reasons for a mixed methods study are summarised. The specific aims of the study and research questions are then outlined, and ethical considerations for the project discussed.

### ***2.1 Background to the current study***

There are significant methodological limitations with the existing evidence on personality disorder in homicide. Controversy surrounding classification, as outlined above, with the lack of a gold standard for assessing the presence of personality disorder is a significant problem with all studies of personality disorder. These issues result in the use of a wide range of measures to assess personality disorder. Within research on homicide in particular, there is a lack of use of standardised assessment tools, with frequent reliance on diagnoses from psychiatric reports or assessments for court. Research on homicide is further compounded by the rarity of homicide, inevitably leading to difficulties with small sample sizes. This means that there is often a relatively small number of cases with personality disorder in general, rendering more detailed analysis of particular types of personality disorder, or associations with characteristics of the offence very difficult. There is, therefore, a lack of robust evidence examining personality disorder amongst homicide perpetrators and, in particular, a lack of evidence exploring this in relation to types of personality disorder and offence related factors in more detail.

Data collected by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness ('The Inquiry') provide an opportunity to address at least one of the methodological limitations outlined; that of small sample size. The Inquiry has been collecting

detailed clinical data on a national case series of all people convicted of homicide, including psychiatric reports prepared for court since 1996.

During the eleven year period from 1996-2006, the Inquiry was notified of 5808 homicides in England and Wales. 11% (635) of all homicides had been diagnosed as having a primary or secondary diagnosis of personality disorder by either mental health services or within the court report. Of those with any previous contact with services (1081; 19%), personality disorder was diagnosed in 42% (426). A diagnosis of personality disorder, as primary or secondary diagnosis, was made in just 16% (406) of cases in psychiatric reports prepared for court.

Prevalence figures obtained as part of the ONS study of the prison population, for the offender population in general, showed that the prevalence of personality disorder ranged from 50% for female prisoners to 64% for male sentenced and 78% for male remand prisoners (Singleton, Meltzer et al. 1998). Given this, it seems likely that the figures from the National Confidential Inquiry, based on clinical diagnoses by clinicians in homicide reports, represent an underestimation of the true prevalence of personality disorder in perpetrators of homicide. Therefore, a comparison of prevalence rates made by standardised assessment with those of report writers would provide a more precise and valid estimate of the true prevalence and allow potential exploration of factors associated with the diagnosis.

Furthermore, on reading a number of such reports, it is clear from both the background history and current presentation that some people fulfil the criteria for a diagnosis of personality disorder but this is not diagnosed in the report. Reluctance to diagnose personality disorder amongst clinicians has been highlighted by other authors (Zimmerman 2010). There is, however, a lack of evidence examining factors which may influence the diagnosis of personality disorder within the context of reports prepared for court. It is possible that clinical and criminological factors associated with the perpetrator may exert an influence. Given high rates of comorbidity between substance misuse and personality disorder (Grant 2004), and the significant

association between previous violence and cluster B personality disorders (Coid, Yang et al. 2006a), it might be expected that such factors may increase the likelihood of a diagnosis of personality disorder being given. Conversely, the commonly held view that personality disorder should not be diagnosed in the presence of severe mental illness (Surtees and Kendell 1979), and other evidence indicating that it is less likely to be diagnosed in the presence of mental illness (Paris 2007) ,might be expected to result in a lower likelihood of a personality disorder diagnosis in cases where this is present. Such data are routinely collected by the National Confidential Inquiry and could be analysed to explore this further.

However, given the issues outlined above, there appears to be a number of other factors which could influence attribution of a diagnosis of personality disorder in reports. These relate to an individual clinician's attitudes towards personality disorder and to wider issues regarding the concept of personality disorder, which are not specific to the individual perpetrator. At a fundamental level, controversy surrounding diagnosis and classification, together with the perceived 'treatability' of personality disorder would seem to be relevant. Furthermore, the potentially stigmatising nature of the diagnosis may render clinicians more reluctant to give a diagnosis, particularly if the patient is perceived as untreatable or if services are unavailable (Zimmerman 2005). Such data are unlikely to be obtained through an analysis of factors associated with the perpetrator and a qualitative approach ascertaining the views of clinicians would be more appropriate than quantitative methods to explore this.

## **2.2 Aims**

- 1 Generate a valid and precise estimate of the prevalence of personality disorder in a national case series of homicide perpetrators with court reports using a standardised tool.
- 2 Investigate if there are significant correlations between specific clusters and dimensions of personality disorder and circumstances of the offence.
- 3 Compare the diagnosis made using the standardised tool with the diagnosis made in reports and examine characteristics of cases in which there is disagreement between the two.

- 4 Explore potential reasons for the lack of attribution of a personality disorder diagnosis in reports.

### **2.3 Research Questions**

1. Is there a discrepancy between the diagnosis made in court reports and that made using a standardised tool?
2. If so, what individual level factors pertaining to homicide perpetrators themselves explain this discrepancy?
3. What factors influence report writers in determining whether or not a diagnosis of personality disorder is given within court reports?

### **2.4 Ethical Considerations**

Ethical approval for the quantitative aspect of this particular project is covered by the ethical approval granted to the National Confidential Inquiry by the National Information Governance Board for Health and Social Care, the Patient Information Advisory Group and exemption under Section 251 of the NHS Act 2006 (formerly Section 60 of the Health and Social Care Act 2001) enabling access to confidential and identifiable information without informed consent in the interest of improving patient care. Ethical approval for the qualitative study was granted by University of Manchester Research Ethics Committee and by the Research Governance Sub-Committee of Lancashire Care NHS Foundation Trust.

In both the focus groups and semi-structured interviews discussion was on general issues surrounding clinicians views on the diagnosis of personality disorder; no individual cases were discussed and no patient data were involved.

## **Chapter 3 – Methodology**

This chapter reviews the methodological considerations and theoretical underpinning of the study design. Quantitative and qualitative methodologies, their strengths and weaknesses and epistemological stances are outlined, followed by a discussion of mixed methods research. The design of mixed methods studies, both in general and in this study, is then explored and finally, consideration given to ways in which attempts were made to ensure rigour within this study.

This is a mixed methods study and so subsequent chapters will address the methods used in that particular aspect of the study in greater detail, along with the results.

### **3.1 Quantitative and qualitative methodologies**

Quantitative methods involve the use of standardised, reliable measures, often on a large scale sample. These tend to involve the examination of an *a priori hypothesis*, whereby the validity of predictions is tested experimentally and results analysed statistically. This is often seen as more generalisable than qualitative methods (Silverman 2011). A quantitative approach is frequently associated with the stance of positivism (Pope 2006). Commonly held values associated with this position are that knowledge is derived from verifiable facts and observable phenomena, that research is hypothesis driven and that facts and values are distinct (Bryman 1988). This stance was highly influential within social research during the previous century and has its roots in the belief that the study of the social world can be conducted through invariant laws, in the same way as the natural world (Snape 2003). There is evidence of the predominance of quantitative methods, as against qualitative methods, during the post war period (Morgan 2007) but, during the following decades, positivism was criticised for the lack of attention paid to 'meanings' inherent within the subject being studied. During the 1970s there was increasing criticism of the positivist approach in relation to questions over the relevance of aggregated data to individual lives and concerns regarding the focus on hypothesis driven research resulting in neglect of the value of exploring alternative explanations (Snape 2003). This led to increasing acceptance of qualitative methods and applications as valid and useful



approaches in a number of fields of psychological and health services research (Nicholson 1991). Indeed, it has been suggested that the relative importance accorded to qualitative research is now similar to that of quantitative research (Morgan 2007)

Opposing the stance of positivism is that of interpretivism, which is associated with the qualitative research body. This focuses on the understanding and interpretation of the social world, in addition to observations. The concept of 'lived experiences' was originally proposed by Wilhelm Dilthey in the 19<sup>th</sup> century as being integral to interpretivism (Snape 2003). The stance associated with interpretivism involves the influence of the researcher's position on the interpretation of data as being unavoidable, and that facts and values are not distinct. This renders objective, value-free research impossible, but transparency within the process can minimise problems caused by this (Snape 2003). Interpretivism challenges many assumptions within quantitative research including a preference for large scale samples with the use of operationally defined variables as a means of ensuring validity and subsequent generalisability of results. Qualitative methods have the ability to study phenomena which would be inaccessible through the use of quantitative methods alone, by examining social phenomena within the locus of their particular context. They are useful in addressing research questions which require exploration of social phenomena, particularly complex issues and can give alternative perspectives to quantitative data in a particular area of study (Pope 2006). Qualitative methods have been shown to provide large quantities of rich data and allow greater flexibility of research design. However, they are often viewed solely as a mechanism for initially gaining an understanding of an area of research prior to a more focused quantitative study, with a lack of recognition of their wider uses as a research methodology (Silverman 2011). This relates in part to a common criticism of qualitative methods: that reliability of data is more difficult to ascertain than with quantitative methods. A further criticism highlighted by Silverman (2011) is that of "anecdotalism", focusing on examples within the data which confirm certain

phenomenon, whilst not considering contradictory evidence, which might threaten the validity of results.

### **3.2 Mixed Methods**

Interest in the use of mixed methods research has increased dramatically in the last 30 years in a number of different fields, including health services research (Bryman 2003). Recognition of the potentially useful contribution of a positivist position by some qualitative researchers, alongside the acknowledgment of the wide range of epistemological and ontological perspectives within the qualitative research body has contributed to this (Snape 2003). There has been a focus on taking a more pragmatic approach to research design, with consideration of a range of different methodologies which may more accurately address a particular research question (Seale 1999). It is felt by some researchers that undue adherence to a particular philosophical position is often employed at the expense of the most appropriate research design to answer the research question (Silverman 2011). Silverman cites Hammersley's comment in relation to this:

*"We are not faced, then, with a stark choice between words and numbers, or even between precise and imprecise data; but rather with a range from more to less precise data. Furthermore, our decisions about what level of precision is appropriate in relation to any particular claim should depend on the nature of what we are trying to describe, on the likely accuracy of our descriptions, on our purposes, and on the resources available to us; not on ideological commitment to one methodological paradigm or another"*

*(Hammersley 1992 )*

There are a number of different reasons and advantages to combining qualitative and quantitative approaches. Greene (1989), as part of evaluation research, identified five main justifications for combining methods. These are:

- Triangulation: corroboration of qualitative and quantitative results
- Complementarity: enhancement or clarification of data from one method, with data from another
- Development: informing of one method by results from the other
- Initiation: exploring contradictions and new perspectives
- Expansion: increasing breadth of study (Greene 1989).

Nonetheless, even amongst those in favour of mixed methods research, there is disagreement regarding the manner in which it should take place, and the extent, with some viewing methods from different paradigms as appropriately combined and others vehemently in opposition to this. This opposition relates to concerns regarding the loss of clarity within analyses given differing data collection processes and types of data gathered, which are inherent in different methods (Snape 2003). Morgan (2007) challenges current assumptions regarding clearly defined boundaries of accepted paradigms. He argues that boundaries are defined arbitrarily, overlap occurs and that different paradigms do not represent clear and distinct epistemological positions. This proposed absence of distinctly defined categories calls into question the argument that different paradigms are incommensurate, thus providing further justification for the use of mixed methods research.

Concerns have also been raised that the burgeoning use of mixed methods has come at the expense of a sufficiently rigorous approach to explaining the rationale for its use, which is further complicated by a lack of precise language for discussing mixed methods as a result of the lack of systematic analysis of mixed methods studies (Bryman 2003).

There is also ongoing controversy from a philosophical perspective as to whether it is possible, or even desirable, to combine such disparate methodologies and simultaneously hold the necessary interpretivist stance of qualitative approaches alongside the more positivist assumptions that underline quantitative methods. Although this debate continues amongst

theorists, the popularity of the mixed methods approach in practice shows no signs of waning.

As Bergman states:

*“Mixed methods research works far better in practice than in theory” (Bergman 2008)p2*

Some of these concerns have been addressed by the proposal of a more pragmatic approach, with a focus on methodology which links both abstract epistemological issues with the necessarily more practical methods actually used (Morgan 2007). Morgan proposes a revision of key issues often seen as distinguishing qualitative and quantitative methods, which he views as artificial distinctions in practice. Firstly, he questions the concept of entirely inductive (as in qualitative research) or deductive (in quantitative studies) research, proposing an “abductive” approach which moves fluidly between induction and deduction. This approach is utilised in this study, with the deductive results of the quantitative aspect feeding into the inductive goals of the qualitative. Secondly, he suggests that absolute objectivity or subjectivity are misnomers, advocating “intersubjectivity” as an approach which recognises the possibility of individual interpretations of a single reality. This approach requires particular emphasis on a reflexive position. Finally, he views the distinction between context-dependent and generalisable findings as artificial, proposing the concept of “transferability”, involving constant questioning of how useful and relevant any results are in any alternative circumstances (Morgan 2007).

When examining the most appropriate research method to answer the research questions in this study, a quantitative approach was more appropriate for the analysis of the prevalence of personality disorder in a large sample of homicide perpetrators and identification of individual level factors associated with the diagnosis. The remaining research question, involving exploration of attitudes and beliefs which may explain these findings, was more likely to be accurately assessed using a qualitative approach as it is particularly suited to research on attitudes and values (Buston, Parry-Jones et al. 1998). Whilst acknowledging concerns

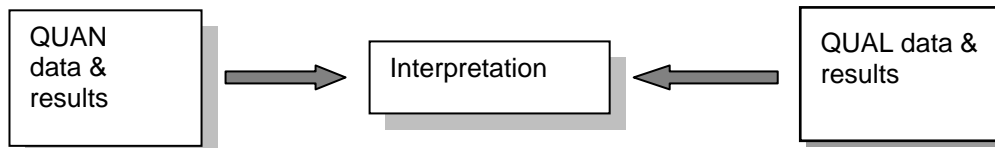
regarding a mixed methods approach it was apparent that this study design was more likely to yield relevant, rich and complementary findings through an exploration of attitudes regarding the diagnosis of personality disorder. This would not have been achievable with quantitative methods alone, and the combination of quantitative and qualitative methods would more fully answer the research questions.

### ***3.3 Approaches to Mixed Methods Research***

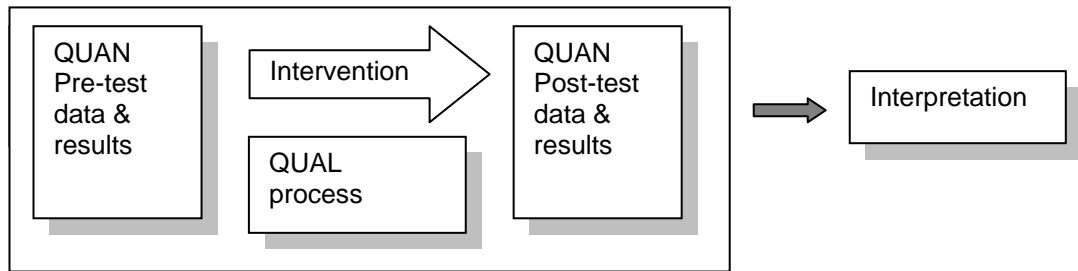
A framework for studies involving mixed methods utilising either concurrent or sequential designs has been developed by Creswell (2003) p68. Concurrently conducted studies can be either a triangulation design, with both qualitative and quantitative results merged together to interpret results, or a concurrent embedded design which involves enhancing a study in one method by the inclusion of a secondary dataset derived from the other method (Figure 3). Sequential mixed methods studies include explanatory, exploratory and sequential embedded designs. The explanatory design involves an initial quantitative study followed by a qualitative study to explain and expand on the quantitative results. This is the approach utilised in this study. The exploratory design involves testing of the initial qualitative results with a quantitative phase, and the sequential embedded design involves a qualitative phase either before or after a quantitative intervention trial to recruit or test the treatment, or explain trial outcomes (Figure 4) (Creswell 2003).

**Figure 3: Concurrently conducted mixed methods studies**

I. Triangulation design

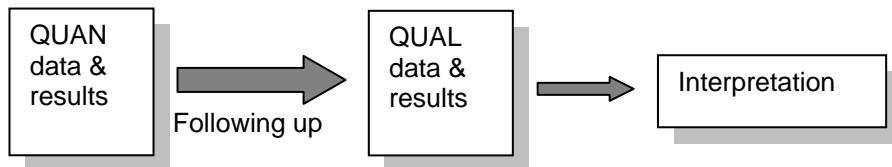


II. Concurrent Embedded Design

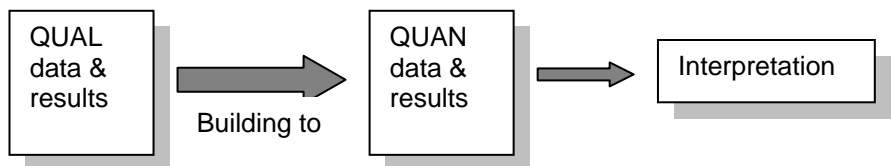


**Figure 4: Sequentially conducted mixed methods studies**

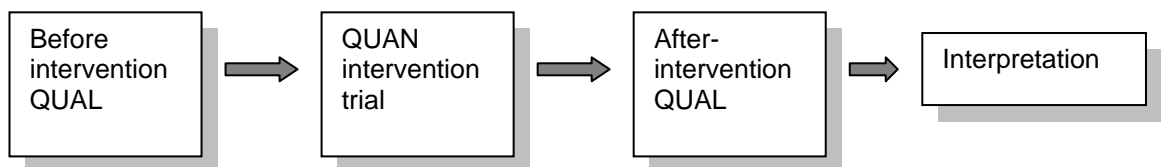
I. Explanatory Design



II. Exploratory Design



III. Sequential Embedded Design



Adapted from Cresswell 2003 p68

### **3.4 Rigour within the research process**

The concept of triangulation, first proposed by Campbell and Fiske as an approach to validate results using different instruments (Campbell 1959), was introduced into qualitative research and is widely seen as a mechanism for validating qualitative results. This is predicated on the assumption that data derived from different methods and sources have differing threats to validity, therefore, if similar results are obtained the risk of inaccurate conclusions is less. This idea has been widely criticised by a number of authors on the grounds that it assumes a 'single reality' with knowable characteristics through the use of different methods and sources of data (Hammersley 2003), and that evidence from epistemologically diverse methods is unlikely to achieve concordance (Snape 2003). This has led to proposals that the true value of triangulation is less in establishing validity, and more in broadening the scope of the analysis (Fielding 1986).

It has been suggested that, rather than necessarily being in conflict, both interpretations of the term can be employed in a complementary manner; both increasing validity and breadth of results. Hammersley argues that the philosophical question of a 'single reality' is of less relevance in practical research and, indeed, any research is predicated on the assumption that there is a single reality with elements which can be discovered and known. Moreover, the use of multiple types of data suggests which interpretations are more likely to have validity. Multiple data sources additionally provides a clearer more detailed picture of the phenomena in question (Hammersley 2003).

Within this study both variants of triangulation have been used. Within the qualitative study semi-structured interviews were used to confirm and increase the validity of themes obtained in the focus groups, along with allowing further development of these themes and the emergence of other potential themes to explain factors influencing the diagnosis of personality disorder in reports. The approach taken was that of the explanatory model of study design, as outlined in

Figure 4. The qualitative aspect as a whole was utilised to add breadth and provide a perspective not available or accessible through the quantitative part of the study.



## ***Chapter 4 - Quantitative study***

This chapter describes the methods used and results obtained within the quantitative study. The first section, on methods, starts with an outline of existing data collection processes within the National Confidential Inquiry as this provided access to the court reports. Measures used to collect data are then described, followed by the sample and the process of analysis of data. The second section describes results obtained through this analysis. These are an estimate of the prevalence of personality disorder in this sample, correlations of dimensions of personality disorder with offence related variables and then factors associated with a diagnosis of personality disorder within court reports. Finally, an analysis of trends in the diagnosis of personality disorder over the duration of the study is presented.

Throughout the results sections percentages are presented as accurate to one decimal place.

### ***4.1 Quantitative Methods***

#### ***4.11 National Confidential Inquiry data collection***

Since 1996 the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness has been collecting detailed data on all homicides in England and Wales. Details on all homicides are provided by the Homicide Index at the Home Office, including perpetrator, victim and method of homicide. Data on antecedents (previous convictions) is acquired from Greater Manchester Police on all perpetrators. Detailed information on the perpetrator is available from psychiatric reports prepared for court, which are collected from Crown Courts. Finally, previous contact with mental health services is established through contact with trusts in the perpetrator's district of residence and, if contact had taken place, further clinical information is gathered on these 'Inquiry cases' by sending a questionnaire to the consultant responsible for the patient's care.

#### **4.12 Measures**

Data are recorded on the Inquiry database on a range of variables from information provided in the court report. These include sociodemographic information, psychiatric history, offending history, the perpetrator's mental state at the time of the offence, whether drugs or alcohol contributed to the offence and the report author's opinion regarding diagnosis and recommendations. Variables pertaining to the victim or victims, such as number, age and relationship, along with method of homicide, are also taken from the Homicide Index as this is more reliable than the psychiatric report for such information.

Those with a diagnosis of any personality disorder and, more specifically, with certain clusters were established using the PAS-DOC (Tyrer 2005) (Appendix 1) on psychiatric reports prepared for court. The PAS-DOC is a document derived version of the Personality Assessment Schedule (PAS) (Tyrer, Alexander et al. 1979). Development of the PAS began in 1976, prior to the introduction of operationalised criteria for personality disorder, in order to examine characteristics of personality disorder, and their associations with each other. Primary traits were selected as those which commonly recurred in the ICD and DSM classifications, along with Schneiderian case histories. Preliminary field studies led to the removal of five primary traits which were highly correlated, resulting in 24 variables. Each trait was rated on the basis of severity of social dysfunction. An agnostic classification was then developed using a computer algorithm to carry out cluster analysis followed by factor and discriminant function analyses. This resulted in the clear identification of four broad categories of personality disorder: sociopathic; passive dependent; anankastic; schizoid. These were further validated by analysis of an additional 256 cases, which also provided a sub classification of 13 categories in total (Tyrer 2000). More recently an algorithm has been developed to address the proposed changes to the classification in ICD-11 (Appendix 2). With regard to the numerical computation of particular domains, 0.2 was added as externalising and internalising domains were considered to be more dominant in terms of disorder than others (Tyrer, personal communication).

The PAS is an extensively used standardised assessment of personality with established reliability and proven predictive value for treatment outcome (Tyrer and Seivewright 1988). Reliability of the ICD-10 version of the PAS has been shown to have excellent interrater reliability in each category (Merson 1994). Cross national reliability for the full PAS is good to excellent for most variables, with lower ratings for those related to mood disturbance such as worthlessness and optimism (Tyrer 1984). These particular variables also exhibit poor temporal reliability, whereas temporal reliability for broader clusters is more reasonable (Tyrer 1983). Criticisms of the PAS include the fact that the categories are not the same as DSM and ICD categories and the dimensional approach taken (Tyrer 2000). However, given that ICD 11 is moving away from a categorical model, and towards a more dimensional assessment (Tyrer 2013), it seems that this will strengthen rather than weaken the clinical utility of the PAS in future. Not only does it provide a dimensional assessment of personality, but it also allows assessment of premorbid personality, not just current functioning. In a population with sizeable proportions of cases with other mental disorders, and symptoms of mental illness at the time of assessment, this is very useful.

A cross-national study examining the inter-rater reliability of the PAS showed improved reliability when an informant was the source of information ( $R_1 = 0.82$ ), compared with the subject themselves ( $R_1 = 0.75$ ) (Tyrer 1984). It follows that, in trying to assess personality status as reliably as possible, it makes sense to use information not only from self-report, but also written records and, where possible, an informant. Although the quality and value of psychiatric reports prepared for court is variable (Chiswick 1985), these reports often combine subject and informant information, a judgement of accuracy and are contemporaneous which aids evaluation of personality. The fact that official sources of information are provided to authors of reports means that the tendency of those with psychopathy to omit significant details of the offence (Porter and Woodworth 2007) can be noted, giving additional insights into personality characteristics. Furthermore, a lifetime diagnosis of personality disorder is conventionally not

given if the patient also fulfils the criteria for a diagnosis of severe mental illness (Surtees and Kendell 1979) as it is often felt that the assessment of personality is confounded by active symptoms of mental illness. Therefore the use of a standardised rating tool is likely to result in a more accurate representation of those with personality disorder, including in those with comorbid mental illness.

The PAS-DOC retains the underlying structure of the PAS, but with modifications to allow information from written records. Reliability of scoring was assessed in a study of case vignettes of known patients in a community mental health team in London. The intraclass correlation coefficient was calculated and showed good to excellent levels of agreement for all personality disorder clusters ( $R_1 = 0.67 - 0.83$ ), other than cluster A (withdrawn) which was fair ( $R_1 = 0.41$ ). Diagnostic accuracy was 71%, with cluster B personalities being most accurately identified (88%) (Tyrer, Coombs et al. 2007).

Inter-rater reliability within the current study was assessed by sending a random sample of 30 (5% of the sample) anonymised reports to Professor Tyrer's team at Imperial College, London. The identifying numbers were randomly generated by staff at the National Confidential Inquiry and the author had no input into the randomisation. These reports were assessed by raters trained in the use of the PAS-DOC, and intra-class coefficients subsequently calculated to establish inter-rater reliability.

#### **4.13 Sample**

Between 1996 until 2006, the National Confidential Inquiry was notified of 5808 homicide perpetrators. All perpetrators under 18 years were excluded at this point as personality disorder is not currently diagnosed in this age group. There are no previous studies looking specifically at prevalence rates of clusters of personality disorder within homicide perpetrators. However, examination of the ONS data on the UK prison population which looks at the offender population in general, allowing for co-morbidity within clusters, indicates rates from 20-28% for

cluster A disorders; 49-72% for cluster B; 7-8% for cluster C and 10% for cluster D in male sentenced prisoners. Rates for female prisoners were 6-24% for cluster A; 31-61% for cluster B; 11-16% for cluster C and 10% for cluster D (Singleton, Meltzer et al. 1998).

Based on this data, a power calculation for sample size required was calculated (Lemeshow, Hosmer et al. 1990). The sample size necessary (n) to estimate the prevalence of any personality disorder and the proportion of offenders with specific clusters of personality disorder to within 5% (d) of the true value with 95% confidence, from a population size (N) of 5000 for males and 500 for females, was calculated as being 600, providing that the sample includes 357 males and 217 females. P represents estimated proportions with personality disorder within the respective clusters and z the critical value of the confidence interval within a standard normal distribution; 1.96 for 95% confidence intervals. The power calculation is detailed below:

$$n = \frac{z^2 P(1-P)N}{d^2(N-1) + z^2 P(1-P)}$$

**From a known male population of 5,000:**

**For Cluster A:** How large a sample is required to estimate the proportion of male offenders with personality disorder A to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 20% to 28%? **Answer: 234 to 292**

**For Cluster B:** How large a sample is required to estimate the proportion of male offenders with personality disorder B to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 49% to 72%? **Answer: 292 to 357**

**For Cluster C+D:** How large a sample is required to estimate the proportion of male offenders with personality disorder C+D to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 10% to 18%? **Answer: 135 to 217**

**For Cluster C:** How large a sample is required to estimate the proportion of male offenders with personality disorder C to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 7% to 8%? **Answer: 98 to 111**

**For Cluster D:** How large a sample is required to estimate the proportion of male offenders with personality disorder D to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 10%? **Answer: 135**

**From a known female population of 500**

**For Cluster A:** How large a sample is required to estimate the proportion of female offenders with personality disorder A to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 6% to 24%? **Answer: 74 to 180**

**For Cluster B:** How large a sample is required to estimate the proportion of female offenders with personality disorder B to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 31% to 61%? **Answer: 199 to 217**

**For Cluster C+D:** How large a sample is required to estimate the proportion of female offenders with personality disorder C+D to within 5% of the true value with 95% confidence

when it is estimated that the proportion of offenders with personality disorder is approximately 11% to 26%? **Answer: 116 to 186**

**For Cluster C:** How large a sample is required to estimate the proportion of female offenders with personality disorder C to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 11% to 16%? **Answer: 116 to 146**

**For Cluster D:** How large a sample is required to estimate the proportion of female offenders with personality disorder D to within 5% of the true value with 95% confidence when it is estimated that the proportion of offenders with personality disorder is approximately 10%? **Answer: 108**

**Hence, having a sample of 600 would satisfy all power calculations provided it included 357 males and 217 females.**

It was also decided that an equal number of cases should be analysed from each year, thus allowing analysis of trends in diagnosis. Although analysis of trends is based on percentage distributions, a proportional number from 1996 and an equal number from each following year was chosen to ensure that sufficient cases from each year were included to allow an accurate estimation of potential trends. It was therefore calculated that 34 males and 21 females should be selected from each year from 1997-2006. 33 males and 17 females were selected from 1996 as data collection did not start until April 1996. This gave 600 cases: 373 males and 227 females. Cases are attributed an identification number ('Form number') according to the order in which they are received by the National Confidential Inquiry from the courts. They are recorded consecutively in the database; there is no clinical aspect to this. Within each particular year and gender group cases were selected by systematic sampling. An initial case was picked at random and every xth case was chosen, x being the total in the group divided by the sample size.

Psychiatric reports are no longer mandatory in cases of homicide following the ruling in R v Reid (2001) whereby it was decided that there would no longer be a requirement for the Crown to obtain a medical report for the benefit of the court (Reid 2001). Therefore the proportion of psychiatric reports received by the National Confidential Inquiry has been decreasing in recent years. However, there has been no significant trends in any diagnostic category over this period (Swinson 2011), and there are no significant trends in personality disorder within this sample. It would seem that the decrease in reports does not appear to be leading to significant bias in results.

#### **4.14 Data analysis**

The data collected from the PAS-DOC (Appendix 1) analysis of 600 reports above were entered on an SPSS database (SPSSInc. 2007) and the analysis carried out using STATA version 11.0 (StataCorp 2009).

Scores from individual personality domains were completed as per the algorithm (Appendix 2). The classification is hierarchical, with those with a sufficiently high score in one domain being classified as Personality Disorder, a high overall score but not sufficiently elevated in one domain as Probable Personality Disorder, high scores on three variables but insufficient data as Possible Personality Disorder and those with high scores on three variables with adequate data as Personality Difficulty. A consensus agreement was reached with Professor Tyrer that, in cases not classified by the algorithm, if the missing data in an individual case exceeded 12 variables (50%), it would not be possible to classify that case. It was agreed within the supervisory team that, in estimating the prevalence of personality disorder, there would be two possible denominators: the total number of cases or the total number of cases minus the number of cases with inadequate data; 95% confidence intervals were calculated for both proportions. Traditional methods of estimating confidence intervals, of using a multiple of the standard error (SE) on either side of the measure should be avoided if proportions are very high or low (Newcombe 2000). Given the high proportion of cases with a diagnosis of personality



disorder, Wilson's confidence interval was used instead (Wilson 1927). This has good statistical properties and achieves greater accuracy, even with more extreme values (Agresti 1998).

The significant degree of overlap between domains of personality disorder unfortunately precluded any analysis of criminological factors associated with particular domains. The proportions in each domain and the extent of overlap were therefore described. The PAS-DOC domains map onto the cluster model of personality disorder classification within DSM IV: schizoid onto A (withdrawn); externalising onto B (flamboyant); internalising onto C (dependent); anankastic onto D (inhibited).

Further analysis of criminological factors associated with dimensional measures of personality disorder were then carried out. The severity of personality disturbance present was calculated as per the algorithm. For those fulfilling the criteria for a definite diagnosis of personality disorder, those cases with more severe personality pathology were identified as either 'severe personality disorder' or 'complex personality disorder', depending on the nature of characteristics. Severe personality disorder is characterised by those who score particularly highly on the externalising domain, and who additionally either fulfill criteria for another domain, or have very high scores for aggression or callousness. Complex personality disorder is present if cases fulfill criteria for two of the remaining domains (internalising, anankastic or schizoid).

Given that the independent variables were dichotomous, logistic regression analysis was carried out to identify any associations between those with severe or complex personality disorder, and offence related variables.

Firstly, key independent variables were entered into univariate analyses for all those with a diagnosis of severe personality disorder. Multivariate analyses were then undertaken to calculate the most significant associations between severe personality disorder and offence related variables. A stepwise estimation model was employed, using first a backward selection to remove variables. Variables which then failed to reach statistical significance at a level of 5%

( $p=0.05$ ) were subsequently excluded from the model. A forward selection was then used, similarly with a statistical significance level of 5% ( $p=0.05$ ) for the addition of variables. Both forward and backward selections were used for validation purposes.

Similarly, key independent variables were entered into a model for a univariate analysis of associations with complex personality disorder to identify independent associations between complex personality disorder and offence related variables, with statistical significance set at 5% ( $p=0.05$ ).

To explore factors associated with the diagnosis of personality disorder in reports, among those diagnosed as personality disordered by the PAS-DOC those with a report diagnosis were compared with those without. This was carried out using chi-squared tests of association, with the use of Fisher's exact test where expected values were less than 5. Given that it was expected that there would be few cases with a report diagnosis who did not fulfil criteria for a diagnosis using the PAS-DOC, it was decided that their clinical characteristics should be reviewed qualitatively in the first instance.

The longitudinal nature of the study also allowed an analysis of trends in diagnosis of personality disorder to be carried out, to evaluate any possible impact of changes in service provision which have occurred during the time period in question.

## **4.2 Quantitative Results**

### **4.21 Prevalence of personality disorder in a national case series of perpetrators of homicide**

During the period from 1996-2006, the Inquiry was notified of 5808 homicides in England and Wales. The power calculation showed that a sample size of 600 was necessary to estimate the prevalence of any personality disorder and the proportion of offenders with specific clusters of personality disorder to within 5% of the true value with 95% confidence, providing that the sample included 357 males and 217 females. Cases were all analysed using the PAS-DOC.

Inter-rater reliability was assessed on a random sample of 30 (5%) court reports by up to five raters and agreement measured using the intra-class coefficient (ICC). All 24 PAS-DOC variables were rated for agreement, giving a mean ICC of 0.58, and median ICC of 0.58. These levels of agreement are comparable to those found in a previous assessment of the reliability of the PAS-DOC, which found ICCs ranging from 0.41 – 0.83, for individual personality clusters (Tyrer, Coombs et al. 2007). Variables with the highest level of agreement were suspiciousness (ICC = 0.83) and irritability (ICC = 0.79), with resourcelessness showing the lowest level of agreement (ICC = 0.37). It is likely that those variables with lower levels of agreement represent those traits which are less explicitly described in court reports. Resourcelessness, for instance, is defined as “lack of inner resolution and resources to deal with adversity in any form” (see Appendix 1), which is likely to be less clearly described, and therefore more open to different interpretations, in the context of a psychiatric report for homicide. Ratings for variables associated with cluster B (externalising) personality disorders, in particular antisocial traits such as aggression (ICC = 0.66), irresponsibility (ICC = 0.68) and sensitivity (ICC = 0.62), tended to show higher levels of agreement than those within other domains. Clinical significance was rated using ranges of ICC developed for inter-rater reliability by Cicchetti and Sparrow (1981): > 0.75 = excellent; 0.6 – 0.74 = good; 0.4 – 0.59 = fair; < 0.4 = poor. Ratings for all variables are shown in Table 1.

**Table 1 : Interrater reliability ratings for PAS-DOC variables**

<b>Variable</b>	<b>Inter-rater correlation (ICC)</b>	<b>Clinical significance<sup>1</sup></b>
Suspiciousness	0.83	Excellent
Irritability	0.79	Excellent
Anxiousness	0.71	Good
Irresponsibility	0.68	Good
Aggression	0.66	Good
Sensitivity	0.62	Good
Worthlessness	0.61	Good
Conscientiousness	0.61	Good
Impulsiveness	0.59	Fair
Childishness	0.59	Fair
Vulnerability	0.58	Fair
Optimism	0.58	Fair
Callousness	0.57	Fair
Lability	0.57	Fair
Pessimism	0.57	Fair
Introspection	0.56	Fair
Rigidity	0.53	Fair
Dependence	0.53	Fair
Submissiveness	0.49	Fair
Shyness	0.49	Fair
Eccentricity	0.48	Fair
Hypochondriasis	0.44	Fair
Aloofness	0.43	Fair
Resourcelessness	0.37	Poor

Scores from individual personality domains were completed as per the algorithm (Appendix 2)

A breakdown of frequencies in each domain, the degree of overlap of particular domains and ratings of severity of personality disorder are detailed in section 4.22.

Three hundred and thirty eight cases fulfilled criteria for at least one domain, i.e. a definite personality disorder diagnosis. These cases were termed 'any PD'. Those who did not fulfil

criteria for a definite diagnosis of personality disorder (n=262) were further analysed according to the algorithm. 13 cases fulfilled criteria for a 'probable personality disorder', with total PAS-DOC scores of over 25 but not sufficient in specific variables to merit a definite diagnosis of personality disorder. Of those that remained (n=249), 102 had three or more scores over three; 6 of these had adequate data, therefore fulfilled criteria for the presence of 'personality difficulty', and 96 had insufficient data so were diagnosed as 'possible personality disorder'. A consensus agreement was reached with Professor Tyrer that, for those cases not classified by the algorithm, if missing data in an individual case exceeded 12 variables (50%) it would not be possible to classify that case.

Only 4 cases fulfilled criteria for a definite diagnosis of no personality disorder; all scores under three with adequate data available, termed 'no PD'. A further 43 cases had all scores under three but an inadequate number of variables. In 100 cases some variables were rated as over three, but, again, there was insufficient data to classify them further. Together these 143 cases were termed 'missing'. This is clearly a substantial proportion of all cases and it is demonstrably difficult to ascertain to what extent this represents the absence of personality disorder in these individuals, the absence of assessment of personality disorder, or even that personality variables are not viewed as significant enough negative findings to document in reports, as would occur with symptoms of mental illness.

Table 2 shows the prevalence of personality disorder, and personality disturbance, within the sample.

**Table 2: Prevalence of personality disorder and personality disturbance**

<b>Degree of personality disorder</b>	<b>n (n = 600)</b>	<b>%</b>
Any personality disorder	338	56.3
Probable personality disorder	13	2.2
Possible personality disorder	96	16
Personality difficulty	6	1
No personality disorder	4	0.7
Missing data	143	23.8

In establishing the prevalence of a definite diagnosis of personality disorder in this sample (any PD), there are two possible denominators; 600 and 457 (total cases minus those with inadequate data). 95% confidence intervals were therefore calculated for both possible denominators using Wilson's Confidence interval (Wilson 1927).

The calculation is as follows, where n= sample size, r = observed number of cases with personality disorder, p=proportion with personality disorder and z=appropriate value from standard Normal distribution:

$$p = r/n$$

$$SE(p) = \sqrt{(p \times (1 - p)/n)}$$

$$95\% \text{ CI} = p - (z \times SE) \text{ to } p + (z \times SE)$$

With a denominator value (n) of 600, r = 338 and z = 1.96 for a 95% confidence interval:

$$\text{If } p = 338/600 = 0.563$$

$$SE(p) = \sqrt{(0.563 \times 0.437/600)} = 0.02$$

$$\text{then } 95\% \text{ CI} = 0.563 - (1.96 \times 0.02) \text{ to } 0.563 + (1.96 \times 0.02)$$

$$= 0.523 - 0.603.$$

With a denominator value (n) of 457, r = 338 and z = 1.96 for a 95% confidence interval:

$$\text{If } p = 338/457 = 0.740$$

$$SE(p) = \sqrt{(0.740 \times 0.260/600)} = 0.02$$

$$\text{then } 95\% \text{ CI} = 0.740 - (1.96 \times 0.02) \text{ to } 0.740 + (1.96 \times 0.02)$$

$$= 0.701 - 0.779$$

Therefore, depending on the denominator used, the prevalence of personality disorder in this sample is either 56.3% with a 95% CI 52.3% - 60.3% if the denominator is the total number of cases (n=600), or 74% with a 95% CI 70.1% - 77.9% if all of those with inadequate data are excluded. Given that it is likely that in those with clinically significant levels of personality disorder the author is likely to mention such characteristics, many of those with insufficient detail in the reports to complete an adequate number of variables will probably not have a diagnosis of personality disorder. Therefore, using the total sample of 600 as a denominator is likely to give a more reliable estimate of the prevalence.

## **4.22 Correlations between domains & dimensions of personality disorder and circumstances of the offence**

### **Frequencies of individual domains**

Scores from individual personality domains were analysed as per the algorithm (Appendix 2). The PAS-DOC domains map onto the cluster model of personality disorder classification within DSM IV: schizoid onto A (withdrawn); externalising onto B (flamboyant); internalising onto C (dependent); anankastic onto D (inhibited).

A breakdown of frequencies is detailed in Table 3.

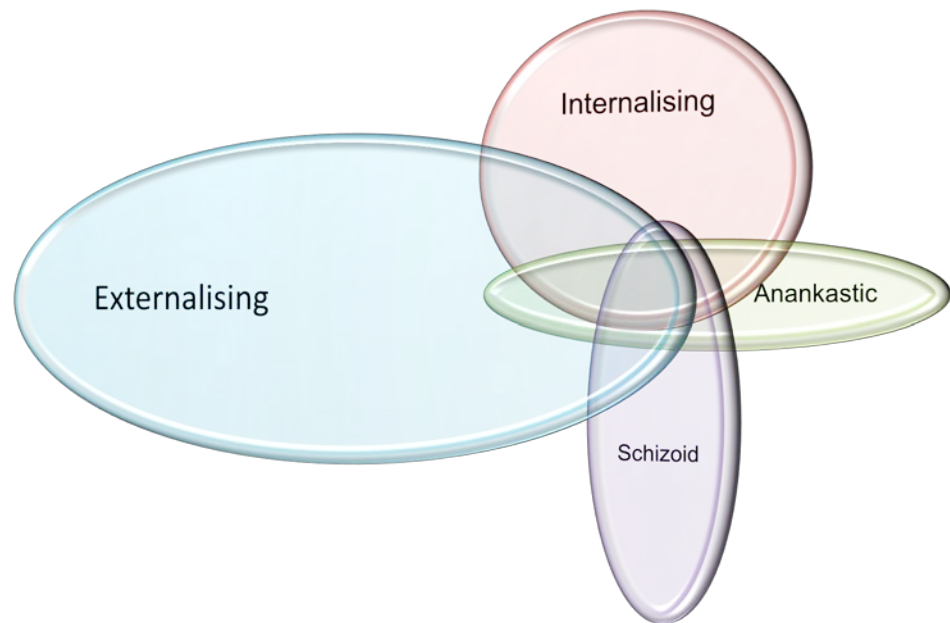
**Table 3: Frequencies of individual personality domains**

<b>Domain</b>	<b>Frequency (n=600)</b>	<b>Percentage (%)</b>
schizoid	75	13
externalising	261	44
internalising	93	16
anankastic	82	14

There was a substantial degree of overlap between domains, with 36 cases falling into at least two domains. Eight cases fulfilled the criteria for all four domains, a further eight for three domains and 20 cases for two domains. The degree of overlap is illustrated in Figure 5.



Figure 5 Degree of overlap between personality domains\*



Given that the domains are not mutually exclusive, and the analysis provides a mixed picture with overlap between the domains in a number of cases, it was decided that it would not be meaningful from a clinical perspective, and not practical, to analyse individual domains separately.

\*This diagram is for illustration purposes only and, although attempts have been made to ensure it represents the degree of overlap as accurately as possible, it is not numerically to scale.

