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Trauma, Personality Disorder, and Offending

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When working with adults who have offended and been given a diagnosis of personality disorder (PD), it quickly becomes apparent that the majority have experienced multiple traumas. First experiences of traumas are frequently perpetrated by their primary attachment figures, often in the context of significant adversity e.g., domestic violence, substance misuse, poverty, social and economic inequality, discrimination, homelessness, criminality, and the care system. What these words do not describe is the overwhelming experience of terror, rejection, betrayal, loss, helplessness, shame, rage, and insecurity of what is home. Across the reported histories of many individuals is the frequent reporting of general behavioural difficulties in childhood, including difficult temperament, “temper tantrums”, running away, aggression, violence, stealing, and substance misuse. Frequently they are labelled as “difficult to manage” children and given diagnoses of oppositional disorder, conduct disorder, Attention Deficit Hyperactivity Disorder (ADHD), and emerging personality disorder that are apparently independent of what has happened to them.

Many individuals were placed in the care of the local authority, increasing the insecurity in their lives, and their “difficult behaviours” often resulted in frequent changes of children’s homes and foster family placements. One of the many tragic descriptions I read was of a patient who after six weeks with a foster family was removed because his behaviour had not changed quickly enough; he was eight years old and had already suffered multiple adverse attachments and abuses. Patients have talked about being taken into care and their behaviour “returning to normal” because they were safe, and then being placed back with the family member who had abused them. Most frequently, patients have spoken about how they were not asked “what happened to you?”

This chapter first explores the relationships between childhood trauma, the diagnosis of personality disorder (PD), and offending. Next, a service user’s narrative understanding of his pathways from childhood traumas to offending is presented.
Finally, psychological approaches to treatment and requirements of services are discussed. First a note on the diagnosis of PD. UK forensic mental health services are structured around psychiatric diagnoses and a diagnosis or significant traits of PD is frequently the only way individuals gain access to services. The diagnosis of PD has been criticised in terms of its validity and reliability (Livesley, 1998; Ramon, Castillo, & Morant, 2001) and the negative judgements that are frequently held about individuals who are given this diagnosis (Lam, Poplavskaya, Salkovskis, Hogg, & Panting, 2016).

A consensus statement for people with complex mental health problems stated that:

If used wholly appropriately, the term personality disorder has some merit in providing a shorthand expression for people who suffer a long-standing pattern of emotional and cognitive difficulties, which interferes with many parts of their everyday life including their relationships, work and social functioning

*Lamb, Sibbald, & Stirzaker, 2018, p.2*

In this chapter I will use the term “given a diagnosis of personality disorder” as it is neutral as to the value or legitimacy of the label and reflects the fact that a psychiatric diagnosis was given by others, but not necessarily accepted by the person. I take a position of understanding personality and PD as including neurobiological, somatic, emotional, attentional, cognitive, and behavioural patterns and impacting on sense of self and others and patterns of relating that have varying degrees of fluidity and adaptability, depending on what happened to individuals, their families, and communities.

Studies have reported that individuals given a diagnosis of PD typically report significantly higher rates of childhood traumas compared to community populations and individuals diagnosed with other psychiatric conditions (Battle et al., 2004). The majority of studies have focused on individuals given a diagnosis of borderline PD (BPD: Afifi et al., 2011), reporting rates of childhood trauma as high as 90%, and antisocial PD (ASPD: DeLisi, Drury, & Elbert, 2019). There have been a few studies of other PD diagnoses, including paranoid, avoidant, dependent, and obsessive-compulsive, that have reported higher rates of childhood traumas than that general population (e.g., Tyrka, Wyche, Kelly, Price, & Carpenter, 2009). These studies are limited by the problems with the diagnosis of PD and the overlap of symptom criteria across the subtypes of PD (Tyrer, 2005).