### ***Dimensional analysis: Relationship between severity of personality disorder and offence related variables***

The severity of personality disturbance present was calculated as per the algorithm. Severe personality disorder is characterised by those who score particularly highly on the externalising domain, and who additionally either fulfill criteria for another domain, or have very high scores for aggression or callousness. Complex personality disorder is present if cases fulfill criteria for two of the remaining domains (internalising, anankastic or schizoid). Frequencies for severe and complex personality disorder are shown in Table 4.

**Table 4 Frequencies of severe and complex personality disorder**

<b>Severity of personality disorder</b>	<b>Number of cases (n=600) (%)</b>	<b>Proportion of PD cases (n=338) (%)</b>
Severe	209 (35)	62
Complex	52 (9)	15
Severe and complex	37 (6)	11

### ***Severe personality disorder***

The results of the univariate analysis are shown in Tables 5 and 6 below, with the caveat that, if interpreted as prevalence ratios, the values of the odds ratios are distorted as a result of the high prevalence of severe personality disorder in the personality disorder group (62%), and therefore must be interpreted with caution.

A number of variables were significantly associated with the presence of severe personality disorder and these are highlighted in bold in Tables 5 and 6 below. Several of the variables pertaining to previous convictions were significant: a history of any conviction for violence (OR 3.22;  $p < 0.001$ ; 95%CI 1.98 – 5.24); previous threats of violence (OR 2.93;  $p = 0.002$ ; 95%CI 1.48 – 5.75); previous offence of possession of a weapon (OR 3.90;  $p = 0.001$ ; 95%CI 1.68 – 9.02); previous criminal damage (OR 3.28;  $p < 0.001$ ; 95%CI 1.90 – 5.65). There was also a significant

association between a victim who was a stranger and severe personality disorder (OR 2.47; p=0.017; 95%CI 1.17 – 5.19).

**Table 5 Univariate analysis for severe personality disorder: sociodemographic and historical variables**

Variable	subcategory	Severe PD n (%) (n=209)	All other PDs n (%) (n=129)	Odds Ratio	p value	95% CI
Gender	male	135 (65)	75 (58)	0.62	0.167	0.32 – 1.22
Previous convictions	<b>any violence*</b>	<b>105 (50)</b>	<b>31 (24)</b>	<b>3.22</b>	<b>0.000</b>	<b>1.98 – 5.24</b>
	<b>threats of violence</b>	<b>48 (23)</b>	<b>12 (9)</b>	<b>2.93</b>	<b>0.002</b>	<b>1.48 – 5.75</b>
	<b>possession weapon</b>	<b>38 (18)</b>	<b>7 (5)</b>	<b>3.90</b>	<b>0.001</b>	<b>1.68 – 9.02</b>
	sexual offence	8 (4)	3 (2)	1.69	0.445	0.44 – 6.48
	<b>criminal damage</b>	<b>81 (39)</b>	<b>21 (16)</b>	<b>3.28</b>	<b>0.000</b>	<b>1.90 – 5.65</b>

\*Subcategories in bold are significant at the level of p<0.05. This is the case in all tables.

**Table 6 Univariate analysis for severe personality disorder: offence related variables**

Variable	subcategory	Severe PD n (%) (n=209)	All other PDs n (%) (n=129)	Odds Ratio	p value	95% CI
Contributed to offence	alcohol	15 (14)	5 (7)	2.14	0.157	0.74 - 6.19
	drugs	4 (5)	0	*	*	*
	alcohol or drugs	16 (19)	5 (9)	2.53	0.088	0.87 – 7.35
Victim number	multiple (over 1)	8 (4)	6 (5)	0.82	0.712	0.28 – 2.41
Victim relationship	family	34 (18)	25 (20)	0.82	0.507	0.46 – 1.46
	son/daughter	20 (10)	19 (16)	0.62	0.167	0.32 – 1.22
	parent	5 (3)	5 (4)	0.62	0.455	0.18 – 2.18
	spouse/partner/ex	57 (30)	42 (35)	0.79	0.342	0.49 – 1.29
	family/spouse	91 (48)	67 (56)	0.72	0.160	0.46 – 1.14
	acquaintance	65 (34)	43 (36)	0.92	0.745	0.57 – 1.49
	<b>stranger</b>	<b>35 (18)</b>	<b>10 (8)</b>	<b>2.47</b>	<b>0.017</b>	<b>1.17 – 5.19</b>
	male stranger	26 (22)	8 (12)	2.11	0.087	0.90 – 4.96
	female stranger	9 (13)	2 (4)	3.56	0.115	0.73 – 17.22
	infant	8 (4)	11 (9)	0.43	0.077	0.17 – 1.10
Method	sharp instrument	97 (48)	59 (47)	1.04	0.852	0.67 – 1.63
	blunt instrument	20 (10)	13 (10)	0.95	0.896	0.46 – 1.99
	hitting / kicking	28 (14)	15 (12)	1.19	0.617	0.61 – 2.32
	strangulation	16 (8)	10 (8)	0.99	0.990	0.44 – 2.27
	shooting	6 (3)	4 (3)	0.93	0.913	0.26 – 3.37
	burning	2 (1)	1 (1)	1.25	0.858	0.11 – 13.89
	suffocation	4 (2)	4 (3)	0.61	0.496	0.15 – 2.50
	arson	8 (4)	4 (3)	1.25	0.717	0.37 – 4.25

Within the multivariate analysis for severe personality disorder, both previous convictions for threats of violence and for criminal damage were removed from the model. This culminated in a set of three variables which were significant at the 5% level. The presence of severe personality disorder was significantly associated with prior convictions for both any violent offence and for possession of an offensive weapon, and with a stranger as a victim. These are shown in Table 7 below:

**Table 7 Variables independently associated with severe personality disorder from multivariate analysis**

<b>Variable</b>	<b>Odds Ratio</b>	<b>p value</b>	<b>95% CI</b>
Stranger	2.26	0.039	1.04 – 4.89
Previous violent conviction	2.60	0.000	1.53 – 4.43
Previous conviction possession of weapon	4.28	0.009	1.43 – 12.78

### ***Complex personality disorder***

The results of the univariate analysis are shown in Tables 8 and 9 below. Variables significantly associated with the presence of complex personality disorder are highlighted in bold. Three variables were removed from the model during the analysis as some of the cells contained zero. The only significant associations were with victim type: the victim being a spouse, partner or ex-spouse/partner (OR 2.19; p=0.012; 95%CI 1.19 – 4.04) or a family member or spouse (OR 2.19; p=0.015; 95%CI 1.17 – 4.12). A stranger as a victim was negatively associated with complex personality disorder (OR 0.21; p=0.033; 95%CI 0.05 – 0.88).

**Table 8 Univariate analysis for complex personality disorder: sociodemographic and historical variables**

<b>Variable</b>	<b>subcategory</b>	<b>Complex PD n(%) (n=52)</b>	<b>All other PDs n (%) (n=286)</b>	<b>Odds Ratio</b>	<b>p value</b>	<b>95% CI</b>
Gender	male	35 (67)	175 (61)	0.77	0.404	0.41 – 1.43
Previous convictions	any violence	19 (37)	117 (41)	0.83	0.542	0.45 – 1.52
	threats of violence	10 (19)	50 (18)	1.12	0.770	0.53 – 2.38
	possession of weapon	5 (10)	40 (14)	0.65	0.392	0.24 – 1.74
	sexual offence	2 (4)	9 (3)	1.22	0.801	0.26 – 5.83
	criminal damage	18 (35)	84 (30)	1.27	0.459	0.68 – 2.37

**Table 9 Univariate analysis for complex personality disorder: offence related variables**

Variable	subcategory	Complex PD n(%) (n=52)	All other PDs n (%) (n=286)	Odds Ratio	p value	95% CI
Contributed to offence	alcohol	3 (10)	17 (11)	0.89	0.859	0.24 – 3.24
	drugs	1 (5)	3 (2)	1.90	0.585	0.19 - 19.19
	alcohol or drugs	4 (17)	17 (15)	1.18	0.789	0.36 – 3.87
Victim number	multiple (over 1)	1 (2)	13 (5)	0.41	0.398	0.05 – 3.22
Victim relationship	family	10 (20)	49 (19)	1.05	0.899	0.49 – 2.24
	son/daughter	7 (14)	32 (12)	1.13	0.780	0.47 – 2.73
	parent	2 (4)	8 (3)	1.29	0.755	0.26 – 6.24
	<b>spouse/partner/ex</b>	<b>24 (47)</b>	<b>75 (29)</b>	<b>2.19</b>	<b>0.012</b>	<b>1.19 – 4.04</b>
	<b>family/spouse</b>	<b>34 (67)</b>	<b>124 (48)</b>	<b>2.19</b>	<b>0.015</b>	<b>1.17 – 4.12</b>
	acquaintance	15 (29)	93 (36)	0.75	0.384	0.39 – 1.44
	<b>stranger</b>	<b>2 (4)</b>	<b>43 (17)</b>	<b>0.21</b>	<b>0.033</b>	<b>0.05 – 0.88</b>
	male stranger	2 (6)	32 (21)	0.24	0.059	0.06 – 1.06
	female stranger	0	11 (10)	*	*	*
	infant	2 (4)	17 (6)	0.63	0.546	0.14 – 2.81
Method	sharp instrument	22 (43)	134 (49)	0.80	0.464	0.44 – 1.46
	blunt instrument	8 (16)	25 (9)	1.86	0.157	0.79 – 4.39
	hitting/kicking	4 (8)	39 (14)	0.52	0.227	0.18 – 1.51
	strangulation	7 (14)	19 (7)	2.14	0.106	0.85 – 5.40
	shooting	3 (6)	7 (3)	2.39	0.218	0.60 – 9.60
	burning	0	3 (1)	*	*	*
	arson	2 (4)	10 (4)	1.08	0.921	0.23 – 5.09
	suffocation	0	8 (3)	*	*	*

\*variables dropped from model as predict failure perfectly

#### ***4.23 Sociodemographic, Clinical and Criminological factors associated with a diagnosis of personality disorder in reports***

Of the 338 cases diagnosed as having personality disorder by the PAS-DOC, 83 (25%) were diagnosed as having personality disorder by report authors. This left 255 cases (75%) with a PAS-DOC diagnosis of PD that were not diagnosed as such by reports. These two groups were compared on a range of clinical, criminological and offence related variables using chi-squared tests. The results of this are shown in tables 10 – 13 below. Those given a diagnosis in reports were significantly less likely to come from an ethnic minority; 6% (n = 5) compared with 19% (n = 46) in the group identified as having a personality disorder by the PAS-DOC, but not diagnosed as such in the report, as detailed in table 10. There were no significant differences between those that were diagnosed in the reports, and those that were not, with regard to gender and age; in both groups just over one third of cases were female, and younger age groups were overrepresented.

Table 10 also shows that there was a statistically significant relationship between certain diagnostic categories and the diagnosis of personality disorder within reports. Of those who were diagnosed in reports (n=83), 69% (n=54) had a history of alcohol misuse compared with only 55% (n=126) of those with no diagnosis in the report. Similarly, 68% (n=54) of those diagnosed in reports had a history of drug misuse compared with 51% (n=121) of those who were not. 85% (n=67) of those with a report diagnosis had a history of either alcohol or drug misuse as against 72% (n=171). This suggests that authors were more likely to diagnose personality disorder in those with histories of alcohol and or drug misuse. Interestingly, when alcohol and drug dependence, and other mental disorders such as schizophrenia and affective disorder, were examined there was no significant differences between those given a diagnosis and those not. There were no significant associations between offence related symptoms, including symptoms of mental illness at the material time or the contribution of alcohol or drugs to the offence, and the diagnosis of personality disorder. However, alcohol or drugs contributing to the offence, although not reaching statistical significance was of borderline significance with a



p value of 0.075. This is consistent with the overall pattern, as detailed above, that the presence of alcohol and drugs, either as a pattern of misuse or as a contributory factor to the offence, increases the likelihood of report authors attributing a diagnosis of personality disorder.

**Table 10 Sociodemographic and Clinical factors associated with a diagnosis of personality disorder in reports**

<b>Variable</b>		<b>Report diagnosis positive n (%) (n=83)</b>	<b>Report diagnosis negative n (%) (n=255)</b>	<b>Pearson chi2</b>	<b>Degrees of freedom</b>	<b>p value</b>
<b>Ethnicity</b>	ethnic minority	5 (6)	46 (19)	6.7958	1	0.009
<b>Diagnosis</b>	schizophrenia	4 (5)	27 (11)	2.5017	1	0.130
	affective disorder	16 (19)	45 (18)	0.1125	1	0.737
	alcohol dependence	19 (23)	42 (16)	1.7455	1	0.186
	drug dependence	11 (13)	21 (8)	1.8394	1	0.175
	<b>alcohol misuse</b>	<b>54 (69)</b>	<b>126 (55)</b>	<b>5.1709</b>	<b>1</b>	<b>0.023</b>
	<b>drug misuse</b>	<b>54 (68)</b>	<b>121 (51)</b>	<b>6.3680</b>	<b>1</b>	<b>0.012</b>
	<b>alcohol or drug misuse</b>	<b>67 (85)</b>	<b>171 (72)</b>	<b>4.8898</b>	<b>1</b>	<b>0.027</b>
<b>Offence related symptoms</b>	psychotic symptoms	7 (10)	22 (10)	0.0008	1	0.977
	symptoms of mental illness	19 (26)	57 (25)	0.0309	1	0.860
	alcohol contributed	8 (16)	12 (5)	2.0027	1	0.157
	drugs contributed	2 (6)	2 (2)	1.7365	1	0.188
	alcohol or drugs contributed	9 (24)	12 (12)	3.1713	1	0.075

There were statistically highly significant relationships between previous convictions for most offences and the diagnosis of personality disorder, as seen in Table 11. 60% (n=50) of those with a report diagnosis, compared with 33% (n=86) of those without, had a prior conviction for a violent offence. For previous threats of violence, 29% (n=24) in the report diagnosis group compared with 14% (n=36) without. The proportion in the report group was 20% (n=17) as against 11% (n=28) for offences of possession of a weapon. A previous conviction for criminal damage was also significantly associated with a diagnosis of personality disorder in the report, with 54% (n=45) in the report diagnosis group and 22% (n=57) without. The only offences not to be associated with an increased likelihood of a diagnosis in the report were sexual offences.

**Table 11 Criminological factors associated with a diagnosis of personality disorder in reports**

<b>Variable</b>		<b>Report diagnosis positive n (%) (n=83)</b>	<b>Report diagnosis negative n (%) (n=255)</b>	<b>Pearson chi2</b>	<b>Degrees of freedom</b>	<b>p value</b>
<b>Previous convictions</b>	<b>violence</b>	<b>50 (60)</b>	<b>86 (33)</b>	<b>18.0903</b>	<b>1</b>	<b>0.000</b>
	<b>threats of violence</b>	<b>24 (29)</b>	<b>36 (14)</b>	<b>9.2907</b>	<b>1</b>	<b>0.002</b>
	<b>possession weapon</b>	<b>17 (20)</b>	<b>28 (11)</b>	<b>4.8370</b>	<b>1</b>	<b>0.028</b>
	sexual offence	3 (4)	8 (3)	0.0404	1	0.736
	<b>criminal damage</b>	<b>45 (54)</b>	<b>57 (22)</b>	<b>29.9275</b>	<b>1</b>	<b>0.000</b>

With regard to the victim , Table 12 show that perpetrators with victims aged 25-34 years were significantly less likely to be diagnosed with personality disorder in the reports, with 10% (n=8) with a diagnosis and 19% (n=53) without. There were no other significant associations in number of victims, victim age or relationship.

**Table 12: Offence related (victim) factors associated with a diagnosis of personality disorder in reports**

<b>Variable</b>		<b>Report diagnosis positive n (%) (n=83)</b>	<b>Report diagnosis negative n (%) (n=255)</b>	<b>Pearson chi2</b>	<b>Degrees of freedom</b>	<b>p value</b>
<b>Victim number</b>	multiple (over 1)	2 (2)	12 (5)	0.8316	1	0.531
<b>Victim age (yrs.)</b>	≤16	12 (15)	32 (13)	0.2376	1	0.626
	<25	23 (28)	73 (29)	0.0102	1	0.920
	<b>25-34</b>	<b>8 (10)</b>	<b>53 (19)</b>	<b>5.0904</b>	<b>1</b>	<b>0.024</b>
	35-44	20 (24)	49 (19)	1.0203	1	0.312
	45-54	14 (17)	34 (13)	0.7105	1	0.399
	55-64	7 (9)	24 (9)	0.0569	1	0.811
	65-74	4 (5)	10 (4)	0.1426	1	0.751
	>75	6 (7)	12 (5)	0.8368	1	0.360
<b>Victim relationship</b>	family	15 (19)	44 (19)	0.00046	1	0.946
	son/daughter	10 (13)	29 (12)	0.0075	1	0.931
	parent (of perpetrator)	2 (3)	8 (3)	0.1419	1	1.000
	spouse/partner/ex	27 (35)	72 (31)	0.3715	1	0.542
	acquaintance	28 (36)	80 (34)	0.0630	1	0.802
	stranger	8 (10)	37 (16)	1.4932	1	0.222

There was a significant association with arson as the method of homicide and the diagnosis of personality disorder in the reports, with 8% (n=6) in the report diagnosis group compared with 2% (n=6) in the group without diagnoses, as shown in Table 13. No other methods of homicide were associated with the attribution of a personality disorder diagnosis in the reports.

**Table 13 Offence related (method) factors associated with a diagnosis of personality disorder in reports**

Variable		Report diagnosis positive n (%) (n=83)	Report diagnosis negative n (%) (n=255)	Pearson chi2	Degrees of freedom	p value
<b>Method</b>	sharp instrument	39 (49)	117 (47)	0.0958	1	0.757
	blunt instrument	8 (10)	25 (10)	0.0000	1	0.999
	hitting/kicking	8 (10)	35 (14)	0.8547	1	0.355
	strangulation	7 (9)	19 (8)	0.1113	1	0.739
	shooting	1 (1)	9 (4)	1.1383	1	0.461
	<b>arson</b>	<b>6 (8)</b>	<b>6 (2)</b>	<b>4.5051</b>	<b>1</b>	<b>0.034</b>
	suffocation	2 (3)	6 (2)	0.0026	1	1.000
	burning/scalding	0 (0)	3 (1)	0.9684	1	1.000

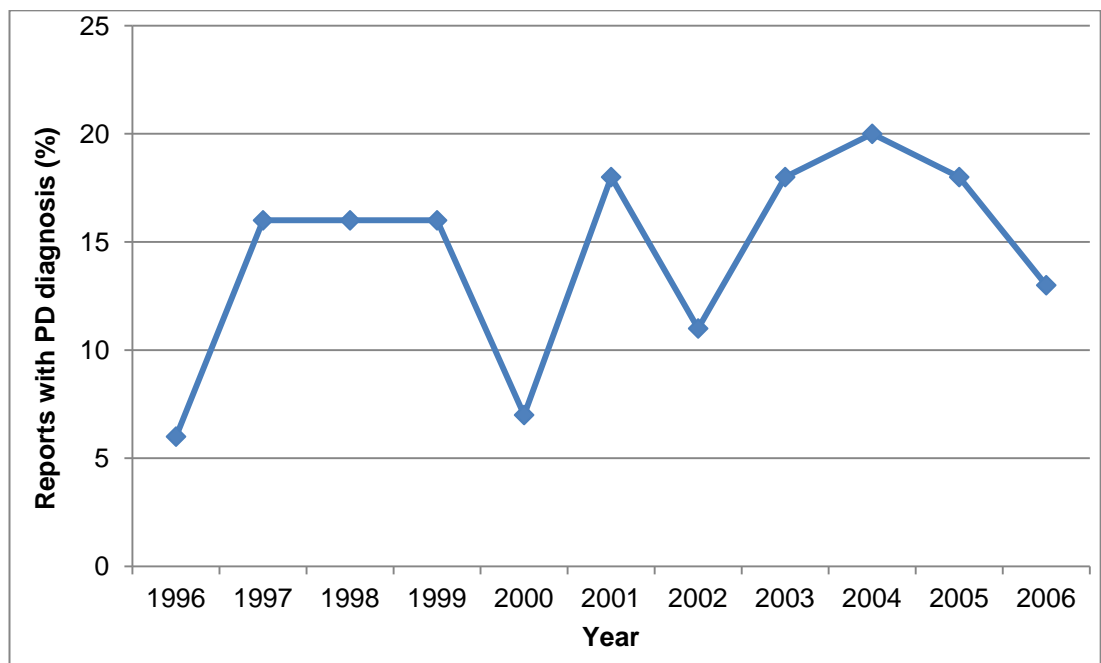
Of the 600 cases in the sample, five were diagnosed as suffering from personality disorder within the report, but not by the PAS-DOC analysis. Given the very small numbers involved it was not possible to conduct any meaningful quantitative analysis of these cases. A brief qualitative review of their clinical characteristics revealed that four of the five had missing data

for at least 18 (75%) variables, with three cases as 'possible personality disorder' as three of the variables present were over three, and the other classified as 'missing data' as no scores were over three. The fifth case had been classified as personality difficulty by the algorithm; there were three or more scores over three but an insufficient score, both in total and in specific variables, to merit either a diagnosis of personality disorder or probable personality disorder.

#### 4.24 Trends analysis

Percentage breakdown of diagnosis of personality disorder within the reports for each year of the study are illustrated in Figure 6.

Figure 6: Reports with diagnosis of personality disorder, year on year



No significant trends were seen in the diagnosis of personality disorder over the duration of the study period, from 1996 – 2006, as calculated using a poisson regression analysis which demonstrated a coefficient of 0 (95% CI 0 – 0.01; p=0.94).

## ***Chapter 5 - Focus Groups***

This chapter begins with the rationale for the use of focus groups to explore results of the quantitative study further. This is followed by a description of the methods used, including the composition and recruitment of participants for the focus groups and processes of data collection and analysis. Finally, the themes emerging from the focus groups are outlined, with a summary of themes which were generated.

### ***5.1 Rationale for Focus Groups***

Within the quantitative study, analysis of factors relating to the perpetrator revealed a number of factors which may increase or decrease the likelihood of a diagnosis of personality disorder being given (see Section 4.23). Factors increasing the likelihood of a diagnosis being given were a history of alcohol abuse, drug abuse or alcohol or drug abuse, previous convictions for violence, threats of violence, possession of a weapon or criminal damage and the method of homicide being arson. The only factor which decreased the likelihood of a diagnosis being given was the age of the victim being between 25 and 34 years. However, the substantial discrepancy between the prevalence of personality disorder in perpetrators of homicide in those who had court reports, as diagnosed by psychiatrists in reports (16%), and the true prevalence as diagnosed by the PAS-DOC (56%) would seem to indicate that factors external to the individual were also exerting an influence. Personality disorder is steeped in controversy in relation to its conceptualisation as a mental disorder, the classification, treatability and the stigmatising nature of the diagnosis. It therefore seemed likely that concerns of psychiatrists preparing reports regarding such issues may have influenced whether or not personality disorder was diagnosed.

Qualitative research is useful in circumstances which are complex and require exploration when relevant variables are not immediately apparent. It can be particularly useful in studying attitudes and beliefs (Buston, Parry-Jones et al. 1998). Given that a detailed understanding of

such phenomena was beyond the scope of the quantitative analysis, these issues were explored further using qualitative methods, with focus groups in the first instance.

As Kitzinger has previously stated:

*“It [the focus group] taps into people’s underlying assumptions and theoretical frameworks and draws out how and why they think as they do. The data generated by this method confront the researcher with the multi-levelled and dynamic nature of people’s understandings, highlighting their fluidity, deviations and contradictions.” (Kitzinger 1994) in (Poso 2008)*

Within focus groups the process of the group and the discussion are used to re-evaluate and clarify the views of participants, and are an ideal manner of exploring attitudes towards an issue (Kitzinger 2006). They offer richness and depth of data and have numerous advantages within qualitative research, not least in providing data less available or accessible outwith the group interaction. Clarification of questions can avoid misconceptions regarding the issue in question, the relatively informal nature allows ‘normal’ conversation with greater candour and other, unanticipated, issues of relevance can often be raised as part of the discussion (Philo 2004). It is possible to explore not only what people think, but why they think it (Morgan 1997). This mirrors the development of attitudes and beliefs generally, which is influenced by interaction with others (Peek 2009). A further advantage is that the rapport which develops both within the participant group, and with the researcher, can lead to participants becoming relaxed and more able to discuss true beliefs (Philo 2004).

There are however, disadvantages to this method, including time and resource implications in recruiting participants, organising the groups and venues and in carrying out the groups. Furthermore, although the group setting may facilitate openness regarding views, if the group is not sufficiently controlled by the moderator, or there are clear inequalities with regard to status of participants, there is a risk of more dominant group members views taking prominence and polarization or conformity of views confounding results (Morgan 1997). Despite these risks,

however, focus groups remain a particularly valuable method of collecting data and lend themselves well to being combined with other qualitative methods, such as interviews on a one to one basis, or questionnaires, through the provision of different perspectives and different types of data (Peek 2009).

## **5.2 Focus Group Methods**

### **5.21 Focus group sample size and composition**

The ideal group size is between four and eight members (Kitzinger 2006), with an upper limit of twelve participants. A smaller size of focus group is preferable as it maximises discussion and allows the expression of varied opinions and disagreement whilst making order within the group easier to maintain. Larger groups render it more difficult for more reserved participants to contribute with the risk of a few individuals dominating the conversation (Peek 2009). Given this, groups of five to six participants were organised. Purposive sampling is the selection of cases with features of interest and relevance to the research question (Silverman 2011). This was used in this study to enable comparisons between clinicians with different levels of experience, both in duration and type of experience.

All participants were Forensic Psychiatrists; either trainees or consultants. It was decided that gaining views of Forensic Psychiatrists still in training, as well as those with experience, would be informative in assessing emerging opinions on personality disorder within the profession, in addition to providing insight into current training. In examining the views of more experienced Forensic Psychiatrists, it was felt that it would be useful to compare those who work solely in clinical practice, with those who have a particular academic interest in personality disorder as approaches between these two groups may differ. A group of practising clinicians were chosen as it was felt that their views would be more generalisable to practising Forensic Psychiatrists, hopefully reflecting views broadly held within the profession. A group of academics with a particular interest in personality disorder was chosen in order to gain views



informed by current evidence, with a more theoretical focus. Segmentation of group composition, separating participants into relatively homogenous groups to allow different perspectives to emerge (Morgan 1998), was carried out in order to minimise the risk of dominance of particular individuals and allow analysis of differences between groups. The three focus groups were therefore trainees (six participants), clinicians (five participants) and academics (five participants).

### **5.22 Focus group recruitment**

For the focus group of trainees, a selection of local specialist trainees was identified and approached via email with a brief description of the study, participant information and consent forms (see Appendix 5). These were sent a week before the focus group to allow adequate time to withdraw if they wished. For the focus group of clinicians, consultant forensic psychiatrists working in North West England were identified and recruited in the same way. For the group of academics, those with expertise in personality disorder at a national level were identified and then recruited using the same process. All of those approached who were available at the time in question agreed to participate and no participants withdrew after receiving the information and the time of the focus group. Details of focus groups participants in terms of demographic information and experience can be seen in Table 14.

**Table 14 Focus group participants: demographic information and experience**

<b>Focus group</b>	<b>Gender male: female</b>	<b>Age (years) mean (range)</b>	<b>Experience in psychiatry (years) mean (range)</b>
Trainees (n = 6)	4:2	33 (30-42)	5 (2 – 11)
Clinicians (n = 5)	2:3	42 (32 – 48)	15 (4 – 22)
Academics (n = 5)	3:2	51 (46 – 65)	22 (18 – 35)

### **5.23 Focus group instrumentation**

Questions on issues to be considered by the focus groups centred on key themes derived from the literature on personality disorder and its diagnosis. These were further refined and included controversy over the diagnosis, treatability, service provision and issues around recommendations for verdict and disposal (see Appendix 3).

### **5.24 Data collection**

The trainee focus group took place after the monthly teaching session as it was felt that participants would find this easy to attend as attendance at the preceding teaching session was mandatory. Both the clinician and academic focus groups were organised to take place during the annual conference of the Forensic Faculty of the Royal College of Psychiatrists in 2008 as all participants were attending the three day event. Rooms were booked through the conference organisers and the groups took place on consecutive evenings after the conference sessions had finished. Refreshments were provided for participants. Each focus group lasted between 45 and 60 minutes. Informed consent was obtained (see Appendix 5) and the participants were aware that they could terminate their involvement in the group at any time if they wished, although no participants did. All focus groups were recorded using electronic recording equipment and subsequently transcribed.

### **5.25 Data analysis**

Data from the focus groups were analysed using NVivo version 9.2 (QSR 2010), qualitative data analysis software to manage the data. Thematic analysis is a process for analysing data collected through ethnographic interviews, the purpose of which is to identify patterns and themes contained within the data (Aronson 1994). Thematic networks have been proposed as a way of facilitating this process (Attride-Stirling 2001). These networks are graphic representations of themes and sub-themes and this technique was adapted for use in organising and presenting data collected during the focus groups.

A coding framework was initially devised based on theoretical issues pertaining to the research questions from the review of the literature, and on relevant issues which emerged from the text of the interviews. The interview transcripts were then systematically dissected, with relevant passages and phrases being applied to the coding framework. Themes were then identified by extracting common and key themes and then were refined to ensure that individual themes were sufficiently broad to encompass ideas from several segments of text, but specific enough to represent one idea or concept. This process generated 124 themes which were examined and analysed further to ascertain goodness of fit. Refinement of themes resulted in the 124 themes being collapsed into 8 main themes with 15 subthemes. The thematic framework with details of both the number of participants who raised the particular theme as an issue and the total number of references to it is shown in Table 15. This process of arranging and rearranging themes culminated in the graphic illustration of themes, as depicted in Figure 5. Each theme was then explored to identify patterns within the data before summarising salient points.

**Table 15: Focus groups themes by participants and references**

<b>Theme</b>	<b>Subtheme</b>	<b>Participants</b>	<b>References</b>
Classification of personality disorder	Validity of categorical system	5	20
	Subtypes of personality disorder	3	10
Diagnostic process	Interpretation of symptoms	5	14
	Threshold for diagnosis	8	27
	The diagnosis of personality disorder and mental illness	6	22
	Diagnosis within context of court report	7	6
Court process	Anxiety regarding giving evidence	7	18
	Interpretation of PD diagnosis within Criminal Justice System	6	16
	Responsibility to Court	6	32
Impact of amendments to the Mental Health Act (1983)		4	12
Recommendations made within reports	Diagnosis	3	20
	Verdict	6	23
	Disposal	7	27
Treatment of personality disorder	Effectiveness of treatment	5	18
	Ethical concerns regarding diagnosis and availability of treatment	8	19
	Service provision	5	16
Training and Experience		7	24
Stigma		6	26

In reporting focus group findings, individual participants are identified by 'T' (trainee group), 'C' (clinician group) and 'A' (academic group) and a randomly allocated number (1-5 or 6) in the results section.

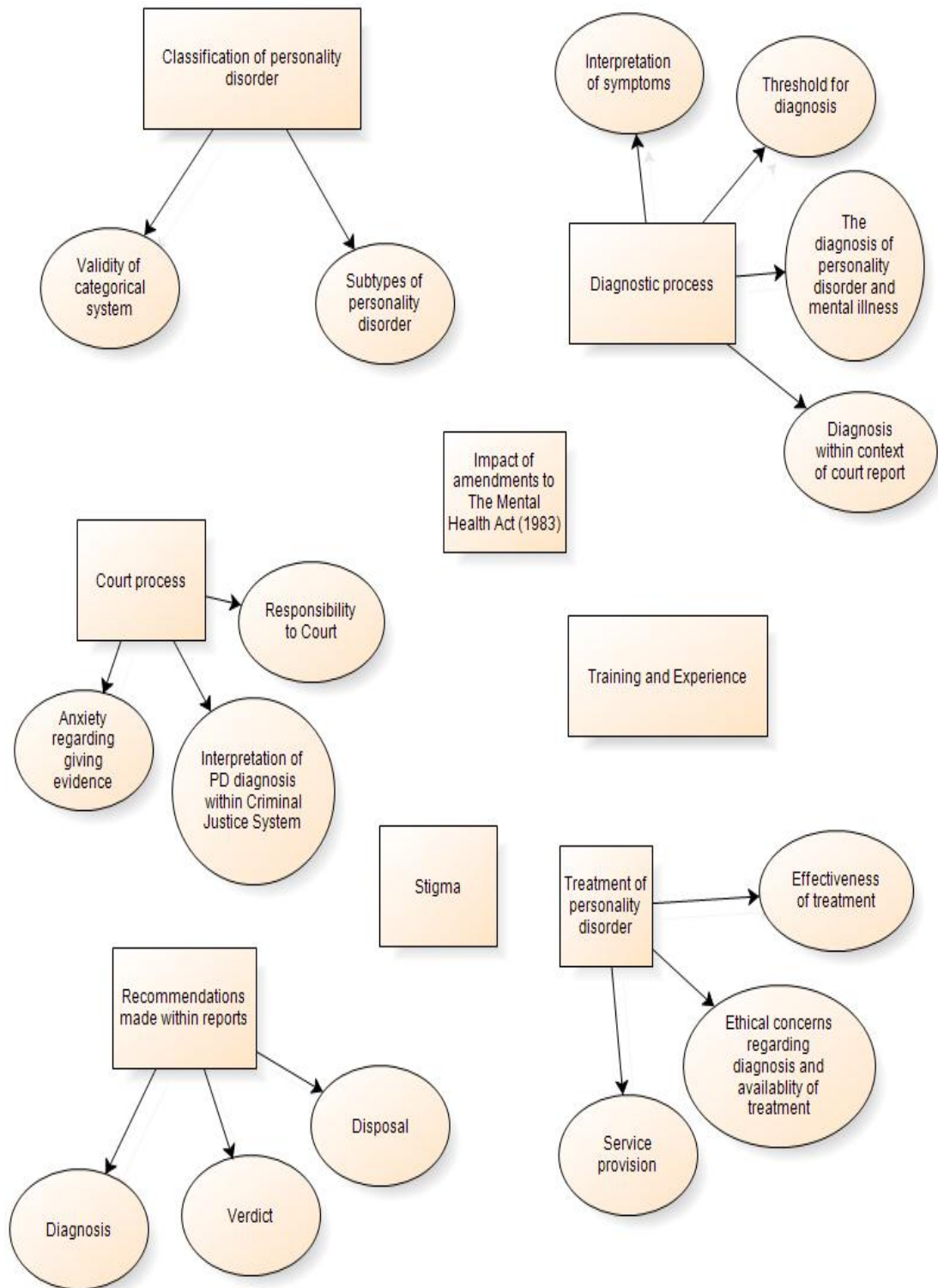
### **5.3 Focus Groups Results**

The focus group results were used to develop initial themes, of which there were 8 main themes with 15 associated subthemes. These then informed the construction of the semi-structured interview schedule (Appendix 4). The semi-structured interviews were more detailed and, given that participants appeared more willing to be frank and open, are likely to be more generalisable. The themes from the semi-structured interviews will therefore be presented and analysed in more detail in Section 6.4 and the themes from the focus groups are presented in Figure 7, and summarised below, with verbatim quotes from participants illustrating themes.

#### **5.31 Themes**

The key themes are: Classification of personality disorder; Diagnostic process; Court process; Impact of amendments to the Mental Health Act (1983); Recommendations made within reports; Treatment of personality disorder; Training and experience; Stigma. There are 15 subthemes associated with these themes. They are not listed in any particular order in relation to significance, but are rather ordered in a clinically intuitive way. This approach is consistent with that of thematic networks; of themes being presented in a non-hierarchical way to allow interconnectivity and fluidity (Attride-Stirling 2001). The themes are presented diagrammatically in Figure 7, with key themes in rectangles and subthemes in circles connected to them.

Figure 7: Focus groups themes



## ***Classification of personality disorder***

Two main subthemes emerged during discussions, which occurred in all groups, regarding the classification of personality disorder. In a general sense, a difficulty in defining categories contributed to a lack of certainty and confidence in making the diagnosis.

*The robustness of the symptoms, or whatever you want to call them that make the diagnosis in the definitions, are still not understood (C2)*

*Defining the different sorts of personality disorders has generally been fairly poor (A3)*

There were concerns regarding the validity of the current categorical system, with particular emphasis within the trainee and clinician groups on the overlap between criminal behaviour and the criteria for antisocial personality disorder, rendering this diagnosis of questionable validity in an offender population. There was also a concern that antisocial personality disorder relies too heavily on behavioural characteristics, rather than interpersonal and affective manifestations of the disorder.

*If you start seeing personality disorder in all these patients then aren't we medicalising crime? (T4)*

*It's all behavioural it's all about, stuff about not having a lot of relationships, not working or having a good work record, erm, being aggressive, you know, being involved in violent acts, it's all you know, very few of them are things like, impulsive, you know, lack of affect (C3)*

Other subtypes were viewed as more straightforward to diagnose, specifically borderline personality disorder, and as identifying traits with a higher degree of temporal stability, such as paranoid personality disorder.

## **Diagnostic process**

Symptoms of personality disorder were viewed as difficult to identify and as less tangible, when compared with those of mental illness, particularly within the context of a relatively brief assessment for a court report. A prominent view within both clinician and trainee groups was that, even if sure of the diagnosis, psychiatrists would be reluctant to give a diagnosis of personality disorder, being much more likely to frame the symptoms as personality traits.

*Basically I talked about personality traits, but was very much confident that the person had a personality disorder, antisocial even (T1)*

Some participants in the trainee group, however, disagreed with this view, believing that this potentially denied the individual treatment.

*Which you could argue then that they're denying someone treatment, you shirk the issue and say this man has traits but not full disorder then you could argue that you're denying someone at least an attempt at treatment, which somebody with mental illness would get without argument. (T6)*

All groups were of the view that, when a diagnosis of personality disorder is made, there is a lack of attention paid to emerging symptoms of mental illness.

*I think there is stigma around personality disorder diagnosis, but almost in the wrong way because once psychiatrists see personality disorder they assume personality disorder but they don't look for the emerging mental illness (T5)*

There was additional anxiety regarding the process of diagnosis in court reports, with a view from trainees and clinicians that rating scales should be used to validate the diagnosis of personality disorder. This was not a universal view; some believed that the diagnosis of personality disorder could be made on clinical grounds in a similar manner to that of mental illness. There was, however, a universal feeling amongst all groups that there is a particular



need in diagnosing personality disorder to acquire a collateral history, other medical records and ideally conduct more than one assessment.

*It's easier to defend a diagnosis of mental illness when challenged whereas it's difficult to do in a personality disorder if you've just used a clinical interview and not used a structured tool (T2)*

### **Court process**

There were high levels of anxiety expressed by most of the trainees, and three within the clinician group, about explaining personality disorder in a court setting, and their opinion being able to withstand cross examination. This was not present in the academic group.

*You can suddenly find yourself standing there thinking whoops I've used the PD term, and who's there to support me in it? (C1)*

Both academics and clinicians were very conscious of the possible negative interpretation of the diagnosis by the court, and the impact on the perpetrator; this was not a view expressed within the trainee group. This led to conflicting views about the role of the psychiatrist in court. Some, in both groups (academics and clinicians), felt that there is an obligation to state findings of the assessment to the court, including if a personality disorder is present. Others felt that psychiatrists should exercise judgement and the diagnosis should be omitted as it may have an inaccurately negative influence on the jury, stating that the overriding principle to adhere to is that of non-maleficence.

*You are aware that what you are saying is going to have an effect you may know that everybody is wrong in interpreting it that way but you can't get away from the fact that that is how they will interpret it. (C4)*

*If it's there, and we know it's there, then we're sort of professionally obliged to state that it's there. (C3)*

*On the grounds that he's dangerous, the doctor said he was dangerous, that gives him another five years, you think Christ what am I doing?.... it is about doing no harm (A1)*

### ***Amendments to the Mental Health act (1983)***

Given the recent, and substantial changes to the Mental Health Act (1983) regarding personality disorder, this was felt to be an important area to consider as potentially changing attitudes to diagnosis. Surprisingly, few psychiatrists had strong views on whether the amendments made any difference to this issue, although some in the clinicians group thought that the broadened definition of mental disorder may make it less easy to hide behind the legal definitions and not give a diagnosis. The removal of psychopathic disorder was seen as a positive move as there was some consternation and discomfort at the concept.

*The whole psychopathic disorder concept is one that troubles people in terms of diagnosis, treatment, they do feel untrained, they do feel isolated in making such diagnosis (C5)*

### ***Recommendations made within reports***

With regard to diagnosis, participants in the clinicians group suggested that authors may decide on what recommendations they intended to make regarding verdict and disposal and then construct the rest of the report to support this view, rather than addressing diagnosis as a separate issue.

*They've looked at what their opinion is going to be, and they work backwards, and because it is irrelevant to the opinion then you leave it out, (C3)*

There were opposing views on recommending diminished responsibility verdicts in individuals with personality disorder. The academic group were concerned that giving the diagnosis may decrease the likelihood of receiving a diminished responsibility verdict.

*You think it's a case where diminished [responsibility] is appropriate erm then on the grounds of schizophrenia or whatever, erm if you then add in about personality disorder it would become a point to actually weaken your case (A2)*

Conversely, some in the clinician group were worried that the diagnosis may act as a mitigating factor and increase the likelihood of a verdict of diminished responsibility.

*The trouble with that with PD you have a risk that yes it gives them that you know erm that mitigation (C5)*

Others in this group, though, felt that it should be available as a possibility for any diagnosis, if they fulfilled the criteria.

*If it is available I think it should be available to everybody (C2)*

There was universal reluctance to recommend a hospital disposal in those with personality disorder. Both the academic and trainee groups had concerns about the impact on their service and colleagues if an individual received a hospital disposal. For this reason, clinicians and trainees both expressed a preference for a transfer from prison as this provides an alternative route such as a return to custody, if treatment is unsuccessful.

*Reluctance to diagnose PD is also related to anxieties about the consequences to you and your service (A4)*

*If there's a question that it's untreatable and they've recommended a 37/41 they think "Oh gosh, I've lumped my colleague with this guy for life" (T4)*

### ***Treatment of personality disorder***

There was a high level of therapeutic nihilism within the trainee group, but an acknowledgement that this may represent a lack of training and knowledge rather than there

being no potential treatment options. The clinician group had concerns about individuals being deemed untreatable in the absence of any attempt to try and treat them.

*I think people are pessimistic about treatability generally, whether that's about not being educated enough or not really following the evidence base for personality disorder as we do for mental illness (T5)*

*The commonest thing I used to see in reports was not that it wasn't psychopathic disorder, but it wasn't treatable. It was that people would say its personality disorder but it's not treatable, having made no efforts to treat (C2)*

Those within the academic group were strongly of the view that if there was no treatment available, the diagnosis should not be given because of the negative impact for the individual.

*The 'do no harm' so if you are making no recommendation or no statement about their prognosis or otherwise for diminished to be considered, erm then you could have serious consequences on an individual by making a diagnosis of Personality Disorder, therefore it's very unlikely that we'd do it (A3)*

Many within the clinician group agreed with this and thought that there was little point in diagnosing if there was no recommendation for treatment.

*People try to avoid because you get no benefit if you're not treating or going to give them treatment, and a whole stack of disadvantages. (C5)*

Some within this group, however, felt that it is the role of the psychiatrist to state an opinion on diagnosis, based on an assessment, and not to alter the opinion as a result of a judgement of the possible impact on sentencing.

*It's not for me to decide telling them this would make it worse for him or better for him it's that I just say this is it. (C2)*

Those within the trainee group commented on service provision, specifically highlighting the DSPD services but feeling that there was a lack of sufficient, wider provision of services. The significant resource implications were commented on, and how feasible it is to offer such services. A theme which emerged within the academic group was the use of diagnoses to facilitate certain desired clinical outcomes; a diagnosis of schizophrenia being made in order to admit to hospital, a shift to a diagnosis of personality disorder if the patient becomes violent or challenging in order to discharge from services, with a return to a diagnosis of schizophrenia if a serious offence is committed in order to facilitate admission to forensic services.

*They start off with someone recognising their psychosis you know they have to go into hospital and come out and they're troublesome and they hit someone and they break their windows, and then they start getting Personality Disorder sometimes it goes right the way down to normal, do you see that? No mental disorder, then they kill someone, and then they're back to schizophrenia usually because that is an entrance to a special hospital (A1)*

### **Training and Experience**

Among both the clinicians and trainees there was a view that psychiatrists are generally more familiar with, therefore more confident in, assessing, diagnosing and managing mental illness rather than personality disorder and so are less likely to diagnose personality disorder.

The trainee group commented more on training issues. There was a view that training on structured assessment tools is lacking, but also that the resource implications of completing such measures is too great for them to have practical utility. They felt they had a lack of awareness of current evidence on personality disorder. Experience in treating patients with personality disorder, although seen as far better in forensic training than other specialties, was still viewed as insufficient.

*I think education is the only way to make this...general training to understand more about PD or on all training rotations or something, because it seems like forensic psychiatrists are the only*

*ones who might actually get experience. Clearly one or two people have proper experience and the rest of us just kind of know a bit about it, so really there's a very small proportion of all psychiatrists who actually know what they're talking about when it comes to this (T5)*

**Stigma**

All groups raised the issue of personality disorder being a diagnosis which is detrimental for patients, and continues to constitute a label which is difficult to remove. It was viewed as having particularly negative consequences within a court setting.

*She gets a bit of a Personality Disorder tag then she's out on her ear (A5)*

*they get a label which then would work against them so if you have a choice of mentioning something that is irrelevant but on the other hand if you do mention it has a negative impact, I think it's perfectly OK to not mention it and take the view that, erm you avoid mentioning things that have negative impacts for other people, that's ok (C1)*

## **Chapter 6 - Semi-Structured Interviews**

This chapter begins with a summary of the findings from the focus groups, and consideration of some methodological difficulties encountered which provides the rationale for the subsequent use of semi-structured interviews. The methods used are then described along with attempts to ensure methodological rigour within the qualitative studies. The final section is a detailed analysis of themes generated from the semi-structured interviews.

### **6.1 Introduction**

Eight themes which were seen as having a potential impact on whether a diagnosis of personality disorder would be given in a court report were generated by the focus groups. These were: Classification of personality disorder; Diagnostic process; Court process; Impact of amendments to the Mental Health Act (1983); Recommendations made within reports; Treatment of personality disorder; Training and experience; Stigma.

There is a risk that if participants in a focus group know one another they may become inhibited in expressing their views (Agar 1995). It has also been suggested that it is difficult to distinguish between comments made expressing true beliefs, and those made because they know others, and what their views are. This is particularly the case if participants are in a senior hierarchical position to other group members (Krueger 2000). Other authors argue that knowing other participants is not necessarily problematic (Kitzinger 1994). Efforts were made to address this in setting up the focus groups, by segmenting participants. From a practical perspective when the relatively small number of forensic psychiatrists in the UK is considered, it would have been exceptionally difficult to organise groups of Forensic Psychiatrists, particularly for the trainee and academic groups, who did not know each other. Therefore, despite efforts to minimise the impact of this, it was the case that some members of all groups knew each other and some were unavoidably in junior or senior roles respectively. It became apparent during the focus groups that there was a tendency for participants within groups to present themselves in what may be perceived as a more favourable light by agreeing with statements made by

colleagues, particularly those senior to themselves. It seemed that these individuals may have been less likely to put forward views which were conflicting, or that could be perceived negatively. This was the case in the presence of colleagues, and particularly for more junior members of the group. This resulted in concerns over how representative the findings were of all members of the group, and therefore also the generalisability of themes. It was therefore decided that the themes generated within the focus groups should be confirmed and explored further using an alternative qualitative method which would avoid these particular issues.

## ***6.2 Rationale for Semi-Structured Interviews***

Focus groups can be ideal for attitudinal research and observing the discussion, and development, of beliefs through interaction (Buston, Parry-Jones et al. 1998). However, for more complex issues needing exploration and where the presence of other participants may inhibit the expression of negatively perceived attitudes, an interview on a one-to-one basis may be a more appropriate method to utilise (Lewis 2003). Such interviews can be advantageous where issues require understanding and clarification of beliefs or attitudes, an individual's decision making and motivation needs exploration and where a detailed personal focus would be of benefit. They are also useful if the subject matter is seen as confidential (Kitzinger 2006), or if the group setting is one where social and professional norms are highly influential, thus stifling views not consistent with that group or profession (Lewis 2003).

Qualitative interviews are increasingly used in health services research (Mays and Pope 2000). They vary in style and the degree to which they are structured, but share common characteristics including an informal style, being rooted in dialogue, a thematic or narrative approach with a flexible structure which flows easily, and involve the reconstruction of knowledge. This approach can be distinguished from the more quantitative approach employed in structured interviews such as surveys (Mason 2002). Qualitative interviews on a one-to-one basis are commonly viewed as being of two main types: in-depth and semi-structured. In-depth interviews tend to be less structured, with broad areas to be covered predetermined, but the



wording, order and manner of questioning is flexible and varies between participants. Semi-structured interviews have key questions which are asked in the same way of all interviewees and involve some probing, but less than in the former type. The flexibility of approaches with regard to the extent to which the sequence of questions can be altered to allow better flow of conversation varies. A potential disadvantage is that, if less probing occurs, more articulate and confident individuals can contribute disproportionately to data gathered (Arthur 2003).

It was decided that carrying out semi-structured interviews would enable further exploration of the themes developed in the focus groups and confirm the importance of key themes, whilst also allowing the emergence of new themes through dialogue. It was decided not to include the members of the focus groups in the subsequent semi-structured interviews owing to concerns regarding the introduction of bias to views as a result of participation in the focus groups. Given the concerns regarding how representative themes were of psychiatrists compiling court reports generally, it was felt that interviewing different participants would increase the representativeness.

As the aim of this aspect of the study was to explore the diagnosis of personality disorder in court reports, psychiatrists with particular experience in writing court reports were chosen for interview, the other being new consultants in order to contrast differing perspectives that experience and more recent training may afford. Given that all participants were consultant forensic psychiatrists it was not felt that the potential disadvantage, as stated above, of disproportionate representation of views of certain individuals would be problematic as all were relatively confident and articulate. It was thought that those with experience would provide a useful assessment of whether the themes from the focus groups reflected those of psychiatrists very involved in the court process. It was hoped that participants would feel more able to be frank and open regarding their views, and feel less constrained by the presence of colleagues, in a one to one situation. The aim was to explore the key themes already established, but have

sufficiently open and flexible interviews to allow different and novel themes to emerge if relevant.

## **6.3 Semi-Structured Interview Methods**

### **6.31 Semi-structured interview sample size and composition**

Following on from concerns raised above regarding the focus groups (Section 6.1), it was decided to interview both new and experienced consultants, seven of each after conducting pilot interviews of one experienced consultant and one new consultant, to allow a sufficient sample for a satisfactory range of opinions. Identification of experienced consultants (n=7) was through the database of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, which has a record of authors of reports, thus allowing the identification of those consultants who have particular expertise in writing court reports. A random sample of newly qualified consultants (within five years of becoming a consultant) (n=7) from North West England was then selected. Inclusion criteria for these participants were that they had qualified as a consultant since 2007 (within the five year period preceding the interviews), and held clinical posts within Forensic Psychiatry. Details of semi-structured interview participants in terms of demographic information and experience can be seen in Table 16.

**Table 16: Semi- structured interview participants: demographic information and experience**

<b>Semi-structured interview participants</b>	<b>Gender male: female</b>	<b>Age (years) mean (range)</b>	<b>Experience within psychiatry (years) mean (range)</b>
Experienced consultants (n=8)	6:2	56 (53 – 62)	28 (26 – 35)
New consultants (n=8)	5:3	37 (34 – 42)	9 (8 – 11)

### **6.32 Semi-structured interview recruitment**

Participants, when identified, were approached via email with a brief description of the study, participant information and consent forms (see Appendix 6). These were sent a week before the interview to allow adequate time to withdraw if they wished. All of those approached agreed to participate and no participants withdrew after receiving the information and the time of the interview.

### **6.33 Semi-structured interview instrumentation**

Given that the purpose of the interviews was to explore further the themes identified in the focus groups, an interview schedule was developed with twelve main semi-structured questions based on key themes that arose in the focus groups, with prompts to help stimulate discussion if necessary (Appendix 4). The main areas covered were diagnosis; recommendations and disposal; ethical issues; recent changes to legislation and service provision; training and education.

### **6.34 Data collection**

Pilot interviews were conducted with one experienced consultant and one new consultant to assess question composition and structure, to ascertain that questions were phrased in a manner which would result in sufficiently rich and relevant data and to gain feedback from participants. The interview schedule did not require amendment following this process as the questions were understood by interviewees and stimulated rich and varied discussions regarding the issues. Feedback from the participants was very positive, one commenting that the interview had made him consider issues that he would not normally have thought about. Data gained from these interviews was therefore included in the final analysis as it contained relevant and insightful opinions which, it was felt in discussion with the supervisory team, would add value to the analysis.

For the subsequent interviews seven new and seven experienced consultants were identified through analysis of numbers of court reports completed using the Inquiry database for the experienced group, and through my awareness of consultants appointed in recent years in North West England for the new consultant group. These interviews took place at a variety of locations according to the most convenient location for interviewees. Some were held at the annual conference of the Forensic Faculty of the Royal College of Psychiatrists in Newcastle in 2012, others at Guild Lodge, Preston, and the remaining ones conducted over the telephone.

It was necessary to conduct some interviews over the telephone as three experienced consultants and one new consultant, were unable to be interviewed in person as they were not attending the conference and work related constraints prevented meeting in person. Including this method of interviewing allowed a broad range of consultants to be interviewed as part of the study. Conducting interviews in person is often seen as preferable to over the telephone owing to the lack of non-verbal cues when not interviewing face to face (Cresswell 2007). Interviews concerning emotionally painful topics, or illegal activities, yield better results if conducted in person (Aquilino 1992). The appropriateness of this method of interviewing is clearly dependent on both the aim of the research and the interviewees. There is evidence that telephone interviewing confers a greater degree of anonymity (Greenfield 2000), therefore may be preferable for sensitive topics. Some researchers have, however, found no difference in quality between the two (Greenfield 2000) . In a study of the views of visitors and correctional officers regarding visiting arrangements in three county jails in the United States, a comparison was made of face-to-face and telephone interviews. This showed a similar quantity and depth of data, and no particular difference in content. The authors concluded that telephone interviewing is an acceptable method of interviewing, particularly if unable to access participants in other ways (Sturges and Hanrahan 2004). Therefore, interviews were conducted in person where possible but, if not, they were conducted over the telephone.

Informed consent was obtained from every participant. Each interview took 30 - 45 minutes, each participant was interviewed on one occasion and the interview could be stopped at any point if the participant wished, although this was not necessary in any cases. As with the focus groups, all were recorded electronically and subsequently transcribed.

### **6.35 Data analysis**

Data from the interviews were analysed using NVivo version 9.2 (QSR 2010), qualitative data analysis software to manage the data. Further exploration of attitudes towards the diagnosis of personality disorder in this population, along with confirming or refuting themes from the focus groups, were then carried out by clustering themes into subcategories. These were then analysed further and examined, with reassessment of the raw data, to ascertain goodness of fit. Clusters of the main themes were then developed. This process initially generated 256 themes which were then collapsed into 8 main themes with 17 subthemes. The thematic framework with details of both the number of participants who raised the particular theme as an issue and the total number of references to it is shown in Table 17.

**Table 17: Semi-structured interview themes by participants and references**

<b>Theme</b>	<b>Subtheme</b>	<b>Participants</b>	<b>References</b>
Classification of personality disorder	Validity of categorical system	9	23
	Current classification system	5	14
	Subtypes of personality disorder	13	56
	Dimensional system	2	12
Diagnostic process	Interpretation of symptoms	5	12
	Threshold for diagnosis	14	38
	The diagnosis of personality disorder and mental illness	14	54
	Diagnosis within context of court report	16	73
Court process	Anxiety regarding giving evidence	4	11
	Interpretation of PD diagnosis within Criminal Justice System	8	38
	Responsibility to Court	13	41
Impact of amendments to the Mental Health Act (1983)		16	25
Recommendations made within reports	Diagnosis	15	31
	Verdict	16	72
	Disposal	16	76
Treatment of personality disorder	Effectiveness of treatment	12	32
	Ethical concerns regarding diagnosis and availability of treatment	16	65
	Service provision	15	73
Training and Experience		16	112
Stigma		15	92

There is ongoing controversy regarding the use of numbers within qualitative data. The inclusion of simple counts to increase the precision of vague term such as 'many' and 'often', sometimes referred to as 'quasi-statistics', is supported by a number of authors (Maxwell 2010). Some authors utilise this point as part of a more general argument against the traditional absolute distinction between quantitative and qualitative research (Hammersley 1992). It can be seen as improving the "*internal generalisability*" of data; provide a check on bias towards a search for uniformity in data by necessitating consideration of divergent views; aid in previously unnoticed pattern recognition; provide evidence for interpretations. There is, however, a danger of reducing evidence to consideration of the quantity of evidence with lack of attention to context, thus incorrectly inflating a sense of generalisability. There is also a risk of conferring a false impression of accuracy in a study with poor methods and design, by confusing precision with validity (Maxwell 2010). Whilst retaining an awareness of the potential pitfalls, I elected to use simple counts in the reporting of themes in the following section. The experienced consultants are identified by 'E' and a randomly allocated number (1-8) and the new consultants identified by 'N' and, similarly, by a randomly allocated number (1-8) in the results section.

### **6.36 Methodological rigour within the qualitative studies**

As detailed in the methodology section, it is crucial to be able to demonstrate ways of ensuring rigour within the qualitative studies. There are certain criteria often cited as being relevant to the quality of an interview. These include an interactive style of questioning which is sufficiently open and flexible to allow the emergence of unanticipated areas (Britten 2006). The interview should elicit spontaneous, detailed and specific answers of sufficient length, involve adequate following up of key points and interpretation throughout the interview, with verification of the interpretation with the subject (Kvale 1996) in (Roulston 2010).

A typology of qualitative interviews has been proposed by Roulston (2010), with six distinct, but often overlapping, approaches: neopositivist; romantic; constructionist; postmodern; transformative; decolonising. The neopositivist approach (Alvesson 2003) assumes that the

interviewee has an inner self which is accessible by an attentive interviewer through sensitive questioning, whilst maintaining a relatively neutral position and contributing minimally to content. The assumption is that both the influence of the researcher and bias within the interview are therefore minimised. Another theoretical assumption is that both the interviewer and interviewee share an understanding of the subject matter. The romantic conception is of greater involvement of the researcher in the interview, with openness regarding their own views to enable more self-revealing conversation from the interviewee. A constructionist approach assumes the interview as a social setting which leads to the generation of situated accounts and a particular version of views on a specific occasion, with a focus on construction of the interview data itself. The postmodern approach questions the concepts of 'subject' and 'field', and of scientific method, and focuses on the representation of society as an ever changing pastiche. Transformative interviews are seen as actively challenging the understanding and beliefs of participants and decolonising interviews relate to culturally sensitive and respectful interviewing of indigenous communities (Roulston 2010)

The neopositivist approach was most relevant to this study in that the aim is to gain greater understanding of participant's current attitudes with minimal influence from the views of the researcher. It is commonly utilised in mixed methods research, often involving the use of semi-structured rather than in depth interviews. This approach is facilitated methodologically by the assumption of a neutral interviewer who does not express their own views and by the use of open questions in a sequence, leading to valid and reliable results. There are a number of criticisms of this including the introduction of bias through the responses acquired, either response bias or social desirability bias; the interviewer biasing the data with their own opinions through question construction, potentially introducing interviewer bias, and the analysis not sufficiently addressing the above concerns. Several possible approaches have been suggested to minimise concerns, and to try and ensure quality in such study: These have been assimilated



into a set of criteria outlined by Roulston (2010). As far as was possible, within time and resource constraints inherent in such a study, these issues were addressed (Table 16).

**Table 18: Measure of quality in this study**

<b>Approach</b>	<b>How addressed</b>
Pilot studies and ethnographic observations	Pilot studies of the interviews were conducted Observations were recorded throughout and immediately after interviews
Multiple methods of data collection to check accuracy; triangulation	Data was collected using both quantitative and qualitative methods. Within the qualitative aspect of data collection, both focus groups and interviews were used.
Multiple interviews with participants to confirm accuracy and stability over time	Time constraints rendered multiple interviews impossible; Interviewees provided with contact details and encouraged to contact me if any further relevant issues occurred to them
Demonstrates longevity of fieldwork to establish credibility of reports	Qualitative study of long duration, with four years between focus groups and semi-structured interviews. Themes generated did not change substantially over this time period, although some new insights emerged. This suggests validity of accounts and consistency of attitudes.
Elimination of bias by using non leading questions in sequence	Questions in the schedule open and non-leading, and asked in the same sequence to all interviewees.
Member checking of interpretations to demonstrate adequate understanding	Throughout interviews interpretations and views regularly checked within individual interviews for clarification and to ensure accurate representation.
Accessible and transparent research process through documentation ensuring replicable	Process thoroughly and comprehensively documented to ensure transparency and replicability.

Adapted from (Roulston 2010)

### ***Reflexivity***

Although, within certain paradigms, there is a desire for neutrality, and concomitant taking of measures to minimise bias inherent within qualitative research, there is an inevitable

influence of the researcher on how the study is both conducted and analysed (Snape 2003). As Schneider stated, interviewers are not "*simple conduits for answers but rather are deeply implicated in the production of answers*" (Schneider 2000).

The process by which the researcher acknowledges and addresses potential influences on the research process is termed reflexivity. Within practice this has been operationally defined as, firstly, consideration of how the presence of the researcher has an impact on responses given (Mays and Pope 2000). In reflecting on my study, the respective position and status of myself, as a trainee with a background in research when the focus groups were carried out and then, as a relatively new consultant during the semi-structured interviews, had a discernible influence. The time period, around four years, between the two data collection time points, made taking a more objective stance towards the focus group results easier as this was reviewed at the time of setting up the semi structured interviews. This also led to an appreciation of where potential gaps were and more interesting aspects to explore in the semi-structured interviews. In some, but certainly not all, interviews with experienced consultants there was a tendency for interviewees to take a somewhat patrician approach to the interview. On the other hand, new consultants with a similar level of experience were more candid and open than may have been the case with an interviewer from a different clinical or academic background, with those with less experience more overtly seeking to leave a good impression. This may have resulted in inhibition of expression of more negative attitudes by these interviewees. However, it was also apparent that the stigma surrounding the diagnosis of personality disorder is such that interviewees felt justified in expressing what could be seen as fairly discriminatory views as they may have been perceived as commonly held attitudes within the profession.

Secondly, reflexivity refers to the impact of an individual researcher's own attitudes and beliefs on the subject matter, both regarding design and formulation of questions and, importantly, in analysis of data. My own background, both in my experience as a forensic

psychiatrist and as a researcher, inevitably had an impact. Clinical experience, both in working with patients with personality disorder and in writing reports for court, meant that I approached this study with an understanding of the relevant issues and not as a 'blank slate'. This understanding has increased throughout this study, as a result of a greater degree of clinical experience in addition to continued involvement in research. I have, however, always held the view that, despite the inherent difficulties in diagnosis and the stigma surrounding it, it is important to give a diagnosis of personality disorder where clinical assessment indicates that it is present. I think that it is fundamentally very difficult to make any progress in refining classification or in developing effective interventions and services without first establishing the nature and extent of the problem. It has also been my experience that giving a diagnosis can be beneficial for patients in both identifying their difficulties and addressing interventions. This experience also meant that I was easily able to relate to the, sometimes complex, issues and dilemmas which arose within the focus groups and interviews and follow these up from a position of awareness. From a practical perspective, it was also an advantage in recruitment of participants and, being viewed as a colleague, seemed to enable interviewees to be open regarding their opinions. Conducting research within the group to which the researcher belongs can be beneficial in that there is familiarity with the particular culture and interactions are more natural, thus facilitating a more easy rapport within the interview (Bonner 2002). A potential pitfall with familiarity with interviewees is an assumption of a shared understanding, leading to a risk of lack of clarity in descriptions. Being aware of this, I was careful to probe interviewees further when this occurred. Despite having my own views on the subject matter, bias potentially introduced by this was minimised by consciously attempting to take a neutral stance within the interviews and contributing minimally to the content. Given that I have worked as a Forensic Psychiatrist for eight years, I am accustomed to taking a dispassionate approach when listening to attitudes and beliefs which do not concur with my own in the context of clinical interviews. These are transferable skills and I made a conscious effort to make no expression of my personal views within the interview. There was also regular feedback on interview technique

from the supervisory team. In many respects, one of the most challenging elements of the study was, surprisingly, in assessing reports as part of the quantitative aspect. This was in approaching the diagnosis of personality disorder as a researcher rather than as a clinician, and discounting clinical intuition in assessing reports. Acknowledging such influences does not necessarily invalidate or devalue data. Rather, it serves to make the research process transparent and the context of data collection and analysis clear, so that it is possible to see that the study has been carried out with sufficient methodological rigour.

## **6.4 Semi-Structured Interview Results**

The semi-structured interviews generated 8 main themes with 17 associated subthemes. Two additional subthemes emerged for the main theme of Classification. Other than this, themes and subthemes were the same as those generated during the focus groups, thus confirming those results. As with the focus groups, they are not listed in any particular order in relation to significance, but are rather ordered in a clinically intuitive way.

### **6.41 Classification of personality disorder**

#### **Validity of Categorical System**

On direct questioning, all experienced and seven new consultants had concerns regarding the validity and reliability of the categorical system. Criticisms were made of the poor specificity and 'checklist' nature of the current classification systems.

*I think the current medical categorical system of diagnosing personality disorders is singularly unhelpful because if you look at any categorical system, you know if you go into DSM IV and tick in boxes for example, most of us will have had those problems at one occasion throughout our lives, yes? (E7)*

*I think if we apply all the criteria very very rigidly and if you view every deviation from the norm as a manifestation of personality disorder I think the real risk is that most of the prisoners, including those who haven't committed homicide, I think would have these diagnostic labels,(N5)*

The overlap between categories, and the difficulties in identifying a particular subtype of personality disorder, leading to the frequent use of the diagnosis Personality Disorder Not Otherwise Specified, was also commented on by an experienced consultant:

*It was Personality Disorder Not Otherwise Specified, in that they had features of all sorts of categorical personalities, and you know, when the most common diagnosis you make is not otherwise specified it does challenge the constructs we use (E7)*

### **Current classification systems**

Amongst those psychiatrists who commented specifically on the current classification systems (all of whom were experienced), there was a preference for the use of DSM IV over ICD10. The criteria and cut-offs in DSM IV were seen as superior, although there was acknowledgement that the drive behind the development of DSM criteria was heavily influenced by financial, insurance related issues, rather than clinical judgement.

*ICD has always been exceptionally poor in its way of defining personality disorder and the DSM has a system where you have a number of criteria and they have cut offs. The reason they do this in the USA is for billing purposes, because if you don't fulfil the criteria you can't claim it back, your treatment back on insurance,(E2)*

There were, however, dissenting views regarding the utility of the checklist system for diagnosis, and concerns about this very stringent, rigid approach, which is present in ICD10 for personality disorder, but no other mental disorders. The use and misuse of the checklist nature of classification systems by lawyers in court, and the potential for psychiatrists aware of this to avoid diagnosing personality disorder as a result, was also raised as a concern by an experienced consultant.

*There are issues about the validity of the categories of diagnosis and I have seen, or have been aware of, psychiatrists being played off against each other because one diagnoses X type of personality disorder and the other diagnoses Y, and then that's used to argue well you can't even agree to what it is...it is a game that the lawyers play and DSM IV and that bit of ICD10 do play into the hands of lawyers who want to play the tick box diagnosis game. I wonder if some people have not made diagnoses of personality disorder in homicide cases because they know*

*that somebody is going to be adding up the number of ticks in the boxes and saying oh you are short of one tick it can't be personality disorder (E8)*

### ***Subtypes of personality disorder***

In response to a direct question as to whether certain subtypes of personality disorder within the current categorical classification systems are easier to diagnose, six experienced and all new consultants felt that this was the case.

Antisocial personality disorder, as defined in DSM IV, was seen as a straightforward and reliable diagnosis to make in this population, whereas dissocial personality disorder within the ICD10 classification was viewed as less valid in identifying core personality traits. However both experienced (n=3) and new (n=1) consultants had concerns regarding the clinical utility of such a diagnosis within the offender population, given its high prevalence and reliance on behavioural characteristics often shared by many offenders. As in the focus groups, the circularity of this was highlighted, as was the need to address other aspects of personality other than behaviour.

*I personally would recommend to anybody to actually use the DSM system but the ICD10 has ludicrous dissocial personality disorder, which is just anybody you don't like, or could behave badly. Antisocial personality disorder is probably one of the most reliable diagnoses in psychiatry, (E2)*

*I think the diagnosis of antisocial personality disorder in an offender is pretty useless unless you do something like the PCLR/PCLSV because I think it's so common that, in a way it's more revealing to report the absence of personality disorder in somebody who's in prison, just to say they have antisocial personality disorder I don't think is very useful (E4)*

*I suppose it's easier to diagnose the antisocial if you have got a good enough history, I mean again I think the difficulty is that anybody who has been in prison a lot and who has*

*offended and then has killed somebody, oh well they are antisocial personality disorder. You can't just rely on the criminal history because they are just criminals, you have to rely on all the other stuff, so it about their ability to form and maintain friendships, and it's the egocentricity of the whole antisocial personality disorder, but I don't think some people take that into account and they just go on, if they have got a forensic history they are antisocial PD, (E5)*

More experienced consultants felt that the constructs of certain subtypes of personality disorders within DSM IV, such as borderline and avoidant, were questionable:

*Some of them are very clear cut syndromes I think, erm..... others are less clear cut and are very fuzzy, and I have to say, I have a little personal twitch around borderline...they even have two kinds of borderline because it is so fuzzy I think you see, you know, anankastic guys, you see dependant/avoidant guys, you see narcissistic guys, you see young, wild, impulsive, antisocial guys erm..... borderline seems a bit more of a mish mash to me, but there are definitely guys in there with things wrong with them, I just don't think they have nailed the descriptions very well yet, and I suspect that will come in time (E6)*

*Some are very difficult erm... you I wonder if avoidant PD exists if it's not social phobia in a mild form (E2)*

Difficulties in distinguishing between paranoid personality disorder and a psychotic illness, particularly on the basis of a single assessment were discussed. One of the more experienced consultants felt that decisions regarding attribution of diagnosis may be influenced more by the perceived lack of clarity of a personality disorder diagnosis in reports, or in court, than by clinical assessment findings.

*Paranoid personality disorder I think is easy to relate causally often to a homicide but many of those cases are rather sort of fuzzy round the edges because of the overlap with a possible psychotic illness. I have seen people who have just gone for the psychosis because it can be*



*put over with a clear cut diagnosis, it's very obviously an abnormality of mind or an abnormality of mental functioning and don't muddy it with the possibility that it may not be a psychosis, it might just be the extreme end of say a paranoid personality disorder. (E8)*

There was disagreement on how straightforward the diagnosis of obsessive compulsive or anankastic personality disorder is, particularly given time constraints.

*I think obsessive compulsive is difficult, I think that unless you really have to, I think, spend quite a lot of time on the instrument (E2)*

*Anankastic personality disorder would also feature quite highly because the symptoms are very erm.... very specific really and very easy to pick up and for the patient to talk about I think, (N7)*

Other factors, unrelated to personality, were also felt to be influential in whether or not a diagnosis is given. These included the influence of physical appearance on dissocial and narcissistic personality disorder and gender on emotionally unstable personality.

*a big muscular patient that would look intimidating talking to you then you start thinking about different personalities and I have often heard people who say dissocial and narcissistic personalities with these patient (N2)*

*I think it's sometimes easier to make a diagnosis of, or at least the cases of most unstable personality disorder that we encounter in females are often so much more florid that one could almost make a diagnosis at the drop of a hat, whereas that same condition in a male might take a lot more teasing out in order to be sure that they had got the features. (E8)*

The lack of experience of dealing with less common personality disorders amongst newer consultants seemed to dissuade them from diagnosing personality disorders other than borderline and antisocial; this was not an issue raised by the more experienced consultants.

Furthermore, within the newer consultant group, an awareness of the potential lack of useful interventions discouraged the diagnosis of dissocial personality disorder, when compared with emotionally unstable personality disorder where there is a perception of more useful treatment available.

*I think an antisocial personality disorder would be someone, I think perhaps the history would be pretty clear so I would be more clear about that. A borderline personality disorder also can be I think more easily understood from the information, but I think I would be sort of wary of making the diagnosis of other personality disorders. (N3)*

*if it was dissocial and then I would be much less likely to comment on that than I would if it was other ones because of the prevalence of dissocial personality disorder in prison, but in part also because of response to treatment. In my head I imagine treatment for unstable personality disorder might be much more available to them, so it's much more useful to comment on that, whereas dissocial less likely to (N6)*

### ***Dimensional system***

Two of the experienced psychiatrists commented on the limitations of the categorical model in the lack of provision for incorporating a measurement of severity, and proposed a dimensional construct as preferable. In the context of a dimensional approach to assessment, the impact of personality disorder on an individual's level of functioning, and the necessity of incorporating this into the assessment process was proposed. This was not an issue raised by any participant in the focus groups. It is possible that, being conducted at a later date, there is increasing support for this approach within the interviews as it is the model being adopted within ICD11.

*I think that the medical categorical systems has nothing at all to do with severity and I think most of us if you look through DSMIV, on a bad day would have at least one, and probably more, personality disorders, ok? I mean all our personalities are different and everybody has*

*one, so that, you know, my logic is that therefore the difference between my personality and someone who is disordered is actually a question of degree not a question of there or not there. I think it's much better to take a psychological view of personalities, which the way I do it you know it's a dimensional construct and then you look for two standard deviations away from the mean. I see it more as blood pressure, or height, you know it's a dimensional thing (E7)*

*I think I have adopted a more structured approach to assessment and diagnosis, so I am much less likely now to say just that somebody has got antisocial personality disorder than I would be to say and erm... you know on the PCL-R, the PCL-SV this is what they score, which means that they have got a pretty severe one, (E4)*

*You have got to go back to how big an impact is this, how big an impact it's had on their lives, you know, if someone has a personality disorder which is an intellectual issue in the sense of, you know, they are still succeeding, married, kids, job, you etc. etc. well it's probably not that significant, if they have never been able to hold down a job, their relationships have been a disaster, you know, or they are always getting sacked for bullying, whatever it is, but if it's having a major impact on their lives then it's more severe (E7).*

## **6.42 Diagnostic process**

### ***Interpretation of symptoms***

Four of the experienced psychiatrists and one new consultant emphasised the need for a thorough assessment of personality with consideration of the impact of any personality difficulties on broader domains and functioning, along with the need for difficulties to be pervasive. The need to examine underlying features, not merely behaviours, was also highlighted. A more comprehensive approach to assessment was also felt to improve management of patients, by identifying underlying problems and causes of the behaviour in question, such that treatment can address those.

*If you use the criteria for each individual personality disorder just as a checklist, I don't think it's particularly valid. I think if you use it in conjunction with a mind-set, that helps you understand what having a personality disorder is all about it's more useful. Otherwise you are making assumptions about the motivation or the drivers to unobserved behaviour, ok for example if somebody is aggressive or violent, they can be aggressive or violent for all sorts of reasons, but if it's about to do with impulse control, if it's about their interpersonal functioning, if it's about how you cognitively, you know what your perception of the environment is, then you interpret the being violent in the setting of the criteria you have to meet to have a personality disorder, does that make sense? (E3)*

*I suppose the behaviours like say headache, well if you have a headache because you have a tumour in your head you do one thing, if you have a headache because you keep banging your head against the wall you have a different, you know if you have a headache because you have migraine you have a different, so knowing where the headaches come from or knowing where the behaviours come from will result in perhaps very different ways of managing, so yes it is important. (E3)*

### **Threshold for diagnosis**

The threshold for diagnosing personality disorder within court reports was seen as relatively high, particularly among more experienced consultants, with a view that the reliability and validity of such a diagnosis is fairly low in less severe or clear cut cases.

*When it's more subtle I think the diagnostic reliability and validity deteriorates as people turn more towards the normal. Like the elephant in the room, most of us usually agree when it's a bad case because it's obvious, if you are having to have a debate about it, it's probably not, I am afraid that's the rule of thumb but I think it's probably quite, you know, has some validity to it (E7)*

*I would suspect that in homicide reports if you get a diagnosis of personality disorder it probably means you have got quite a severe one, it's likely to be because it's fairly obvious and in a sense you would feel a bit silly not mentioning it. (E4)*

Two of the new consultants expressed a tendency to avoid actually giving the diagnosis of personality disorder, but a willingness to describe symptoms present so that the court is aware of risk related issues. This view was not present amongst more experienced consultants. Of note, this view was present among some psychiatrists in the trainee focus group, but also within the clinician focus group, containing more experienced psychiatrists.

*I suppose in some I try to circumnavigate that by describing what the factors of someone's personality are without necessarily giving them a full diagnosis which is (laughs) sitting on the fence in many ways. I think if I identified personality traits that I felt were related to risk I would always detail them even if I didn't give the diagnosis. (N6)*

### ***The diagnosis of personality disorder and mental illness***

In response to a direct question (Appendix 4), all new consultants and five experienced consultants felt that mental illness was a more straightforward diagnosis to make, when compared with personality disorder. One of the factors contributing to this was the pervasive nature of personality disorder, compared with the often more sudden and distinct changes seen in mental illness. The resultant comparison of characteristics with a perceived 'normality' within the general population, rather than with the individual's previous presentation was seen as exacerbating this. Further explanations included the lack of appreciation of the need for a more longitudinal assessment, and more easily identifiable symptoms within a single assessment

*The diagnosis of mental illness involves at some point change away from some sort of previous normality, is a very different activity from diagnosing a developmental disorder where the comparison is not with some previous normality its by comparison with a "normal*

*population". We don't talk about personality illness; we talk about personality disorder because it's a very fuzzy, much more fuzzier notion (E1)*

*I often, I am more certain as to whether or not somebody has an auditory hallucination than I am certain as to whether or not they are lacking in remorse, in a one off assessment people can weep buckets and want to give the impression that they are full of remorse when in fact they are not,(E8)*

Issues surrounding co-morbid mental illness and personality disorder were raised by both experienced and newer consultants. The belief that personality disorder should not be diagnosed in the presence of severe mental illness was discussed by two experienced consultants. Both experienced and new consultants also commented on the lack of attention given to personality assessment and the diagnosis of personality disorder within secure services, once the patient has a diagnosis of severe mental illness; interestingly the converse view was given in the focus groups, that symptoms of mental illness are overlooked when a personality disorder diagnosis has been made.

*You need to actually accept that you can be, you know, why is it actually that some of your patients with schizophrenia, you know that have got schizophrenia but everybody hates them, why is that? Why are they so awful? Why are they vile? Why are they creeping up the back of people, you know they have not assaulted that poor nurse because the voices were telling...even though they say, it's because they are also a psychopath.(E2)*

*so you have to train people because, as I say, most of our mentally ill guys have got some sort of PD and I think that's another under-diagnosis, I think you know, once we have said paranoid schizophrenia often we don't bother too much about nailing additional PD's if you see what I mean, and only if they are of sort of epic severity do we bother, but loads of them, in this hospital and in the RSU's I am sure have significant personality disorders but hidden a bit under*

*the mental illness and were we fussed we could diagnose them too, I mean I am sure we underdiagnose them. (E6)*

The impact of not identifying personality disorder was seen as leading to a lack of perceived need to address personality related issues, with regard to both the treatment of personality disorder and risk. Furthermore, it was also felt that the interpretation of behaviour and symptoms was significantly influenced by the initially attributed diagnosis.

*Much of the focus is on risks related to the actual mental illness and some reference to personality disorder, but there is a tendency to not particularly address it conclusively or definitively because it is felt the mental illness is the bigger problem ergo personality disorder does not need attention, or needs only minimal intervention (N2)*

*If mentally ill guys present and do something a bit odd or a bit unusual or whatever, you tend to look for a mental illness explanation, but as I say loads of them are both (E6)*

The difference in the respective risks and benefits to the individual of giving a diagnosis of personality disorder compared with a diagnosis of mental illness was raised by experienced and newer consultants. There was a perception that a diagnosis of personality disorder may adversely affect the patient, without bringing with it the clear benefits of treatment and intervention which would follow a diagnosis of mental illness.

*I mean I do make the diagnosis all the time I have to say, erm.... but you do think twice in the sense that probably people are not going to do very much about it, so the balance of erm... possibly doing someone harm and possibly getting them benefit I think is different for mental illness than it is for personality disorder, if you make a diagnosis of mental illness you would hope that that may be helpful in getting someone some treatment erm... but I think that's much less likely if you make a diagnosis of personality disorder,(E4)*

*I worry that those diagnoses of personality disorder will affect the patient negatively, whereas I suppose I always think that making a clear diagnosis of mental illness is a helpful thing to do for a patient because, you know, it will be good for communicating and getting help from other agencies (N5)*

Amongst new consultants, but not experienced, there was a universal view that they were more confident in making a diagnosis of mental illness and were reluctant to diagnose personality disorder, partially due to a lack of experience in working with patients with personality disorder. Additionally there were suggestions that, because of this, psychiatrists would try and find an axis 1 disorder even if personality disorder seemed the most likely primary diagnosis.

*I think in reality I think because I don't work, I think solely with patients with personality disorder erm... and because I don't regularly use the IPDE, I have been training in doing the IPDE but unfortunately don't use it on a regular basis myself, although I am involved in sort of discussion about it, I think I certainly wouldn't feel as confident to diagnose PD as mental illness. I suppose you could say that's wrong really because obviously the rating scales for erm... schizophrenia are in the same way really so why do we feel more confident in just giving a clinical diagnosis of that compared to erm... yes, personality issues (N4)*

*which is the psychiatrist's alibi where you actually say, look, this guy, even as a lay person, this guy is a nasty piece of work and we are talking about personality disorder here, but people try and tease out and find some form of psychiatric disorder, particularly PTSD, if somebody has been in the armed forces and they have committed homicide, it is not unusual for somebody to say ah! PTSD and then possible personality disorder in Axis II. (N8)*

### **Diagnosis within the context of court reports**

Difficulty in making the diagnosis in the absence of corroborative information, in a single assessment, was raised by four experienced and six new consultants. Issues surrounding



availability and accessibility of relevant informants, particularly given the nature of the offence and the potential involvement of family members as witnesses or victims were also highlighted as being problematic.

*a lot of the evidence of personality disorder comes from the interpretation of aspects of the history, either as it is given by the person or as it is set out in the various records that may be available, and of course a combination of the two, I think that part of the diagnosis of personality disorder comes from seeing the way the person behaves and interacts and a one off consultation where there is an obvious agenda, I don't think lends itself to the sort of interactions that may help with that. The other bit that is often missing in a, when you do a report on homicide, is information from people who know the person well, like partner, was it maybe the partner who is actually the victim, family and so on. Having said that, as long as you approach it in, as long as you approach the assessment with sufficient thoroughness and you have enough information, then you ought to be able to reliably make the diagnosis (E8)*

There was a feeling that, despite these difficulties, certain subtypes such as borderline and antisocial personality disorders were more easily and reliably identified in such an assessment. Other personality characteristics, such as envy, were seen as more difficult to elicit in a single interview.

*I think those [borderline and antisocial personality disorders] are easier in terms of, for a lot of those you probably would tell even before you get to the collaborative history by the informant just from the history, you see the pattern of relationships, the intensity, the instability and even on the interview itself you would be able to see evidence that I think we are talking about personality disorder, so by the time you get an informant you are actually confirming what you already suspect. (N8)*

*Some of those things [e.g. envy] are almost impossible to elicit in a classic way, certainly from the questionnaire, you actually have to know the patient quite well, know an awful lot about*

*them erm to actually find these things, things like sort of erm...envy, problems with envy, which is very difficult erm.. to actually sort of define in terms of a one off interview, you can see it if you get enough history, which the adult general psychiatrist rarely does, but the forensic psychiatrist might (E2)*

Six of the sixteen psychiatrists interviewed; one experienced and five new consultants, strongly felt that a diagnosis of personality disorder should not be given without a psychometric assessment to confirm it. Psychometry was also seen as beneficial in mitigating against cultural gaps between the psychiatrist and the individual. This was also a prominent view from trainees and clinicians in the focus groups.

*the reason psychometry is important is because although it doesn't necessarily map on to DSM, what it gives you is, if you like, approach to the diagnosis from two different paradigms, I think I normally do it because I mainly do murder trials and appeals and I think the stakes are so high you ought to leave no stone unturned (E1)*

*I actually think, well I suppose I think it's a bit unethical to diagnose, label somebody as personality disorder without actually doing a proper PD assessment on them, by just sort of, just looking at the information you get for a court report. I think you should, obviously if somebody has got , you know a long history of offending behaviour, particularly a history of violence, other offending behaviour and you know, they were diagnosed as having a conduct disorder as a child erm.. and on paper it looks like they have got an antisocial personality disorder, you would, I would comment on it but I wouldn't be saying this person, you know, definitely has this diagnosis, because I have not done an IPDE on them. (N7)*

However, concerns were raised at the interpretation of findings of standardised assessments by psychologists within reports, with a view that often the clinical aspects of personality are looked at in isolation from how they impact on functioning, which was viewed as

critical in making the diagnosis. Other concerns were also raised regarding the incorrect use of instruments, or at the attribution of psychopathy in young people.

*I think psychologists make a diagnosis of PD in the absence of the consequential criterion, in other words they look at the norm, where the person falls on a normal distribution in relation to whether their trait or disorder on the psychometry and so on and so you can have people who wouldn't satisfy the criterion of a diagnosis of PD within DSM because they don't have the consequential aspect, they have the traits but they don't have the bad consequences out of it (E1)*

*Yes I mean I sometimes question some of the psychological reports, yes, done by psychologists for independent reports, I have seen reports where people have either misinterpreted the data or use the wrong instrument. I have seen somebody who used the PCL-SV, the actual shorter version, you know the screening version, and based on that they actually came to the conclusion regarding psychopathy for somebody who was actually 18 (N8)*

There were also concerns that the future role of psychiatry was in question as a result of the predominance of psychologists involved in such assessments for court, and the lack of confidence which psychiatrists themselves have in interpreting them.

*The knowledge, the say, the authority, the wisdom, is increasingly at the hands of the psychologist and not the psychiatrist. (E2)*

*I think we lack confidence, this is the problem, we are very confident when it comes to psychosis because we know the pharmacological, when it comes to anything to do with say...schema, you know forecasts, we shy away, we rarely challenge, am yet to see a psychiatrist challenge a psychologist...yes, saying I do not agree with you, can I see the raw data, this does not actually add up, yes, because they use a language which is alien to us, and the difficulty then is that we are left to manage these difficult patients, (N8)*

## **6.43 Court process**

### ***Anxiety regarding giving evidence***

Three newer consultants expressed a reluctance to diagnose personality disorder owing to concerns regarding being challenged in court and being able to justify the diagnosis. This echoed concerns raised in the trainee and clinician focus groups.