Childhood traumas, adverse attachments, and adversity have been shown to affect the development of all systems that come under the rubric of personality (Briere, Hodges, & Godbout, 2010), so it is unsurprising that high rates of trauma are reported by individuals who have been given a diagnosis of PD (Battle et al., 2004). Conversely, having one trusted adult always available has been found to be significant feature of resilience in the face of increasing adversity, particularly for emotional well-being (Bellis et al., 2017).

Whilst high rates of childhood traumas and adversities have been consistently found, a proportion of individuals who had been given a diagnosis of PD did not...
report childhood traumas. Studies have examined the role of genetics to the aetiology of PD diagnoses, predominantly BPD and to a lesser extent ASPD, with heritability estimates ranging between 40% and 50% for BPD (Luyten, Campbell, & Fonagy, 2020). Much of this research has been carried out using self- or third-party report questionnaires to assess PD traits and temperament, which limits the capacity to disentangle what is temperament and what is the impact of trauma. Later studies have reported that genetics accounts for a declining amount of the variance with increased exposure to traumatic life events (Luyten et al., 2020). Reviews have noted limitations in this area including categorical assessment of PDs and limited reference to problems with PD diagnoses. Boyle and Johnstone (2020) have detailed other forms of adversity, e.g., negative forms of power including gender, race, economic, and ideological, which they argue can provide part of the reason why people who have not suffered obvious trauma experience significant emotional distress. There is evidence that repeated “small T” experiences – being in the out-group, micro aggressions that communicate negative messages, e.g., you are stupid, unwanted, bad – lead to the same physical, emotional, and social consequences as “big T” trauma (Perry, podcast communication in Brown, 2021).

**Childhood Traumas and Offending**

Individuals who have offended have been found to have far higher rates of childhood traumas, adverse attachments, and adversity than the general population. Studies have consistently found rates of between 50–70% for diagnoses of PD in forensic populations (Fazel & Danesh, 2002). Studies have found that accumulating traumas and adverse childhood experiences contribute to the most serious, violent, and chronic offending (Craig, Piquero, Farrington, & Ttofi, 2017). As noted in Chapter 1, there has been increasing focus on the multiple ways in which childhood traumas can be causal factors for offending. Howard and McMurran (2012) have argued that examining PD traits has greater potential for conceptualising the relationships between PD and offending, including impulsiveness, dysregulation of emotions, attitudes to violence, and problem-solving abilities. There is significant consistency across (1) areas of functioning that are affected by childhood trauma and adversity, (2) PD diagnostic traits, and (3) dynamic risk factors (DRFs), e.g., impulsivity, cognitive and emotional regulation, difficulties relating to self and others, and with stress and coping. This is consistent with recent critique of DRFs that these factors are broad concepts that represent a multitude of inter- and intra-personal systems (Ward, 2016).

No specific associations between types of childhood trauma, diagnoses of PD, and types of offending have been found (Altintas & Bilici, 2018). It appears that other factors (e.g., age of victim, chronicity, relationship to perpetrator, available support, protective factors) and the meaning of childhood traumas and adversities specific to the individual are more significant in understanding the pathways to offending behaviours. As summarised in Chapter 1, there are numerous potential relationships between childhood trauma and DRFs, and the identification of specific pathways
Trauma, Personality Disorder, and Offending

At an individual level is required to understand the relationships between childhood traumas and adverse attachments, the resulting survival strategies that are subsequently given a diagnosis of PD, and offending.

There are obvious links between the impact of childhood trauma and adversity on the development of self and PD diagnostic traits such as beliefs that others will harm, not protect or nurture, and of themselves as bad, weak, unlovable, and the patterns of coping, that can be formulated as contributing to an individual attempting to gain primary good/basic needs through offending. For example, the experience that the majority of people during childhood harmed you and the feelings of being weak and helpless, can result in learning to gain safety and feelings of strength and powerfullness through violence to fend off would be attackers and avoid feeling or showing vulnerability. This may represent changes in the initial survival adaptations to childhood trauma, e.g., emotional numbing and dissociation may subsequently come to support the suppression of vulnerability and disconnection from emotions that is a factor in later offending. The unique and changing responses of the individual are recognised as arising from interactions between the nature and duration of adverse attachments, trauma, and adversity, the age ranges in which these were experienced, the meaning to the individual, and presence of exacerbating or attenuating factors and that neurobiological response patterns appear to change with age (Perry, Pollard, Blakley, Baker, & Vigilante, 1995).