*I think for me what would really, really matter is can I defend a diagnosis in the court. My experience with personality disorder diagnosis is harder to defend in court. I wouldn't like to over-medicalise and I think the bottom line is I think a personality disorder diagnosis is very, when it's challenged it's very hard to defend, unlike psychotic illnesses. (N3)*

Another new consultant felt that the profession may be more cautious in giving a potentially controversial diagnosis in the light of recent high media profile doctors subject to litigation.

*I think it has in the sense that there has been all these high profile cases, now people are more cautious and also fear being challenged. There is also the child; you know the family welfare one by the paediatrician? You have to be absolutely sure; I think it was Roy Meadows, who diagnosed that solicitor with personality disorder without any corroborating influence. (N8)*

### ***Interpretation of personality disorder diagnosis within the Criminal Justice System***

There was a general view that a diagnosis of personality disorder would be perceived negatively in court. This was also a strong theme within all focus groups. One psychiatrist felt that personality disorder is seen by courts as

*Sort of tiger country, as hopeless, as unchanging (E1)*

More specifically, comments were made about negative perceptions by other agencies, such as probation services, and the detrimental impact on the patient. The disparity in views of

personality disorder compared with mental illness within the media was also acknowledged by a newer consultant

*I think if you come up in court and say this person has a personality disorder, a reporter will equate that to evil, but if you say somebody has a psychotic illness, I think people are more sympathetic, it is not under your control, you are a victim, you are unfortunate with the genes, (N8)*

Concerns were raised by a new consultant that there is a risk of courts perceiving psychiatrists as medicalising variants of normality.

*I think that is what the judge took as well in the sense that aren't these things understandable, some of the things the defendant did, aren't they understandable in the circumstances, so I think effectively that's what he was saying, in that perhaps we were trying to give them some labels which are not needed.(N3)*

However, an experienced psychiatrist felt that this needed to be balanced against the risk of not identifying a disorder which explains clearly abnormal symptoms or behaviour.

*Equally the other way, if you've got this incredibly weird guy doing all sorts of odd stuff and you say I think he has got no mental disorder, I think that does the profession no favours either (E6)*

Another experienced psychiatrist felt that, in many ways, symptoms of personality disorder can be less understandable to the public than symptoms of psychosis, and that there is a duty to explain this to the court to aid understanding. He went on to explain that, although there may be a negative perception of personality disorder by the court, psychiatrists can influence this view by how they present their findings and highlighting to what extent the risk of violence is related to personality disorder, and how much to other factors.

*sometimes actually paradoxically it's the personality disorders that are, can actually be thought of as more disturbed by the man in the street than someone who is quietly sitting in the court with the voices going on like a tape all the time....you know, if you say someone has a severe personality disorder which is related to violent offending and they are not treatable, the court will read that as "this man is very dangerous and should be locked up forever". I do think doctors diagnose untreatable horrible conditions in people all the time, it's how you phrase it and how you advise the court. Sometimes you have to do, so yes, actually the reason this man appears unusual is that he has a personality disorder, however in this case it was not relevant to the killing because the fact that he had, you know, drunk 18 pints, taken 3g of speed and was running round with a machete was more relevant. (E7)*

### **Responsibility to Court**

The sense of responsibility inherent in carrying out an assessment and compiling a report in these cases was commented on by all interviewees. The duty to advise the court, and, in particular to explain issues surrounding personality disorder given the expertise and knowledge that psychiatrists have, which is not seen in other disciplines was discussed by two experienced psychiatrists

*everyone else is saying what do you mean there is nothing wrong with him, so I think you have to, you know, what you are trying to do in report writing is help the court and the jury if you see what I mean, as well as tell the truth (E6)*

*I don't see how you can't not offer advice because if it's there then I suppose it's part of our job to say it's there and describe it and say what it might do to the person in terms of risk or whatever, because it's nobody else's job. I used to think that probation officers probably knew something about PD but I don't think they do anymore so if we are not doing it nobody else will, and it is going to give, or it should give, the prison and the parole board and whatever in the future, insight into how these people may need to change to be less of a risk in the future. (E5)*

Another experienced psychiatrist was firmly of the view that, even if the court does not follow recommendations, that should not discourage psychiatrists from setting out their views.

*what the court does with it, you know, they can say well thank you very much doctor we accept that your view is he is very unwell but, like they do in some cases of mental illness, we don't accept that that substantially diminishes their responsibility, the court wishes to register it's approval by passing a horrendously long sentence, but that's for the court to do (E7)*

In contrast to the focus groups, the distinction in a psychiatrist's role in this capacity, compared with their clinical role where the overriding principle is to act in the patient's best interests, was highlighted by both new and experienced consultants.

*our duty if we are accepting sort of the contract to provide a court report, then our duty is very clear, it has to be to tell the court exactly what we think and it is not about the treatment issue it is about an opinion really (N3)*

*Whatever they decide well you pick up the pieces and you do your best and so on...the best interest of the patient has nothing to do with the criminal trial because they are not a patient, they are a defendant (E1)*

*If you tailor your report to take account of the individual's needs, then you may be avoiding doing the subject of your report no harm but you run the risk of doing harm to the public,(E8)*

One of the experienced consultants went on to comment on the difficulty in adopting this position in circumstances where the psychiatrist writes a court report for a patient who is under their care. Even in cases where there is no prior knowledge of, or relationship with, the perpetrator, it was felt by both of these psychiatrists that, for the subject of the report and the psychiatrist, not assuming a doctor-patient relationship during the assessment is very difficult.

*I have seen experts go into court, I think improperly, go into court giving evidence in murder trials on their own patients, and you can see that it influences their thinking because they are thinking more of the individual as a patient, because they have a therapeutic relationship, than as a defendant (E1)*

*Is it ordinary medical ethics or is it justice ethics, and this idea that you leave medical ethics at a courtroom door, I don't think it's as simple as that (E8)*

*I don't think it's possible for you to have, in the assessment, for you to have a relationship with the defendant which somehow is outside of any form of medical communication, because even if you tell the individual, look I am a doctor but you are not my patient, nothing is confidential, this is all for a court purpose and so on, within five minutes they have forgotten all that because your whole being screams doctor, and all the techniques you use, empathy, the communication, it's all medical (E1)*

#### **6.44 Impact of amendments to the Mental Health Act (1983)**

In response to the direct question (Appendix 4) regarding whether recent amendments to the Mental Health Act (2007) have impacted on the likelihood of giving a diagnosis of personality disorder, less than half of experienced (n=3), and new (n=3) consultants felt that it had. One of the changes was the removal of the category of psychopathic disorder, which included personality disorder, and the inclusion of personality disorder with mental illness under the broader category of mental disorder. Despite the fact that this means there is no legal requirement to be more specific regarding diagnosis, experienced consultants still felt that it is good practice to define disorders clinically.

*I suppose with the change in the Act then you don't, in a way, you don't have to be as specific, technically you can say that they just have a mental disorder, but clinically I would still hope that I would describe that disorder and describe it as an actual personality disorder and*



*name that personality disorder, and even give it an ICD, rather than just say a personality disorder, which is what a lot of people say. (E5)*

It was also felt that the term psychopathic disorder was stigmatising and conceptually confusing, and that its removal makes writing reports and communication with patients easier. This was also present as view within this theme within focus groups.

*If you actually mention it, you would then have to talk about personality disorder or psychopathic disorder in the old Act in terms of diminished responsibility, and I think people find that a hard concept to grasp, and therefore it's a lot easier not to talk about it than to raise it and then make a mess of it. (E6)*

*It's nice not to have to say that somebody has a psychopathic disorder, that was really hard to say somebody. I think it makes it easier to talk about personality as it really is (N5)*

Fears that the change in the Act may result in the admission to hospital of many more patients with personality disorder were expressed by a new consultant. The remainder of both new and experienced consultants, however, did not feel that the changes had resulted in particular changes to the admission of patients with personality disorder, and that the decision still rests with clinicians. It was also highlighted that it continues to be used as a reason for excluding patients from services.

*It lowers the threshold for personality disorder patients to be admitted and I think that potentially opens the floodgates, so I think I would be a bit more wary on that account, (N3)*

*I don't think it has actually because..... I think there has always been clinical discretion as to what, it's not the case that you have to admit everyone with mental disorder and I think the Mental Health Act is still quite clear that you don't have to admit .... So I think it's still very much down to clinical discretion, (N6)*

*Just because there is a widening of the definition and you can include people with personality disorders in mental disorder doesn't mean that we are going to give them any sort of help, that hasn't changed only the definition has changed, that's my personal opinion. (N1)*

## **6.45 Recommendations in reports**

### **Diagnosis**

When asked directly (Appendix 4) what would influence whether a diagnosis of personality disorder would be given all experienced consultants were very clear that it would be whether or not they thought that the individual had a personality disorder. All newer consultants, however, were more cautious in attributing the diagnosis. Two felt that it was still worth stating, although there was an awareness of the potential implications, either for the patient, or in court.

*Although I think it is still well worth doing, there is a worry in the back of my mind that erm... that this patient may find things more difficult not less, because of the personality disorder diagnosis (N5)*

Three newer consultants were wary of diagnosing personality disorder in the absence of a previously confirmed diagnosis by either other reports for court, or by mental health service. Another new consultant would only make the diagnosis if it was felt to be useful in the future management of the patient. In a similar manner, another new consultant was of the belief that, if a diagnosis is made, it would subsequently be necessary to make recommendations with regard to treatment and disposal.

*One issue would depend on whether the patient has a previously diagnosed personality disorder or not and whether he has been involved with the psychiatric services before, and what has been their opinion of him. If I am seeing the patient for the first time and he has not been known to the service, obviously I think I would be far more cautious in assigning a diagnostic label to him (N3)*

*Whether I thought it would be useful in their aftercare, so whether I thought it would be useful in terms of disposal (N6)*

In relation to the appropriateness of allowing intended recommendations on verdict and disposal to influence whether the diagnosis is given, one experienced psychiatrist felt strongly that it is not appropriate, although another experienced consultant felt that it is probably fairly common practice. This view was also prevalent within the clinician focus group, suggesting that this may well be the case.

*I do not look towards the consequences of the diagnosis in a legal context when I am making the diagnosis, I mean I just say does the person come within it, the legal implications are a second stage and you try and cut yourself off from that when you are diagnosing. (E1)*

*Because of the uncertainties in the subject around diagnosis, around what should do about it, because of these elements of judgement, I think people work out what they need to do to try and make it easier to get the result they think is the right one. You can have an argument about the rights and wrongs of that if you want, but I just think that's the way some people, sometimes in complicated situations which could go either way, they think it's easier or better to do it that way. (E6)*

There was also thought to be a gender disparity in likelihood of giving a diagnosis, in that two experienced psychiatrists felt that, in the context of a history of violent offending, women were more likely to be diagnosed as personality disordered than men.

*Female offenders are different, women are different I am afraid...because you are smaller, have been conditioned since childhood to be a good girl and not to do naughty things and hit other people and so you have to have a lot of psychopathology to overcome the sociological barrier, also probably the physical barrier to be seriously violent and a killer (E2)*

## **Verdict**

There were differences in opinions as to whether psychiatrists have, or would, support a verdict of diminished responsibility in patients with personality disorder. Within the caveat that the decision ultimately rests with the jury, all experienced consultants responded in the affirmative, compared with 5 new consultants (n=8). It was felt that, if there was a clear link between the offence and the personality disorder, that the question of whether or not to recommend diminished responsibility is an ethical one, in that it would be unethical not to.

*If it was directly related to the personality disorder I would probably feel, you know, honour bound or from an ethical point of view to offer that to the court as diminished, the court may decide it's not, but if I think someone has a mental disorder that was directly related to the killing, then that is what I understood to be diminished would be, then the court has to decide whether it's substantial enough or relevant enough. That's why sometimes I offer diminished in cases I don't want to, I think the person isn't, you know, in my moral sense is outraged, but if, you know, they have a mental disorder that is related to the killing, I think we are ethically bound to make the court aware of that. (E7)*

*Although I know diminished responsibility isn't a capacity based assessment (laughs) but in my head really it is, and I think if the capacity is affected and directly related to the personality disorder traits, then I think I would feel more comfortable so if I can identify quite clearly between the offence and the personality disorder (N6)*

Recommending diminished responsibility in personality disorder was seen as a complicated issue, fraught with difficulties and debates in court. It was felt by three experienced consultants that many psychiatrists avoid either making the diagnosis, or recommending diminished responsibility in order to avoid such conflict.

*They think where are we going, that this is just going to make an enormous fuff, waste everybody's time and money, it's going to get awfully awkward and bloody, it's easier if I don't make the diagnosis. So I think that's one of the reasons it's under-diagnosed, (E6)*

*I don't know, as I said I meant I think there is a certain reluctance in homicide in particular to actually raise the issue of PD because you have then got to go and talk about things like irresistible impulse and things like that in terms of diminished. I don't think people know enough or are comfortable enough about PD to then argue diminished as a basis of that PD if that's what you are wanting to do (E5)*

There was a clear view from three newer consultants that symptoms seen in personality disorder are not sufficient to fulfil criteria for diminished responsibility and, by extension, those with personality disorder should not be seen as less responsible for the offence by way of a diminished responsibility verdict. This was more in keeping with views in the focus groups.

*I think if you have a number of psychiatrists they are more likely to agree on a functional disorder as opposed to PD and there are always stereotypes about personality disorder patients being responsible for their actions as opposed to somebody who has got a functional illness, whether it is subject to loss of control is quite clear, so on that basis I personally would be less inclined. I mean when you look at the actual thing, there could be temporary insanity if you like, I lost it in that moment in time, I lost control of my faculties, in theory yes, but it's hard, because it's easier when you are talking about someone hearing voices for instance, they say I was hearing command hallucinations, they thought they were acting out in self-defence, but with personality disorder to say they were in a rage and they lost control, people would say that's exactly what people do on a Saturday night when they start to drink so (N8)*

*The issue I have been asked is whether there is an issue of diminished responsibility and obviously if someone is labelled with a personality disorder technically they would come within the remit of the defence, and I suspect that that may, could possibly influence my labelling, I*

*mean it could bring him within the limit of, say of the diminished responsibility defence, so that diagnosis could be used to actually to reduce the criminality or culpability. (N3)*

Another new consultant agreed with this premise and went on to say that diminished responsibility, in his view, was a pathway to a hospital disposal, rather than a separate legal entity.

*Here is my prejudgement for people coming out here, in that I think these are patients that don't have impaired reality testing and they often have some very ingrained negative ways of interacting with people erm... and I am, I suppose, not convinced that a personality erm.... I think these are people who are quite capable of making, you know, reasonable decisions in terms of other things, reasonably well, not disturbed by mental illness... I hope I am not tying myself in a knot here.... I suppose I see diminished as a way of accessing hospital rather than, rather than the criminal justice system as a consequence of one's actions and I have very little faith that hospitalisation for personality disorder is useful (N5)*

All but one of the experienced consultants, and four newer consultants thought that gender played a role, in that psychiatrists would be more likely to feel sympathy for female offenders, and make recommendations for diminished responsibility, and possibly a hospital disposal. It was also felt that the criminal justice system would similarly treat female offenders differently from their male counterparts, particularly in cases where the perpetrator is a mother and the victim her baby.

*I think it would with females, I think there is a tendency to try and look at, particularly if they have a background of abuse and that sort of thing, that, you know, they would try and recommend a diminished and a hospital disposal. I think in general people tend to feel sorrier for the females than the men, and the men come across as perhaps sort of bad people, whereas women are victims. (E5)*

*Again I, I have found that male psychiatrist are more likely to recommend diminished with female defendants. Especially if they are attractive (E3)*

*I do think they do on juries erm... you know, if you look at some extreme cases, not recently but when I was an SPR I was involved in a couple of mothers who murdered, killed babies when they were whatever, and they really, really wanted to find these people diminished. Even if you couldn't find any depression people would really want you to find some other stress or something, and you know that went for lawyers, courts, juries everybody, so I do think that there is things about erm... you know the circumstances and the situations where people want to come to certain verdicts for various and different reasons for different people, different roles. I would hope I wouldn't change what I wrote in a great way because of sex, you know trying to be nice to poor women who have been victimised or anything but you know (E6)*

Despite diminished responsibility indicating a lesser degree of responsibility for the offence, the potentially negative consequences of receiving a diminished responsibility verdict in those with personality disorder for whom a hospital disposal is not deemed appropriate were highlighted by another experienced consultant. This was a view shared by both experienced and new consultants.

*Increasingly I think with Government policy being in favour of PD being in prisons not in hospitals, I think you will often have the situation that in a sense the PD individual wins on the verdict swings but loses on the disposal roundabout, so he gets diminished responsibility manslaughter but he doesn't get a Hospital Order. One of the problems about people with PD getting diminished but not getting the hospital order is that they go into prison and at the end of the tariff their risk is unaltered because their disorder has essentially not been treated. (E1)*

Few psychiatrists had particular opinions on whether recent changes to the provisions for diminished responsibility had had any impact, and those that did were conflicting in their views. One experienced psychiatrist felt that the particular wording of the legislation means that the

threshold for establishing diminished responsibility is now relatively low. However, a newer consultant thought that the need to establish causation would make it more difficult to obtain a verdict of diminished responsibility, and that this would actually increase the likelihood of diagnosing personality disorder in the report.

*It's an incapacity test and the causation elements is not only, it isn't, as far as we know until a court of law tells us different, it isn't whether the abnormality of mental functioning arising from the perpetrator's medical condition was the main cause of the killing, it's whether it was a significant contributing factor. That's a pretty low threshold (E1)*

*the diminished responsibility law has also changed and that it now far more, far narrower than what it was before, so with the change in the law of diminished responsibility, causation now has to be established between the act and the disorder, I think it is restrictive and I think I would be more comfortable making a personality disorder diagnosis without worrying that it will automatically result in the reduction of the liability. (N3)*

### **Disposal**

When directly questioned, fewer experienced psychiatrists (n=3) felt that hospital disposal is appropriate for those with personality disorder, compared with newer consultants (n=5). There was a view amongst both experienced and new consultants that patients with personality disorder should not be coming directly to hospital, reiterating views in all focus groups. This related in part to a lack of evidence regarding effective clinical treatment, and also that services may be 'stuck' with them.

*I can't imagine I would, I mean unless, because I don't think it would do them a lot of good in hospital, do you know what I mean, if there was, if there was a good evidence as there was for mental illness that it helps I might recommend it.(E3)*



*You basically don't want these people on 37/41 because you may never be able to discharge them and you may never be able to treat their psychopathology, and you are stuck with them forever (E2)*

However, one experienced and one new consultant suggested that, despite a lack of clarity regarding effective service provision themselves, a solution to this may be to seek advice from experts working in specialist personality disorder units. The experienced psychiatrist also went on to point out that services for personality disorder are still available to treat such patients.

*I would have to be sure that erm... that, yes the hospital service could offer treatment which the prison otherwise couldn't do. I think it would be difficult to feel a little more confident about that because I am very clear about treatment services for erm... patients with schizophrenia or depression or other types of mental illness. I would have to do a lot research really in terms of availability of treatment and specific treatments for aspect of personality disorder and be able to compare that to custodial settings. You would have to ask whether it would be appropriate if whether you would recommend, yes, a second opinion really from a consultant working in that service (N4)*

*as long as there are clinicians in hospitals who have services in which they can treat people with personality disorder I will, from time to time, say we need the opinion of such a person, and I can't imagine that, even with the closure of the DSPD units it means that there will be no people with personality disorder being treated in the forensic estate. (E8)*

Another experienced psychiatrist felt that certain symptoms of personality disorder would be amenable to treatment and, in these cases, a hospital disposal may be appropriate.

*I tended to recommend hospital disposal and sometimes within that 37/41's to the more...the Ashworth classification of the secondary psychopath, the ones that have got other*

*emotional problems rather than the cold, callous PD which probably at that time were mainly untreatable anyway. (E5)*

However, an experienced psychiatrist working in medium security had experienced significant problems when referring personality disordered patients to high security, when that level of security was necessary. He went on to comment that high secure services appeared to prefer patients being transferred after sentencing on a prison transfer, rather than directly from court with a hospital order. This suggestion was confirmed by two experienced consultants working in high secure settings.

*I think that I probably make less recommendations for hospital orders, mainly because of high security's attitudes to PDs. I have increasing difficulties getting people with what I think are barn door PDs into maximum security because there are some of these people who I am not comfortable managing in medium security for a variety of reasons erm... you know one from the mix of people, the small size of the unit, the length of time that these people are likely to need, you know let alone the risk issues of them in a small unit, being able to manage the staff appropriately, you know you have small numbers of staff so you can't rotate them through the supervision problems, which actually makes the organisation quite vulnerable....the usual view I have had from maximum security has been let them get a prison sentence and then we will look at them afterwards and see if we are going to transfer them in for a course of treatment during their sentence.(E7)*

*Well to be fair I think hardly anyone still makes hospital order recommendations on the basis of PD, hardly ever for serious offences. All our PD's are sentenced guys, we are not admitting, it probably seven or eight years since the high secure hospital in which I work admitted a erm... PD guy from the courts for an offence if you see what I mean, they all get lifed off or whatever it is and then will come in later. (E6)*

One of these consultants thought that part of the reason for this is lack of confidence in being able to treat such patients.

*if you are going to take responsibility and you say this bloke committed this GBH or murder or rape because of his personality disorder, and I as a psychiatrist am going to treat this personality disorder and his dangerousness will diminish, I don't think many psychiatrists are confident in making those set of claims, so they sort of say you do what you like and if we can help later we will give it a whirl (E6)*

There were conflicting views about the benefits of a hospital disposal, with one experienced psychiatrist feeling that patients were not given a hospital disposal as a result of stigma, yet another who viewed a hospital disposal as potentially highly detrimental.

*On the other hand people would probably say PD equals bad person, therefore they should not have a hospital disposal. (E5)*

*Based on my experience in high security I have seen so many people whose lives have been really totally messed up by being wrongly given a hospital disposal for personality disorder. They are very very serious both in terms of the consequences for the individual and in terms of cost, you know sort of, I can think of 2 or 3 really where they have spent 10/15 years unnecessarily in a high secure hospital, which is a waste of everyone's time and money. I don't think anyone does any harm if they say I am not going to recommend a hospital order but will recommend transfer or a hybrid order, (E4)*

The recent hybrid order (Section 45A of the Mental Health Act (1983)) was proposed by both new and experienced psychiatrists as a way of managing this. However, another experienced consultant felt that this abrogation of responsibility has negative consequences for the patient, and that the ability to transfer patients back to prison results in therapeutic nihilism and a lack of sufficient effort on the part of services to try and treat.

*I don't know whether the 45a or whatever would be worth considering in those circumstances, I think that's what it was raised for, for the PD's rather than for the mental illness so that you could perhaps give it go and then if they are on an indeterminate sentence get them back to prison (E5)*

*Probably Section 45a would be, if he absolutely requires hospital treatment at this point in time erm... Section 45a would look like a more sensible option with follow-up by probation and health if required, rather than it just being the responsibility of erm...mental health professionals (N1)*

*I wonder whether that's about not wishing to take responsibility for them when they eventually return to the community. It may be that bringing them in on a prison transfer is a bit more straightforward, but straightforward in some ways and not in others, my view is it often allows us to get off, let ourselves off the hook. If you can just send them back to prison when the going gets tough you do, and not being able to do that focuses your mind better, I mean if they are going to get better treatment in prison I think that does put doctors in an ethically difficult position. The ethical position is why aren't we providing treatment for them, or even care, (E7)*

A number of new consultants thought that services provided by prisons were more effective than in hospital. An experienced psychiatrist though, questioned the need for further evidence on treatment, feeling that care of patients is more important and also questioned the ability of some to function in custody, when they struggle to cope in the community.

*I think particularly so in male patients, I don't think their services are fair in many places erm.... also often I think actually prison provides just as good if not better services in certainly, like in personality disorder I think particularly for a lot of dissocial personality disorder (N6)*

*I think the other thing that people forget about medicine in general, sometimes we don't have to provide treatment we have to provide care, now if people are disordered and we can*

*care for them in a more humane and appropriate and safer way for us and the public, then treatability becomes less relevant to me. I am not saying that all, you know if somebody has a personality disorder all people need to be in a hospital because they don't, and I think this is where the severity is relevant - if someone is severe enough to not be able to function well in society, they are probably not going to function well in prison and maybe we should be caring for them. (E7)*

## **6.46 Treatment**

### ***Effectiveness of treatment***

All consultants referred to the perceived lack of availability of effective treatment, and how that influences them and their colleagues. Taking a pragmatic and realistic approach to what might be achievable was advocated and thought to potentially improve outcomes. An alternative approach was suggested, that by moving away from diagnostic categories and focusing on specific problems, may be more effective and less stigmatising.

*The second thing is a sort of sensible awareness of what can be achieved in treatment, so that you get away from the two extremes of erm... cause I am definitely a moderate on this, I get away from the two extremes of either there is nothing can be done for this guy, you know, cast him out into the darkness or put him on a hospital order and keep him in a high secure hospital for 20 years and do nothing with him, (E4)*

*If you have got treatment that is tried and tested and has a track record and that person is willing, and particularly if in the past they have engaged in similar treatments in the community, then you could say the outlook is likely to be good.(N8)*

*It still is a somewhat controversial diagnosis to make in relation to somebody in that there is an awful lot of therapeutic nihilism associated with the diagnosis. Clearly diagnosis is very*

*important for guided treatment, I think there is a lot you can do in terms of looking at the kind of problems people had and trying to target treatment for that, (N5)*

Perhaps unsurprisingly, emotionally unstable personality disorder was seen as more amenable to treatment than dissocial personality disorder by three new consultants.

*If somebody has got antisocial personality disorder it's almost like well so what, what are you going to do about it, it's different if somebody say had an emotionally unstable personality disorder, because you may want to make recommendations regarding that, you know regarding disposal erm... because they might be amenable to treatment,(N7)*

Two of the experienced psychiatrists had concerns regarding labelling individuals as untreatable, partly as a result of the stigmatising and blaming impact of this. The concern, of deeming someone untreatable without any attempt to treat, was also raised in the focus groups. The therapeutic nihilism surrounding diagnosis and management led to concerns about the potential this has for limiting any progress towards more effective treatment in the future.

*the danger I often feel is we label people untreatable when it means that, you know we can't find a way of treating them, you know, you shouldn't blame the patient (E7)*

*I also think at some level, you know, we may not know what to do about them now, but that doesn't mean to say that the professions of psychiatry and psychology shouldn't continue to be involved, you can't do... you know if you have an untreatable cancer you don't just say well we won't erm..., do anything, you continue to look for ways to try and improve the treatment of cancer, you, in the last 20 years of course there have been major advances and you have to be in the ballpark with these guys so that you can continue looking at the disorder in the hope that, you somebody has some good ideas.(E6)*

### ***Ethical concerns regarding diagnosis and availability of treatment***

On direct questioning all experienced (n=8) and most new (n= 6) consultants thought that it was ethical to give a diagnosis in the absence of a recommendation regarding verdict or disposal. This contrasted markedly with all focus groups, where the majority of participants were not of this view. There was a clear view from experienced psychiatrists that diagnosis is a separate issue from treatment, with parallels being drawn with other branches of medicine, and that to not give the diagnosis for this reason is ethically questionable.

*I don't actually because, well, there are lots of conditions in medicine where there is no treatment, so for example some things you just don't think you can treat, erm...that does not mean to say you shouldn't say the person has the disorder, they are separate. The diagnosis is separate from treatment; I mean you don't not make the diagnosis because you can't treat it. What a bizarre notion. (E1)*

*That's like saying well I am not going to treat his blood pressure so I pretend he doesn't have it, I mean I think it makes more sense to say he has it but there is nothing I can do about it (E3)*

The moral and stigmatising associations with the diagnosis were seen as exacerbating the issue by an experienced consultant. There was an acknowledgement from another experienced consultant that the diagnosis has a negative impact for the patient, but a newer consultant also felt that similar misgivings were not also seen in diagnosing severe mental illness.

*The diagnostic criteria is set out and the sooner we get it erm... accepted as a diagnosis, you know, just like any other diagnosis and remove any moral connotations the better really (E4)*

*There is an ethical issue there because they are going to get life, but they are going to get life with a longer tariff than they would if they had pleaded guilty to murder. (E8)*

*But it is funny isn't it that we don't think twice really about saying this patient's got really a lifelong psychotic illness, which would have usually negative consequences for the life...yet, yes we shy away from saying someone has got particularly dissocial or borderline personality disorder (N4)*

Although psychiatrists found making the diagnosis difficult, identifying that a problem exists, and what it is, was seen as potentially beneficial in and of itself. An experienced psychiatrist discussed how he had found it beneficial in clinical practice, but how until comparatively recently, it wasn't common practice to inform patients of this diagnosis.

*I think there is something about making a diagnosis and leaving it without any follow on from that, that I certainly found quite uncomfortable. I think it's probably on both sides actually, because I think not diagnosing it perhaps can cause as many problems as diagnosing it (N2)*

*Not talking about it won't make things any better (N4)*

*It was the 1990's before I would tell patients that they had a personality disorder, and once I started doing it I found it was actually, it helped the therapeutic relationship because you could then have a dialogue about what things need to change or how to deal with the crises that would inevitably arise at times when the personality was put under the greatest degree of stress (E8)*

A newer consultant was of the view that, although such a diagnosis may mean a longer custodial sentence that managing to reduce an individual's risk would also be a positive step for them.



*Because of your assessment you have highlighted a whole world of extra risk that may be very difficult to modify....erm... I think there are serious ethical and moral implications for that... however... I do think that the benefits outweigh the downside, I think it's a funny bit of medicine, clearly a bit of medicine where there is very little you are going to be doing to actually help the patient in a way that they find helpful, they might well be spending longer incarcerated erm.... but you would like to think that in the long term I would like to be helpful to the person because it's in their interests to be managed in a way that reduces risk, (N5)*

### **Service Provision**

In response to a direct question, one experienced and four new consultants felt that recent policy changes involving the closure of the DSPD units within the high secure hospitals and expansion of treatment for personality disordered offenders within the prison system would impact on the likelihood of giving a diagnosis of personality disorder.

Despite changes in service provision expanding treatment for those with personality disorder, and, in particular, the document "Personality Disorder: No Longer a Diagnosis of Exclusion" (National Institute for Mental Health in England 2003), it still seems to be the case that it is used to exclude patients from services, which is likely to have an impact on recommendations made within reports. A newer consultant discussed previously doing this.

*I rather got swept up in a erm.... in erm... indicating that people were personality disordered and therefore being much more rejecting of them in terms of offering them assistance and erm.. using it as a way of erm... pushing patients away I suppose (N5)*

Often this is facilitated by altering a patient's diagnosis from one of severe mental illness to personality disorder, as was described by two experienced consultants. It was also conceded by both experienced and new consultants that this problem is more marked in general adult psychiatry compared with forensic psychiatry as a result of resource and time constraints. This was also a theme which emerged within the academic focus group.

*diagnostic shift, which was that the person went from having Schizophrenia to having personality disorder when they started to be violent on the ward, and of course the reason for that was because the consultants were interested in their own concerns, which is that I don't want to look after this person, I am going to use diagnosis to exclude them from services (E1)*

*I can well see where actually there might be a cognitive bit of slippage in my diagnostic approach in the, confronted with somebody, you open ward with sort of staffed by female nurses and I have got this large violent individual who may have schizophrenia really, but somehow I can't quite see it today, all I can see is his personality disorder, (E2)*

*general psychiatrists, who still tend to use PD as a pejorative term to exclude people from services, and the number of people we admit with diagnosed personality disorder but get better when we treat their schizophrenia is quite significant (E7)*

*It's still a very pejorative label, almost less pejorative in a way in forensic psychiatry I think but in local services, looking at that interface, because I think because we have got the luxury of time and resources to work with patient, I think we are able to work in ways that suit our patient's personalities, even if they are disordered, in a much better way than I think local services are resourced to do. (N5)*

*awful pressures on any adult general psychiatrist, it's all about gatekeeping and keeping nasty people out of your wards, if you got a way of turning them down, and I would probably do the same in their position (E2)*

This also seems to be the case with psychiatrists working in both medium secure services and prisons who are involved in referring to high secure settings, in the experience of a consultant working in high security.

*If the referring doctor says it's a PD I will put it down the PD chain, and if they say it's a mental illness I will put it down the mental illness chain, erm..... I look at those letters and think*

*phwer... he's got a mental illness as well, over 60/70% of the time. RSU doctors for whatever reason, working in prison, and of course there are different pressures on them there, erm... still in their letters officially vastly under-diagnose mental illness, and I think all our PD guys are dual diagnosis after they have been here six months, so they come in on the PD ticket (E6)*

However, it was suggested by a consultant working in medium secure services that this diagnostic shift occurs in the opposite direction when high secure services are referring patients to lower levels of security.

*What is happening in high security for instance where they are now saying pure PD is a rarity in high security, so you wonder whether they have added a mental illness and given it a label that would market these people to LSU's and MSU's and so on, so there are a lot of other unexplained dynamics in what's happened. (N8)*

The lack of priority placed on personality disorder within the context of government policy, and therefore the lack of capacity within mental health services to manage these patients, was seen as a particularly relevant factor by two experienced consultants.

*They've forced mental health services to look after 90% SMI and the other ¼ of a text book of psychiatry in 10% of the time, what that's delivered is a generation of services which are not geared up to use personality disorder, to diagnose or treat personality disorders and still use it as a diagnosis of exclusion, whatever you have managed to do in England. (E7)*

*That's the only PD court case we have had in 10 years, we are just not doing it because we don't, we are not sufficiently confident in our ability to resolve all the problems you know... (E6)*

There was, however, a view from both experienced and newer consultants that, if services for personality disorder were developed further and information regarding them adequately disseminated, it would decrease reluctance to diagnose personality disorder and increase willingness to refer for treatment.

*The thing that really gets people detecting mental disorder in prisoners and stuff like that is not the insistence that you have to screen for it but a feeling that by picking it up you are doing something useful and making a difference really so... erm.. I do think yes if you build the services you will get people making the diagnosis more often (E4)*

Issues and controversy surrounding DSPD services were commented on by two experienced psychiatrists. There was significant concern at the reluctance of psychiatrists to become involved in service development for personality disorder, and the impact on the profession, with the growing involvement of psychologists in these services.

*The great hope for personality disorder is actually the DSPD service, this was actually the great hope for psychology, the psychiatrist having turned their backs in terror on these patients, psychology was actually on the verge of cleaning up eventually these would be national services, had they not had the financial rug pulled out from under their feet, these were going to be service run by psychologists and actually the DSPD in one of the prisons, which remains, merely hires in a forensic psychiatrist to prescribe on occasions. I found this frightening, I felt that psychiatry, for the profession, psychiatrists were going to disenfranchise themselves from PD, the thing of the future....unfortunately the thing of the future has become rapidly the thing of the past in terms of service provision for personality disorder, but within that the key to it was being able to make a diagnosis, (E2)*

The lack of focus on, and lack of experience in, personality disorder that many forensic psychiatrists display was seen by an experienced consultant as resulting in an excessively cautious approach, with an unrealistic expectation of what is achievable in reducing risk in these patients. He felt that the approach should shift to intensive support, monitoring and management of risk in lower secure settings and the community.

*The mind-set of forensic psychiatrists dealing with the rehabilitation of people with personality disorder has to be a bit different from dealing with mental illness so I have*

*encountered a couple of cases recently where psychiatrists have said, you know, this person shouldn't be discharged from a high secure hospital, PD patients, because he still presents a risk, like full stop, and I can see what, well I think they are being a bit stupid anyway even in a mentally ill person, but I think that if you are dealing with PD I think you have to accept that what you are going to do is reduce the risks a bit through treatment if you are lucky, hopefully, but you are not going to take them away, they are still going to remain a substantial risk and I think we need to acknowledge that much more and say that, you know, the object of this is to devise erm.. a safe management, reasonably safe management plan for the person in the community and we accept that sometimes that's not going to work out, but probably you have made things safer than they were otherwise (E4)*

Comments also made by an experienced consultant regarding current attempts to manage personality disordered patients in the community in collaboration with the voluntary sector as part of a drive to develop personality disorder services in Wales.

*We are also working with the voluntary sector to develop erm.... alternatives to hospital for managing people with personality difficulties, erm.... by one of the housing associations in Wales has had some experience of running kind of, they call them rehabilitation units, but basically they take people in and give, you know, improve their style of living. I think we are beginning to become more committed to erm... the generation of people who are leading mental health services, the majority of us do feel that personality disorder needs more attention, and the advantage of Wales over England is that there are only 7 clinical directors or directors of mental health services in Wales, you know we can get us all round the table in a pub to discuss it.... in sense, you know, as far as I am concerned the academic debate about what particular brand of suffering is interesting but less important than the primary role, to relieve suffering and minimise harm (E7)*

## **6.47 Training and Experience**

All consultants were of the view that training in personality disorder is inadequate, and markedly inferior to that in severe mental illness. This was also a view which was universally expressed in all focus groups. More experienced consultants, however, conceded that training had improved in recent decades, although still fails to focus on the relevant issues with regard to personality disorder diagnosis and management.

*I am not sure we teach, well even my SHO trainees now, if you talk to them about personality disorder they will list the criteria under each heading for a specific diagnosis, they have no concept of what the core features of having a personality disorder is, so I suppose the response is I don't think we teach it. I think they end up having a checklist, you could have a monkey doing it if they could read, you know, they have this, you know, and I suppose they are not using as a, helping you to structure your clinical judgement, they are just using it as a checklist, which is a yes or a no, and as I said it's the behaviour without understanding why that behaviour occurred, (E3)*

Newer consultants (n=4), having just completed their training, frequently commented on the lack of standardisation of training in personality disorder, and that training and exposure to different types of personality disorder was more a matter of luck and which placement they were allocated to, rather than an effort to ensure that all trainees received satisfactory experience in personality disorder. One of the reasons for this was thought to be the lack of provision of personality disorder services, resulting in consultants involved in training not having had relevant experience and training themselves.

*I would say that my training has come much more from practical experience than it has from anything else and certainly much more from forensic work than from anything prior to that erm... so yes, patchy (N6)*

*I think that a lot of them therefore take a very biological view in the training here, and that's because the system has been set up for many years to deliver services for SMI rather than the other ¾ of the text book of psychiatry. What that means is the whole services, the consultant doing the training and everybody else has become de-skilled (E7)*

One of the newer consultants thought that there is a prevailing attitude that psychiatrists need not attend training courses as either they do not require additional training, or see it as irrelevant as personality disorder is not an area of priority within services. As a result training courses are often attended by nursing staff who are increasingly taking on roles traditionally carried out by junior medical staff. This results in inadequate exposure to personality disordered patients by trainees.

*I know in other disciplines too often, you know, they go to various course which are available and I don't know whether we are a bit snobby about that at times, in that there are these erm... yes, masters courses and various course available, and I think we think we know it all but, you know, I am pretty sure we don't. I think we should be more open to being involved in this erm... form of training really...again there is a danger that we just go to all the trainings for all the core body of patients that we see at the moment rather than trying to generalise our skills really erm...(N4).*

*Trainees don't see enough crisis cases now because they are dealt with by nursing staff working in A & E so the trainees have got much less experience thinking about personality disorder and (N5)*

Additionally, the tendency not to admit patients with a pure personality disorder was highlighted by an experienced consultant as a particular problem, as he recounted the value in working with such patients earlier in his career.

*It really helped me in terms of learning about PD to get moved to the PD unit where in those days we had some, unsullied by mental illness, PD's and whereas now nearly everyone on our PD unit is dual diagnosis, now a lot of them mental illness is well controlled so you tend to see it in a bit cleaner way than on the mental illness unit, but it certainly helped me to see them without the mental illness in terms of learning and finding out about them. (E6)*

Two experienced psychiatrists felt that the lack of focus on personality disorder by senior academics and clinicians, and the view that it is not a priority is of concern. This view was seen by one as a particular worry given that personal values have a greater influence on personality disorder diagnosis and management, compared with mental illness, and extends to viewing any difficulties as the patient's responsibility.

*I think training in the area has been influenced by an attitude on the part of many psychiatrists, oh if it's a personality disorder it's all down to them, so you know you would get somebody in a crisis, you went up with only a diagnosis of personality disorder and you simply discharged them and say well it's their responsibility whether or not they do XY or Z (E8)*

There were a number of suggestions as to how training in personality disorder could be improved. Ensuring that it is part of mandatory training for all trainees, in a systematic manner, was proposed by one experienced consultant.

*We change it by actually making it mandatory to be part of continuing professional development that consultants should be able to demonstrate, you I have to go on this, a whole list of crap, you know so I know all about fires, do I know how to wash my hands, as a psychiatrist I don't touch patients, but actually can I make a diagnosis of borderline personality disorder using any reliable criteria, no I don't have to do that at all. It needs to be mandatory within the context of training junior staff, that they have to have you know, not only the do they have to demonstrate they can illicit the symptoms of depression and schizophrenia, but they*



*have to be able to demonstrate they can illicit the symptoms of borderline personality disorder.(E2)*

Both new and experienced psychiatrists discussed benefits to their own clinical assessment as a result of training in standardised instruments such as the IPDE and PCL-R, and suggested this as a way of improving training, particularly for general adult psychiatrists. It was also suggested that, given the greater exposure to and experience of, personality disorder in forensic services, that forensic psychiatrists may have a role to play in assisting training of general adult psychiatrists.

*I guess standardised criteria for diagnosis and training in the diagnostic instruments, because for me it was very useful learning the PCL-R and stuff like that, which even if I wasn't actually formally doing it, the fact that I knew about it in the back of my mind made me better at giving a personality disorder diagnosis and so I think those sort of structured diagnostic instruments (E4)*

*I have felt more confident since doing IPDE training, although I haven't actually used the IPDE on a patient because the training for me was much more about how to think about assessing personality and how personality affects presentation in a kind of systematic and logical way than it was about actually for me doing IPDE on patients (N5)*

One of the newer consultants thought that trying to alter the prevailing often discriminatory view against those with personality disorder with psychoeducation for psychiatrists would be more beneficial than specific training courses.

*that there are patients that we don't want to accept and fight against and feel terribly uncomfortable, I think something about trying to change that sort of culture rather than about specific training perhaps would be very useful (N6)*

An experienced psychiatrist described the emotional reactions triggered by dealing with patients with personality disorder. In relation to this, a new consultant acknowledged the emotional difficulties and personal reactions inherent in treating those with personality disorder and felt that recognition and support in dealing with this would be helpful.

*The interesting way they manage to seduce you, make you hate them, make you love them, make you, you know feel sorry for them, make you want to run a mile from them (E2)*

*Nevertheless there is still underlying, not necessarily stigma but a general thing of the worry of these patients with "personality disorder" and I think the trainee's doubts about how to handle their own feelings with these patients. We used to have a balint group which I personally found helpful and I think sort of would help with some of these but I don't think such groups...they are few and far between. At one point the opportunity increased but for some reason the older provisions of these reflective practice groups have been struck off, mainly in favour of so called psychotherapy competencies. I think there should be some container whereby to pour out all these distress, where all of us could.... It would be really really beneficial, some reflective practice sometimes, so I think that is something that they can reinstate or incorporate as a part of the psychotherapy in the curriculum as it used to be before. (N2)*

### **6.48 Stigma**

Personality disorder is still very much seen as a pejorative diagnosis, and a significant degree of therapeutic nihilism is associated with it. All consultants interviewed commented on this, in relation to services and their perceptions of others' views, in particular general adult psychiatrists. Again, this was also felt strongly within all focus groups.

*Despite all the work on it not being a diagnosis of exclusion etc. there is still such a culture within psychiatry, much more general adult than in secure services, but across both, that there are patients that we don't want to accept and fight against and feel terribly uncomfortable,(N6)*

An experienced consultant with significant experience in treating personality disordered patients had concerns that other agencies within the criminal justice system viewed personality disorder as unchangeable and untreatable, and the impact that has, not only on the individual, but also with regard to Human Rights and civil liberties.

*MAPPA I mean the police (laughs), really just looking at people and just looking at what they had done, you know maybe 20 years ago, and just basically taking the view, you know we don't want this guy out of hospital, you know even if there was somebody you had taken at the end of sentence, about 4 or 5 years working with them. DSPD services are working with the prisons to try and make things a bit safer to have MAPPA just taking the view, oh you know he did some horrible stuff the job of mental health services is to keep him locked up forever...there is a couple of cases where I have had real difficulty with MAPPA and I thought the police were really doing something that in our country they are not supposed to do, which is to keep people locked up without trial... (E4)*

The stigma surrounding personality disorder was seen by both new and experienced consultants as leading to reluctance to diagnose personality disorder in young people, as a result of concerns regarding the future impact of the diagnosis. However, an experienced consultant also felt that this may lead to the diagnosis being overlooked. This has the obvious consequences of potentially beneficial interventions not being made when it may be possible to treat some of the problems.

*There is a difficulty and I am not sure whether you would call it an ethical one, erm... or a moral one, but it's certainly a difficulty, in relatively young people where I have certainly tried to avoid making a diagnosis of personality disorder in case it was done for self-fulfilling prophecy, so you know once you label an 18 year old with personality disorder people give up on them (E8)*

*I guess you are always reluctant to make the diagnosis in younger people, so I am sure that a lot of personality disorder is overlooked in 18 to 21 years olds cause you just think ah they are young and you know they will grow out of it sort of thing (E4)*

Stigma surrounding the diagnosis also led to concerns regarding diagnosing personality disorder in different cultures, and the difficulties inherent within that, given that the diagnosis involves deviation from the norms of an individual's culture. As a result, the threshold for diagnosing personality was felt to be much higher when assessing those from different ethnic backgrounds.

*ethnicity I think is always an issue with personality about assessing, I mean I have been in a three week tribunal debating about the difference between narcissism and obsequiousness in someone of Chinese origin, where the argument used was he must be narcissistic he wears Ben Sherman shirts. I think different cultures, especially when you are measuring things like, you know, deference to authority and things like that; those are I think cultural constructs. I have made mistakes in both directions, you know, I have interpreted some things as being cultural appropriate and had them seem by a culturally appropriate colleague who says "nah they're mad", and I have had it the other way round as well, where I have thought, you know and they have said "no no this is perfectly normal", I think the importance of assessing personality in a culturally appropriate way is underestimated (E7)*

*Ethnicity or culture raises caution in you and maybe you require, in sense, even more barn door obvious symptoms of the disorder in order to make the diagnosis where there is the risk that culture may be interfering with it (E1)*

This was also stated by one of the interviewees who was from a different ethnic background.

*I think it's both a lack of understanding as well as a combination of being too politically correct, because I have assessed people of African origin, and I have been saying this is personality disorder, but my white colleagues would say, well I think this sounds more like a paranoid disorder, and I see look, this is a PD, it's just that people are very careful. (N8)*

An experienced consultant also felt that there were cultural differences in attitudes to mental disorder which have an impact on whether an individual seeks help for such difficulties.

*I am generalising very much, but certainly in the Caribbean population they do not want to be considered to be nutters and therefore if they were PD in prison they would not make themselves known and say can I have a hospital disposal please, and they wouldn't tell their solicitor, they wouldn't tell nurses, and therefore they are more likely to be just sitting in prison rather than asking for help (E5)*

Another experienced consultant was of the view that approaching the assessment differently, with increased use of psychometric assessments and advice from experts in that culture, can help to minimise some of these problems.

*cultural issues that does make it much more difficult, but that's another reason why I would want psychometry because I think that would hopefully does cancel out some of the cultural aspects. What I have sometimes done is to list the phenomena as I have observed them and then asked them to instruct a sociologist to go through the criteria and say which of all your symptoms that you find, say which of these are congruent and which are not (E1)*

When asked if they thought they were typical of most forensic psychiatrists, interestingly, all experienced consultants thought not whereas all but one new consultant felt that they were. One new consultant said

*I think I started off really thinking PD was a waste of time and why do they keep turning up and bothering me (laughs) and only latterly did I discover that I didn't really know anything about*

*it and I was being really judgemental and unjust. I am in the process of starting to perhaps be able to think about it more reasonably, so I think I am quite typical (N5)*

## ***Chapter 7 - Discussion***

This chapter reviews the methodology and its limitations before reviewing results from both quantitative and qualitative aspects of the study, including comparisons with other studies. Finally, the implications of these findings are considered, from both the perspectives of the individual perpetrator and of clinicians involved in the process. Wider, more systemic implications for the current revisions of classification systems and service development are then given consideration.

### ***7.1 Methodological Issues and limitations***

This is a mixed methods study utilising quantitative methods to ascertain an estimate of the prevalence of personality disorder within a national sample of homicide perpetrators who have had court reports, and correlates of both receiving a diagnosis, and of dimensions of personality disorder. This is followed by an exploration of the process of diagnosing personality disorder to ascertain reasons for the discrepancy in diagnosis reached using a standardised tool and that given by clinicians in court reports. This is explored using qualitative methods; both focus groups and semi structured interviews.

Methodological issues which impact on assessing an individual to establish the prevalence of personality disorder include the sources of information, the instrument used, the timing of the assessment and the presence of other mental disorders. Assessment can be carried out by either interviewing patients or by analysing notes and documents.

A limitation of this study is that the prevalence of personality disorder was established through assessment of court reports, rather than conducting face to face interviews. A structured interview is viewed as the most robust method and, clearly, insights obtained through observing interpersonal skills at first hand can be of great value in the assessment. Furthermore, interviews, if sufficiently flexible, can allow greater exploration of potentially significant personality traits. There are, however, concerns over inadequate levels of agreement

when inter-rater reliability is assessed, and issues surrounding the validity and veracity of self-reported accounts of personality (Tyrer, Coombs et al. 2007). This latter concern would potentially be accentuated in this population. Informant information can be valuable in addressing this (Zimmerman 1986). A recent study using both informant and self-report versions of the SNAP -2 (Schedule for Nonadaptive and Adaptive Personality – 2<sup>nd</sup> Edition), showed acceptable to excellent reliability between the two measures, and that the informant version demonstrated more personality disorder pathology consistently (Keulen-de-Vos, Bernstein et al. 2010). There is increasing evidence of the temporal instability of personality disorder (Skodol 2005) (Shea 2002). This underlines the importance of not only seeking informant information, but also information from contemporaneous records which, unlike the other two sources, would be uncontaminated by the recent offence, trial and likely detention in custody or hospital. Thus, if this study was to be carried out using interviews, it would require interviews with both the perpetrator and an informant along with assessment of any available medical records. Moreover, commonly used, well validated, standardised interview based assessments of personality and psychopathy such as the IPDE, SCID II and PCL-R would take several hours to complete and, given necessary time constraints on visits within custody, would require several visits per individual.

In assessing the presence of personality disorder in relation to the offence, it would be desirable to conduct the assessment without undue delay after the offence. In order to explore personality disorder in perpetrators of homicide, interviews would have to take place after homicide conviction, resulting in a likely time period of between 12-18 months between the offence and assessment. Documentation from assessments carried out as part of the trial process, thus in much greater proximity to the offence, provide very useful insights which would potentially be unavailable at a later assessment.

Further potential difficulties in conducting interviews with perpetrators of homicide in custody became apparent as part of another study at the National Confidential Inquiry; a



psychological autopsy study of homicide. This similarly involved interviewing homicide perpetrators with a number of standardised tools. Several problems were encountered including difficulties in gaining approval from the prison service, resulting in approval only being granted to conduct research in one prison establishment. Recruiting offenders and informants was problematic; similar difficulties were experienced in a similar study approaching relatives of homicide perpetrators (May 2000). It is also likely that those individuals who would consent to involvement in the study would not be representative of homicide perpetrators as a whole, leading to a biased sample.

The power calculation for this study indicated that 600 perpetrators would need to be assessed for analysis of, not just personality disorder, but also clusters. There were, unfortunately, no previous data on clusters of personality disorder within perpetrators of homicide on which to base the power calculation and therefore it had to be based on data pertaining to offenders in general (Singleton, Meltzer et al. 1998). It would have been entirely unfeasible to conduct perpetrator and informant interviews and acquire sufficient records, particularly in light of the problems outlined above, for this number of perpetrators within the time and resource constraints of this study.

Given that psychiatric reports prepared for court are routinely collected as part of the data collection process of the National Confidential Inquiry, and often combine subject and informant information along with relevant background information from official sources including medical records, it was decided to explore assessing personality disorder based on these documents. As detailed earlier, the PAS-DOC is a document derived version of the Personality Assessment Schedule, amended to enable ratings to be made from documents yet retaining the same structure as the original PAS (Tyrer 2005). It allows for both categorical and dimensional assessments of personality disorder, which is highly valuable given increasing interest in moving towards a more dimensional assessment of personality disorder. It assesses premorbid personality which helps to reduce the potential bias introduced by concurrent symptoms of

mental illness. Clearly information provided by homicide perpetrators to the author is potentially biased by the purpose of the assessment; in an assessment for court purposes the perpetrator is likely to try and present themselves in a favourable light. A diagnosis based not solely on current or recent traits, but on historical lifetime characteristics will help to minimise this bias.

Assessments of inter-rater reliability showed a mean ICC of 0.58, and median ICC of 0.58. These levels of agreement are similar to those found in a previous assessment of the reliability of the PAS-DOC, which found ICCs ranging from 0.41 – 0.83, for individual personality clusters (Tyrer, Coombs et al. 2007). Interrater reliability in personality assessments, using a range of assessment tools and in a variety of settings, is often relatively poor (Clark 2001). This is compounded by the temporal instability of personality status (Shea 2002) and, given that the PAS-DOC combines both an assessment of past personality pathology and current presentation, will influence the levels of agreement with this instrument. However, as detailed in section 4.21, the more antisocial traits tended to be more reliably rated within this study.

It is also probable that information from any informant could introduce bias in the light of the recent offence; the nature of the bias will depend in part on the circumstances of the offence and the victim. On the other hand, relatives may actually become more reflective with regard to the perpetrator's characteristics in the aftermath of the homicide, providing greater depth of information and insight.

This assessment, being pre-trial, would avoid the delay inherent in conducting interviews after conviction. However, a limitation of using reports prepared for court is that the assessment of personality disorder is dependent on the information available within the report. Authors are likely to provide clinical data which they perceive as being germane to the questions which they have been asked to address. This has a potential impact not only on the assessment of personality but also on other variables used in the analysis. However, criminological variables were obtained from the Homicide Index, which is a reliable source of data, and the

sociodemographic and clinical variables are ones which would be expected to be addressed in a standard psychiatric assessment. A study examining the quality of reports at the National Confidential Inquiry showed that the particular variables used in this analysis, such as diagnosis, substance misuse and symptoms at the offence, were among those addressed most comprehensively in the reports (Crosby 2011) .

A consequence of assessing the prevalence of personality disorder through analysis of reports, rather than interviews, is that the information available within reports may have resulted in the underestimation of the prevalence of any personality disorder. An agreement was reached that, in cases not already classified by the algorithm, with missing data in an individual case exceeding 12 variables (50%) it would not be possible to classify that case. This resulted in 23.8% (n=143 cases) being unclassified. Further dimensional analysis indicated that 19.2% (n=115) fulfilled criteria for probable personality disorder, personality difficulty or possible personality disorder. It is possible that, with more information available, some of these cases may have reached criteria for a definite diagnosis of personality disorder. Only 0.7% (n=4 cases) had sufficient information to fulfil criteria for a definite absence of personality disorder. It is impossible to ascertain to what extent this represents the absence of personality disorder in the individual cases with inadequate data, the absence of assessment of personality disorder by the author of the report, or even that personality variables are not viewed as significant enough negative findings to document in reports, as would occur with symptoms of mental illness. It is likely that, in many cases, the lack of information on certain personality traits means that the author did not consider those characteristics as pathological, and that they probably did not have a personality disorder. Nonetheless, the prevalence within the sample should be viewed as a conservative estimate.

A further issue which may have introduced bias into the prevalence of personality disorder within this sample is the decreasing number of court reports received by the National Confidential Inquiry, following R v Reid (2001). It is clearly difficult to ascertain how this group of

perpetrators differs from those who do have a report. In exploring how significant this might be. The proportion of perpetrators who were in contact with mental health services but did not have a report completed were examined. As part of the data collection process of the National Confidential Inquiry, it is established whether perpetrators of homicide have had any contact with mental health services and a questionnaire is then completed by their consultant. Of the 5808 perpetrators in this sample, 1081 (19%) had previous contact with mental health services and, of this group, 42% (n=426) had a diagnosis of personality disorder. 79% of these individuals had a report prepared for court, i.e. 21% of those with personality disorder who were in contact with mental health services did not have a psychiatric report. There were no significant trends in the proportion of those in contact with services but without a report, year on year, throughout the duration of the study, even after the ruling in *R v Reid* (Reid 2001). Figures for other diagnoses were: schizophrenia 6%; affective disorder 12%; alcohol dependence 30%; drug dependence 43%. I considered using the questionnaire data to complete the PAS-DOC but it does not provide sufficient information regarding personality variables to adequately complete the schedule.

There is also a group of homicide perpetrators who neither have a report completed for court nor are in contact with services. The prevalence of personality disorder in this group is unknown and therefore it is not possible to calculate the 'true prevalence' of personality disorder in the whole sample of homicide perpetrators. It seems possible therefore that the group who may have mental disorder who are neither in contact with mental health services or assessed for a court report would contain some with a diagnosis of personality disorder. Unfortunately, given that there is no information available on this group, there does not appear to be any reliable way of ascertaining if, or how, this group differs from those who do have reports and therefore, ascertaining the prevalence of personality disorder amongst homicide perpetrators as a whole.

The main purpose of the study, however, was to examine differences between those diagnosed in reports and those not, and to explore possible reasons for this discrepancy in diagnosis. This issue therefore does not affect the remaining analyses as they are concerned with comparisons within the sample of reports. In the sub analysis of those diagnosed in reports, compared with those who weren't, it seems possible that a type II error (the failure to reject a false null hypothesis, i.e. a false negative) may have occurred with certain variables. The presence of schizophrenia, for instance, may be expected to dissuade authors from diagnosing personality disorder as there is a view that personality cannot be assessed in the presence of severe mental illness (Surtees and Kendell 1979), but this did not reach significance, with a p value of 0.13.

The degree of overlap between different domains of personality disorder was substantial. The possibility of removing all overlapping cases for analysis purposes, thus giving a more 'pure' sample within each domain, was discussed. However, it is likely that those fulfilling criteria for more than one domain are those with more severe personality pathology and removing these cases from analysis would bias any subsequent analysis. The degree of overlap between categories does call into question the utility of such a categorical model of classification from a clinical perspective.

The generalisability of themes which emerged during the qualitative aspect of the study is clearly contingent on minimising selection bias. Within the focus groups, the trainee group consisted of trainees within the North West of England. This had the potential to introduce bias, particularly in relation to experiences of training. However, by the use of purposive sampling, the group contained individuals who had previously trained in a variety of regions within the UK, and indeed one trainee who had trained outwith the UK. Furthermore, they represented a wide range of experience, with some having extensive experience of working with individuals within both high secure and DSPD settings. This sampling method should have minimised any bias introduced by this.

Within the clinician and academic groups, however, there were some issues with prominence of more dominant individuals and, particularly in the clinician group, the presence of consultants in a directly senior hierarchical position to others may have resulted in stifling of some views. Although a wide range of opinions emerged from the groups, it was felt that a different approach was required to explore themes further. By the subsequent use of an alternative methodology, semi-structured interviews, emergent themes could be viewed as more generalisable than from the focus groups alone. There were a number of different approaches which could have been taken. A survey questionnaire could have increased the sample size of the second part of the qualitative study, thus increased generalisability, although it would not have facilitated detailed exploration of attitudes, which was the main purpose of this aspect. Semi-structured interviews, however, enable the collection of much more detailed and thorough data on themes already established from the focus groups whilst being sufficiently flexible to allow the emergence of key issues not previously identified (Adams 2008). Another option would have been to conduct in-depth, less structured interviews, to allow the emergence of novel themes not already identified in the focus groups. After discussion with the supervisory team it was decided that, given that the purpose was to explore themes already identified, a semi structured approach would simultaneously allow exploration and discussion of attitudes whilst ensuring that relevant points were included. It would also allow more meaningful and reliable comparison between different participants, in particular between new and experienced consultants.

There is potentially an element of selection bias introduced by the sample of consultants interviewed. New consultants were recruited from the North West of England, which may have introduced bias, however, not all had trained within that region and so had a range of different experiences. The sample of experienced consultants was chosen on the basis of experience in writing reports, not clinical experience. This was because it was felt that, in assessing the diagnosis within reports, it would be more relevant to select those with significant experience in

report writing. Notwithstanding this, all of those in the experienced consultant group had extensive clinical experience in working with those with personality disorder. This may be partially because consultants would often be selected to do reports as a result of their expertise in the field, particularly in cases such as homicide. This resulted in a group of experienced consultants with a wide range of experience who are highly regarded in the field of personality disorder. The range of experience within the group led to a variety of opinions which were often very informed and tended to be less stigmatising and prejudiced as they had often chosen to work with those with personality disorder. Although this resulted in very rich data, it must be acknowledged that the attitudes which emerged are potentially less generalisable to those psychiatrists who do not work with individuals with personality disorder, who may continue to hold views which are more discriminatory and stigmatising.

## ***7.2 Quantitative results***

### ***7.21 The prevalence of personality disorder***

The estimated prevalence of any personality disorder within the sample of 600 perpetrators of homicide was 56.3% (95% CI 52.3% - 60.3%). Given that this figure is predicated on the assumption that all those with inadequate data to score on the PAS-DOC did not have a personality disorder, this should be seen as a conservative estimate of the prevalence within this sample as it is likely that at least some of those without data had a personality disorder. There are no other studies looking at the prevalence of personality disorder within this population in the UK, although studies of both the offender population and of homicide perpetrators in other countries demonstrate similar prevalence rates. In the ONS study of the UK prison population as a whole in 1997, the prevalence of personality disorder ranged from 50% for female prisoners to 64% for male sentenced and 78% for male remand prisoners, as established using the SCID II (Singleton, Meltzer et al. 1998). In an extensive study of all individuals convicted of homicide or attempted homicide from 1988 to 2001 in Sweden, the prevalence of personality disorder as a primary or secondary diagnosis in a subgroup of 1091

offenders was 54%. Diagnosis was ascertained in these cases by examination of standardised psychiatric assessments (Fazel and Grann 2004) . Interestingly, studies basing diagnoses on those made within psychiatric reports result in much lower prevalence rates. In a study of all homicides in Iceland between 1900 and 1979, the prevalence of personality disorder was found to be 21.3%, although it is also relevant that this relies on psychiatric assessments over 50 years ago (Petursson and Gudjonsson 1981). Another study, although looking only at matricide in Scotland from 1957 to 1997, found a prevalence of 19% for personality disorders based on similar records (Clark 1993). Such prevalence rates, although from psychiatric assessments over several decades, would indicate that perhaps practice in relation to this is remaining fairly consistent as they are not dissimilar from the proportion of homicide perpetrators diagnosed with personality disorder within the reports in this sample in the UK. It also needs to be acknowledged that the prevalence of personality disorder in my study is not the prevalence of personality disorder among homicide perpetrators as a whole, but is the prevalence within those that have had reports completed.

Nearly one fifth of the sample in this study fulfilled criteria for a level of personality disturbance not severe enough for a definitive diagnosis of personality disorder (probable personality disorder, possible personality disorder and personality difficulty). There is a lack of evidence on the presence of sub threshold personality disturbance in the offender population, although there are data in community samples. A national epidemiological study of 8391 members of the UK general population were assessed using the screening version of the SCID II and severity of personality disturbance was then established using five levels of severity. The group rated as personality difficulty, with some pathology but not sufficient for a diagnosis of personality disorder, constituted nearly half of the sample (48.3%) (Yang, Coid et al. 2010). This is clearly a substantially higher proportion than within this sample, as this sample, of homicide perpetrators, is more likely to fulfil criteria for a definitive diagnosis of personality disorder rather than personality disturbance which would be expected in the general population.



## **7.22 Correlations between domains and dimensions of personality disorder and circumstances of the offence**

In the analysis of individual domains 44% (n=261) of the sample had a personality disorder within the externalising domain (cluster B), with lower proportions in the other domains: 13% (n=75) in schizoid (cluster A); 16% (n=93) in internalising (cluster C); 14% (n=82) in anankastic (cluster D). The high prevalence of those in the externalising domain was not surprising given the well documented association between cluster B personality disorders and violence (Johnson, Cohen et al. 2000; Coid, Yang et al. 2006a). In their examination of homicide perpetrators in Sweden, Fazel and Grann (2004) showed lower prevalence rates for all clusters: 6% cluster A; 17% cluster B; 1% cluster C. The proportion of Personality Disorder – Not Otherwise Specified in their study was 24%, the commonest personality disorder diagnosis. As the authors concede, these data are retrospective and are not based on standardised diagnostic instruments, but on clinical assessments previously carried out (Fazel and Grann 2004). It is therefore likely that this may lead to an underestimation of the proportions within certain clusters. The lack of certainty regarding attributing the diagnosis of personality disorder is perhaps evident from the frequency of the diagnosis Personality Disorder – Not Otherwise Specified. Other evidence examining the prevalence of particular clusters of personality disorder comes from ONS data on the UK prison population which, allowing for co-morbidity within clusters, indicates rates from 20-25% for cluster A disorders; 49-72% for cluster B; 7-8% for cluster C and 10% for cluster D in male sentenced prisoners. Rates for female prisoners were 6-24% for cluster A; 31-61% for cluster B; 11-16% for cluster C and 10% for cluster D (Singleton, Meltzer et al. 1998). These prevalence figures are slightly higher than in this study.

The degree of overlap of domains prevented further, clinically meaningful, analysis within domains. This is perhaps unsurprising given evidence suggesting significant comorbidity between all clusters in the general population (Coid, Yang et al. 2006a) and in personality disordered offenders (Duggan, Mason et al. 2007). Furthermore, it appears that as the degree of personality disturbance worsens in severity, the typical prototypes of personality disorder tend

to overlap and merge (Yang, Coid et al. 2010). When the nature of this population, and the high prevalence of personality disorder, is considered, it might be expected that a significant degree of overlap may occur, even between clusters.

Within the dimensional analysis, 62% of those with a personality disorder, 35% of the total sample, had a severe personality disorder and 15% of personality disorder cases had a complex personality disorder, 9% of the total sample. This means that 66% of those assessed as having a personality disorder had a severe or complex personality disorder. This is clearly a very high proportion but, given the nature of the sample, is not surprising. Indeed, in a sample of prisoners selected for assessment for the DSPD programme, 67% (n=50) were assessed as having a complex or severe personality disorder (Tyrer 2009). It is arguable that this population may exhibit a similar level of psychopathology to the sample of homicide perpetrators. In looking at the diagnosis of personality disorder in reports in these cases, authors were significantly more likely to diagnose personality disorder in those in whom the PAS-DOC identified as severe (34% compared with 9%) and complex (60% compared with 18%). Both of these results are significant with a p value of < 0.001, This would be an expected finding and, indeed, would be concerning in many respects if those with much more significant personality pathology were not more likely to be identified as such.

Offence related variables that were significantly associated with severe personality disorder were previous convictions for violence and having a stranger as a victim. The presence of personality disorder within the externalising domain is necessary for severe personality disorder. Therefore, given the well documented association of cluster B personality disorders with criminal convictions (Coid, Yang et al. 2006a), it might be expected that these individuals would have significantly more previous convictions. Moreover, evidence indicates a much stronger association between criminal convictions and severe personality disorder, than with antisocial personality disorder alone (Yang, Coid et al. 2010). Similarly, there is thought to be an increased prevalence of antisocial personality disorder in serial killers (Geberth and Turco

1997), which are predominantly characterised by victims who are strangers. There is also an association between psychopathy and stranger victims (Dowson and Grounds 1995). Although psychopathy could not be assessed owing to the nature of the study, it seems probable that those with psychopathy within the sample would fall within the severe personality disorder group.

Concerns have been raised at the approach to assessing severity necessitating the presence of significant personality pathology across domains/clusters, and that potentially high risk individuals with more 'pure', but very severe, personality pathology may not be identified as sufficiently severely disordered (Adshead and Sarkar 2012). Studies show that pathology spanning domains leads to much greater societal dysfunction, even if mild, compared with very severe pathology in only one domain (Tyrer 1996). It is also the case that increasing severity of personality pathology tends to result in individuals fulfilling criteria for more than one domain (Yang, Coid et al. 2010).

Complex personality disorder is characterised by personality disorder spanning two domains other than the externalising domain. This group was associated with the victim being known to the perpetrator, either being a current or ex-partner or spouse, and negatively associated with the victim being a stranger. There is limited evidence on associations between particular victims and subtypes or clusters of personality disorder, although a case series of homicide perpetrators has suggested an association between paranoid personality disorder and spousal homicides (Stone 1998).

### ***7.23 Factors associated with a diagnosis of personality disorder in reports***

Of the 338 cases diagnosed as having a personality disorder by the PAS-DOC, only one quarter (n = 83) were diagnosed within the reports. Those given a diagnosis in reports were significantly less likely to come from an ethnic minority; 6% (n = 5) compared with 19% (n = 46)

in the group identified as having a personality disorder by the PAS-DOC, but not diagnosed as such in the report. UK psychiatrists have been shown to view those from different ethnic backgrounds differently, and that this influences diagnosis (Lewis, Croftjeffreys et al. 1990). There is evidence that the prevalence of personality disorder, as diagnosed clinically within mental health services, is lower in ethnic minority groups (Raffi 2010), although this was not the case in this study using the PAS-DOC, a standardised assessment, where proportions were 58% of white perpetrators compared with 49% of those from ethnic minorities.

Other factors associated with attributing the diagnosis included a history of alcohol or drug misuse. Although not reaching statistical significance, alcohol or drugs being seen as contributory factors to the offence was of borderline significance. There is a well-documented association between personality disorder, in particular cluster B disorders, and both substance and alcohol misuse in a variety of settings, both in clinical populations (Grant 2004), and young community samples (Moran, Coffey et al. 2006). Within populations of homicide perpetrators, there is frequent comorbidity between personality disorder and substance misuse. In a sample of 71 homicide perpetrators with alcohol or drug abuse in Sweden, the proportion with comorbid personality disorder was 58% (Lindqvist 1991). In a study looking at 90 mentally ill homicides in Finland, of the 51% with personality disorder all had comorbid substance misuse disorders (Putkonen, Kotilainen et al. 2004). Some other evidence from Scandinavia also demonstrated that those with personality disorder were more likely to have evidence of alcohol contributing to the offence, when compared with homicide perpetrators with autistic spectrum disorders and psychosis respectively (Wahlund and Kristiansson 2006) (Putkonen, Collander et al. 2001). There is no previous evidence exploring whether or not a diagnosis of substance misuse increases the willingness of an author to attribute the diagnosis of personality disorder. It does seem likely though, that when the evidence linking the two and the frequency with which they are seen together in a clinical setting, especially within forensic services, are considered,

authors may be more likely to contemplate giving the additional diagnosis of personality disorder in those with substance misuse.

A similar rationale may explain the significantly increased likelihood of diagnosing personality disorder in individuals with previous convictions for violent offences. There is a significant association between cluster B personality disorders and previous criminal convictions for violent offences and custodial sentences within community samples (Coid, Yang et al. 2006a) and, indeed, as has been discussed previously, the criteria for diagnosing both antisocial and dissocial personality disorders includes behaviours which would result in arrest, and violence and aggression. It is therefore unsurprising that authors are more likely to diagnose personality disorder in such individuals. It is interesting, however, that there was no significant difference for previous sexual offending. This is surprising as many sex offenders have personality disorders or abnormal personality traits (Gordon and Grubin 2004). It has been demonstrated, in a sample of elderly sex offenders compared with elderly offenders without a history of sex offences, that the prevalence of personality disorder was similar in both groups at 33%, but that the sex offenders tended to exhibit prominent schizoid, obsessive compulsive and avoidant personality traits, with much less antisocial traits (Fazel, Hope et al. 2002). These are personality traits that are often less immediately apparent than antisocial traits in a standard psychiatric assessment, which may account for the apparent disparity. Arson as a method of homicide was associated with the diagnosis of personality disorder in reports. There is a documented association between arson and personality disorder (Geller 1987), particularly in those who repeatedly engage in fire setting (Koson 1982). It is also often the case that in assessing any individual engaged in fire setting, a particularly detailed account of the behaviour would be carried out. It is possible that such an assessment elicited features which otherwise may not have been uncovered in a less detailed assessment.

The presence of mental illness such as schizophrenia or affective disorder might be expected to decrease the likelihood of a diagnosis of personality disorder as commonly there is

a reluctance to diagnose if there is also a diagnosis of severe mental illness (Surtees and Kendell 1979). It was therefore unexpected that it was not significantly less likely that a diagnosis of personality disorder would be made in those cases who also had a diagnosis of schizophrenia or affective disorder.

It was somewhat surprising that, in the light of significant changes in policy, service provision and legislation affecting those with personality disorder over the time period of the study, from 1996 to 2007, there were no trends seen in the diagnosis of personality disorder within reports.

### **7.3 Qualitative themes**

Given that only one in four cases identified as having personality disorder by the PAS-DOC had been diagnosed by report writers it appeared that factors over and above those pertaining to individual perpetrators were exerting an influence on the diagnosis. Qualitative methods were therefore used to explore attitudes and beliefs of clinicians regarding the diagnosis of personality disorder in court reports; focus groups followed by semi-structured interviews. Themes which emerged in the focus groups were explored in more detail in the semi-structured interview.

#### **7.31 Classification**

That only one quarter of those diagnosed as personality disordered with the PAS-DOC were diagnosed as such by authors of reports clearly indicates a significant problem with the diagnosis, both its construct and clinicians' attitudes towards it. All consultants interviewed were aware of the limitations of current classification systems and expressed disquiet regarding this. Concerns were raised regarding the validity and reliability of the diagnosis, and these views are echoed in a survey of international personality disorder experts regarding DSM IV, whereby 68% felt the classification had poor validity and 51% poor reliability (Bernstein, Iscan et al. 2007). A UK based survey of Forensic Psychiatrists, both consultants and senior trainees, found

that 71% lacked confidence in the inter-rater reliability of the diagnosis (Haddock, Snowden et al. 2001). One of the concerns regarding validity in my study was of poor specificity; again this view was expressed in the survey of personality disorder experts in that most felt the categorical system does not adequately describe patients, and that most patients with personality disorder have more than one subtype of personality disorder. Two thirds of respondents in this survey also felt that categories did not reflect psychopathological entities (Bernstein, Iscan et al. 2007). This concern was also raised in this study, in that the construction of particular subtypes, in particular borderline personality disorder, was seen as unsatisfactory. The frequent use of Personality Disorder – Not Otherwise Specified was felt to underline flaws in the current categorical system. This is a common criticism; Personality Disorder – Not Otherwise Specified has been shown to be the commonest diagnosis in unstructured clinical interviews, and has been described as a “wastebasket diagnosis for persons who fall between the cracks” (Verheul and Widiger 2004).

Although some of the experienced psychiatrists in the current study expressed a preference for DSM, 75% of the personality disorder experts surveyed by Bernstein (2007) thought that it should be replaced, and in another survey of psychiatrists and clinical psychologists, only 16.8% felt that it is “very clinically useful” (Spitzer, First et al. 2008). In this study it was acknowledged that empiricism was not, and is not, the driver behind DSM, but consensus of committees and financial considerations are of greater influence. This is a well-documented concern. In the personality disorder experts survey, the vast majority thought that the diagnostic threshold was agreed by clinical consensus and that patients were forced into DSM categories to satisfy insurance forms (Bernstein, Iscan et al. 2007). This dissatisfaction with DSM has been expressed both in the US and the UK. The lack of evidence and validity of diagnostic descriptions has been criticised and described as “expedient compromises arrived at by committees with internal disagreements and by superiors to committees trying to meld apples and oranges.” (Horowitz 1998). Within the UK, it has been described as “Diagnosis for Simple

Minds”, or “Diagnosis as a Source of Money” (Tyrer 2010). The checklist nature of both classification systems, with somewhat arbitrary cut off points, was viewed as superior in DSM IV, compared with ICD 10, but the risk of psychiatrists avoiding making the diagnosis owing to anxiety about the misinterpretation of diagnosis in court by way of box ticking, was highlighted. This aspect of classification has also been heavily criticised elsewhere, being referred to as “menu-driven” (Horowitz 1998) and “vote-counting” (Tyrer 2010).

Although antisocial personality disorder was viewed as a straightforward and reliable diagnosis to make, the issue of criterion contamination was seen to jeopardise clinical utility. This is a longstanding criticism (Blackburn 1988), and is central to controversy over the core traits of psychopathy (Cooke, Michie et al. 2004).

The limitations of a categorical system, and support for a dimensional approach, with a view that personality is a continuous, rather than discrete, construct were raised by some experienced psychiatrists. This view was shared by the personality disorder experts in the international survey who overwhelmingly agreed with statements that disorders are better conceived dimensionally, and that this is supported by the data. They also felt that personality disorder is better understood as an extreme variant of normal personality, not a separate disease entity. Despite this, only 55% supported a dimensional approach, with 69% preferring a mixed categorical and dimensional system. This may in part reflect views also expressed that categorical systems are easier to use and communication with colleagues is more straightforward with this approach (Bernstein, Iscan et al. 2007). A survey of US psychologists comparing the utility of DSM IV with dimensional models from a clinical perspective, however, demonstrated a preference for a dimensional approach in communicating with patients, treatment planning, describing personality and covering difficulties (Lowe and Widiger 2009). This may reflect different epistemological backgrounds, and the familiarity that psychiatrists have with a categorical model given that is more closely aligned with a medical model of classification (Sarkar and Duggan 2010).



Further support for a dimensional approach centred on the incorporation of measures of severity and the impact on levels of functioning within a dimensional model. Both severity and functioning are integral to the PAS-DOC utilised within the quantitative aspect of this study (Tyrer 2005).

### **7.32 Diagnostic Process**

The need to address the more general criteria for personality disorder, prior to consideration of individual traits, was emphasised by experienced consultants. This problem, of adopting a “bottom up” approach to diagnosis has led to proposals for a hierarchical process, with consideration of general criteria first (Sarkar and Duggan 2010).

It was felt that the threshold for diagnosis is high; in experienced consultants this related to concerns regarding reliability and validity in less severe cases, in newer consultants anxiety regarding the potentially negative impact of the diagnosis was influential. Reluctance to diagnose personality disorder during an initial clinical interview as a result of concerns regarding the stigmatising nature of the diagnosis was shown in a national sample of US clinicians, with regard to borderline personality disorder (Zimmerman 1999).

Comorbidity with other mental disorders is common, but often not diagnosed (Zimmerman 2005); a fact commented on by experienced consultants. The increased risk of violence and crime, as established in the UK700 study (Moran 2003), was commented on by an experienced consultant. It has been suggested that there is an “*additive effect*” with regard to the “*load*” of symptoms and outcomes with severe mental illness and comorbid personality disorder (Adshead and Sarkar 2012). Despite awareness of poorer outcomes and increased risks, it was felt that often personality disorder assessment is not given due consideration within services that predominantly treat severe mental illness. This may then be exacerbated by negative attitudes towards those with personality disorder, resulting in less available and accessible services for those in significant need (Tyrer 2010). Given indications in this study that clinicians

may be reluctant to give the diagnosis in court reports in the absence of available treatment, it is possible that this is influential. Other possible reasons for clinicians' reluctance to diagnose comorbid personality disorder have been suggested as the view that disorders in two axes (in DSM) are unhelpful, the diagnosis is stigmatising, there is significant comorbidity with personality disorders and the diagnosis does not have a significant impact on treatment planning (Zimmerman 2005). This latter reason was identified by both experienced and new consultants. It was also suggested that clinicians intentionally misdiagnose personality disorders as axis 1 disorders in order to avoid giving a personality disorder diagnosis. This was also found in a study examining bipolar affective disorder and borderline personality disorder, which found significant under diagnosis of personality disorder (Zimmerman 2010).

The significance of information from informants to make the diagnosis of personality disorder in court reports was expressed by most consultants. Evidence suggests that informants detail more personality disorder pathology than subjects themselves. This is particularly the case among Forensic patients who may withhold information, especially in the context of a pre-trial report, or may try and give socially desirable responses (Keulen-de-Vos, Bernstein et al. 2010). It was felt by consultants, though, that even without this information a diagnosis could be made with a sufficiently thorough assessment. In relation to this, was the view that a diagnosis of personality disorder should not be given in the absence of assessment with a standardised assessment tool. In many respects this seems reasonable given the disparity in prevalence rates, as described above, in that when standardised assessment tools are used prevalence rates are consistently higher than unstructured clinical interviews alone, suggesting a higher degree of validity in such assessments. However, it was very apparent when reading the court reports, that there was often ample clinical evidence to give a diagnosis of personality disorder, but it was not given, suggesting a reluctance to diagnose rather than insufficient evidence precluding the diagnosis. Nevertheless, the inevitable consequence of this is that, with the time

and resource constraints limiting the feasibility of conducting a full psychometric assessment in all cases, many individuals with possible personality disorder will not be diagnosed as such.

Further concerns were raised regarding the predominance of psychologists within the field of psychometric assessments, both in interpreting results of assessments with no consideration of the context from a functioning perspective, and in using instruments incorrectly. This was also the view elicited in a survey of criminal barristers in the UK, who, although viewing personality disorder as within the remit of psychology rather than psychiatry, were critical of psychologists in their poor use of instruments and vagueness of reports and evidence in court (Leslie, Young et al. 2007). However, in my study, the lack of confidence of psychiatrists in challenging psychometric assessments was seen as problematic. It is therefore somewhat disappointing that evidence from a survey of UK psychiatrists on the DSPD proposals suggests that there is little appetite to redress this, with only 22% thinking that doctors should be involved in assessing personality disorder, 18% feeling that psychiatrists should have the lead role in DSPD services compared with 31% who thought that psychologists should take the lead. Only 3% of those surveyed felt that psychiatrists had no role whatsoever in the process (Haddock, Snowden et al. 2001)

### **7.33 Court Process**

Aspects of the court process were seen as contributing to reluctance to diagnose personality disorder by the majority of interviewees. Newer psychiatrists felt anxious about being able to justify the diagnosis in court. Such anxiety is not uncommon; in the survey of barristers referred to above, many commented on significant levels of anxiety being apparent, particularly among inexperienced psychiatrists, when being cross examined (Leslie, Young et al. 2007). Given the lack of confidence in diagnosing personality disorder (Haddock, Snowden et al. 2001), anxiety about being challenged publicly is to be expected. According to barristers, the most important factor in giving evidence was clarity of language, followed by a clear prognosis and firm conclusions and recommendations (Leslie, Young et al. 2007). It is manifestly difficult

to discuss personality disorder in such a manner from a position of low confidence in ability to diagnose.

Common perceptions of personality disorder, within both the media and from other agencies, can be negative and stigmatising and there was an understandable reluctance to diagnose in this context. There were conflicting views on how personality disordered individuals may be perceived; clearly this is to some extent dependent on individual cases. Even among more experienced psychiatrists there was an acknowledgement that, in some cases, behaviour and symptoms are less understandable than those seen in severe mental illness. Drawing on more philosophical texts, Sir Isaiah Berlin suggested

*“if I find a man to whom it literally makes no difference whether he kicks a pebble or kills his family, since either would be an antidote to ennui or inactivity, I shall not be disposed, like consistent relativists, to attribute to him merely a different code of morality from my own or that of most men, or declare that we disagree on essentials, but shall begin to speak of insanity and inhumanity; I shall be inclined to consider him mad, as a man who thinks he is Napoleon is mad.”*

(Berlin 1962)

It was the view of experienced consultants that it is the duty of the psychiatrist to explain the behaviour in question, and any contribution that it makes to future risk. All consultants were very clear regarding the responsibility to advise the court, although raised ethical issues regarding the role of the psychiatrist in trying to reconcile the positions of acting in the patient's best interests which is integral to clinical practice, with issues pertaining to public protection. The consensus view was that the latter must be at the forefront of decisions, but an experienced psychiatrist felt that the removal of any therapeutic aspect from the assessment was unrealistic and impossible. This debate centres on what is termed the 'Dual Agent' role; acting on behalf of both the court and patient. It is argued that it is impossible to reconcile these roles as the defendant inevitably struggles with viewing the psychiatrist as anything other than a doctor and it is seen as impossible for clinicians to interview them without using their clinical skills. It is suggested that this is likely to lead to inadvertent disclosures with a potentially negative

outcome (Stone 1984). A suggested approach to this dilemma is entire abandonment of the traditional doctor role, and acting entirely as an agent of the court (Appelbaum 1997). Taking a more moderate and reasoned position from a UK perspective, a framework has been proposed combining medical ethics (principles of beneficence and non-maleficence) with justice ethics (truthfulness and respect for autonomy and human rights) (O'Grady 2002). There is a lack of evidence on the impact of particular diagnoses on these issues; however, it is likely that wider ethical concerns regarding personality disorder further exacerbate these difficulties. The more ethically difficult position of psychiatrists providing reports and giving evidence on their own patients was an issue of concern for one of the experienced psychiatrists. In such cases, the ethical quandaries outlined have even greater resonance but, unfortunately, this is a position which is unavoidable for many Forensic Psychiatrists in the UK.

The concerns outlined regarding both the court setting and ethical dilemmas inherent in the criminal justice process as a whole understandably lead to misgivings regarding giving the diagnosis and, in some cases, may dissuade completely. It would be interesting to ascertain to what extent the reluctance to diagnose personality disorder in reports is related to criminal justice system factors, and how far it relates to more clinical matters. This could be explored by repeating the quantitative aspect of this study on case notes from both forensic and general adult mental health settings. Such information could be very useful in identifying particular problems in diagnosing personality disorder, and exploring approaches to rectifying the problem.

### ***7.34 Mental Health Act (1983) amendments***

Most consultants did not feel that changes to the Mental Health Act 1983, which came into practice in 2009, had any impact on the likelihood of diagnosing personality disorder. There was an understandable view that the removal of the category 'psychopathic disorder' was an improvement, in both clarity and in decreasing stigma. Prior to the Act being passed, there had been many fears about the fact that the amendments rendered it easier to subject a patient to

compulsory powers (Moncrieff 2003); indeed the Royal College of Psychiatrists described the new Act as “*unethical, unsafe and unworkable*” (Shooter 2002). Although one new consultant had concerns about a significant increase in numbers of patients with personality disorder, all of the other consultants did not feel that there had been a material change in admissions, and that clinicians continue to exercise clinical discretion in practice.