There has been a focus on understanding the motivations for offending using theories of human motivation e.g., the Good Lives Model (GLM: Ward & Stewart, 2003). The GLM proposes that individuals seek to meet their needs for primary goods (safety, freedom from emotional distress, belonging, autonomy, competence, etc.) and formulates DRFs as aspects of persons and their environments which indicate a higher probability that these goal-directed actions will involve crime (Heffernan, Wegerhoff, & Ward, 2019). This highlights the need to use theories of personality development and functioning, including the impact of childhood trauma.

Impact of Childhood Traumas on Personality Development

Childhood traumas, adverse attachments, and adversity have been found to negatively impact on the development of individuals’ neurobiological, affect regulation, somatic, attentional, impulse control, cognitive, relational, self/identity, and behavioural systems (e.g., Anda et al., 2006; D’Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Streeck-Fischer & van der Kolk, 2000). These difficulties frequently result in attention deficits, hyperactivity, hypervigilance to threat, impaired mentalisation ability, somatisation, and aggression against self and others (e.g., Streeck-Fischer & van der Kolk, 2000; van der Kolk, 2014). There is a strong consistency between these areas and the diagnostic criteria for PDs, including difficulties with attention, impulse control, emotions, beliefs and thoughts, behaviours, sense of self and others, and patterns of relating to self and others. The symptoms of PD can be understood to have developed as survival mechanisms to minimise threat and regulate emotional distress. This is
consistent with the Power Threat Meaning Framework (Boyle & Johnstone, 2020) for understanding a diagnosis of PD as survival adaptations that have become unhelpful and damaging.

**Threat, Safety, and Attachment Theory**

Attachment theory is an empirically based theory of how normal emotional, psychological, and behavioural development occurs through interactions with the infant’s attachment figures (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982). Attachment theory has evidenced that children, beginning in infancy, attempt to survive adverse attachments though adapting to their attachment figures to meet their basic needs (primary goods), primarily safety and emotional regulation. In childhood, these resilient survival strategies are internalised as stable representations of self and others that drive patterns of reacting and relating. The nature of childhood traumas and adversity means that there is a lack of emotional and psychological understanding (attunement) that is the necessary relational means by which children internalise secure (healthy) emotional and cognitive understanding (mentaliisation) that are central to healthy development.

Attachment theory proposes that through the repeated experiences of attunement and repair of misattunements from (secure) attachment figures, infants’ experience being accepted, understood and their basic needs met, and people as safe and predictable. This forms the basis of emotional regulation, in which all emotions are acceptable and tolerable (Bowlby, 1988). These repeated experiences are initially encoded in procedural memory as felt experience. As language develops a parallel system of verbal understanding of self and others develops (Lyons-Ruth, 1999). Insecure, frightening, abusive, and neglecting attachment figures do not provide the safety necessary for healthy development, and infants adapt to maintain proximity to the attachment figure to gain some degree of safety by excluding aspects of themselves which are not acceptable. Three insecure attachment styles have been identified: *avoidant/dismissive* in which emotions and need for others are excluded and independence valued; *ambivalent/preoccupied* in which independence and exploration is excluded and emotions and needs are expressed to maintain the attachment relationship; and *disorganised* characterised by a seemingly chaotic mix of approach and avoidance behaviours, such as walking towards the attachment figure whilst looking away (Hesse & Main, 2000) and high levels of dissociation that represents the unsolvable dilemma of seeking safety from the source of anxiety. Insecure attachment styles are associated with adverse parenting and the disorganised attachment style is more strongly associated with childhood trauma and neglect by attachment figures. High rates of insecure attachment style have been reported for individuals who report a trauma history, those who have offended or been given a diagnosis of PD (Bakermans-Kranenburg & van IJzendoorn, 2009; Hudson & Ward, 1997). In adolescence and adulthood these same strategies often result in being given a PD diagnosis and offending (Fonagy, 2003). For example, aggression and violence as a defended means of relating to others, expression of unprocessed emotion, and re-enactment of trauma.
The Body’s Defence System: Fight, Flight, Freeze, and Collapse