### **7.35 Recommendations within reports**

Interestingly, all experienced consultants stated that they would give a diagnosis solely on the grounds as to whether they felt it was present or not. This was not the case with newer consultants, who often commented on the perceived need to make later recommendations on verdict and disposal; a feeling of a need to ‘do something’. Amongst new consultants there was an awareness of a different risk/benefit balance in diagnosing personality disorder, with less available treatment to benefit the patient yet potentially more negative consequences within the criminal justice system. They also commonly felt that they would be more likely to diagnose if the individual had previously been given a diagnosis by services or in another report, illustrating a lack of confidence in their own ability. This concurs with previous findings that ratings of self-competence in diagnosing and treating those with personality disorder is directly related to experience (Black, Pfohl et al. 2011). There was also a belief shared by experienced and new consultants that females are more likely than males to receive a diagnosis of personality disorder on the basis of societal views of women who engage in violent behaviour. When explored though, there was no significant difference within this sample in the proportion of females with personality disorder (as confirmed by the PAS-DOC) diagnosed by report authors, compared with males: proportions were 23% and 25% respectively.

All experienced consultants but just over half of new consultants would be willing to consider making recommendations for a diminished responsibility verdict in those with personality disorder; this being made much easier, and indeed necessary from an ethical standpoint, if a clear association between personality disorder symptoms and the offence exists.

Some of the experienced consultants commented that other psychiatrists may avoid giving the diagnosis owing to perceived difficulties justifying their resultant position on diminished responsibility in court.

Those newer consultants who would not consider diminished responsibility were of the view that symptoms of personality disorder could not be sufficient to impair responsibility to the extent that consideration of a diminished responsibility defence would be appropriate. There are conflicting views in the literature regarding this, with some agreeing that personality disorder should not be a mitigating factor (Spence 2001). Other authors would contend, however, that an individual with severe personality disorder with a history of violence should be seen as suffering from a “disease of the mind” (p128) and should perhaps be seen as lacking the capacity to be legally responsible for any antisocial behaviour at the material time (Palermo 2007). Surveys of attitudes of nursing staff overwhelmingly indicate that those with personality disorder should be seen as responsible for their actions (Webb and McMurrin 2007) and tend to be blamed more and excused less for aggressive behaviour, compared with those with schizophrenia (Feather and Johnstone 2001).

Several consultants felt that gender has an influence, with courts being more likely to want to give diminished responsibility verdicts and hospital disposals to females as a result of a greater degree of sympathy and attempts to understand their behaviour. Certainly, looking at data from the National Confidential Inquiry on homicide perpetrators with personality disorder from 1996 to 2006, 12% of females received a diminished responsibility verdict and 18% a hospital order, compared with 3% and 10% for men respectively, although, given the multifactorial reasons behind such verdicts, it is impossible to determine if gender specifically contributed to the disparity.

There was recognition that, often in personality disorder cases, hospital disposal is unlikely and that if personality disorder is the reason given for diminished responsibility there are

negative consequences of the diagnosis with regard to sentencing and parole. It seems that the diagnosis of, what may be seen as, an untreatable condition has the potential to constitute 'evidence' to justify increased duration of sentence initially, and subsequently to make parole less likely (Padfield 2000).

Fewer experienced consultants felt that hospital disposal is appropriate for personality disorder, than had felt recommendations for diminished responsibility are appropriate. This is consistent with evidence that indicates those with a primary diagnosis of severe personality disorder are deemed unsuitable for admission to medium security (Grounds, Gelsthorpe et al. 2004), and that over half of those with personality disorder referred from high security to medium security for admission are refused (Tetley, Evershed et al. 2010). Although in this study some felt that certain symptoms may be more amenable to treatment, many were concerned regarding the lack of evidence for treatment and the risk of patients becoming 'stuck' in hospital. The impacts of this in not only duration of stay for the patient, but also financial implications for the trust, were highlighted. This is consistent with themes from a qualitative study of lead clinicians in medium secure settings in England and Wales which demonstrated that it was seen as a more difficult decision to admit a patient with comorbid personality disorder owing to concerns about lack of response to treatment and the detrimental impact on both staff and other patients (Grounds, Gelsthorpe et al. 2004).

In the current study there were several comments about the difficulties in referring patients with personality disorder to high secure settings on a hospital order, and that they preferred patients to be transferred after conviction to allow them to be transferred back to custody should management in hospital be untenable. It was confirmed by consultants from high security that this is the current pathway into care for such individuals. There are clear risks inherent in relying upon an individual with personality disorder who would benefit from treatment in hospital being identified within the prison system and it is argued that decisions such as this are more appropriately taken in court, at the time of trial, and that there is little justification for the



inevitable delay in admission to hospital (Eastman 1996). An alternative, which was seen as a reasonable compromise by many in this study, is to transfer an individual utilising a 'hybrid order', Section 45A of the Mental Health Act 1983. This allows transfer to hospital for treatment but, should it transpire that the patient is untreatable, they can be transferred back to prison for the remainder of their sentence. Although this would appear to offer an ideal solution, concerns were raised by an experienced consultant in this study that this may result in therapeutic nihilism; these are often very complicated and challenging patients to work with, and it was felt that, should the option to transfer back to prison be there, the level of perseverance with managing and treating such patients may be lessened.

Treatment for personality disorder is available to varying degrees within the custodial system and it was the view of many newer consultants that those with personality disorder are more appropriately treated and managed within prison. An experienced consultant argued against this point, in questioning whether, if an individual struggles to cope in the community as a result of their personality disorder, the harsher environment of prison is really the most appropriate setting for them to be managed in.

### **7.36 Treatment**

There was a view that there is a lack of availability of effective treatment for personality disorder. This is a widely held belief; only 54% of Forensic Psychiatrists in a UK survey felt that it is treatable, with higher proportions in South England and Wales and amongst special hospital psychiatrists (Haddock, Snowden et al. 2001). Some consultants in this study were of the view that taking a more pragmatic approach to what is achievable in treatment is preferable to engaging in the polarised debate regarding treatability. Recent guidelines for the treatment of Antisocial Personality Disorder from the National Collaborating Centre for Mental Health (NCCMH 2009) propose a similar approach, with the emphasis on management which supports patients and helps them to develop coping strategies for dealing with problems, rather than pursuing a cure. These guidelines may help to dispel some of the therapeutic nihilism and offer

positive, pragmatic guidance for working with this difficult and challenging group. Crucial aspects to this include clear communication and joint working with multiple agencies along with smoother pathways through care and between services (Duggan and Kane 2010). In relation to other types of personality disorder, some consultants thought that treatment may be more effective in those with borderline personality disorder. There is certainly a much larger body of evidence regarding treatment for these patients, with evidence of effectiveness of some psychotherapeutic interventions including mentalisation based therapy and dialectical behavioural therapy (Kealy and Ogrodniczuk 2010). The point that labelling those with personality disorder as 'untreatable' is premature, and merely reflects a lack of evidence base was highlighted. This argument is also put forward by Silk in relation to Antisocial Personality Disorder, in that, although most psychiatrists believe that it is untreatable, there is actually an unsatisfactory and inadequate evidence base for this assertion (Silk 2010). It has also been stated;

*"Treatability was never a yes/no matter and all we have to show for years of medico-legal argument is an expensive 'maybe' and the absurd suggestion that sitting in hospital is treatment..... Personality disorder is a psychological disability. Quick or simple remedies are no more likely than for chronic schizophrenia – and the principles of rehabilitation are also the same. So get on with it."* (Maden 2008) p457

A further important point made within the semi-structured interviews is that the only way in which evidence will emerge and treatments for this population will improve is by the ongoing engagement of psychiatrists with these patients and services.

There was a prominent view within the focus groups that it is unethical to give a diagnosis of personality disorder in the absence of any recommendation for treatment. Within the interviews, however, only two new consultants were of this view. All other consultants were firmly of the opinion that it is unethical not to, if it is clinically apparent. This reluctance to diagnose was in

part related to the negative attitudes and stigma surrounding personality disorder, in particular in comparison to schizophrenia. In a survey of nurses' attitudes, patients with personality disorder were rated more highly as deceptive, demanding, negative and weak as against patients with schizophrenia. Staff were less sympathetic, more angry and felt that those with personality disorder were less deserving (Feather and Johnstone 2001).

It was also suggested that patients may actually benefit from being given a diagnosis, with identification of the problems. As was suggested in relation to borderline personality disorder, not telling patients their diagnosis reinforces the stigmatising nature of it (Kealy and Ogradniczuk 2010). Nonetheless, this remains a controversial issue. In an interview recalling a conversation with a patient, an eminent Professor of Forensic Psychiatry stated

*“He said ‘Well I’m a personality disorder aren’t I?’ I said ‘I never use that term, I don’t use that term in my clinic, it’s not something I ever say to any patient’.”*

(Grounds and Gordon 2007)

A common justification for concealing information from patients is that beneficence is of greater import than respect for autonomy. This carries with it the presumption that the doctor knows best, which it is argued, is not an infallible position. Another position is that patients do not want to be told the truth. It is important, in relation to this, to separate a rejection of the clinician's opinion from a desire never to have heard it (Kanaan 2009). A narrative review on diagnostic disclosure in psychiatric and oncology patients demonstrated that most patients prefer to be told their diagnosis, partly as it can allay fears. There was a higher degree of reluctance to discuss diagnoses within psychiatry, and amongst older clinicians (Mitchell 2007). Other authors take a more non-absolutist approach, viewing occasional “*benign deceptions*” as possibly acceptable with adequate moral considerations (Sokol 2007).

Some of the consultants felt that recent policy changes in service provision for personality disordered offenders would impact on giving the diagnosis. Despite it being several years since the publication of "Personality Disorder: no longer a diagnosis of exclusion" (National Institute for Mental Health in England 2003), it seems that it remains a diagnosis of exclusion in many services. Sixty per cent of those referred to medium security from the Personality Disorder unit at Rampton Hospital between 1997 and 2007 were rejected as the medium secure unit had a policy of not accepting those with personality disorder (Tetley, Evershed et al. 2010). Another study showed that 40% of those detained in high secure units under the legal category of psychopathic disorder who were deemed suitable for transfer by their Responsible Medical Officers were essentially 'stuck' in the system, and not being transferred to lower levels of security (Dolan, Thomas et al. 2005).

A qualitative survey of lead clinicians in medium security indicated that those with a primary diagnosis of personality disorder would be considered unsuitable for admission as a result of concerns regarding treatability, bed blocking and disruption. One clinician stated that forensic services had become a "*psychosis only service*", where as previously there had been equal numbers of patients with psychosis and personality disorder (Grounds, Gelsthorpe et al. 2004).

The lack of priority placed on personality disorder services from a policy perspective was felt to contribute to the lack of available services by one experienced consultant. The impending implementation of Payment by Results for Mental Health Services, with its necessary focus on evidence based interventions and diagnosis (Solomka 2012), may exacerbate the problem of insufficient provision of services given the less robust evidence base and controversy regarding diagnosis, when compared with diagnoses such as schizophrenia. It is felt that stigmatising attitudes in care providers and service planners contributes to the marginalisation of this group leading to restriction of resources for service availability and accessibility. It is contended that this is facilitated in part by denying or minimising the prevalence of personality disorder, thus obviating the need for further development of services (Kealy and Ogrodniczuk 2010). One of

the experienced consultants felt that one of the most important factors which would increase the willingness of clinicians to diagnose personality disorder would be the development of more services to treat these individuals.

It was the opinion of several consultants interviewed that often difficult patients have their diagnosis changed from one of severe mental illness to that of personality disorder in order to exclude them from services, in particular in general adult services as a result of pressures on beds and a lack of resources. It was also felt that this can happen in referrals to high secure units. Although there is evidence of under diagnosis of personality disorder with comorbid mental illness, there does not appear to be any empirical evidence suggesting diagnostic change for these reasons. It was, however, a theme which was spontaneously expressed by most of the experienced psychiatrists.

In discussing the DSPD units, one consultant was very concerned at the significant involvement of psychologists in these services. As detailed previously, it has been shown that the position of prominence of psychology within these services is supported by several psychiatrists, very few of whom would be willing to be involved (Haddock, Snowden et al. 2001). A similar concern has been raised in relation to the new proposals for managing personality disordered offenders, by Forensic Psychiatrists at Broadmoor Hospital. They felt that there was a need for much greater involvement of psychiatrists in both the diagnosis and case formulation, highlighting the risk of missed organic illness diagnoses and over diagnosis of personality disorder when based on a questionnaire at face value (Witharana 2011). Within the semi structured interviews a consultant working in one of the DSPD units felt that the lack of experience and confidence amongst clinicians and other agencies has resulted in an excessively risk averse system to the extent that patients remain within high security far longer than necessary as there is insufficient focus on intensive support and management in the community. As discussed above, this is a well-documented difficulty within high security (Dolan, Thomas et al. 2005; Tetley, Evershed et al. 2010).

### **7.37 Training**

Training in personality disorder was universally acknowledged as being inadequate, with a lack of standardisation in training curricula, which was seen to be exacerbated by a lack of dedicated personality disorder services for trainees to gain experience in and consultant supervisors who themselves had poor training, thus were not in a position to satisfactorily supervise trainees. More experienced consultants did state though, that, in their experience, training had improved over recent decades. It was felt by both experienced and new consultants that there is a lack of interest in, and perceived need to acquire, further training in personality disorder among psychiatrists, which has resulted in other disciplines taking advantage of training opportunities and subsequently taking on more roles in the treatment and management of patients with personality disorder. A survey of a range of different mental health clinicians demonstrated that, when compared to other disciplines such as nursing and social work, psychiatrists were less likely to want additional training (Black, Pfohl et al. 2011).

Several suggestions were made as to how to improve this including making training in personality disorder mandatory for trainees and encouraging psychiatrists to become trained in standardised assessment tools as it was the experience of new and experienced psychiatrists that this improved clinical assessment and understanding of personality disorder generally. It was felt that this may be particularly useful for general adult psychiatrists, for whom treatment of personality disorder is an integral part of their work, yet often have less opportunities for such training, compared with forensic psychiatrists. The benefits of specific training courses are well documented, in both improving knowledge and understanding and reducing stigma. Specific educational courses on personality disorder for prison staff on a DSPD units led to a positive impact on staff attitudes and increased levels of knowledge, skills and understanding (Bowers, Carr-Walker et al. 2005). A one day workshop on STEPPS (Systems Training for Emotional Predictability and Problem Solving), a group treatment programme for individuals with borderline personality disorder resulted in increased awareness of difficulties with low self-esteem and distress inherent within the disorder and greater empathy towards patients. It also increased

feelings of competence and desire to work with these patients (Shanks, Pfohl et al. 2011). There is also evidence that a self-instructional programme for nurses led to increased knowledge and improvements in attitudes and behaviour towards patients with personality disorder (Miller 1996). Adequate supervision and support for staff working with patients was also highlighted as critical in this study. In a qualitative assessment of staff treating personality disordered patients within forensic services it emerged how staff often underestimated how emotionally draining and challenging it would be, and described high levels of stress, particularly if they had regular face to face contact with patients (Fortune, Rose et al. 2010). Problems can include displacement, damaging repetition and boundary violations. Good supervision involves attending to the staff member's needs and boundary setting, and should provide support and a space for reflection and advice. Reflective practice for those working with personality disorder is essential (Moore 2012). Importantly, the absolute need for high quality support, supervision and training has been recognised in the recent guidelines for Antisocial Personality Disorder (NCCMH 2009).

### **7.38 Stigma**

All consultants expressed concern at the ongoing stigmatising nature of the diagnosis of personality disorder. This was felt to be problematic both within psychiatry and with other agencies involved in managing such patients, at times resulting in what one consultant felt was an abrogation of their human rights. The stigmatising nature becomes even more pertinent when considering the diagnosis of personality disorder in young people and there was reluctance expressed by several participants regarding giving the diagnosis to young people. There is a careful balance to be struck between labelling someone at such a young age, resulting in exclusion from services, and identifying a problem and intervening at an early stage, when treatment may be more effective.

The pejorative nature of the diagnosis was also seen to impact on diagnosis in ethnic minorities, in that it was felt that clinicians have a higher threshold in these cases, partially as a

result of unfamiliarity with different cultural norms. This view is consistent with results from the quantitative aspect of the study, where not dissimilar proportions were diagnosed as personality disordered by the PAS-DOC; 58% of white perpetrators compared with 49% of those from ethnic minorities. Those given a diagnosis in reports, however, were significantly less likely to come from an ethnic minority; 6% ( $n = 5$ ) compared with 19% ( $n = 46$ ) in the group identified as having a personality disorder by the PAS-DOC, but not diagnosed as such in the report ( $p=0.009$ ).

UK psychiatrists have been shown to view those from different ethnic backgrounds differently, and that this influences diagnosis (Lewis, Croftjeffreys et al. 1990). There is evidence that the prevalence of personality disorder, as diagnosed clinically within mental health services, is lower in ethnic minority groups (Raffi 2010). However, there are indications that referrals for ethnic minorities to specialist services for severe personality disorder are increasing, although often with more severe presentations (Geraghty and Warren 2003). It is unclear whether this is an issue with diagnosis or delay in assessments owing to cultural differences in help seeking behaviour, as was raised in this study. A further difficulty is that personality disorder assessment tools were developed in Western male populations, leading to concerns over cultural generalisability. There do appear to be indications that the PCL-R and PCL-SV can function with regard to psychopathic traits, even if aetiological differences exist with regard to emotional and cognitive aspects (Jackson 2007). The clear problem in not identifying personality disorder in ethnic minorities is not dissimilar to difficulties more broadly; of poorly targeted interventions, poor risk assessments and inadequate provision of services.



## **7.4 Implications and Future Developments**

There is a significant problem with personality disorder not being identified by psychiatrists writing court reports in homicide cases and this has implications for the individual, for clinicians generally, and more far reaching systemic implications. A cornerstone of medical practice is the principle of beneficence and non-maleficence and attributing the diagnosis of personality disorder could appear to conflict with both; it has a potentially profound detrimental impact on the individual yet yields, at times, barely discernible benefits with insufficient availability of effective treatment.

For the individual, it remains a highly stigmatising diagnosis. In the context of the criminal justice system, it can have negative consequences even if used successfully to decrease a charge of murder to one of Section 2 manslaughter on the grounds of diminished responsibility. The new provisions for diminished responsibility, as detailed in Section 52 of the Coroners and Justice Act (2009), make diminished responsibility more explicitly available for personality disorder through increased medicalisation of the defence, with an abnormality of mental functioning which needs to arise from a recognised medical condition. There must then be a substantially impaired ability to do one or more of: understanding conduct; form a rational judgement; exercise self-control. Finally, the abnormality of mental functioning must provide an explanation (not necessarily the sole explanation, but a significant contributory factor) for the killing. Given that personality disorder is a recognised medical condition and is likely to provide an explanation for the killing, the critical question regards the substantial impairment of specified abilities. It has been suggested that, unless it can be proven that the ability to exercise self – control is substantially impaired, personality disorder is unlikely to fall within the new plea (Mackay 2010). The crucial issue is the threshold for substantial impairment, and whether it will continue to be interpreted as previously determined in *R v Lloyd* (Lloyd 1967) as 'less than total – more than trivial' (Eastman 2012). Although, anecdotally, there have been cases where diminished responsibility has been successfully pleaded on the basis of personality disorder, the

impact of these changes on those with personality disorder will necessarily involve interpretation by the Court of Appeal to ascertain how this will function in practice (Eastman 2012).

The diagnosis of personality disorder can constitute evidence which leads to both increased duration of sentence and decreases likelihood of parole owing to the perceived immutability of the diagnosis (Padfield 2000). Furthermore, it is often used to exclude patients from mental health services (Grounds, Gelsthorpe et al. 2004; Tetley, Evershed et al. 2010). Given the 'sticky label' of the diagnosis, it is likely to continue to impact on the care and treatment offered to an individual within the wider context of the NHS in the future. Additionally, the diagnosis has a potential impact on wider societal issues such as future prospects for employment and housing, discrimination in the workplace and other legal matters such as custody of children (Bartlett 2011).

Despite the stigmatising nature, most patients wish to be told of their diagnosis (Mitchell 2007) and not identifying it can reinforce the stigma associated with it (Kealy and Ogrodniczuk 2010). Furthermore, although robust evidence of effective treatment is currently limited, the absence of a diagnosis would be likely to preclude a patient from future treatment that may be of benefit.

From a clinical perspective it is clear that personality disorder remains a significant problem and challenge within psychiatry. It is highly prevalent both within homicide offenders, as shown here, and within the offender population in general (Singleton, Meltzer et al. 1998). Failure to identify individuals with personality disorder does not result in the disappearance of difficulties, either for the patient or for services, and there is a need for an open debate among clinicians regarding the problems inherent in the diagnosis and concerns which clinicians have. In the context of court reports, it could be seen as ethically questionable to deliberately omit pertinent risk related information such as a diagnosis of personality disorder which is known to significantly increase risk, in cases as severe as homicide.

Often, lack of confidence and experience in assessing and managing personality disorder leads to a reluctance to diagnose and become involved in their management. Better training in personality disorder, for consultants as well as trainees, may make psychiatrists more comfortable in making the diagnosis by improving knowledge and understanding. Training can also be highly effective in altering attitudes and desire to work with these patients (Bowers, Carr-Walker et al. 2005).

With regard to wider issues, the classification and diagnosis of personality disorder are not merely points of academic interest and of influence within a narrow medical field. The impact of the diagnosis is so significant to both the individual and to society that it is essential that we have a robust classification system which is able to provide valid and reliable diagnoses in a clinically meaningful and useful manner.

Revisions of the current classification systems are underway. It was hoped that DSM5 would be published in 2013 but the current proposals have been rejected by the APA Scientific Committee (Tyrer 2013). Preliminary recommendations for ICD 11 involve abolishing individual categories of personality disorder, replacing this with an initial assessment of whether the individual fulfils a general, monothetic, definition of personality disorder and then, if so, allocating a rating of severity of personality disturbance: mild, moderate or severe. This is to enable a smoother transition from normality to increasing pathology, recognising the continuous nature of personality. These can then be qualified by trait domains: detached; dissocial; emotional; anankastic, following a similar assessment to that used in this study. This is to be a secondary assessment and defined by monothetic criteria to reduce heterogeneity (Tyrer 2013). The focus on universal factors, rather than subtypes is thought to potentially be more valid (Tyrer, Crawford et al. 2011). The other significant difference is that, given increasing evidence regarding the lack of temporal stability of personality disorder, the new classification will permit the diagnosis to be made at any age (Tyrer 2013). Hopefully this will help to facilitate earlier intervention, at a stage where there is good evidence of the effectiveness of interventions

(Hawkins 2003), thus countering the prevailing view of personality disorder as being untreatable, and helping to reduce the therapeutic nihilism and stigma which exacerbate difficulties in an already challenging group of patients.

It is clear that mental health services can play a valuable role in managing these patients, whether in an advisory capacity or more directly taking responsibility. A wider acknowledgement of the extent of the problem with a debate about what can be offered from a service perspective is long overdue. Not identifying the problem in the first place has a detrimental impact for patients with regard to accessing potential treatment, and more broadly in that, without a clear idea of the extent and nature of the problem, it is impossible to develop appropriately targeted interventions and effective services. This also impacts on the capacity to conduct meaningful and useful research into potentially effective interventions in the future. Therefore, even in the absence of good evidence regarding effective treatment, it remains critical that those with personality disorder are identified as such with regard to both current clinical and risk considerations, but also, importantly, as the first step in developing effective interventions and services for this group.

One of the critical issues in relation to treatment of personality disorders is whether this should be the responsibility of mental health services, or whether it should be managed jointly by criminal justice agencies, social work and probation with advisory input from psychiatrists. The MacLean Committee's report in Scotland resulted in management of high risk offenders with personality disorder along similar lines to other high risk offenders, prioritising offence and risk over treatment, with treatment of personality disorder in offenders occurring entirely within the prison system (Scottish Executive 2000). Indeed, it has recently been stated by individuals working with those with personality disorder in Scotland that "*There is little interest or expertise in personality disorder within forensic mental health services*" (Russell 2012). There have been some recent developments within the prison system, although nothing systematic or standardised across settings. These have included consideration of a PIPE like approach

(Psychologically Informed Planned Environments) in one prison, and training both generally on personality disorder and in specific therapies such as mentalisation based therapy in others. A proposal is currently out for consultation which looks to develop a multiagency approach to managing those with challenging behaviour who impact on a number of agencies. It is suggested that this is through Persistent Challenging Behaviour Partnerships, which would involve housing, police, prison, social work, criminal justice social work and health. A widening of the remit of forensic mental health services is part of this, to enable the provision of advice and support to criminal justice and housing colleagues, along with joint working where appropriate (Roper 2012). This is a similar approach to that taken by the Sex Offender Liaison Service in Lothian and Borders. This service works closely with criminal justice social work and police offender management units providing clinical input regarding the management of individuals posing a risk of sexual harm, who invariably have personality disorder. The input varies from telephone or email advice to direct, comprehensive clinical assessment. It is a flexible approach with ongoing advice and re-assessment where necessary. It has had a very positive response from referrers in the utility, accessibility and support offered (Russell 2012)

Following completion of the initial research on the DSPD programme, the Department of Health and the National Offender Management Service (NOMS) moved forward to the next stage of the strategy for managing offenders with personality disorder In England and Wales. This is a joint approach between the NHS and NOMS. It involves a whole systems pathway with primary input within the Criminal Justice System, within prisons and the community, with input from the NHS where required; if individuals with a comorbid mental illness fulfil criteria for detention in hospital under the Mental Health Act (1983) and it is appropriate at that time to treat them in hospital. One of the principal aims is early identification and management, and improved detection, of individuals. The pathway is to meet the needs of offenders with severe personality disorder who present a high or very high risk of serious harm (Joseph and Benefield 2012). Entry criteria have shifted from that for the DSPD programme, of a 'functional link'

between personality disorder and risk of violence, to a 'clinically justifiable link', established through case formulation (Howard and McMurrin 2012). The lack of robust, high quality evidence from the DSPD programme is unfortunate, in that it would have appeared to have had the potential to identify treatments and environments which may be effective in managing and reducing risk in this population. The new pathway approach is an opportunity to move forward from this, addressing problematic issues which have now been identified and exploring what it is about personality disorder, whether related to personality characteristics themselves, or other factors such as substance misuse, which increase the risk in this population. Identification of this critical aspect can hopefully facilitate more meaningful debate and progress on effective management within this group.

There are a number of areas where further research on personality disorder is warranted. With regard to specific issues within this study, an interview based assessment of the prevalence of personality disorder in this population would help to address the problem of missing data, to ascertain whether this represents an absence of personality disorder, or the lack of personality assessment. It would also be interesting to explore whether the reluctance to attribute a diagnosis of personality disorder reflects concerns pertaining to the Criminal Justice process, or attitudes more broadly within mental health services; analysis of mental health service records could provide this.

As regards wider issues which impact on clinicians' attitudes and beliefs, and willingness to diagnose personality disorder, further longitudinal research on the development of personality disorder, in particular antisocial personality disorder and the interaction of conduct disorder and callous unemotional traits, would be timely in light of the removal of the age threshold in the ICD-11 classification. There is a clear need for good quality evidence on interventions, both early interventions and treatment interventions for personality disorders other than borderline personality disorder. Given that the lack of evidence on effective treatment and interventions, and resultant lack of availability of services, was a significant factor in dissuading clinicians from

giving the diagnosis, this is long overdue. There is a dearth of high quality trials emerging from the DSPD pilot programme and the current development of new strategies to manage those offenders with severe personality disorder is an ideal opportunity to remedy this, by conducting robust trials within this population. Finally, current knowledge regarding the particular elements of personality disorder which increase the risk of violence is in its relative infancy. Problematic elements facing research in this area include the lack of a temporal relationship between personality disorder and violence, the circularity of antisocial personality disorder and violence along with problems of comorbidity; within personality disorders and with Axis 1 disorders, particularly substance abuse. Exploration of precise traits and characteristics which increase the risk of violence is essential in order to target interventions effectively.

The failure to identify those with personality disorder has serious implications for the individual in increasing stigma and potentially denying them available treatment. Wider consequences include, from a criminal justice perspective, psychiatrists not availing courts of information which potentially increases an individual's risk of violence and, clinically, not identifying the extent of the problem rendering the development of appropriately targeted interventions and services very difficult.

There are a number of issues that have arisen within this study which highlight problems within mental health services. The extent of missing data within the reports was concerning; 23.8% had less than 50% of variables assessed. There is a need for the clinical assessment of personality disorder to be addressed, with all reports including a thorough assessment of personality with the incorporation of psychometric assessments such as the IPDE or PAS where warranted. This is particularly pertinent in assessment of those from ethnic minorities, given the significantly lower rates of diagnosis in this group. It is also important to be explicit regarding the absence of a personality disorder diagnosis, as is standard practice with mental illness. Training in personality disorder remains inadequate and patchy and undoubtedly contributes to ongoing stigma. Improving training for all psychiatrists, along with training for all involved in the

management of personality disorder across the NHS and Criminal Justice System, will address not only educational objectives in improving knowledge but also help in decreasing some of the more negative attitudes and pejorative views held.

One of the factors dissuading psychiatrists from diagnosing personality disorder was the lack of availability of effective treatment and services. Until effective treatment is available and accessible, it is liable to remain a stigmatising diagnosis which clinicians are reluctant to make. In order to increase detection of personality disorder there is a need to develop and provide services with demonstrable evidence of improvement in outcomes. There is some evidence of the effectiveness of particular interventions (Kealy and Ogrodniczuk 2010) and increasing recognition of how management of those with personality disorder can be improved across all services (Duggan and Kane 2010). There has been reluctance among the majority of psychiatrists to meaningfully become involved in addressing issues regarding the management of personality disorder. Psychiatrists need to demonstrate willingness to engage with the planning and delivery of services such that the most appropriate and effective, service model for managing these challenging individuals can be developed. It seems logical then, that with further development of services and potential treatments, the myth that all those with personality disorder are untreatable may start to be dispelled, along with some of the stigma and prejudices surrounding the diagnosis.



## ***Bibliography***

- Adams, A. a. C., A. L. (2008). Questionnaires, in-depth interviews and focus groups. Cambridge, UK:, Cambridge University Press.
- Adshead, G. and J. Sarkar (2012). "The nature of personality disorder." Advances in Psychiatric Treatment **18**(3): 162-172.
- Agar, M. H. a. M., J. (1995). "Focus groups and Ethnography." Human Organization **54**: 78-86.
- Agresti, A. a. C., B., A. (1998). "Approximate is better than "exact" for interval estimation of binomial proportions." American Statistics **52**: 119-126.
- Alvesson, M. (2003). "Beyond Neopositivists, Romantics, and Localists: A Reflexive Approach to Interviews in Organisational Research." The Academy of Management Review **28**(1): 13-33.
- American Psychiatric Association (1994). Diagnostic and Statistical manual of Mental Disorders (4th Edn) (DSM-IV). Washington, DC, American Psychiatric Association.
- Andersen, H. S., D. Sestoft, et al. (2000). "A longitudinal study of prisoners on remand. Psychiatric prevalence, incidence and psychopathology in solitary vs non-solitary confinement." Acta Psychiatrica Scandinavica **102**: 19-25.
- Andershed, H., M. Kerr, et al. (2002). "Understanding the abnormal by studying the normal." Acta Psychiatrica Scandinavica, Supplementum **412**: 75-80.
- Appelbaum, P. S. (1997). "A theory of ethics for forensic psychiatry." Journal of the American Academy of Psychiatry & the Law **25**(3): 233-247.
- Appleby, L., Shaw, J., Kapur, N., Windfuhr, K., Ashton, A., Swinson, N., While, D. et al (2006). Avoidable Deaths  
London: Stationery Office, The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.
- Aquilino, W. S. (1992). "Telephone versus Face-to Face Interviewing for Household Drug Use Surveys." International Journal of the Addictions **27**(1): 71-91.
- Arboleda-Florez, J. and H. L. Holley (1991). "Antisocial burnout: an exploratory study." Bulletin of the American Academy of Psychiatry & the Law **19**(2): 173-183.
- Aronson, J. (1994). "A Pragmatic View of Thematic Analysis." The Qualitative Report **2**(1).
- Arthur, S. a. N., J. (2003). Structuring data collection. Qualitative Research Practice. J. a. L. Ritchie, J. London, Sage Publications Ltd: 110-115.
- Attride-Stirling, J. (2001). "Thematic networks: an analytic tool for qualitative research." Qualitative Research **1**(3): 385-405.
- Bailey, J. and M. MacCulloch (1992). "Patterns of reconviction in patients discharged directly to the community from a special hospital: implications for aftercare." Journal of Forensic Psychiatry **3**: 445-461.

- Baltes, P. B. (1997). "On the incomplete architecture of human ontogeny. Selection, optimization, and compensation as foundation of developmental theory." American Psychologist **52**(4): 366-380.
- Barrett, B. and P. Tyrer (2012). "The cost-effectiveness of the dangerous and severe personality disorder programme." Criminal Behaviour and Mental Health **22**(3): 202-209.
- Barry, C. T., P. J. Frick, et al. (2000). "The importance of callous-unemotional traits for extending the concept of psychopathy to children." Journal of Abnormal Psychology **109**(2): 335-340.
- Bartlett, P. (2011). "DSM-5 and ICD-11 on personality disorder: A lawyer's perspective." Personality and Mental Health **5**(2): 144-151.
- Bateman, A. and P. Fonagy (2001). "Treatment of borderline personality disorder with psychoanalytically oriented partial hospitalization: an 18-month follow-up.[see comment]." American Journal of Psychiatry **158**(1): 36-42.
- Bateman, A. W. and P. Fonagy (2000). "Effectiveness of psychotherapeutic treatment of personality disorder." British Journal of Psychiatry **177**: 138-143.
- Bateman, A. W. and P. Fonagy (2004). "Mentalization-based treatment of BPD." Journal of Personality Disorders **18**(1): 36-51.
- Belsky, J., K. H. Hsieh, et al. (1998). "Mothering, fathering, and infant negativity as antecedents of boys' externalizing problems and inhibition at age 3 years: differential susceptibility to rearing experience?" Development & Psychopathology **10**(2): 301-319.
- Bergman, M. M. (2008). Introduction: Whither Mixed Methods. London, Sage Publications Ltd.
- Berlin, I. (1962). Does Political Theory still exist?, Princeton University Press
- Bernstein, D. P., C. Iscan, et al. (2007). "Opinions of Personality Disorder Experts Regarding The DSM-IV Personality Disorders Classification System." Journal of Personality Disorders **21**(5): 536-551.
- Black, D. A. and P. Spinks (1985). Predicting outcomes of mentally disordered and dangerous offenders. Albany, State University of New York Press.
- Black, D. W., C. H. Baumgard, et al. (1995). "A 16- to 45-year follow-up of 71 men with antisocial personality disorder." Comprehensive Psychiatry **36**(2): 130-140.
- Black, D. W., B. Pfohl, et al. (2011). "Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians." Cns Spectrums **16**(3): 67-74.
- Blackburn, R. (1968). "Personality in Relation to Extreme Aggression in Psychiatric Offenders." British Journal of Psychiatry **114**: 821-828.
- Blackburn, R. (1975). "An empirical classification of psychopathic personality." British Journal of Psychiatry **127**: 456-460.
- Blackburn, R. (1988). "On moral judgements and personality disorders: The myth of the psychopathic personality revisited." British Journal of Psychiatry **153**: 505-512.

- Blackburn, R. (1993b). Crime and Mental Disorder. Chichester, John Wiley and Sons Ltd.
- Blackburn, R. (1993c). Classification of offenders. Chichester, John Wiley and Sons Ltd.
- Blackburn, R. (1998). Psychopathy and the Contribution of Personality to Violence. New York, Guildford Press.
- Blackburn, R. and J. M. Lee-Evans (1985). "Reactions of primary and secondary psychopaths to anger evoking situations." British Journal of Clinical Psychology **24**: 93-100.
- Blackburn, R., C. Logan, et al. (2005). "Higher-order dimensions of personality disorder: hierarchical structure and relationships with the five-factor model, the interpersonal circle, and psychopathy." Journal of Personality Disorders **19**(6): 597-623.
- Blackburn, R. and S. J. Renwick (1996). "Rating scales for measuring the interpersonal circle in forensic psychiatric patients." Psychological Assessment **8**: 76-84.
- Bohman, M. (1996). "Predisposition to criminality: Swedish adoption studies in retrospect." Ciba Foundation Symposium **194**: 99-109.
- Bonner, A. a. T., G. (2002). "Insider-outsider perspectives of participant observation." Nurse Researcher **9**(4): 7-19.
- Bowers, L. (2002). Dangerous and severe Personality Disorder. Reactions and Role of the Clinical Team. London/New York, Routledge.
- Bowers, L., P. Carr-Walker, et al. (2005). "Changes in attitudes to personality disorder on a DSPD unit." Criminal Behaviour and Mental Health **15**(3): 171-183.
- Bowlby, J. (1951). Maternal care and mental health. Geneva, Switzerland, World Health Organisation.
- Bowlby, J. (1982). Attachment. New York, Basic Books.
- Britten, N. (2006). Qualitative interviews. Oxford, Balckwell Publishing Ltd.
- Brookman, F. (2005). Psychological Explanations of Homicide. London, Sage Publications.
- Brown, S. L. and A. E. Forth (1997). "Psychopathy and sexual assault: static risk factors, emotional precursors, and rapist subtypes." Journal of Consulting & Clinical Psychology **65**(5): 848-857.
- Bryman, A. (1988). Quantity and Quality in Social Research. London, Unwin Hyman.
- Bryman, A. (2003). Why do Researchers Integrate/Combine/Mesh/Blend/Mix/Merge/Fuse Quantitative and Qualitative Research? London, Sage Publications Ltd.
- Burke, H. and S. Hart (2000). Personality disordered offenders:conceptualization, assessment and diagnosis of personality disorder. Chichester, John Wiley and Sons Ltd.
- Burns, T., J. Yiend, et al. (2011). "Treatments for dangerous severe personality disorder (DSPD)." Journal of Forensic Psychiatry & Psychology **22**(3): 411-426.

- Buston, K., W. Parry-Jones, et al. (1998). "Qualitative research." The British Journal of Psychiatry **172**(3): 197-199.
- Cale, E. M. (2006). "A quantitative review of the relations between the 'Big 3' higher order personality dimensions and antisocial behaviour." Journal of Research in Personality **40**: 250 - 284.
- Campbell, D. T. a. F., D.W. (1959). "Convergent and discriminant validation by the multitrait-multimethod matrix." Psychological Bulletin **56**(2): 81-105.
- Campbell, M. A., S. Porter, et al. (2004). "Psychopathic traits in adolescent offenders: an evaluation of criminal history, clinical, and psychosocial correlates." Behavioral Sciences & the Law **22**(1): 23-47.
- Caruso, J. C., Witkiewitz, K., Belcourt-Dittloff, A. and Gottlieb, J.D. (2001). "Reliability of scores from the Eysenck personality questionnaire: a reliability generalization study." Educational and Psychological Measurement **61**: 675 - 689.
- Caspi, A., J. McClay, et al. (2002). "Role of genotype in the cycle of violence in maltreated children. ." Science **297**(5582): 851(854).
- Caspi, A. and T. E. Moffitt (1993). "When do individual differences matter? A Paradoxical Theory of Personality Coherence." Psychological Inquiry **4**(4): 247-271.
- Caspi, A., T. E. Moffitt, et al. (1996). "Behavioral observations at age 3 years predict adult psychiatric disorders. Longitudinal evidence from a birth cohort." Archives of General Psychiatry **53**(11): 1033-1039.
- Caspi, A. and B. Roberts (2001). "Personality Development Across the Life Course: The Argument for Change and Continuity." Psychological Inquiry **12**(2): 49-66.
- Chiswick, D. (1985). "Use and abuse of psychiatric testimony." British Medical Journal Clinical Research Ed **290**(6473): 975-977.
- Church, A. T. (1994). "Relating the Tellegen and five-factor models of personality structure." Journal of Personality and Social Psychology **67**: 898-909.
- Clark, L. A., Livesley, W. J. and Morey, L. (1997). "Personality disorder assessment: the challenge of construct validity." Journal of Personality Disorders **11**: 205-231.
- Clark, L. A. a. J. A. H. (2001). Assessment instruments, Guilford Press.
- Clark, S. A. (1993). "Matricide: the schizophrenic crime?" Medicine, Science and the Law **33**: 325-328.
- Clarke, S., P. Thomas, et al. (2013). "Cognitive analytic therapy for personality disorder: randomised controlled trial." The British Journal of Psychiatry **202**(2): 129-134.
- Cleckley, H. (1982). The mask of sanity. St.Louis, MO, C.V.Mosby.
- Cloninger, C. R., Svrakic, D.M. and Przybeck, T.R. (1993). "A psychobiological model of temperament and character." Arch Gen Psychiatry **50**(975 - 90).
- Coccaro, E. F., L. J. Siever, et al. (1989). "Serotonergic studies in patients with affective and personality disorders. Correlates with suicidal and impulsive

- aggressive behavior.[erratum appears in Arch Gen Psychiatry 1990 Feb;47(2):124]." Archives of General Psychiatry **46**(7): 587-599.
- Cohen, P. and J. Brook (1987). "Family factors related to the persistence of psychopathology in childhood and adolescence." Psychiatry **50**(4): 332-345.
- Coid, J. (1998). Axis II Disorders and Motivation for Serious Criminal Behaviour. Washington, DC, American Psychiatric Press, Inc.
- Coid, J. (2003). "Epidemiology, public health and the problem of personality disorder  
10.1192/bjp.182.44.s3." Br J Psychiatry **182**(44): 3s-10.
- Coid, J., N. Kahtan, et al. (1999). "Patients with personality disorder admitted to secure forensic psychiatry services." British Journal of Psychiatry **175**: 528-536.
- Coid, J., M. Yang, et al. (2006b). "Violence and psychiatric morbidity in the national household population of Britain: public health implications." British Journal of Psychiatry **189**: 12-19.
- Coid, J., M. Yang, et al. (2006a). "Prevalence and correlates of personality disorder in Great Britain." British Journal of Psychiatry **188**: 423-431.
- Cooke, D. J. (2003). Cross-Cultural Aspects of Psychopathy. New York, Guildford Press.
- Cooke, D. J. and C. Michie (2001). "Refining the construct of psychopathy: towards a hierarchical model." Psychological Assessment **13**(2): 171-188.
- Cooke, D. J., C. Michie, et al. (2004). "Reconstructing Psychopathy: Clarifying the significance of antisocial and socially deviant behaviour in the diagnosis of psychopathic personality disorder." Journal of Personality Disorders **18**(4): 337-357.
- Cornell, D. G., J. Warren, et al. (1996). "Psychopathy in instrumental and reactive violent offenders." Journal of Consulting & Clinical Psychology **64**(4): 783-790.
- Costa, P. T. and T. Widiger (1994b). Personality disorders and the five-factor model of personality. Washington, DC, American Psychological Association.
- Cote, G. and S. Hodgins (1992). "The prevalence of major mental disorders among homicide offenders." International Journal of Law & Psychiatry **15**(1): 89-99.
- Crawford, D. A. (1977). "The HDHQ Results of Long Term Prisoners: Relationships with Criminal and Institutional Behaviour." British Journal of Social and Clinical Psychology **16**: 391-394.
- Crawford, M. J., N. Koldobsky, et al. (2011). "Classifying Personality Disorder According to Severity." Journal of Personality Disorders **25**(3): 321-330.
- Crawford, T. N., P. R. Shaver, et al. (2006). "Self-reported attachment, interpersonal aggression, and personality disorder in a prospective community sample of adolescents and adults." Journal of Personality Disorders **20**(4): 331-351.