The stress response system is in the lower parts of the brain and when its survival strategies of flight, fight, freeze, and collapse are triggered, the higher-level functions including impulse control, reflection, and problem solving are effectively taken “off line” and behaviour is driven autonomically. Studies have shown that childhood trauma and adversity hypersensitises the stress response system to perceiving threat, which affects multiple areas of functioning, including attention, impulsivity, and aggressive and avoidant behaviours (Perry, 2008). PD traits and offending can be formulated as driven by a hypersensitised stress response system. For example, substance misuse can be seen as a flight response to numb emotional pain that disinhibits a hypersensitised attention for threat and increases the likelihood of a fight response of violence. Perry et al. (1995) have described how, as the lower parts of the brain do not hold a concept of time, the stress response system reacts as if the past traumas are occurring now. This can explain why individuals’ reactions can appear either out of proportion or “come out of nowhere”, and why some individuals who have good insight and knowledge of skills continue to offend.

A consistent narrative from individuals who have offended has been to perceive threat, from either their victim or others and displaced on to their victim. Thus, some offending is a fight response to eliminate perceived or actual threat, often reinforced by beliefs that others will harm and that to feel weak is intolerable. Schore (2003) argued that violence can be understood as the fight response dysregulated by childhood trauma.

Flight responses of suppression of emotion, not seeking support from others, numbing through substances, and avoidance of expected conflict through compliance can lead to increasing emotions and a violent fight response to the next stress or. In some sexual offences, compulsive sexual behaviours are flight responses to numb feelings of inadequacy and gain feelings of acceptance that can contribute directly to offending, for example, through sex with children who are seen as less likely to be rejecting.

The collapse response, in particular dissociation, which functions to protect the individual from unescapable fear or pain, can become highly sensitised responses at times of extreme emotion or a chronic pattern of depersonalisation that can drive violence (Moskowitz, 2004). As Streeck-Fischer & van der Kolk (2000) described, “under stress they pass the dehumanisation that they themselves have experienced onto others” (p.911).

These stress responses are frequently seen across forensic services. Individuals’ rejection of services and denial of offending can be understood as flight responses to expected harm and rejection from services. Individuals’ complaining about staff and services, often classed as having narcissistic and antisocial PD traits, can be considered fight responses. Both of these can represent distorted means of meeting primary needs, e.g., safety, autonomy. For an individual with a trauma history, people are the threat, and the threat increases with increased proximity. Programmes and therapy can be highly threatening because of the expectations to disclose aspects of themselves. Flight responses of refusing to attend, deflecting or saying very little, fight responses such as dismissing the value of the service or making unrealistic demands,
freeze responses of disconnection, and collapse e.g., silent, dissociated, confused, are common in treatment. These reactions are frequently misunderstood as superficially engaging, lack of motivation, or not ready for treatment. Furthermore, as beliefs and values are stored in the higher parts of the brain and implicit biases are stored in the lower parts of the brain, this can explain how someone holds for example anti-violence beliefs and values and still having implicit biases that result in violent behaviour (Perry, 2006). This can guide formulation and intervention with individuals, who emphasise that they do not have pro-offending beliefs and yet continue to react with violence.

Individuals’ stress responses patterns can change through repeated predictable experiences of moderate stress and co-regulation with another (Perry, 2006). This requires staff to have the capacity to provide effective containment of the individual through physiological and psychological calmness, attuning to the behaviours as survival strategies and focusing on developing a sense of safety in the moment, thus beginning to relearn the autonomic threat system (Perry, 2008). Focusing on increasing understanding of flight and fight reactions and how to sooth the stress response system before responding can increase resilience (e.g., Dana, 2018). To quote a patient, “breathing, rather than reacting, gives me that five second gap to then be able to think about what I am doing and remember that my aggressive urges are going to make things worse”.

Emotional Regulation

Difficulties with emotional regulation, including seeking support from others, is a consistent impact of childhood traumas and is reflected in PD symptoms and DRFs. For example, emotional numbing has been found to be associated with youth aggression, and a mediator between trauma and callous–unemotional traits (Allwood, Bell, & Horan, 2011; Kerig, Bennett, Thompson, & Becker, 2012). Attachment theory suggests that if our emotions are responded to with neglect or punishment, we feel the unacceptability and badness of our emotions and suppress our emotional experience and expression to survive. Inconsistent and unpredictable care in response to our expression of emotions is internalised, as only heightened expressions of emotions are responded to (Fonagy, Steele, Steele, Moran, & Higgitt, 1991). When abuse is by an attachment figure, emotions have to be excluded so as to maintain sufficient proximity to the abusive attachment figure to survive, hence the high rates of dissociation and apparently “odd” behaviours that function to exclude anxiety. These resilient adaptations are internalised and form stable patterns of emotional regulation, underpinned by negative beliefs about others that in adulthood perpetuate emotional difficulties in part by excluding corrective emotional experiences with others.

Capacity to Play

Related to safety and emotional regulation, the capacity to play in childhood is necessary for development. It is through play that a range of responses can be tried and
competence developed, including creativity, problem solving, coping, and emotional expression. Streeck-Fischer and van der Kolk (2000) described how during chronic trauma, children are preoccupied with survival, which prevents the capacity to playfully and curiously try out a variety of ways to engage with the world and exploring self and others is threatening. Play in children who have experienced trauma has been found to be rigid and constricted, with no modification over time (Terr, 1981). There is similar restrictiveness in adults given a diagnosis of PD, and in some DRFs, that perpetuates survival strategies, in which neglect, rejection, violence, and the belief that nothing can change are dominant, and offending is seen as the only option. Lack of self-exploration is often seen in individuals within forensic services, who are too anxious, hopeless, or mistrustful to explore themselves and others or “play” with new ways of being. Role play and experiential techniques have a similar quality to play and can be experienced as threatening or something they have to “get right” to avoid punishment. For some individuals, the spontaneity and fun of play is a reminder of ridicule and punishment, which they respond to with survival strategies, re-enacting abusive or humiliating responses, perpetuating aggression or detachment as responses to change techniques.

Re-enactments

Ardino (2012) reported that a characteristic of trauma is the compulsion to re-enact the trauma and considered that antisocial acting out of unresolved childhood trauma may be a consistent feature in the behaviour of those who offend. Some of the symptoms for BPD (e.g., intense and unstable relationships) and other PDs (e.g., callous unconcern for the feelings of others in antisocial PD; the tendency to misconstrue the actions of others as hostile in paranoid PD; excessive preoccupation with being criticised or rejected in social situations in avoidant PD) may represent manifestations of re-enactments of previous traumas. Part of the compulsion to re-enact is considered to be the need for consistency and predictability with primary experiences, even when these are traumatic, as unpredictability is threatening (Perry, 2008). Ardino (2012) considered that re-enactments may be crucial in understanding how past trauma may be involved in maintaining risk of reoffending. Streeck-Fischer & van der Kolk (2000) highlight that unless caregivers understand re-enactments, they are liable to label the child as oppositional, rebellious, unmotivated, and antisocial. Within adult forensic services re-enactments are often labelled as “manipulative”, “antisocial”, “therapy-interfering”, and “narcissistic” or “settled”, “quiet”, “loner”, “odd”, rather than as state-dependent response patterns.

Service User Narrative

The impact of adverse attachments and trauma on development of an individual and pathways to offending are described below by Tom. Tom has been in prison and forensic mental health services, and given several psychiatric diagnoses including PD and paranoid schizophrenia. Tom described his pathway from childhood traumas to
Because of my dissociation that developed in response to my mum and mainly my dad’s difficulties and the bullying I suffered at school, I was not able to learn life’s lessons, as you have to be able to remember things; and because of the dissociation, it totally blanked out things that I needed to know and learn to be able to look after and take care of myself. This contributed to my trying to kill myself when I was a teenager. All of life’s lessons I’ve have been taught have been harsh ones, the sexual abuse I’ve been through, the bullying by the kids on the estate and dad’s bullying of mum. These lead to the schemas I developed, it’s like the schemas came about through mum and dad. I sometimes couldn’t trust the people who were supposed to take care of me because of their problems, Dad’s problems. I learnt that people were not safe, my mistrust schema. It’s like the people who love me put mistrust in me and all the schemas that came with that. The bullying at school compounded my mistrust, and the sexual abuse compounded it further. I couldn’t compute, I couldn’t do anything with it, I couldn’t understand it, I was like a ‘rabbit in head lights’ all my life my mind was switched off with overwhelming anxiety. Due to the dissociation, I couldn’t work it out. It came out in my relationships and in the pub when I was drunk. I was angry and confused all the time and I was not able to sort it out. I drank until I blacked out to keep the shutters down. When I was stoned, I now know, that this was similar to how I felt when I was zoned out as a kid; the dissociation was a way of keeping the shutters down. Drinking didn’t actually keep the shutters down; I was reacting with violence.

After my index offence I went to prison for the first time, which is a frightening, fear provoking, stressful and paranoid place, and I was coming off drugs. This was when I first started hearing voices and seeing things. My mistrust and paranoia increased. I started to believe that my soul had been taken. Through the work I have done I realised that this is dissociation.

Tom described changes he has made and what contributed to him making these. “Being locked up and getting the proper help I needed. I can now think before I act and I know that drugs and alcohol are not the solution”. When asked what had contributed to his dissociation and mistrust having reduced, he said his therapist who had worked with him for many years, “Pushing my boundaries but not too quickly”. He recalled several years ago that he had been strongly encouraged by a member of his clinical team to attend an occupational therapy group session and his verbally angry refusal, as he felt pushed, albeit positively, too far for where he was at that time. He described that back then that he would not talk to anyone and that his therapist had had to get him talking. He described, “I had become too inward on myself (shrunken boundaries), I was keeping everything inside and I was keeping the shutters down”. He described his therapist’s persistent and paced pushing and encouragement as central to him being able to change. He described
I only ever experienced coldness during my childhood and this had contributed significantly to my disconnection from myself and my feelings and it feels good to be able to now feel emotions of love and warmth towards myself for achieving something.

Psychological Approaches to a Diagnosis of Personality Disorder and Offending

Psychological therapies have proposed relationships between aspects of personality and violence, e.g., CBT (Beck & Deffenbacher, 2000), attachment theory (Fonagy, 2003), GLM (Ward & Stewart, 2003), and schema therapy (Bernstein, Arntz, & Vos, 2007). CBT is the predominant approach in UK prison and forensic mental health services. The focus on the attitudes, thoughts, emotions, motivations, and behaviours that contributed to offences presupposes that individuals can identify and describe these. Individuals who experienced childhood traumas and adverse attachments and who are given a diagnosis of PD are highly likely to have difficulties in identifying and disclosing their thoughts, emotions, and beliefs about themselves and their offending, and to find this triggering their stress response system, shutting down their cognitive abilities. Childhood traumas impact most at a physiological and emotional level and this is increasingly being recognised across therapies that are incorporating a focus on emotions, the stress-response system, and body focused work (van der Kolk, 2014). Schema therapy is based on and incorporates much of the aspects identified above, and has been extended for use in forensic services; thus, this model is explored in further detail.

Schema Therapy

Schema therapy (ST: Young, Klosko, & Weishaar, 2003) was developed in response to the ineffectiveness of standard CBT with patients given a diagnosis of PD. ST is based on attachment theory, specifically that when basic human needs that are not met in childhood, due to adverse attachments and trauma, children adapt to their attachment figures and traumas, in combination with temperament, in order to survive. Through the internalisation of these experiences, schemas about self, others, and the world develop and the then adaptive survival responses are primarily emotionally encoded. These adaptive survival strategies subsequently become maladaptive coping modes or self-states in non-adverse environments.

The maladaptive modes are loosely linked to the fight, flight, fawn, and collapse/comply stress-response system, e.g., detached avoidant protector mode as flight, bully attack mode as fight and fawn, and compliant surrenderer mode as the fawn response. The pain, fear, loss, and anger of childhood trauma and adversity and resultant schemas are conceptualised as held in the child modes (vulnerable, impulsive, and angry child modes). Critic modes (punitive, demanding) are conceptualised as either the internalisation of the adverse attachment figure or abuser, or a coping mode in which the critic is attempting to meet childhood needs through criticising/punishing their behaviour. Healthy adult mode represents the capacity to reflect, manage responses – including
impulses, expressions of need, vulnerability, and anger – effectively and engage effectively in relationships. Schemas and modes are considered to provide an explanatory model for the development and functioning of clusters of traits that are given a diagnoses of personality disorder. The therapeutic relationship is considered central in providing corrective emotional experiences and there is an emphasis on emotion-focused experiential techniques and sensory experiences, to heal and develop resilience (Briedis & Startup, 2020).

Bernstein et al. (2007) proposed that offending often represents maladaptive attempts to meet basic needs. Theorised offending modes include predator, conning manipulator, paranoid over-controller, and self-aggrandiser. These are theorised to be active at the time of an offence and function to stop the individual from feeling “weaker” modes, e.g., vulnerable child mode. Keulen-de Vos et al. (2016) examined the offending of patients given cluster B PD diagnoses and reported more child, paranoid ovecontroller, and detached self-soother modes leading up to, and more, over-compensatory (bully attack and predator) modes during their crimes. They concluded that it appeared that vulnerable feelings, such as shame and abandonment, often played a role in crimes, consistent with studies on reactive aggression. Similar patterns have been consistently seen across patients in forensic settings.

A recent RCT with patients in high security forensic hospitals in the Netherlands and given a diagnosis of predominantly antisocial, other cluster B and paranoid PDs, found that both treatment with individual schema therapy and treatment with other individual therapies (CBT, integrative/eclectic, systemic) showed moderate to large improvements on outcomes of rehabilitation (gaining leave) and PD symptoms after three years, and that ST had superior outcomes (Bernstein et al., 2021). Bernstein et al. found that the ST condition was quicker to lower vulnerabilities and promote strengths and had modest advantages over other treatments in improving traits such as self-control and self-regulation. Further, the ST condition showed rapid improvements in the first two years, which was considered in part due to ST’s focus on creating the therapeutic bond. ST does not require individuals to be motivated or “ready for treatment” (Bernstein et al., 2012). Lack of motivation and difficulties in engaging in treatment are considered coping mode responses to schemas, typically mistrust, defectiveness, abandonment, and emotional deprivation triggered by the treatment process (re-enactments).

Schema therapy’s focus on conceptualising individuals’ maladaptive modes as arising from childhood traumas and adverse attachment and working on these as these occur in response to therapy and services, is central to providing forensic services with a useable and effective model to work with individuals whose survival strategies are often seen as “not treatment ready”, “unmotivated”, or “just wanting to cause trouble”. ST (and similar models) provides a means of developing an integrated understanding of individuals’ lives, rather than excluding offending or being only seen as offenders. Service users have reported the helpfulness of ST in understanding themselves and their offending, the emotion focused techniques, and the importance of the safety of the therapeutic relationship (Tan, 2015; Walji, 2015).

ST’s developmental frame provides a means of working with individuals’ offences that holds these in the context of what has happened to them, formulates their
cognitive defences, such as minimising or blaming others, as coping strategies and focuses on meeting underlying needs for safety that enables individuals to explore themselves, their development, and their offending, as demonstrated in Tom’s narrative. Developing safety in the therapeutic relationship involves working in vivo with maladaptive coping modes including detached protector, paranoid overcontroller, and bully attack mode reactions within sessions. Focusing on containing and co-regulating their avoidant (flight) and overcompensation (fight) responses through body-focused work and naming the likely underlying needs and related fears provides emotional experiences of another attempting to understand, contain and support them. This can initially trigger further maladaptive mode responses arising from mistrust and uncertainty of a different response from another to their implicit map of self, others, and world. However, at the same time this experience is still being felt. Alongside this, there is the focus on the emotional links between present triggers for maladaptive mode coping and past attachment adversity and trauma. Working on these links is thus working on reducing survival strategies that are represented in DRFs e.g., offending beliefs and urges, interpersonal aggression, emotional control, difficulties with supervision. For example, using imagery rescripting to reduce bully attack mode to a staff member, whose specific behaviour was a reminder of an adult male perpetrator of childhood physical abuse and humiliation, using present day safe relationships to create safety in the past image, and then using this safety to strengthen healthy adult mode in imagery rescripting of his present-day interactions with the member of staff.

Strengthening healthy adult mode functioning and reducing use of offending modes increases experience of personal strengths and support from others and reduces the strength of mistrust abuse and other schemas. This provides the basis for working on offending using a combination of maladaptive mode mapping of the offence cycle and experiential techniques (e.g., imagery rescripting and gestalt chair work) to strengthen individuals’ health adult capacity to contain maladaptive modes and change offending patterns. Applying this to a generalised case example, John had undertaken thinking skills programmes in which DRFs of sexual preoccupation, poor relationships, and poor problem solving (sex with sex workers or one-night stands etc.) were identified driving his sexual violence and outstanding treatment targets. John was described as presenting with a superficial understanding of these DRFs and how to manage these in the future. ST formulated that his experience of avoidant attachment figures resulted in defectiveness and emotional deprivation schemas that contributed to his seeking acceptance and intimacy through detached avoidant protector mode, including sex with sex workers or one night stands as this reduced the risk of rejection. However, this reminded him of his defectiveness and increased his shame and perpetuated his cycle. The build-up of shame, combined with rejection when attempting to develop a meaningful relationship, was formulated to escalate his hypersensitivity to rejection, and when perceiving humiliation from a sex worker or one-night stand, he shifted into bully attack mode, discharging unprocessed emotions through violence against his victims.

In ST the focus was on developing safe emotional connection with his therapist and keyworkers, providing repeated experiences of being understood, accepted, and
encouraged to develop. Chair work with his child and maladaptive modes focused on giving voice to these parts of himself and their functions, and strengthening his healthy adult mode to be able to effectively meet his primary needs for acceptance and belonging. Imagery rescripting was used to work with his pain and loss of the emotionally depriving relationship with his parents and subsequent abuses, and the development of his preoccupation with sex. The last part was imagery rescripting on his mode shifts in his offending cycle and developing the basis for his relapse prevention plan including effective means of meeting his basic needs. Outcome goals/measures, in addition to reassessment of DRFs, were directly related to the schema and mode formulation, e.g., increased emotional connection across a range of relationships including with staff, supervisors, and other pro-social peers that provided feelings of acceptance and belonging, as well as increased feelings of competence in relationships and in occupation.

Whether the approach is ST or another trauma-focused model, forensic services would benefit from a model that formulates the impact of adverse attachments and childhood traumas on an individuals’ personality and related DRFs, to be able to effectively respond to offending behaviours. The challenge arising from this understanding is the need for services in the face of financial and political demand for “high volume, low touch” therapies (Perry, podcast communication, in Brown, 2021), to deliver intensive long-term treatments by highly trained and experienced staff that provides consistent and predictable relational safety and moderate and predictable stress that builds resilience, which in the longer term can be more cost-effective (Bamelis, Arntz, Wetzel, Van Der Kolk, & Evers, 2015; Ward, 2016).

Further Reading


References