- Cresswell, J. W. (2007). Qualitative Inquiry and Research Design: Choosing Among Five Approaches. London, Sage Publications.
- Creswell, J. W., Plano Clark, V. L. and Garrett, A., L. (2003). Methodological Issue in Conducting Mixed Methods Research Designs. London, Sage Publications Ltd.
- Crosby, J. A. (2011). A comparison of court reports by forensic psychiatrists and general adult psychiatrists in homicide cases. MSc, University of Manchester.
- D'Silva, K. and C. Duggan (2010). "Revisiting the overcontrolled–undercontrolled typology of violent offenders." Personality and Mental Health **4**(3): 193-205.
- Dadds, M. R., J. L. Allen, et al. (2012). "Love, eye contact and the developmental origins of empathy v. psychopathy." The British Journal of Psychiatry **200**(3): 191-196.
- Dinwiddie, S. H. and E. W. Daw (1998). "Temporal stability of antisocial personality disorder: blind follow-up study at 8 years." Comprehensive Psychiatry **39**(1): 28-34.
- Dolan, M. and M. Doyle (2000). "Violence risk prediction. Clinical and actuarial measures and the role of the Psychopathy Checklist.[see comment]." British Journal of Psychiatry **177**: 303-311.
- Dolan, M. and M. Doyle (2007). "Psychopathy: diagnosis and implications for treatment." Psychiatry **6:10**: 404-408.
- Dolan, M. and R. Fullam (2003). "Theory of mind and mentalizing ability in antisocial personality disorders with and without psychopathy." Psychological Medicine **34**(6): 1093-1102.
- Dolan, M., S. D. Thomas, et al. (2005). "The needs of males detained under the legal category of 'psychopathic disorder' in high security: Implications for policy and service development." Journal of Forensic Psychiatry & Psychology **16**(3): 523-537.
- Dowson, J. H. and A. T. Grounds (1995). Personality disorders:basic concepts and clinical overview. Cambridge, Cambridge University Press.
- Dowson, J. H. and A. T. Grounds (1995). Specified personality disorders:clinical features. Cambridge, Cambridge University Press.
- Doyle, M., Khanna, T., Lennox, C., Shaw, J. et al (2013). "The effectiveness of an enhanced thinking skills programme in offenders with antisocial personality traits." Journal of Forensic Psychiatry & Psychology **24**(1): 1-15.
- Duggan, C., N. Huband, 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**(2): 95-125.
- Duggan, C. and E. Kane (2010). "Developing a National Institute of Clinical Excellence and health guideline for antisocial personality disorder." Personality and Mental Health **4**(1): 3-8.

- Duggan, C., L. Mason, et al. (2007). "Value of standard personality assessments in informing clinical decision-making in a medium secure unit." The British Journal of Psychiatry **190**(49): s15-s19.
- Eastman, N. (1996). "Hybrid orders: An analysis of their likely effects on sentencing practice and on forensic psychiatric practice and services." The Journal of Forensic Psychiatry **7**(3): 481-494.
- Eastman, N., Adshead, G., Fox, S., Latham, R. and Whyte, S. (2012). Forensic Psychiatry. Oxford, Oxford University Press.
- Eaton, N. R., R. F. Krueger, et al. (2011). "Contrasting prototypes and dimensions in the classification of personality pathology: evidence that dimensions, but not prototypes, are robust." Psychological Medicine **41**(06): 1151-1163.
- Edelbrock, C., R. Rende, et al. (1995). "A twin study of competence and problem behavior in childhood and early adolescence." Journal of Child Psychology & Psychiatry & Allied Disciplines **36**(5): 775-785.
- Edens, J. F., L. S. Guy, et al. (2003). "Psychopathic traits predict attitudes toward a juvenile capital murderer." Behavioral Sciences & the Law **21**(6): 807-828.
- Egan, V. (2009). The 'Big Five': Neuroticism, Extraversion, Openness, Agreeableness and Conscientiousness as an Organisational Scheme for Thinking About Aggression and Violence. Chichester, Wiley-Blackwell.
- Ekblad, S. (1988). "The children's behaviour questionnaire for completion by parents and teachers in a Chinese sample." Journal of Child Psychology & Psychiatry & Allied Disciplines **31**(5): 775-791.
- Elder, G. H., Jr., A. Caspi, et al. (1986). Resourceful and vulnerable children: family influence in hard times. Berlin, Springer.
- Eldergill, A. (2006). Personality disorder, the law and individual rights. London, Hodder Arnold.
- Erb, M., S. Hodgins, et al. (2001). "Homicide and schizophrenia: maybe treatment does have a preventive effect." Criminal Behaviour & Mental Health **11**: 6-26.
- Eronen, M. (1995). "Mental disorders and homicidal behavior in female subjects." American Journal of Psychiatry **152**(8): 1216-1218.
- Eronen, M., Hakola, P. and Tiihonen, J. (1996a). "Factors associated with homicide recidivism in a 13 year sample of homicide offenders in Finland." Psychiatric Services **47**: 403 - 406.
- Eysenck, H. J. a. E., M.W. (1985). Personality and Individual Differences: A Natural Science Approach. New York, Plenum.
- Farrington, D. P. (1995). "The Twelfth Jack Tizard Memorial Lecture. The development of offending and antisocial behaviour from childhood: key findings from the Cambridge Study in Delinquent Development." Journal of Child Psychology & Psychiatry & Allied Disciplines **36**(6): 929-964.
- Farrington, D. P. (1998). Predictors, causes, and correlates of youth violence., University of Chicago Press.

- Farrington, D. P. (2000). "Psychosocial predictors of adult antisocial personality and adult convictions." Behavioral Sciences & the Law **18**(5): 605-622.
- Farrington, D. P. (2005). "The importance of child and adolescent psychopathy." Journal of Abnormal Child Psychology **33**(4): 489-497.
- Farrington, D. P. (2006). Family Background and Psychopathy. New York, Guildford.
- Fazel, S. and J. Danesh (2002). "Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys.[see comment]." Lancet **359**(9306): 545-550.
- Fazel, S. and M. Grann (2004). "Psychiatric morbidity among homicide offenders: a Swedish population study." American Journal of Psychiatry **161**(11): 2129-2131.
- Fazel, S., T. Hope, et al. (2002). "Psychiatric, demographic and personality characteristics of elderly sex offenders." Psychological Medicine **32**(02): 219-226.
- Feather, N. T. and C. Johnstone (2001). "Social norms, entitlement, and deservingness: Differential reactions to aggressive behavior of schizophrenic and personality disorder patients." Personality and Social Psychology Bulletin **27**(6): 755-767.
- Fergusson, D. M., L. J. Horwood, et al. (2000). "Offending trajectories in a New Zealand birth cohort." Criminology **38**: 525-552.
- Fielding, N. G. a. F., J.L. (1986). Linking Data. London, Sage.
- First, M., Gibbon M, Spitzer RL, Williams, JBW, Benjamin LS. (1997). Structured Clinical Interview for DSM-IV Axis II Personality Disorders, (SCID-II). Washington, D.C., American Psychiatric Press, Inc.
- Fortune, Z., D. Rose, et al. (2010). "An Evaluation of New Services for Personality-Disordered Offenders: Staff and Service User Perspectives." International Journal of Social Psychiatry **56**(2): 186-195.
- Frick, P., J. (2002). "Juvenile Psychopathy from a Developmental Perspective: Implications for Construct Development and Use in Forensic Assessments." Law and Human Behavior **26**(2): 247.
- Frick, P. J., E. R. Kimonis, et al. (2003). "The 4 year stability of psychopathic traits in non-referred youth." Behavioral Sciences & the Law **21**(6): 713-736.
- Frick, P. J., T. R. Stickle, et al. (2005). "Callous-unemotional traits in predicting the severity and stability of conduct problems and delinquency." Journal of Abnormal Child Psychology **33**(4): 471-487.
- Geberth, V. J. and R. N. Turco (1997). "Antisocial personality disorder, sexual sadism, malignant narcissism, and serial murder." Journal of Forensic Sciences **42**(1): 49-60.
- Geller, J. (1987). "Fire-setting in the adult psychiatric population." Hospital and Community Psychiatry **38**: 501-506.
- Geraghty, R. and F. Warren (2003). "Ethnic diversity and equality of access to specialist therapeutic community treatment for severe personality disorder." Psychiatric Bulletin **27**(12): 453-456.



- Gillstrom, B. J. and R. D. Hare (1988). "Language-related hand gestures in psychopaths." Journal of Personality Disorders **2**: 21-27.
- Gordon, H. and D. Grubin (2004). "Psychiatric aspects of the assessment and treatment of sex offenders." Advances in Psychiatric Treatment **10**(1): 73-80.
- Grant, B. F., Stinson, F. S., Dawson, D. A., et al (2004). "Co-occurrence of 12 month alcohol and drug use disorders and personality disorders in the United States: results from the National Epidemiological Survey on Alcohol and Related Conditions." Archives of General Psychiatry **61**: 361-368.
- Gray, N. S., M. J. MacCulloch, et al. (2003). "Forensic psychology: Violence viewed by psychopathic murderers." Nature **423**(6939): 497-498.
- Greene, J. C., Caracelli, V. J. and Graham, W. F. (1989). "Toward a Conceptual Framework for Mixed-method Evaluation Designs." Educational Evaluation and Policy Analysis **11**(3): 255-274.
- Greenfield, T. K., Midanik, L.T. and Rogers, J.D. (2000). "Effects of Telephone versus Face-to-Face Interview Modes on Reports of Alcohol Consumption." Addiction **95**(20): 277-284.
- Grounds, A., L. Gelsthorpe, et al. (2004). "Access to medium secure psychiatric care in England and Wales. 2: A qualitative study of admission decision-making." Journal of Forensic Psychiatry & Psychology **15**(1): 32-49.
- Grounds, A. and H. Gordon (2007). "In conversation with John Gunn." Psychiatric Bulletin **31**(1): 25-28.
- Gunn, J. (2000). Personality disorder: a clinical suggestion. Oxford, Butterworth-Heinemann.
- Haddock, A. W., P. R. Snowden, et al. (2001). "Managing dangerous people with severe personality disorder." Psychiatric Bulletin **25**(8): 293-296.
- Hakkanen, H. (2005). "Homicide by ligature strangulation in Finland: offence and offender characteristics." Forensic Science International **152**(1): 61-64.
- Hakkanen, H. and T. Laajasalo (2006). "Homicide Crime Scene Behaviors in a Finnish Sample of Mentally Ill Offenders." Homicide Studies **10**(1): 33-54.
- Hammersley, M. (1992). What's Wrong with Ethnography? London, Routledge.
- Hammersley, M. (2003). Troubles with Triangulation. London, Sage Publications Ltd.
- Hare, R. D. (1983). "Diagnosis of antisocial personality disorder in two prison populations." American Journal of Psychiatry **140**(7): 887-890.
- Hare, R. D. (1993). Without conscience: The disturbing world of the psychopath among us. New York, Pocket Books.
- Hare, R. D. (1998). Psychopaths and Their Nature: Implications for the Mental Health and Criminal Justice System. New York, The Guildford Press.
- Hare, R. D. (2003). The Hare Psychopathy Checklist-Revised (2nd Ed). Toronto, ON, Multi-Health Systems.
- Hare, R. D. (2003). Manual for the Revised Psychopathy Checklist. Toronto, ON, Canada, Multi-Health Systems.

- Hare, R. D., S. D. Hart, et al. (1991). "Psychopathy and the DSM-IV criteria for antisocial personality disorder." Journal of Abnormal Psychology **100**(3): 391-398.
- Hare, R. D., L. M. McPherson, et al. (1988). "Male psychopaths and their criminal careers." Journal of Consulting & Clinical Psychology **56**(5): 710-714.
- Harpur, T. J. and R. D. Hare (1994). "Assessment of psychopathy as a function of age." Journal of Abnormal Psychology **103**(4): 604-609.
- Harris, G. T., Rice, M.E. and Cormier, C.A. (1991). "Psychopathy and violent recidivism." Law and Human Behavior **15**: 625-637.
- Hart, S. D. and R. J. Dempster (1997). Impulsivity and psychopathy. New York, Guilford Press.
- Hart, S. D., P. R. Kropp, et al. (1988). "Performance of male psychopaths following conditional release from prison." Journal of Consulting & Clinical Psychology **56**(2): 227-232.
- Haslam, N., E. Holland, et al. (2011). "Categories versus dimensions in personality and psychopathology: a quantitative review of taxometric research." Psychological Medicine FirstView: 1-18.
- Hawkins, J. D. a. H., T.I. (2003). Prevention in the school years. Early Prevention of Adult Antisocial Behaviour. D. P. a. C. Farrington, J. W. Cambridge, Cambridge University Press.
- Helzer, J. E., L. N. Robins, et al. (1985). "A comparison of clinical and diagnostic interview schedule diagnoses. Physician reexamination of lay-interviewed cases in the general population." Archives of General Psychiatry **42**(7): 657-666.
- Hill, C. D., R. Rogers, et al. (1996). "Predicting aggressive and socially disruptive behavior in a maximum security forensic psychiatric hospital." Journal of Forensic Sciences **41**(1): 56-59.
- Hill, J. (2002). "Biological, psychological and social processes in the conduct disorders." Journal of Child Psychology & Psychiatry & Allied Disciplines **43**(1): 133-164.
- Hodgins, S. (1994). "Status at age 30 of children with conduct problems." Studies of Crime and Crime Prevention **3**: 41-62.
- Hodgins, S. (2007). "Persistent violent offending: what do we know?" British Journal of Psychiatry **190**(supplement 49): 12-14.
- Hodgins, S., S. A. Mednick, et al. (1996). "Mental disorder and crime: Evidence from a Danish birth cohort." Archives of General Psychiatry **53**(6): 489-496.
- Horowitz, M. J. (1998). "Personality Disorder Diagnoses." American Journal of Psychiatry **155**: 1464.
- Howard, R. and M. McMurrin (2012). "Editorial: Whither research on 'high-harm' offenders with personality disorders?" Criminal Behaviour and Mental Health **22**(3): 157-164.

- Huang, Y., R. Kotov, et al. (2009). "DSM–IV personality disorders in the WHO World Mental Health Surveys." The British Journal of Psychiatry **195**(1): 46-53.
- Huesmann, L. R., L. D. Eron, et al. (1984). "Stability of aggression over time and generations." Developmental Psychology **20**: 1120-1134.
- Jackson, R. L., Neumann, C. S. and Vitacco, M. J. (2007). "Impulsivity, Anger and Psychopathy: The Moderating Effect of Ethnicity." Journal of Personality Disorders **21**(3): 289-304.
- Jenkins, J. M. and M. A. Smith (1990). "Factors protecting children living in disharmonious homes: maternal reports.[see comment]." Journal of the American Academy of Child & Adolescent Psychiatry **29**(1): 60-69.
- Johns, J. H. and H. C. Quay (1962). "The effect of social reward on verbal conditioning in psychopathic and neurotic military offenders." Journal of Consulting Psychology **26**(3): 217-220.
- Johnson, J. G., P. Cohen, et al. (1999). "Childhood Maltreatment Increases Risk for Personality Disorders During Early Adulthood" Arch Gen Psychiatry **56**(7): 600-606.
- Johnson, J. G., P. Cohen, et al. (2000). "Adolescent personality disorders associated with violence and criminal behaviour during adolescence and early adulthood." American Journal of Psychiatry **157**: 1406-1412.
- Joseph, N. and N. Benefield (2012). "A joint offender personality disorder pathway strategy: An outline summary." Criminal Behaviour and Mental Health **22**(3): 210-217.
- Kanaan, R. (2009). "Truth-telling in psychiatry." Psychiatry **8**(12): 471-472.
- Kealy, D. and J. S. Ogrodniczuk (2010). "Marginalization of Borderline Personality Disorder." Journal of Psychiatric Practice **16**(3): 145-154.
- Keulen-de-Vos, M., D. P. Bernstein, et al. (2010). "Patient versus informant reports of personality disorders in forensic patients." Journal of Forensic Psychiatry & Psychology **22**(1): 52-71.
- Kitzinger, J. (1994). Focus Groups: Method and Madness. London and Bristol, Taylor and Francis.
- Kitzinger, J. (2006). Focus Groups. Oxford, Blackwell Publishing.
- Kohut, H. (1973). "Thoughts on narcissism and narcissistic rage." Psychoanalytic Study of the Child **27**: 360-400.
- Kolvin, I., F. J. W. Miller, et al. (1988). Risk/protective factors for offending with particular reference to deprivation, Cambridge University Press.
- Koson, D. F. a. D., J. (1982). "Arson: a diagnostic study." Bulletin of the American Academy of Psychiatry & the Law **10**: 19-49.
- Kotov, K., Ruggero, C. J., Krueger, R. F., Watson, D., Yuan, Q. and Zimmerman, M. (2011). "New Dimensions in the Quantitative Classification of Mental Illness." Arch Gen Psychiatry **68**(10): 1003-1011.
- Kratzer, L. and S. Hodgins (1999). "A typology of offenders: A test of Moffitt's theory among males and females from childhood to age 30 years." Criminal Behaviour & Mental Health **9**: 57-73.

- Krueger, R. A. a. C., M.A. (2000). Focus Groups: A Practical Guide for Applied Research. London, Sage Publications Ltd.
- Kvale, S. (1996). Interviews: An Introduction to Qualitative Research Interviewing. London, Sage Publications Ltd.
- Lahey, B. B., E. L. Hart, et al. (1993). "Neurophysiological correlates of Conduct Disorder: A rationale and review of research." Journal of Clinical Child Psychology **22**: 141-153.
- Langstrom, N. and M. Grann (2002). "Psychopathy and violent recidivism among young criminal offenders." Acta Psychiatrica Scandinavica, Supplementum **412**: 86-92.
- Lasch, C. (1979). The culture of narcissism: American life in an age of diminishing expectations. New York, Warner.
- Laurell, J. and A. M. Daderman (2007). "Psychopathy (PCL-R) in a forensic psychiatric sample of homicide offenders: some reliability issues." International Journal of Law & Psychiatry **30**(2): 127-135.
- Leaff, L. A. (1978). The antisocial personality: psychodynamic implications. New York, Brunner / Mazel.
- Lemenshow, S., D. W. Hosmer, et al. (1990). Adequacy of Sample Size in Health Studies, John Wiley and Sons.
- Lenzenweger, M. F., Johnson, M. D. and Willett, J. B. (2004). "Individual Growth Curve Analysis Illuminates Stability and Change in Personality Disorder Features. The Longitudinal Study of Personality Disorders." Arch Gen Psychiatry **61**: 1015-1024.
- Leslie, O., S. Young, et al. (2007). "Criminal barristers' opinions and perceptions of mental health expert witnesses." Journal of Forensic Psychiatry & Psychology **18**(3): 394-410.
- Lewis, A. (1974). "Psychopathic personality: a most elusive category." Psychological Medicine **4**(2): 133-140.
- Lewis, G. and L. Appleby (1988). "Personality disorder: the patients psychiatrists dislike." Br J Psychiatry **153**: 44-49.
- Lewis, G., C. Croftjeffreys, et al. (1990). "Are British Psychiatrists Racist?" British Journal of Psychiatry **157**: 410-415.
- Lewis, J. (2003). Design Issues. London, Sage Publications Ltd.
- Lindqvist, P. E. R. (1991). "Homicides committed by abusers of alcohol and illicit drugs." British Journal of Addiction **86**(3): 321-326.
- Livesley, W. J. (2001). Handbook of Personality Disorders: Theory, Research and Treatment  
\_Guildford Press.
- Livesley, W. J. (2003). Practical Management of Personality Disorder Guildford Press.
- Livesley, W. J. (2011). "An Empirically-Based Classification of Personality Disorder." Journal of Personality Disorders **25**(3): 397-420.
- Livesley, W. J., K. L. Jang, et al. (1993). "Genetic and environmental contributions to dimensions of personality disorder.[see comment]." American Journal of Psychiatry **150**(12): 1826-1831.

- Livesley, W. J. a. J., K.L. (2008). "The behavioural genetics of personality disorder." Annual Review of Clinical Psychology **65**(3): 247-274.
- Lloyd, R. v. (1967). 1 Q.B. 175.
- Loeber, R., J. D. Burke, et al. (2002). "What are adolescent antecedents to antisocial personality disorder?" Criminal Behaviour & Mental Health **12**(1): 24-36.
- Loeber, R., P. Wung, et al. (1993). "Developmental pathways in disruptive child behaviour." Development & Psychopathology **5**: 101-132.
- Loevinger, J. (1979). "Construct Validity of the Sentence Completion Test of Ego Development." Applied Psychological Measurement **3**(3): 281 - 311.
- Loney, B. R., P. J. Frick, et al. (1998). "Intelligence, Callous-Unemotional Traits and Antisocial Behaviour." Journal of Psychopathology and Behavioural Assessment **20**(3): 231-247.
- Lopez-Ibor Jnr, J., J. (2009). Personality disorders: an introductory perspective. New Oxford Textbook of Psychiatry. M. G. Gelder, Andreasen, N.C., Lopez-Ibor Jnr, J., J. and Geddes, J.R. Oxford, Oxford University Press. **1**: 847.
- Loranger, A. W. (1992). "Are current self-report and interview measures adequate for epidemiological studies of personality disorders?" Journal of Personality Disorders **6**: 313-325.
- Lorr, M. (1978). "The structure of the California Q-set." Multivariate Behavioral Research. **13**: 387-393.
- Losel, F. and D. Bender (2003). Protective factors and resilience. Cambridge, Cambridge University Press.
- Lowe, J. R. and T. A. Widiger (2009). "Clinicians' Judgments of Clinical Utility: A Comparison of the DSM-IV With Dimensional Models of General Personality." Journal of Personality Disorders **23**(3): 211-229.
- Luntz, B. and C. Widom (1994). "Antisocial personality disorder in abused and neglected children grown up." American Journal of Psychiatry **151**(5): 670-674.
- Lynam, D. R. (1998). "Early Identification of the Fledgling Psychopath: Locating the Psychopathic Child in the Current Nomenclature." Journal of Abnormal Psychology November **107**(4): 566-575.
- Lynam, D. R. (2002). "Fledgling Psychopathy: A View from Personality Theory." Law and Human Behavior **26**(2): 255.
- Lytton, H. e. a. (1990). "Child and Parent effects in boys' conduct disorder: A reinterpretation." Developmental Psychology **26**: 683-697.
- Mackay, R. D. (2010). "The Coroners and Justice Act 2009 - partial defences to murder (2)The new diminished responsibility plea." Criminal Law Review **4**: 290 - 302.
- Maden, T. (2008). "Can personality disorder be treated? - in 100 words." The British Journal of Psychiatry **192**(6): 457.
- Mason, J. (2002). Qualitative Interviewing. Qualitative Researching. London, Sage Publications Ltd: 62.

- Maxwell, J. A. (2010). "Using Numbers in Qualitative Research." Qualitative Inquiry **16**(6): 475 - 482.
- May, M. (2000). "'Murderer's relatives'. Managing stigma, negotiating identity." Journal of Contemporary Ethnography **29**(2): 198-221.
- Maynard, R. A. (1997). Kids having kids: Economic costs and social consequences of teen pregnancy. Washinton,DC, The Urban Institute Press.
- Mays, N. and C. Pope (2000). "Qualitative research in health care. Assessing quality in qualitative research.[see comment]." BMJ **320**(7226): 50-52.
- McGurk, B. J. and R. E. McGurk (1979). "Personality Typres among Prisoners and Prison Officers: An Investigation of Megargee's Theory of Control." British Journal of Criminology **19**(1): 31-49.
- Megargee, E. I. (1966). "Undercontrolled and Overcontrolled Personality Types in Extreme Antisocial Aggression." Psychological Monographs **80**(3): 1-29.
- Merson, s., Tyrer, P., Duke, P. and Henderson, F. (1994). "Inter-rater reliability reliability of ICD-10 guidelines for the diagnosis of personality disorders." Journal of Personality Disorders **8**: 89 - 95.
- Miller, S. A. a. D., N. C. (1996). "Increasing staff knowledge of and improving attitudes toward patients with borderline personality disorder." Psychiatric Services **47**: 533-535.
- Millon, T. (2011). Disorders of Personality. Introducing a DSM/ICD spectrum from Normal to Abnormal. New Jersey, John Wiley & Sons.
- Mitchell, A. J. (2007). "Reluctance to disclose difficult diagnoses: a narrative review comparing communication by psychiatrists and oncologists." Support Cancer Care **15**: 819-828.
- Moffitt, T. E. (1993a). "Adolescence-Limited and Life-Course-Persistent Antisocial Behavior: A Developmental Taxonomy." Psychological Review October **100**(4): 674-701.
- Moffitt, T. E., A. Caspi, et al. (2002). "Males on the life-course-persistent and adolescence-limited antisocial pathways: follow-up at age 26 years." Development & Psychopathology **14**(1): 179-207.
- Moffitt, T. E., Caspi, A., Rutter, M., Silva, P.A. (2001). Sex Differences in Antisocial Behaviour: Conduct Disorder, Delinquency, and Violence in the Dunedin Longitudinal Study (Cambridge Studies in Criminology) (Paperback) Cambridge, Cambridge University Press.
- Moncrieff, J. (2003). "The politics of a new Mental Health Act." The British Journal of Psychiatry **183**(1): 8-9.
- Moore, E. (2012). "Personality disorder: its impact on staff and the role of supervision." Advances in Psychiatric Treatment **18**(1): 44-55.
- Moran, P., C. Coffey, et al. (2006). "Personality and substance use disorders in young adults." British Journal of Psychiatry **188**: 374-379.
- Moran, P. and S. Hodgins (2004). "The correlates of comorbid antisocial personality disorder in schizophrenia  
" Schizophrenia Bulletin **30**: 791-802.

- Moran, P., Walsh, E., Tyrer, P., Burns, T. Creed, F. and Fahy, T. (2003). "Impact of comorbid personality disorder on violence in psychosis." The British Journal of Psychiatry **182**(2): 129-134.
- Morgan, D. (1998). Planning Focus Groups. London, Sage Publications.
- Morgan, D. L. (1997). Focus Groups as Qualitative Research. London, Sage.
- Morgan, D. L. (2007). "Paradigms Lost and Pragmatism Regained: Methodological Implications of Combining Qualitative and Quantitative Methods." Journal of Mixed Methods Research **1**(1): 48-76.
- Muller-Isberner, R. and S. Hodgins (2000). Evidence-based treatment for mentally disordered offenders. Chichester, John Wiley and Sons Ltd.
- National Institute for Mental Health in England (2003). Personality disorder: no longer a diagnosis of exclusion. D. o. Health.
- NCCMH (2009). Antisocial personality disorder: treatment, management and prevention. [Full guideline]. Leicester and London, The British Psychological Society and the Royal College of Psychiatrists.
- Neumann, C. S., M. J. Vitacco, et al. (2005). "Reconstructing the "Reconstruction" of Psychopathy: A Comment on Cooke, Michie, Hart, and Clark." Journal of Personality Disorders **19**(6): 624-640.
- Newcombe, R., G., and Altman, D., G. (2000). Proportions and their differences. London, BMJ Books.
- Nicholson, P. (1991). Qualitative Psychology: Report Prepared for the Scientific Affairs Board of the British Psychological Society. London, British Psychological Society.
- O'Grady, J. C. (2002). "Psychiatric evidence and sentencing: ethical dilemmas." Criminal Behaviour and Mental Health **12**(3): 179-184.
- Oldham, J. M., A. E. Skodol, et al. (1992). "Diagnosis of DSM-III-R Personality Disorders by two structured interviews: Patterns of comorbidity." American Journal of Psychiatry **149**: 213-220.
- Olweus, D. (1979). "Stability of aggressive reaction patterns in males: A review." Psychological Bulletin **86**: 852-875.
- Osborn, A. F. (1990). "Resilient children: a longitudinal study of high achieving socially disadvantaged children." Early Child Development and Care **62**: 23-47.
- Padfield, N. (2000). "Detaining the dangerous." The Journal of Forensic Psychiatry **11**(3): 497-500.
- Palermo, G. B. (2007). "Editorial: new vistas on personality disorders and criminal responsibility." International Journal of Offender Therapy & Comparative Criminology **51**(2): 127-129.
- Paris, J. (2007). "Why Psychiatrists are Reluctant to Diagnose Borderline Personality Disorder." Psychiatry (Edgmont) **4**(1): 35-39.
- Patterson, G. R. (1991). An early starter model for predicting delinquency. Hillsdale, NJ, Erlbaum.
- Peek, L. a. F., A. (2009). "Using focus groups: lessons from studying daycare centers, 9/11, and Hurricane Katrina." Qualitative Research **9**(1): 31-59.

- Petursson, H. and G. H. Gudjonsson (1981). "Psychiatric aspects of homicide." Acta Psychiatrica Scandinavica **64**(5): 363-372.
- Philo, G. a. M. B. (2004). Bad News from Israel. London, Pluto Press.
- Pope, C. a. M., N. (2006). Qualitative methods in health research. Oxford, Blackwell Publishing Ltd.
- Porter, S. and M. Woodworth (2007). "'I'm sorry I did it... but he started it': a comparison of the official and self-reported homicide descriptions of psychopaths and non-psychopaths." Law & Human Behavior **31**(1): 91-107.
- Porter, S., M. Woodworth, et al. (2003). "Characteristics of sexual homicides committed by psychopathic and nonpsychopathic offenders." Law & Human Behavior **27**(5): 459-470.
- Poso, T., Honkatukia, P. and Nyqvist, L. (2008). "Focus groups and the study of violence." Qualitative Research **8**(1): 73 - 89.
- Putkonen, A., I. Kotilainen, et al. (2004). "Comorbid personality disorders and substance use disorders of mentally ill homicide offenders: a structured clinical study on dual and triple diagnoses." Schizophrenia Bulletin **30**(1): 59-72.
- Putkonen, H., J. Collander, et al. (2001). "Personality disorders and psychoses form two distinct subgroups of homicide among female offenders." The Journal of Forensic Psychiatry **12**(2): 300-312.
- QSR (2010). NVivo qualitative data analysis software. , QSR International Pty Ltd Version 10. .
- Quinsey, V. L. (1995). "The prediction and explanation of criminal violence." International Journal of Law & Psychiatry **18**(2): 117-127.
- Quinton, D., A. Pickles, et al. (1993). "Partners, peers and pathways: Assortative pairing and continuities in conduct disorder." Development & Psychopathology **5**: 763-783.
- Raffi, A. a. M., A. (2010). "Ethnic distribution of personality disorder." The Psychiatrist **34**: 36-37.
- Raine, A. (1993). "Features of borderline personality and violence." Journal of Clinical Psychology **49**(2): 277-281.
- Rasmussen, K. and S. Levander (1996). "Symptoms and personality characteristics of patients in a maximum security psychiatric unit." International Journal of Law & Psychiatry **19**(1): 27-37.
- Reid, R. v. (2001). 1 Cr AppR. 21.
- Reiss, D. and J. M. Neiderhiser (2000). "The interplay of genetic influences and social processes in developmental theory: specific mechanisms are coming into view." Development & Psychopathology **12**(3): 357-374.
- Roberts, A. D. L. and J. W. Coid (2009). "Personality disorder and offending behaviour: findings from the national survey of male prisoners in England and Wales." Journal of Forensic Psychiatry & Psychology **21**(2): 221-237.



- Roberts, B. W. and W. F. DelVecchio (2000). "The Rank-Order Consistency of Personality Traits From Childhood to Old Age: A Quantitative Review of Longitudinal Studies." Psychological Bulletin January **126**(1): 3-25.
- Robins, L. N. (1966). Deviant children grown up: A social and psychiatric study of sociopathic personalities. Baltimore, Williams & Wilkins.
- Robins, L. N. (1978). "Sturdy childhood predictors of adult antisocial behaviour: replications from longitudinal studies." Psychological Medicine **8**(4): 611-622.
- Robins, L. N., Regier, D.A. (1991). Psychiatric Disorders in America. New York, The Free Press.
- Robins, L. N., J. Tipp, et al. (1991). Antisocial Personality. New York, The Free Press.
- Rogers, R., J. Johansen, et al. (1997). "Predictors of adolescent psychopathy: oppositional and conduct-disordered symptoms." Journal of the American Academy of Psychiatry & the Law **25**(3): 261-271.
- Roper, R. (2012). Shared Responsibility, Joint Operations. Consultation Draft. Scotland, Cross Cutting Issues Forum.
- Rosenstein, D. S. and H. A. Horowitz (1996). "Adolescent attachment and psychopathology." Journal of Consulting & Clinical Psychology **64**(2): 244-253.
- Roulston, K. (2010). "Considering quality in qualitative interviewing." Qualitative Research **10**(2): 199 - 228.
- Russell, K. a. D., 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. Oxon, Routledge.
- Rutter, L. N., B. Maughan, et al. (1979). Fifteen Thousand Hours: Secondary Schools and Their Effects on Children. Cambridge, MA, Harvard University Press.
- Rutter, M. (2012). "Psychopathy in childhood: is it a meaningful diagnosis?" The British Journal of Psychiatry **200**(3): 175-176.
- Rutter, M., D. Quinton, et al. (1990). Adult outcomes of institutionally reared children. Cambridge, Cambridge University Press.
- Salekin, R., R. Rogers, et al. (1996). "A review and meta-analysis of the Psychopathy Checklist and Psychopathy Checklist-Revised: Predictive validity of dangerousness." Clinical Psychology: Science and Practice **3**: 203-215.
- Sarkar, J. and C. Duggan (2010). "Diagnosis and classification of personality disorder: difficulties, their resolution and implications for practice." Advances in Psychiatric Treatment **16**(5): 388-396.
- Schmitt, D. P., Allik, J., McCrae, R.R. and Benet-Martinez, V. (2007). "The geographic distribution of Big Five personality traits: patterns and profiles of human self-description across 56 nations." Journal of Cross-Cultural Psychology **38**: 173-212.
- Schneider, B. (2000). "Managers as evaluators: Invoking objectivity to achieve objectives." Journal of Applied Behavioural Sciences **36**: 159 - 173.

- Schug, R. A., A. Raine, et al. (2007). "Psychophysiological and behavioural characteristics of individuals comorbid for antisocial personality disorder and schizophrenia-spectrum personality disorder." British Journal of Psychiatry **191**: 408-414.
- Seagrave, D. and T. Grisso (2002). "Adolescent Development and the Measurement of Juvenile Psychopathy." Law and Human Behavior **26**(2): 219.
- Seale, C. (1999). The Quality of Qualitative Research. Oxford, Blackwell.
- Seivewright, H., Tyrer, P. and Johnson, T. (2002). "Change in personality status in neurotic disorders." The Lancet **359**: 2253–2254.
- Serin, R. C. and N. L. Amos (1995). "The role of psychopathy in the assessment of dangerousness." International Journal of Law & Psychiatry **18**(2): 231-238.
- Shanks, C., B. Pfohl, et al. (2011). "Can Negative Attitudes towards patients with Borderline Personality Disorder be changed? The effect of attending a STEPPS workshop." Journal of Personality Disorders **25**(6): 806-812.
- Shea, M., T., Stout, R., Gunderson, J. et al (2002). "Short-term diagnostic stability of schizotypal, borderline, avoidant and obsessive-compulsive personality disorders." American Journal of Psychiatry **159**: 2036-2041.
- Shooter, M. (2002). White Paper on the Reform of the Mental Health Act 1983. Letter from the Chair of the College's Public Policy Committee. . London, Royal College of Psychiatrists. .
- Silk, K. R. (2010). "Introduction to the special issue on National Institute for Health and Clinical Excellence guidelines." Personality and Mental Health **4**(1): 1-2.
- Silverman, D. (2011). Interpreting Qualitative Data. London, Sage Publications Ltd.
- Simonoff, E. (2001). "Gene-environment interplay in oppositional defiant and conduct disorder." Child & Adolescent Psychiatric Clinics of North America **10**(2): 351-374.
- Singleton, N., H. Meltzer, et al. (1998). Psychiatric morbidity among prisoners. G. S. Service, Office for National Statistics
- Skeem, J. L. and E. P. Mulvey (2001). "Psychopathy and community violence among civil psychiatric patients: results from the MacArthur Violence Risk Assessment Study." Journal of Consulting & Clinical Psychology **69**(3): 358-374.
- Skodol, A. E., Pagano, M. E., Bender, D. S. et al (2005). "Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder over two years." Psychological Medicine **35**: 443 - 451.
- Snape, D. a. S., L. (2003). The Foundations of Qualitative Research. London, Sage Publications Ltd.
- Sokol, D. K. (2007). "Can deceiving patients be morally acceptable?" BMJ **334**(7601): 984-986.

- Solomka, B. (2012). Payment by results for mental health (England): Position Statement PS02/2012. London, Royal College of Psychiatrists.
- Spence, S. A. (2001). "Personality disorder: agency and responsibility " British Journal of Psychiatry **179**: 558.
- Spitzer, R. L., M. B. First, et al. (2008). "Clinical Utility of Five Dimensional Systems for Personality Diagnosis: A "Consumer Preference" Study." The Journal of Nervous and Mental Disease **196**(5): 356-374  
310.1097/NMD.1090b1013e3181710950.
- SPSSInc. (2007). SPSS for Windows, Version 16.0. Chicago, SPSS Inc. .
- Stanger, C., T. M. Achenbach, et al. (1997). "Accelerated longitudinal comparisons of aggressive versus delinquent syndromes." Development & Psychopathology **9**(1): 43-58.
- StataCorp (2009). Stata Statistical Software: Release 11. College Station, TX, StataCorp LP.
- Stone, A. A. (1984). "The ethical boudaries of forensic psychiatry - a view from the ivory tower." Bulletin of the American Academy of Psychiatry & the Law **12**(3): 209-219.
- Stone, M. H. (1998). The personalities of Murderers: The Importance of Psychopathy and Sadism. Washington, DC, American Psychiatric Press, Inc.
- Sturges, J. E. and K. J. Hanrahan (2004). "Comparing Telephone and Face-to-Face Qualitative Interviewing: a Research Note." Qualitative Research **4**(1): 107-118.
- Surtees, P. G. and R. E. Kendell (1979). "The hierarchy model of psychiatric symptomatology: an investigation based on present state examination ratings." British Journal of Psychiatry **135**: 438-443.
- Swinson, N., Flynn, S., While, D., Roscoe, A., Kapur, N., Appleby, L., Shaw, J. (2011). "Trends in rates of mental illness in homicide perpetrators." British Journal of Psychiatry **198**(6): 485-489.
- Taylor, P. J. (2006). Treatment of serious offenders with personality disorder: effect, effectiveness and individuality. London, Hodder Arnold.
- Taylor, P. J., C. Newrith, et al. (2006). Treating personality disorder: toowards a future of more mutually satisfactory and rewarding outcomes. London, Hodder Arnold.
- Tedeschi, J. T. (1983). Social influence theory and aggression. New York, Academic Press.
- Tetley, A. C., S. Evershed, et al. (2010). "Difficulties in the pathway from high to medium secure services for personality-disordered patients." Journal of Forensic Psychiatry & Psychology **21**(2): 189-201.
- Tiihonen, J., M. Eronen, et al. (1993). "Criminality associated with mental disorders and intellectual deficiency.[comment]." Archives of General Psychiatry **50**(11): 917-918.
- Tyrer, P. (1996). "Comorbidity or consanguinity." British Journal of Psychiatry **168**: 669-671.

- Tyrer, P. (2005). Personality Assessment Schedule - Document-Derived Version (PAS-DOC). Department of Psychological Medicine, Imperial College.
- Tyrer, P. (2007). "Personality diatheses: a superior explanation than disorder." Psychological Medicine **37**(11): 1521-1525.
- Tyrer, P. (2010). "Personality Structure as an Organizing Construct." Journal of Personality Disorders **24**(1): 14-24.
- Tyrer, P. (2013). "The classification of personality disorders in ICD-11: Implications for forensic psychiatry." Criminal Behav. Ment. Health, **23**: 1 - 5.
- Tyrer, P., M. S. Alexander, et al. (1979). "Reliability of a schedule for rating personality disorders." British Journal of Psychiatry **135**: 168-174.
- Tyrer, P., Cicchetti, D., V., Casey, P., R., Fitzpatrick, K. et al (1984). "Cross-national reliability study of a schedule for assessing personality disorders." Journal of Nervous and Mental Diseases **172**: 718-721.
- Tyrer, P., N. Coombs, et al. (2007). "Critical developments in the assessment of personality disorder." The British Journal of Psychiatry **190**(49): s51-s59.
- Tyrer, P., N. Coombs, et al. (2007). "Critical developments in the assessment of personality disorder." British Journal of Psychiatry **190**(supplement 49): 51-59.
- Tyrer, P., S. Cooper, et al. (2005). "Temporal reliability of psychological assessments for patients in a special hospital with severe personality disorder: a preliminary note." Criminal Behaviour & Mental Health **15**(2): 87-92.
- Tyrer, P., Cooper, S., Rutter, D., Seivewright, H., Duggan, C., Maden, T., Barrett, B., Joyce, E., Rao, B., Nur, U., Cicchetti, D., Crawford, M. and Byford, S. (2009). "The assessment of dangerous and severe personality disorder: lessons from a randomised controlled trial linked to qualitative analysis." Journal of Forensic Psychiatry and Psychology **20**(1): 132-146.
- Tyrer, P., M. Crawford, et al. (2011). "Reclassifying personality disorders." The Lancet **377**(9780): 1814-1815.
- Tyrer, P., Mulder, R., Crawford, M., Newton-Howes, G., Simonsen, E., Ndeti, D. et al (2010). "Personality Disorder: a new global perspective." World Psychiatry **9**: 56-60.
- Tyrer, P. and N. Seivewright (1988). "Pharmacological treatment of personality disorders." Clinical Neuropharmacology **11**(6): 493-499.
- Tyrer, P., Strauss, J. and Cicchetti, D. (1983). "Temporal reliability of personality in psychiatric patients." Psychological Medicine **13**: 393 - 398.
- Tyrer, P. a. C., D. (2000). Personality Assessment Schedule. Personality Disorders: Diagnosis, Management and Course. P. Tyrer. Oxford, Butterworth Heinemann.
- Tyrer, P. a. J., T. (1996). "Establishing the severity of personality disorder." American Journal of Psychiatry **153**: 1593-1597.

- Verheul, R. and T. A. Widiger (2004). "A Meta-Analysis of the Prevalence and Usage of the Personality Disorder Not Otherwise Specified (PDNOS) Diagnosis." Journal of Personality Disorders **18**(4): 309-319.
- Viding, E. and E. J. McCrory (2012). "Why should we care about measuring callous–unemotional traits in children?" The British Journal of Psychiatry **200**(3): 177-178.
- Vitelli, R. (1997). "Comparison of early and late start models of delinquency in adult offenders." International Journal of Offender Therapy and Comparative Criminology **41**: 351-357.
- Vizard, E., L. French, et al. (2004). "Severe personality disorder emerging in childhood: a proposal for a new developmental disorder." Criminal Behaviour & Mental Health **14**(1): 17-28.
- Völlm, B. and N. Konappa (2012). "The dangerous and severe personality disorder experiment – Review of empirical research." Criminal Behaviour and Mental Health **22**(3): 165-180.
- Wahlund, K. and M. Kristiansson (2006). "Offender characteristics in lethal violence with special reference to antisocial and autistic personality traits." Journal of Interpersonal Violence **21**(8): 1081-1091.
- Webb, D. and M. McMurrin (2007). "Nursing staff attitudes towards patients with personality disorder." Personality and Mental Health **1**(2): 154-160.
- Werner, E. E. (1993). "Risk, resilience and recovery: Perspectives from the Kauai longitudinal study." Development & Psychopathology **5**: 503-515.
- Werner, E. E. and R. S. Smith (1992). Overcoming the Odds. Ithaca, NY, Cornell University Press.
- Westenberg, P. M. and J. Block (1993). "Ego development and individual differences in personality." Journal of Personality & Social Psychology **65**(4): 792-800.
- Williamson, S. E., R. D. Hare, et al. (1987). "Violence: Criminal psychopaths and their victims." Canadian Journal of Behavioural Science **19**: 454-462.
- Wilson, E., B. (1927). "Probable inference, the law of succession, and statistical interference." Journal of American Statistical Association **22**: 209-212.
- Wilson, J. Q. and R. J. Herrnstein (1985). Crime and human nature. New York, Simon and Schuster.
- Witharana, D., Ho, D. K. and Larkin, F. (2011). "Personality disordered offenders - complex patients requiring more expertise " The Psychiatrist **35**: 355-356.
- Woodward, M., Nursten, J., Williams, P. and Badger, D. (2000). "Mental Disorder and Homicide: A Review of Epidemiological Research." Epidemiologia E Psichiatria Sociale **9**(3): 171-189.
- Woodworth, M. and S. Porter (2002). "In Cold Blood: Characteristics of Criminal Homicides as Function of Psychopathy." Journal of Abnormal Psychology **111**(3): 436-445.
- Wootton, J. M., P. J. Frick, et al. (1997). "Ineffective Parenting and Childhood Conduct Problems: The Moderating Role of Callous-Unemotional Traits." Journal of Consulting & Clinical Psychology April **65**(2): 301-308.

- World Health Organisation (1992). The ICD-10 Classification of Mental and Behavioural Disorders. Geneva, World Health Organisation.
- Yang, M., J. Coid, et al. (2010). "Personality pathology recorded by severity: national survey." The British Journal of Psychiatry **197**(3): 193-199.
- Yu, R., J. R. Geddes, et al. (2012). "Personality Disorders, Violence, and Antisocial Behavior: A Systematic Review and Meta-Regression Analysis." Journal of Personality Disorders **26**(5): 775-792.
- Zimmerman, M. (1994). "Diagnosing personality disorder: a review of issues and research methods." Arch Gen Psychiatry **51**: 225-245.
- Zimmerman, M., Pfohl, B., Stangl, D., et al (1986). "Assessment of DSM-iii personality disorders: the importance of interviewing an informant." Journal of Clinical Psychiatry **47**: 261 - 263.
- Zimmerman, M., Rothschild, L. and Chelminski, I. (2005). "The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients." American Journal of Psychiatry **162**(10): 1911-1918.
- Zimmerman, M., Ruggero, C. J., Chelminski, I. et al (2010). "Psychiatric diagnoses in patients previously overdiagnosed with bipolar disorder." Journal of Clinical Psychiatry **71**: 26-31.
- Zimmerman, M. a. M. J. L. (1999). "Differences between clinical and research practices in diagnosing borderline personality disorder." American Journal of Psychiatry **156**: 1570-1574.

## ***Appendices***

### ***Appendix 1: PAS DOC***

#### **Personality Assessment Schedule – Document-Derived Version (PAS-DOC)**

This modified PAS schedule is designed to formalize the assessment of personality disorder from notes and other documents only. It is therefore highly dependent on the quality of such data and it is advisable to obtain as many sources of information as possible.

There are 24 personality variables to be assessed in PAS-DOC, the same as in the original PAS. However, the analysis of the data does not use the same algorithm as the PAS (awaiting development) although the scoring system is generally similar. As the data have to be extracted from written information the instructions for scoring are different and, for reliability purposes, it is helpful to record in writing the main items that are judged to indicate the scoring of the trait concerned.

In scoring personality traits it is recognised that most written information about subjects refers to mental state manifestations. However, underlying personality is often disclosed by descriptions of habitual behaviour and attitudes, and evidence is also available of the quality and nature of relationships and general functioning with others. If the written information indicates repetitive patterns it is reasonable to regard these as having at least some link to personality status, but allowance may be made for symptoms of mental illness if the data suggest that behaviour or relationships are out of step with normal function at a time of crisis or severe mental disturbance. It is normally recommended in PAS-DOC that the results are presented in terms of the severity of personality disorder rather than type as the severity scores are more robust and also more likely to be accurate when only limited data are available.

## **Use of the schedule**

**Stage 1 - Overview.** The material used to score PAS-DOC is examined and assessed for (i) comprehensiveness (high value indicated by a longitudinal historical report drawing on information from several sources and being person-focused rather than a symptom description), (ii) balance (a dispassionate account attempting to give appropriate weight to all sources of information, and (iii) corroboration (documents from several sources which agree independently with regard to ratings, or evidence in the report that such corroboration has been sought in accessing multiple types of information).

In the case of several types of information each should be scored separately using the modified version of the reliability scale from the original PAS (below). This will be of value when judging contradictory information from different documents, when, in general, information from the superior data source will be preferred. A system by which assessments from all data sources can be included in the analysis is being prepared.

In examining the data source please note that the two basic requirements are essential and at least two of the preferred requirements before the scale can be completed.

### **Basic requirements:**

1. Source of information uses direct observations and descriptions of subject, or if indirect, have included the descriptions of a direct source
2. At least part of the documentation refers to the person in such a way as to indicate habitual functioning and behaviour rather than merely current status



**Preferred requirements:**

1. More than one document
2. More than one source of information (or if from one only to include observations of others)
3. Some comment about past behaviour & experiences between 5 and 20 years in some form
4. Life chart or story incorporated into data source
5. Contact with health, police and educational services listed

*When completing the schedule please note that currently all 24 traits ideally need to be scored so even if information is very limited please try and score every item (with bracketed zeros if no adequate information).*

**Reliability of information**

On the basis of the comprehensiveness, balance and corroboration of your information, how would you rate its overall quality in assessing personality status?

Rating 0 Highly reliable information. Evidence from documents covers all aspects of habitual behaviour and relationships and enables assessment to be made with fair confidence

Rating 1 Reasonably reliable information but some reconstruction necessary to enable scoring to be made

Rating 2 Limited information with only some personality variables covered adequately and need for considerable extrapolation to complete scoring

Rating 3 Scanty information with very little material given about personality status either directly or indirectly

## **Stage 2 – Rating of traits**

*Ratings of severity:* The ratings are made on a nine-point scale for all variables. The number is recorded in the appropriate box at the side of each item or on an accompanying sheet. The scale is specifically designed to record abnormal personality traits and most normal variation will occur between scores 0 and 3. The greater the severity of the trait the greater will be the rating. In addition to the specific points mentioned for each scale, the following general principles should be used to determine the score for a particular trait.

Score 0. Trait absent. Presence of the trait is undetected in any form in the written material.

Score 1. The presence of the trait is suspected in mild degree from reading the written material but has no negative influence on general functioning or quality of relationships.

Score 2. The personality trait is suspected in moderate degree but has no significant negative influence on general functioning or quality of relationships.

Score 3.. The personality trait is strongly suspected from written material and this is judged to give rise to the problems in occupational, social and interpersonal functioning at times of stress, but not habitually.

Score 4. The personality trait is marked, is shown in several setting, and produces some difficulties in occupational, social and interpersonal adjustment and this tends to be of a mild but persistent nature.

Score 5. The personality trait is marked, continually influences behaviour and leads to definite problems in occupational, social and interpersonal relationships.

Score 6. The personality trait has a major influence on behaviour and tends to affect all aspects of life. The problems in occupational, social and interpersonal relationship are such that major breakdown occurs (e.g. divorce, social isolation, prolonged unemployment), as a direct result of the personality abnormality.

Score 7. The personality trait is so prominent that it is noticed repeatedly and consistently. Independent living in the community is almost impossible because of the severity in occupational, social and interpersonal relationships.

Score 8. The personality trait dominates behaviour completely (thus it is rarely scored) and cannot be given to more than one rating in the schedule). The disturbance produced by the trait is so marked that prolonged periods of institutional care (e.g. hospital, prison, nursing home) take up a large part of the life history in the absence of any formal illness.

Note: most normal variation is accounted for between the ratings of 0 and 3. Only a small number of individuals rate higher scores than 3. The key issues in deciding whether a score of more than 3 is justified are:

- (a) Good evidence of behavioural disturbance and problems in relationships quite independent of any mental state abnormalities.
- (b) The suffering and underachievement that the trait produces, both to the subject and others.
- (c) The absence of adaptive characteristics that prevent the negative effects of the personality trait from being compensated.

Additional notes on PAS-DOC

## Procedure for scoring

It will be noticed on the final scoring sheet there is a space for 'the final score'. If the scores on the scale are obtained from several sources of information it will be necessary to derive a final score from the combined data. In general the more reliable data (see above) will take preference but for specific individual items it may also be considered that the 'less reliable' source is superior to the 'more reliable' one, so this general principle is subject to over-ride.

Useful items of information from written records that may be related to personality status and, when corroborated from other data, could be linked to a personality disorder diagnosis

(1) *Marital relationship* – if unmarried has the subject ever cohabited? If married or divorced how many times have the couple separated for any reason during marriage?

(2) *Child care*. Have there been any problems with the children of the patient? Have any children been involved with the police or official agencies and have they ever been in care?

(3) *Has the subject ever been in debt?* What were the circumstances?

(4) *Employment*. How many jobs has the subject had since leaving school? What were the circumstances of leaving these jobs? Was the subject ever sacked from a job or did they leave because of problems with colleagues?

(5) *Legal*. Has the subject ever been convicted of an offence? If so, what was the offence and outcome?

(6) *Does the subject drink alcohol. Take illegal drugs or gamble?* If so, have any problems arisen as a consequence of these activities?

(7) *Housing*. How many addresses has the subject had in the last 10 years? What were the reasons for moving? Has the subject ever been homeless?

(8) *Adolescent problems*. Did the subject have any problems when attending school after the age of 11? If so, what was the outcome?

1. PESSIMISM

Gloomy outlook on life that prevents successful adjustments and which may adversely affect others

(1)

Often not mentioned directly in written material but comments such as 'always miserable', 'expects the worst', and 'unhappy for most of the time' allows the trait to be separated from recurrent mood disturbance independent of personality. Instability of mood is not considered here.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 A pessimistic outlook on life with no effect on behaviour.

Ratings 4-6 Depressive behaviour including social withdrawal and morbid depression to the extent that others notice and are affected by the behaviour.

Ratings 7-8 Persistent pessimism and depressive behaviour with almost complete withdrawal and isolation.

## 2. WORTHLESSNESS

Persistent and ingrained low self-esteem



Comments relevant to worthlessness in written material include 'feelings of inferiority and inadequacy', 'low opinion of self' and 'poor self-image when compared with others'. Some of this may need to be inferred to some extent as such comments will not normally be prominent.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild feelings of inferiority, fully compensated and not obviously apparent to others.

Ratings 4-6 Strong feelings of inferiority, affecting behaviour. Subject will not do things he/she is capable of because of abnormality low self-esteem. At least some impairment at work and social adjustment.

Ratings 7-8 Strong feelings of inferiority amounting to worthlessness. Because of those feelings subject requires continuous reassurance and support. Not able to work regularly or make any useful relationship.

Do not confuse worthlessness with depression although the two often coexist.

3. OPTIMISM

Persistent optimism and positive expectations despite evidence that these may be unrealistic





Comments relevant to optimism in written material include 'always cheerful', '(unrealistically) optimistic about the future', 'always active and energetic', 'expectations of success', 'financial difficulties because of over-optimism'. These would normally be accompanied by evidence of inappropriateness if optimism clearly misplaced.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Subject/Informant

Note

Ratings 1-3 Subject is more cheerful than most others and is capable of communicating his/her cheerfulness to them.



Ratings 4-6 Over-cheerfulness leads to unrealistic ambitions and aspirations, including overspending, over-confidence and impaired judgement, so subject may be sacked from work or be in serious debt. Subject remains optimistic and self-important in spite of these problems.

Ratings 7-8 Breakdown in relationships, inability to maintain stability in any aspect of social, occupational or interpersonal life because of abnormal cheerfulness, over-optimism and self-importance.

To merit a high rating the optimism has to be more or less continuous and not part of any mood disorder. Short periods of abnormal optimism of less than 2 weeks should be regarded as evidence of lability of mood rather than evidence of abnormal optimism. If in doubt delay rating till lability trait scored.

#### 4. LABILITY

Rapid fluctuation in mood with consequent changes in behaviour

(4)

Comments relevant to lability in written material include 'sudden changes in mood', 'unstable mood', 'unpredictability and irritability' (but related to mood rather than other influences).

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

Subject/Informant

Note

Ratings 1-3 A tendency towards mild exaggeration of mood swings in response to life changes.

Ratings 4-6 Marked lability, noticeable to others and leading to problems because of strength of mood swings. Most mood changes responsive to life events but may be independent. Unpredictability of subject's behaviour because of mood change also a source of difficulties.

Ratings 7-8 Breakdown in social, occupational and personal relationship because of abnormal swings in mood. In these instances it would be more likely that the changes are independent of life events so that they cannot be manipulated in any way.

5. ANXIOUSNESS

Characteristic and persistent anxiousness with both expectations and anticipation of disaster.

(5)

Comments relevant to anxiousness in written material include 'always anxious', 'chronic tension', 'expectations of trouble', 'life-style restricted because of over-anxiety', and 'limited activities because of persistent fear of dangers.'

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Subject/Informant

Note

Ratings 1-3 Mild anxiety-proneness which is normally suppressed so that others are not aware of it.

Ratings 4-6 Anxiety noticeable to others, leading to changes in behaviour.

Ratings 7-8 Frequent or continuous anxiety of such severity that breakdown in social adjustment occurs.

## 6. SUSPICIOUSNESS

Consistently suspicious and negatively doubtful of the intentions of others

(6)

Comments relevant to suspiciousness in written material include 'always suspicious', 'hostile towards others', 'never trusts anybody', 'feels others are plotting or acting against him (her)', 'does everything on own as doubts contribution of others'. As suspiciousness often has close links to mental state it is important to try and distinguish the effects of personality from mental state.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Subject/Informant

Note

Ratings 1-3 Mild feelings of suspiciousness, not noticed by others. Subject tends to have relatively few friends but is capable of close relationships and will trust those he/she knows well.

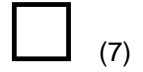
Ratings 4-6 Problems in social adjustment because of abnormal suspiciousness. Takes a very long time to get to know people and only trusts a very small number of people. Feels that others criticize him/her without adequate cause.

Ratings 7-8 Breakdown in relationships and social adjustment because of abnormal suspiciousness.

At extreme ratings the patient is completely isolated because he/she feels all are against him/her.

7. INTROSPECTION

Introverted, inward-looking attitudes, thinking and behaviour with reluctance to involve self with others



Comments relevant to introspection in written material include 'preference for own company', 'avoidance of others', 'unaware of surroundings (with tendency to ignore own needs)', 'limited communication', 'solitary interests', 'self-absorption'.

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

.....

*Subject/Informant*

Note

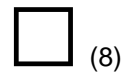
Ratings 1-3 Mild introspection and introversion, not noticeable to others.

Ratings 4-6 Problems in adjustment because of excessive rumination and introspection, often with a tendency to indulge in fantasy. These feelings may lead to problems by indecision, impaired judgment and poor relationships.

Ratings 7-8 Completely bound up in self to the exclusion of other matters, indulges in much fantasy. Self-neglect frequent.

## 8. SHYNESS

Persistent discomfort in social situations with reluctance to become involved



Comments relevant to shyness in written material include 'social withdrawal (because of perceived discomfort)', 'diffidence with others', 'anxiety in social settings', 'excessive modesty', 'apprehensive in company'.

Relevant extracts from written information

.....  
.....  
.....

.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild shyness, but this is compensated and others do not notice it.

Ratings 4-6 Excessive shyness and lack of self-confidence leading to avoidance of people and personal discomfort when with people.

Ratings 7-8 Subject unable to work adequately or make relationships because of symptoms. In severe cases may be completely isolated.

It is important to exclude natural aloofness and detachment from shyness – the former group are not distressed in the company of other people, shyness is always associated with some feelings of anxiety.

9. ALOOFNESS

Detachment and lack of awareness of the needs of others. Individual appears able to live entirely independently of social contacts.



Comments relevant to aloofness in written material include 'neglect of personal relationships', 'indifference to needs of others', 'ignores other people and does not understand them', 'preference for solitary activities'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild detachment leading to a reluctance to involve subject in close relationships. Not noticeable to others, and adequate relationships made with close friends and relatives.

Ratings 4-6 Abnormal aloofness noticeable to others and leading to problems in social adjustment, mainly in interpersonal relationships.

Ratings 7-8 Excessive detachment and lack of interest in other people. No close relationships. Indifference to other people's feelings and opinions.

Lack of interest in other people is unrelated to shyness or psychiatric symptomatology such as social fears. Subject does not feel distressed with other people and merely has no interest in them.

#### 10. SENSITIVITY

Persistent excessive touchiness and sensitivity to criticism with confrontational response.

(10)

Comments relevant to sensitivity in written material include 'frequently takes offence against apparent slights', 'easily aggravated by others', 'prickly in relationships', 'sensitive in relationships'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild sensitivity. May be upset easily but does not show it except to close friends and relatives.

Ratings 4-6 Excessive personal sensitivity with a tendency to self-reference (e.g. feels people are being critical when they are not). This leads to problems in social adjustment (e.g. frequent changes of job, broken relationships).

Ratings 7-8 Excessive sensitivity leads to breakdown in social performance. Extreme tendency to self-reference.

Sensitivity to the feelings of others is not an abnormal phenomenon and should not be included in this rating. This rating is concerned with personal sensitivity and touchiness. If

in doubt about this rating, delay till ratings of vulnerability, impulsiveness and irritability are made.

11. VULNERABILITY

Lack of resilience in coping with major events with inability to cope and delay in recovery of normal function.

(11)

(How do you think you would cope with a crisis such as death in the family, car accident or loss of your job?)

Comments relevant to aloofness in written material include 'neglect of personal relationships', 'indifference to needs of others', 'ignores other people and does not understand them', 'preference for solitary activities'.

Relevant extracts from written information

.....  
.....  
.....

.....  
.....  
Subject/Informant

Note

Ratings 1-3 Reacts more than most to adversity but does not show these feelings to others.

Ratings 4-6 Abnormally vulnerable, reacts excessively to adversity, so leading to social maladjustment for a prolonged period. Eventually, however, more normal functioning is resumed until the next adverse episode.

Ratings 7-8 Subject vulnerable to even the minor stresses of life to which he/she reacts as though they were major problems. Breakdown in social adjustment because of this.

It is important to separate vulnerability from sensitivity and resourcelessness. Although all three may be present in one individual, the characteristics are separate. The sensitive person is touchy and reacts easily to implied criticism, the vulnerable person reacts to major life events by feelings of distress which may take a long time to resolve and are not commonly associated with compensatory action, and the resourceless person reacts to adversity by not coping and just giving up. When assessing vulnerability do not include sensitivity and resourcelessness.

## 12. IRRITABILITY

Describes angry and argumentative attitudes towards others with inability to settle and fit in with views that are not entirely consonant with one's own

Comments relevant to irritability in written material include 'short-tempered (independent of violence)', 'frequent arguments with others', 'angry intolerance of others', 'shouting and stomping when aggravated', and general comments about irritability, particularly when associated with tension, conflictual settings, relationship problems and joint activities.

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

Note

Ratings 1-3 Mild irritability, kept under control.

Ratings 4-6 Abnormally irritable. Leading to social adjustment problems (e.g poor relationships with others)

Ratings 7-8 Severe irritability, making it very difficult for subject to make adequate relationships with others. Inability of the subject to cope in any environment which involves sudden changes because of severe irritability.

13. IMPULSIVENESS

Describes the execution of actions without prior thought and planning



\* Comments relevant to impulsiveness in written material include 'getting into debt because of sudden and rash spending', 'risky behaviour in sexual, occupational or leisure activities', 'impulsive self-harm', and all actions that are associated with sudden decision making and subsequent remorse as seen to have been carried out in error.

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

.....

Note

Ratings 1-3 Mild impulsiveness, not noticeable to others, or causing no problems in social adjustment.

Ratings 4-6 Impulsiveness associated with regret which has led to problems of social adjustment (e.g. loss of job).

Ratings 7-8 Frequent impulsiveness leading to criminal behaviour and/or breakdown in social functioning throughout adult life.

Impulsiveness may be associated with aggression; both traits may be rated in these circumstances.

#### 14. AGGRESSION

Persistent and (usually) unprovoked physical aggression towards properties or individuals

(14)



Comments relevant to aggression in written material tend to be frequent because of its societal impact and include descriptions of verbal and physical violence not related to mental state, 'threatening and hostile behaviour', 'repeated criminal offences', 'abusive behaviour' and 'anger in relationships'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Note

Ratings 1-3 Anger and aggression felt frequently but kept to himself/herself.

Ratings 4-6 Aggression abnormal and leads to social difficulties (e.g. trouble with police), and violence at home. Do not rate criminal offences here unless they are a direct consequence of aggressiveness.

Ratings 7-8 Breakdown of social adjustment with long history of antisocial behaviour, usually with criminal record.

15. CALLOUSNESS

Describes indifference and insensitivity to the needs of others and, in more extreme instances, pleasure in the suffering of others

(15)

Comments relevant to callousness in written material include 'inability to understand the feelings of others', 'interests in torture, mutilation and other activities leading to prolonged suffering, 'complete absence of remorse after actions that cause harm to others', and general observations about sadistic or other impersonally aggressive behaviour that creates pleasure.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Note

Ratings 1-3 Mild insensitivity and indifference to others feelings.

Ratings 4-6 Cold and indifferent to the extent that S is only capable of a few relationships, and these are really close.

Ratings 7-8 Marked callousness with or without sadistic behaviour, leading to breakdown in social functioning and frequent criminal involvement.

## 16. IRRESPONSIBILITY

Describes actions and other behaviour that shows lack of forethought and any sense of personal ownership, so that when things go wrong they can always be blamed on someone else

(16)

Comments relevant to irresponsibility in written material include 'inability to manage finances responsibly', 'failure to understand or appreciate responsibilities or tasks', 'putting oneself at risk without realising the dangers', and persistent behaviour associated with negative outcomes such as gambling, sexual promiscuity, overspending, lying and 'passing the buck' for one's own failings.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Note

Ratings 1-3 Mildly irresponsible, feelings kept under control, not noticed by others or, if manifest, not causing real problems.

Ratings 4-6 Highly irresponsible, takes risks repeatedly, problems in social adjustment (e.g. in debt, frequent accidents, unwanted pregnancies). Do not rate criminal offences automatically unless they stem from irresponsibility.

Ratings 7-8 Irresponsibility so great that S needs to be constantly supervised and cannot live independently because of this.

Irresponsibility and impulsiveness are often found together but differ as impulsiveness is always associated with acts and usually with subsequent regret; irresponsibility may be passive and is associated with the transfer of responsibility to others. The phenomenon of learned helplessness in chronic mental illness may complicate assessment.

17. CHILDISHNESS

*Subject*

Do you ever act in a childish way or would you regard yourself as fairly mature?

Do you ever manipulate people to get your own way?

(17)

Comments relevant to childishness in written material include 'immaturity', 'selfish attitudes and perception 'only interested in self and ignores needs of others', 'egotistical', 'shallow and self-centred', 'easily diverted by whim and excitement', and other behaviour that would normally be thought of as more appropriate to childhood or early adolescence.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Note

Ratings 1-3 Self-centred attitudes with occasional childish behaviour but this is seldom noticeable to others.

Ratings 4-6 Immature behaviour and marked selfishness leading to social adjustment problems.

Ratings 7-8 Severe childishness, cannot live independently because of this. All relationships involve others supervising or caring for S.

## 18. RESOURCELESSNESS

Lack of inner resolution and resources to deal with adversity in any form

(18)

Comments relevant to resourcelessness in written material include 'inability to cope when under pressure', 'tendency to give up very easily', 'inability to maintain activity in any one task over a long period'. Note that some mental illness can lead to resourcelessness (eg chronic schizophrenia) so allowance may need to be made for this in assessment.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

Note

Ratings 1-3

Copes with problems with some difficulty but does not involve others to an unnecessary extent.

Ratings 4-6 Others involved in coping with S's problems, impairing social functioning. Frequent problems in work.

Ratings 7-8 Unable to cope with life's practical difficulties without continuous support. Not able to live independently because of this.

#### 19. DEPENDENCE

Excessive need to be supported by others with reluctance to take own decisions

Comments relevant to dependence in written material include 'reliance on one or more people to an excessive degree', 'lack of independence (taking account of any other mental disorder)', 'needing constant support' and 'insistence of transfer of responsibility for activities in life to others (or another)'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note



Ratings 1-3 Some dependence in excessive need for advice and reassurance from close relatives or friends but behaviour seldom abnormal

Ratings 4-6 Excessive reliance on others, leading to social adjustment problems.

Ratings 7-8 Completely dependent on individual group or institution. Unable to work or function independently at any level.

## 20. SUBMISSIVENESS

Excessive passivity and deference to the wishes of others

(20)

Comments relevant to submissiveness in written material include 'easily led and dominated', 'inability to make own wishes and needs felt', 'rarely expresses opinions' and 'always takes the passive role in relationships'.

Relevant extracts from written information

.....  
.....

.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild submissiveness and compliance, but stands firm on major issues.

Ratings 4-6 Very submissive, unwilling to express own views, is dominated in most relationships.

Ratings 7-8 Gives in to everybody, no independent function, exploited by others.  
Breakdown in social functioning.

## 21. CONSCIENTIOUSNESS

Excessive concern with planning and executing activities in a predetermined way, with great respect for order and organising everything in great detail.

(21)

Comments relevant to conscientiousness in written material include 'comments on obsessionality', 'love of order', 'need to plan in detail', 'inability to carry out task unless worked out in great detail first', 'concern with cleanliness and order' and 'excessive attention to small matters'.

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

*Subject/Informant*

Note

Ratings 1-3 Over-fussy and conscientious, preoccupied with routine and excessively meticulous, but no social adjustment problems.

Ratings 4-6 Conscientiousness abnormal, plans excessively far ahead, adjustment problems because of need for meticulous planning.

Ratings 7-8 Excessive conscientiousness accompanied by doubt. Unable to achieve anything as the smallest of tasks becomes a major enterprise. Unable to work or use

leisure, leads to interpersonal breakdown. In severe cases subject will usually have many obsessional symptoms.

In making a rating do not include obsessional symptoms (i.e. symptoms which the subject recognizes to be silly and consciously tries to overcome), unless these are part of the underlying personality of the subject. Also recognize that conscientiousness is thought to be a favourable personality trait and may be exaggerated by S or informant.

## 22. RIGIDITY

Excessive inflexibility and desire for ritualised solutions to everyday living

(22)

Comments relevant to rigidity in written material include 'inability to compromise and insistence that own views are paramount', 'difficulty in adapting to change', 'maintenance of standard ways of responding to problems long after they have ceased to be useful', and 'inability to alter arranged plans'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

\*Is he/she a person of fixed ideas?

\*Do other people get upset with S because he/she is inflexible?

(Give examples of problems caused by inflexibility)

*Subject/Informant*

Note

Ratings 1-3 Rigidity present but attempted compensation by subject leads to no social adjustment problems.

Ratings 4-6 Rigidity extreme, refuses to change, often dominating others. Marked problems in social adjustment because of rigidity, although if subject is driving and energetic he/she may appear successful initially.

Ratings 7-8 Inflexibility so severe that life is completely ritualistic and impairment of adjustment so marked that independent life is impossible.

### 23. ECCENTRICITY

Bizarre and odd behaviour and activities carried out with no conscious desire to shock or impress but because of indifference to the concerns and opinions of others

(45)

Comments relevant to eccentricity in written material include 'unusual habits or beliefs that affect behaviour', 'bizarre habits (eg walking naked in the rain), 'ignoring of social norms' and 'very peculiar clothing and accessories'.

Relevant extracts from written information

.....

.....

.....

.....

.....

.....

.....

*Subject/Informant*

Note

Ratings 1-3 Mild eccentricity, often deliberately stressed because it does not conform, but no social adjustment problems.

Ratings 4-6 Marked eccentricity. S unable or unwilling to conform, recognized as odd by others, marked social impairment. Has odd thinking, speech and beliefs that cause problems in adjustment.

Ratings 7-8 Behaviour and attitudes so bizarre that life in society impossible without supervision.

A low rating should be given if the subject acts in an eccentric way to attract attention. The true eccentric is oblivious to others' reactions. Any unusual beliefs or perceptions may only be rated if they are independent of mental illness such as schizophrenia.

24. HYPOCHONDRIASIS

Excessive preoccupation with the maintenance of health, avoidance of disease and investigation of alleged disease

Comments relevant to hypochondriasis in written material include 'preoccupation or anxiety over health', 'excessive concern over diet and diet supplements', 'frequent assessment of supposed physical illness', and 'great attention to sometimes rigid life style regimes'.

Relevant extracts from written information

.....  
.....  
.....  
.....  
.....  
.....

*Subject/Informant*

Note

Ratings 1-3 Mild hypochondriasis. Over-concerned about minor illness and health (e.g. takes vitamins or health foods regularly).

Ratings 4-6 Hypochondriasis marked. S frequently considered himself/herself to be ill even when physically healthy. Social adjustment problems; hypochondriasis affects behaviour and relationships.



Ratings 7-8 Hypochondriasis dominates S's life. Considers himself/herself to be ill despite contrary evidence. Unable to live independently because fears about health dominate behaviour.

Many people with a history of mental illness are naturally concerned about its likely recurrence and its effects on other people. Do not rate such concern as abnormal unless it is excessive.

**Personality Assessment schedule**

Name of interviewer .....

Name of subject .....

Age of subject .....

Nature of information .....

Reliability of source (see (R) box) .....

Current diagnostic formulation .....

.....

Current treatment (if any) .....

.....

Date .....

Place of interview .....

Previous acquaintance of subject and information source: YES/NO .....

Duration of acquaintance of subject and informant:.....

ICD-10 code (mental state diagnosis) .....

DSM code (Axis I diagnosis).....

Please check that you have rated all the items. Note here any additional personality characteristics that have not been rated elsewhere.

## **Appendix 2: PAS DOC Algorithm**

### **Revised classification of ICD-11 personality disorder using PAS-DOC (provisional assessment February 2012)**

#### Stage 1

Examine all 24 scores. If none is greater than 2 code as 0 (no personality disorder) and do not proceed further. If there is substantial omission of data allow for this in rating reliability.

#### Stage 2

Compute scores for individual personality domains as follows:

- (1) Externalising domain - add scores for variables 12, 13, 14, 15, 16 and 17, divide total by 6. If score for 3 is 4 or more add 0.2.
- (2) Internalising domain - add scores for variables 1, 2, 4, 11, 17, 18, and 19, divide total by 6. If score for 20 is 4 or more add 0.2.
- (3) Anankastic domain - add scores for variables 5, 10, 21, 22 and 24, divide total by 5.
- (4) Schizoid domain - add scores for variables 6, 7, 8, 9 and 23, divide total by 5.

If scores for only one of the variables is missing for any of the domains divide by one fewer number. If two are missing divide by two fewer and subtract 0.2 from the divided score. If three are missing divide by three fewer and subtract 0.3 from the divided score and regard subsequent diagnosis as 'possible' only.

### **Rating of severity of personality disturbance**

Five methods to indicate personality disorder present in some degree:

- (i) If mean score for any domain is 2.4 or more personality disorder is present and the relevant domains qualify the diagnosis. If substantial missing data present score as 'personality disorder – unspecified' unless other calculations supersede this.
- (ii) If the total PAS-DOC score is 25 or more personality disorder is probably present
- (iii) If scores for two of the three domains (internalising, anankastic and schizoid) score more than 2.3 then complex personality disorder is present (with domains specified as qualifiers)
- (iv) If externalising domain score is 3.3 or more and either another domain score is 2.3 or more or aggression or callousness score is 4 or more score as severe personality disorder
- (v) If three or more scores on PAS-DOC are 3 or more and the person does not satisfy conditions for personality disorder above, score as personality difficulty if missing data <12 and 'possible personality disorder' if missing data 12 or greater.

If scoring not clear from methods above send data set to Peter Tyrer for decision.

## **Appendix 3: Focus group prompts**

### **Introduction**

Thank you all for coming.

My name is Nicola Swinson and I am a SpR in Forensic Psychiatry and the Clinical Research Fellow at the National Confidential Inquiry. For my PhD I am looking at personality disorder in perpetrators of homicide.

In the seven year period from April 1997-2003 the Inquiry was notified of 3933 homicides in England and Wales. 11% of all homicides had been diagnosed as having a primary or secondary diagnosis of personality disorder. Of those with any previous contact with services (639; 16%), personality disorder was diagnosed in 34%. A diagnosis of personality disorder was made in just 13% of cases in psychiatric reports prepared for court.

Given other literature on the prevalence of personality disorder in offender populations it seems likely that this is an underestimation of the true prevalence of personality disorder in perpetrators of homicide. Additionally, on reading a number of such reports it would appear that clinically some of these people would fulfil the criteria for a diagnosis of PD yet this isn't diagnosed in the report.

I would like you all to have a discussion within this group to find out your views on why there appears to be such a discrepancy, between symptoms being reported and the diagnosis given. What do you think might be the reasons for this?

### **Prompts**

1. Is controversy over the treatability of PD a factor?

If not treatable is it ethical to give diagnosis? Are we just stigmatising patients unnecessarily?

Are clinicians reluctant to accept 'difficult' patients so not giving diagnosis?

Is it ethical to detain someone if feel no effective treatment?

How does availability of PD services and recent changes in policy & legislation impact on this?

Are there ethical issues if no services available?

Has practice changed after 'PD: not a diagnosis of exclusion'?

Do DSPD services have any impact? What determines referral to hospital/prison?

What effect might the new MHA have?

2. How do issues surrounding verdict and disposal affect this?

Should they get Diminished Responsibility?

Should they get a hospital order? Or be transferred after conviction on a sec 47?

3. How do other factors such as gender, type of PD and CM diagnoses influence this?

4. Given what we've discussed, what does everyone think should be done:

Should we be saying that people have a diagnosis of PD?

Should they get DR?

Should recommendations be made in court reports re diagnosis, treatment and appropriate treatment setting, or should it be dealt with post sentencing?

## **Appendix 4: Semi- structured interview schedule**

### **Introduction**

As part of the National Confidential Inquiry, court reports are collected on as many homicide cases as possible. In the 10 year sample from 1996-2006, 16% stated a diagnosis of PD in the report conclusions which, looking at the literature, would seem to be an underestimation of the true prevalence in this population. Also, looking through the reports, symptoms of PD are outlined in the body of the report in a substantial number, yet it isn't mentioned in the conclusions. I am looking to explore reasons behind this apparent discrepancy.

### **Open questions**

1. What influences whether or not you make a diagnosis of PD in court reports?
2. Is this how you have always practised?

### **Diagnosis**

3. Do you think there are any issues regarding the validity and reliability of PD as a diagnosis?

Are there certain types of PD that you would be more comfortable making a diagnosis of?

Does gender/ethnicity/age influence the likelihood of diagnosing PD?

4. Would you feel differently regarding making a diagnosis of PD compared with mental illness?

Why?

### **Recommendations and Disposal**

5. Have you ever /would you recommend(ed) diminished responsibility in someone with a primary diagnosis of PD?

-In what circumstances?

-Would gender/ethnicity/age have an impact? What other factors would influence your decision to do this?

6. In such cases, did you, or would you, recommend a hospital disposal?

-can you tell me why this was/is?

-does gender/ethnicity/age have any impact on your practice

#### **Ethical issues**

7. Do you think there are any ethical or moral issues in diagnosing PD in the absence of recommendations for treatment?

- What do you think these are?

- In your view, should psychiatrists be providing information about PD to the court if not making a recommendation for disposal or treatment in relation to it?

#### **Recent changes in legislation and service provision**

8. Do you think changes in the Mental Health Act have had an impact on whether you are likely to give someone a diagnosis of PD?

- Have the broadened definition of mental disorder and removal of the treatability clause changed your practice in this?

- Why do you think that?

9. Do you think closure of DSPD services and proposals to treat PD within the prison system will influence the diagnosis of PD in reports?

#### **Training and Education**

10. What are your views on training and education in PD for psychiatrists?

11. How typical of forensic psychiatrists do you think you are?

12. Are there any issues that we haven't covered that you think are important



## Appendix 5: Focus Group Participant Information Sheet

The University  
of Manchester

MANCHESTER  
1824



the national confidential inquiry into suicide and homicide by people with mental illness

PO Box 86, Manchester M20 2EF

Tel: 0161 275 0700/1 Fax: 0161 275 0712  
www.manchester.ac.uk/nci

### PARTICIPANT INFORMATION SHEET

#### 1. Study title

Personality Disorder in Perpetrators of Homicide

#### 2. Invitation paragraph

You are being invited to take part in a research study. Before you decide if you want to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

#### 3. What is the purpose of the study?

The National Confidential Inquiry collects information on all homicides by those in contact with mental health services. Additionally, it collects court reports on as many homicides as possible. It seems likely that the proportion of homicide perpetrators currently given a diagnosis

of personality disorder is an underestimation of the true prevalence of personality disorder in this population. As part of my PhD, I am looking to explore possible reasons for this discrepancy (see Protocol version 5 for further details).

4. Why have I been chosen?

I would like to conduct focus groups with clinicians and academics who prepare court reports in homicide cases to explore their views on diagnosing personality disorder and subsequently making recommendations in such reports.

5. Do I have to take part?

No. Participation is entirely voluntary. If you do decide to take part you will be given a copy of this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. I will seek permission from you to use any data that have been gathered up to that point.

6. What will happen to me if I take part?

If you decide to take part, I will arrange to conduct a focus group involving you at a time and place convenient to all participants. This will cover issues surrounding your views on the diagnosis of personality disorder in court reports and the subsequent making of recommendations. I will need to record the focus group but will erase the recording at the end of the study.

7. What are the possible disadvantages of taking part?

The possible disadvantage of taking part is that, given the subject matter, the focus group needs to be of sufficient length to address relevant issues adequately. However, I will try to keep the duration to around 45 minutes.

8. What are the possible benefits of taking part?

Views of clinicians and academics are critical in trying to understand challenges to diagnosis of personality disorder in the court process. Issues underlying this can then hopefully be addressed through recommendations at a service and policy level.

9. Will my taking part in this study be kept confidential?

The focus group will be taped. It will then be typed up and all references to names removed. The recording will be erased at the end of the study. All transcripts will be kept in a locked filing cabinet in a locked office. Only those people directly involved in analysing the data will have access to it. Any published paper or report using this information will be completely anonymous. Under no circumstances will any identifying information be released to anyone.

10. What will happen to the results of the research study?

The results of the study will be published in my PhD thesis, and in papers to be submitted to journals. They may also be presented at conferences.

11. Who is organising and funding the research?

The research is part of a PhD which has been funded by, and conducted at, the School of Community Based Medicine, the University of Manchester.

12. Who has reviewed the study?

Ethical approval granted by University of Manchester Research Ethics Committee 4. Study data and material may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS trust, for monitoring and auditing purposes, and this may well include access to personal information

13. Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-ordinator on 0161 2757583 or 0161 2758093 or by email to [research-governance@manchester.ac.uk](mailto:research-governance@manchester.ac.uk)

13. Contact for Further Information

Thank you for considering taking part in this study. For further information please contact Dr Nicola Swinson.

## **Appendix 6: Semi-structured Interview Participant Information Sheet**

The University  
of Manchester

MANCHESTER  
1824



the national confidential inquiry into suicide and homicide by people with mental illness

PO Box 86, Manchester M20 2EF

Tel: 0161 275 0700/1 Fax: 0161 275 0712  
[www.manchester.ac.uk/nci](http://www.manchester.ac.uk/nci)

### **PARTICIPANT INFORMATION SHEET**

1. Study title

Personality Disorder in Perpetrators of Homicide

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide if you want to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

3. What is the purpose of the study?

The National Confidential Inquiry collects information on all homicides by those in contact with mental health services. Additionally, it collects court reports on as many homicides as possible. It seems likely that the proportion of homicide perpetrators currently given a diagnosis of

personality disorder is an underestimation of the true prevalence of personality disorder in this population. As part of my PhD, I am looking to explore possible reasons for this discrepancy (see Protocol version 5 for further details).

4. Why have I been chosen?

I would like to conduct semi-structured interviews with clinicians who prepare court reports in homicide cases to explore their views on diagnosing personality disorder and subsequently making recommendations in such reports.

5. Do I have to take part?

No. Participation is entirely voluntary. If you do decide to take part you will be given a copy of this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. I will seek permission to use any data that have been gathered up to that point.

6. What will happen to me if I take part?

If you decide to take part, I will arrange to interview you at a time and place convenient to you. This can be done either in person or over the telephone. The interview will cover issues surrounding your views on the diagnosis of personality disorder in court reports and the subsequent making of recommendations. The interview can be stopped at any time you wish. I will need to record the interview but will erase the recording at the end of the study.

7. What are the possible disadvantages of taking part?

The possible disadvantage of taking part is that, given the subject matter, the interview needs to be of sufficient length to address relevant issues adequately. However, I will try to keep the interview to around 30 minutes.

8. What are the possible benefits of taking part?

Views of clinicians are critical in trying to understand challenges to diagnosis of personality disorder in the court process. Issues underlying this can then hopefully be addressed through recommendations at a service and policy level.

9. Will my taking part in this study be kept confidential?

The interview will be taped. It will then be typed up and all references to names removed. The recording will be erased at the end of the study. All transcripts will be kept in a locked filing cabinet in a locked office. Only those people directly involved in analysing the data will have access to it. Any published paper or report using this information will be completely anonymous. Under no circumstances will any identifying information be released to anyone.

10. What will happen to the results of the research study?

The results of the study will be published in my PhD thesis, and in papers to be submitted to journals. They may also be presented at conferences.

11. Who is organising and funding the research?

The research is part of a PhD which has been funded by, and conducted at, the School of Community Based Medicine, the University of Manchester.

12. Who has reviewed the study?

Ethical approval granted by University of Manchester Research Ethics Committee 4. Study data and material may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS trust, for monitoring and auditing purposes, and this may well include access to personal information

13. Complaints

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. If they are unable to resolve your concern or you wish to make a complaint regarding the study, please contact a University Research Practice and Governance Co-coordinator on 0161 2757583 or 0161 2758093 or by email to [research-governance@manchester.ac.uk](mailto:research-governance@manchester.ac.uk)

14. Contact for Further Information

Thank you for considering taking part in this study. For further information please contact Dr Nicola Swinson.

## Appendix 7: Consent form



the national confidential inquiry into suicide and homicide by people with mental illness

PO Box 86, Manchester M20 2EF

Tel: 0161 275 0700/1 Fax: 0161 275 0712  
[www.manchester.ac.uk/nci](http://www.manchester.ac.uk/nci)

Participant Identification Number for this Study:

# CONSENT FORM

**Title of Project: Personality Disorder in Perpetrators of Homicide.**

**Please initial box**

1. I confirm that I have read and understand the participant information form for the above study and have had the opportunity to ask questions of the researcher.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.
3. I understand that the interview or focus group will be recorded.
4. I understand that relevant sections of data collected during the study may be looked at by responsible individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in the research. I give my permission for these individuals to have access to this data.

5. I agree that I may be quoted anonymously.

6. I agree to take part in the above study

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature