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# Psychological assessment and treatment of adolescent offenders with psychopathic personality traits

Susan Cooper & Paul Tiffin

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## Abstract

*Young people with psychopathic traits are encountered relatively frequently in custodial and other forensic settings. For a number of reasons such individuals pose a challenge to those professionals working with them. This paper aims to summarise the current literature regarding possibilities for assessing and treating adolescents with offending behaviours affected by psychopathic personality traits. The literature strongly indicates that offenders with psychopathic personality traits engage in various types of offending behaviour at a much higher rate than offenders without psychopathic traits, both inside and outside institutional settings. A number of therapeutic approaches have been attempted and these are outlined. Research findings to date indicate that such young people may be more difficult to engage and less amenable to intervention than other individuals with offending behaviours. In the face of such practical challenges professionals working with these individuals are likely to require considerable support and training. Because this group can generate negative reactions in staff working with them, consideration must be given to how staff can be best prepared for and supported in this work. The importance of multi-disciplinary working during assessment and treatment is highlighted.*

## Historical background

IT WAS IN 1923 that the German psychiatrist, Kurt Schneider (better known for inventing the term 'schizophrenia'), first used the term 'psychopath' to describe individuals with a pathologically disturbed or distorted personality although it was almost 30 years later when his original paper was published in English (Schneider, 1950). Moreover, it was not until two decades later that the term gained its more specific application to individuals with marked antisocial patterns of behaviour following the publication of Cleckley's *Mask of Sanity*. In this book, Cleckley suggested that psychopaths represented a distinct group of individuals demonstrating a marked lack of empathy with others, callousness, cruelty and a marked propensity to manipulate others. Furthermore, Cleckley asserted, whilst often appearing sane and rational, these people were so disturbed as to warrant a label of mental illness (Cleckley, 1988; Cleckley, 1941). There was a resurgence in interest in the concept of psychopathy in the 1980s with the publication of Hare's Psychopathy Checklist (Hare, 1980).

This tool was constructed mainly in relation to Cleckley's concept of psychopathy and has since become the defining measure by which the personality syndrome is diagnosed in adults (see later). Whether or not the clustering of psychopathic traits represent a discrete disorder or are distributed in the general population in a continuous way can be debated. What is clear is that individuals who reach the current criteria for the diagnosis are responsible for a disproportionate number of serious criminal offences (Gretton, Hare & Catchpole, 2004). Psychopathic traits are associated with increased rates of both violent and non-violent crime, more serious and sadistic offences, materially motivated offences, weapon use, and a criminal career that starts early, is longer and more diverse (Edens *et al.*, 2001; Forth, 1995; Forth, Hart & Hare, 1990; Frick, O'Brien *et al.*, 1997; Gretton *et al.*, 2004; Hare, 1991; Hare, Clark, Grann & Thornton, 2000; Hare & McPherson, 1984; Williamson, Hare & Wong, 1987).

Numerous studies with adult and adolescent offenders have found that psychopathy

is related to serious misconduct, in both criminal justice and hospital settings (Frick, Kimonis, Dandreaux & Farell, 2003; Hare & McPherson, 1984; Hill, Rogers & Bickford, 1996; Myers, Burket & Harris, 1995; Serin, 1991; Skeem & Cauffman, 2003; Wong, 1984). This includes verbal and physical aggression (Edens, Poythress & Lilenfield, 1999; Forth *et al.*, 1990; Hill *et al.*, 1996), and instrumental aggression (aggression used to achieve a goal) (Cornell *et al.*, 1996; Murdock-Hicks, Rogers & Cashel, 2000; Murrie, 2002; Stafford & Cornell, 2003). In relation to institutional behaviour in particular, it has been suggested that psychopaths may employ manipulation and violence in order to 'liven up' their environment and stimulate themselves. This is presumably related to their 'need for stimulation and proneness to boredom' (Hare, 1970). The high rates of aggression are also not surprising given their poor empathic abilities and paucity of guilty and remorseful feelings (Hare & McPherson, 1984). This has been put succinctly as follows:

*'Psychopathy's defining characteristics, such as impulsivity, criminal versatility, callousness, and lack of empathy or remorse would make the conceptual link between violence and psychopathy straightforward.'* (Silver, Mulvey & Monahan, 1999).

For this reason the United Kingdom Government has given much consideration to the management and treatment of adults with 'dangerous and severe personality disorders' (DSPD) (Home Office & Department of Health, 1999) and specialist units have been developed within criminal justice and health settings.

#### *Psychopathy in young people*

The concept of psychopathy in children and adolescents (sometimes referred to as 'nascent psychopathy') is also understandably controversial. Researchers have demonstrated, however, that psychopathic personality structure is evident at early age (Christian, Frick, Hill Tyler & Frazer, 1997; Frick, O'Brien *et al.*, 1997). Some authors stress the developmental nature of psychopathy. As Vincent and Hart (2002) point

out, 'presumably, the traits of a personality disorder do not have a sudden onset at the moment an individual turns 18 years of age' (p.153). In keeping with this, some stress the potential importance of early detection and possible intervention in young people with marked antisocial behaviour and attitudes (Lynam, 2002).

However, the validity of applying a 'static' personality disorder label to a developing character in a young person has been called into question (Vincent & Hart, 2002). Steinberg (2002) suggests that manifestations of psychopathy in youth may be transitory. As adolescents develop with age and experience, psychopathic personality traits may change, reflecting psychosocial maturity.

Currently there are two main schools of thought regarding nascent psychopathy. One group of researchers propose that those children who concurrently fulfil the criteria for both a hyperkinetic disorder, for example Attention Deficit Hyperactivity Disorder (ADHD) and Conduct Disorder (CD) (i.e. demonstrate marked antisocial and aggressive behaviour), are at high risk of developing into adult psychopaths (Lynam, 1996). In support of this theory various similarities in psychological and neurophysiological measures between children with comorbid ADHD/CD and adults diagnosed with psychopathy are cited (Lynam, 1997, 1998). Another, not mutually excluded, group of authors emphasise Cleckley's (and more latterly, Hare's) concept of psychopathy, with the characteristics of lack of empathy, callousness, superficial charm and manipulativeness applied to those under 18 years of age (Frick, 2002; Frick, Bodin & Barry, 2000). These emerging traits are then interpreted in the context of the developmental stage of the individual, with proponents of such a model urging caution in interpreting any findings given the implications of a diagnosis of psychopathy in a young person and the uncertainty relating to the background of developmental change (Frick, 2002).

Recent Governmental strategies relating to DSPD (see above) currently exclude adolescents and no such services exist for those under 18 years of age. Instead, services work-

ing with adolescent offenders are required to deliver effective assessment and treatment without this structure. Using current research, however, it is possible to outline suggestions for assessing and treating high risk adolescents with psychopathic personality traits.

## Assessment

### *The principles of assessment*

Given that a core feature of psychopathy is 'image management' and a tendency to manipulative others, it is essential that clinical evaluation utilises both direct assessment and the collection of information from as wide a range of collateral sources as possible. The clinical interview should be used to gather a developmental history, evaluate personality traits and interpersonal functioning, cognitive functioning, the presenting problem, the young person's goals, attitudes and other factors underlying offending behaviour and motivation to change. Meeting with parents/carers is also important, not only because they can assist with this process but this aids a collaborative working relationship with the adolescent's family.

Whilst the usual guidelines regarding confidentiality, consent and access must be observed, information obtained from criminal records (including warnings, cautions and reprimands), social and health services (both National Health Service and, where available, prison healthcare) can prove invaluable in building up a picture of an individual's pattern of behaviour and attitudes.

In addition, psychometric tests provide a standardised approach to assessment. The tests selected will depend on the young person, but tests of personality, clinical symptoms, experience and expression of anger, motivation to change and attitudes are usually useful. A comparison of test scores before and after treatment may be used to monitor change. In addition, observation of the adolescent in a range of settings (ward, education, visits, etc.) is essential as it can complete the picture of the young person.

The issue of co-morbidity needs to be considered. In adults, there is co-morbidity between psychopathy and other mental dis-

orders (Blackburn, 2000; Hart & Hare, 1997) and other personality disorders, such as borderline personality disorder (Coid, 1992; Stuart *et al.*, 1998). It should also be remembered that those adolescents considered to have psychopathic traits are a heterogeneous group and efforts should be made to understand the range of difficulties being presented (Gendreau *et al.*, 2002).

Assessment should lead to a formulation, which outlines the adolescent's temperament, early life experiences, and offending/problematic behaviours. From this formulation, treatment targets and a management plan emerge. These should be agreed with the adolescent and the multidisciplinary staff team. Attempts to commence offence-focused treatment in the absence of a more thorough assessment and formulation may prove ineffective, particularly if the young person is not motivated to change.

### *Assessment instruments*

Whilst it is possible to come to a diagnostic formulation using clinical judgement alone, increasingly a diagnosis of psychopathy will be supported by the findings from a more structured assessment. The most favoured tool for assessing psychopathic personality traits in adults is with the Psychopathy-Checklist-Revised (Hare, 1991; Hare, 2003). This is based on a structured interview, usually taking two to three hours to administer in addition to time spent gaining information from collateral sources. Based on the information gained, scores are allocated to the different items, according to the manual provided. In the case of adults, a cut-off score is provided, above which a diagnosis of psychopathy is made. There is also a Screening Version of the PCL (Hart, Cox, Hare & Systems., 1995) and a Youth Version for use in young people aged 12–18 (Forth, Kossen & Hare, 2003). The PCL-YV consists of the following 20 items (see Table 1 alongside).

The PCL-YV measures the same personality traits as the PCL-R, although it has modifications to certain, developmentally sensitive, items to reflect the limited life span and experiences of adolescents and the greater influence of family, peers and school

on their lives as opposed to intimate partners and work experience. For example, the item 'many short-term marital relationships' on the PCL-R was changed to 'unstable interpersonal relationships'. Even so, psychopathy can be difficult to assess in childhood and adolescence because it is often not until late adolescence or early adulthood that people live more independently and traits such as impression management, irresponsibility and sexual promiscuity manifest (Vincent & Hart, 2002).

Unlike the PCL-R for adults, there is no recommended cut off point with the PCL-YV because it is unclear whether psychopathy in young people is best constructed as a continuum or categorical diagnostic entity (Forth *et al.*, 2003). Thus, it is inappropriate to diagnose psychopathy in adolescents using the PCL-YV alone.

For boys under the age of 12 years the Antisocial Process Screening Device (APSD) has been developed (Frick & Hare, 2001). This is an observer-rated checklist with similar categories to the PCL-YV. Data on the reliability and validity of this instrument are not yet widely available, and, like the PCL-YV, no cut-off score has been suggested by the authors.

It is necessary to think about how the findings of the PCL-YV and related instruments are conveyed to the young person and other professionals. Forth *et al.* (2003) note that the term psychopath has many negative connotations, both with professionals and lay people and argue that clinicians should not label children and adolescents as psychopathic. Once individual cases are labelled as such, it may be difficult to eliminate labels such as manipulative or deceitful. In addition, people scoring high on the PCL are often thought of as a high risk to others and untreatable leading to an emphasis on containment rather than treatment (Anderson & Spanier, 1980; Gendreau *et al.*, 2002).

Alternatively, Hemphill and Hart (2002) point out that with adults many diagnostic terms have negative connotations but are still used because they convey important information and that psychopathy should be no different. However, clinicians may prefer

to discuss issues in terms of individual traits in relation to norms rather than use the term 'psychopathy' itself (Hemphill & Hart, 2002). It has also been pointed out that referring to personality traits rather than 'diagnosis' allows more space for the possibility for developmental change (Stafford & Cornell, 2003).

#### *Risk assessment*

Perceived risk may be the main reason for referral to services and assessments are used to make important decisions about the adolescent, such as their suitability for open conditions or release. It is important to note that at this time there are no tools for accurately predicting whether an adolescent will re-offend. However, following the development of structured clinical risk assessments with adult offenders, risk assessment tools with adolescents are starting to emerge. The Structured Assessment of Violence in Youth (SAVRY) (Borum, Bartel & Forth, 2003) was developed to provide a structured professional assessment of the risk of violence posed by young people (including sexual violence) and is appropriate for use with young people aged 12–18. It is composed of 24 risk items (historical, social/contextual and individual factors) drawn from existing research and professional literature on adolescent development and aggression and violence in youth. The Youth Level of Service Case Management Inventory (Hoge & Andrews, 2002) is a similar guide to assess risk of general re-offending. It is important to remember that more formal risk assessment tools complement rather than replace clinical judgement and there are important limitations to their use. For a more comprehensive review of this area see Tiffin and Richardson (2005).

### **Interventions and management**

#### *General principles*

A management plan, included targeted interventions, should arise from the assessment and formulation process. Professionals should be able to decide what needs the individual presents with and if, and how, these can be met using the resources available.

No.	Item Label	Description
1	Impression management	Appears insincere and charming, particular where secondary gain is likely. May be described as having the 'gift of the gab'.
2	Grandiose sense of self-worth	Has a grossly inflated view of own abilities and self-worth.
3	Need for stimulation/ proneness to boredom	Has a chronic and excessive need for excitement and may do things that are exciting or challenging. May complain that work, school and relationships are boring.
4	Pathological lying	Lying and deceitfulness part of the individual's personality. Their readiness to lie can be quite remarkable.
5	Conning/ manipulative	Cheats, exploits and manipulates others, with no regard for the victims.
6	Lack of remorse or guilt	Shows a lack of remorse for the negative consequences of his/her actions. May fail to recognise the seriousness of their actions or repeatedly engage in harmful activities.
7	Shallow affect	Appears unable to experience a normal range and depth of emotion. As a result, they have superficial bonds with others. May appear cold and unemotional.
8	Callous/lack of empathy	Shows a callous disregard for the feelings, right and welfare of others. Only concerned with themselves.
9	Parasitic lifestyle	Exploiting others part of lifestyle. They rely on others for financial support.
10	Poor anger control	Easy angered or frustrated. May be described as short-tempered or hot headed and tend to respond to frustration, failure, discipline with violent behaviour or verbal abuse.
11	Promiscuous sexual behaviour	Sexual relationships are impersonal, trivial or casual. This may be reflected in frequent 'one night stands', infidelities, prostitution and a willingness to engage in a variety of sexual activities.
12	Early behavioural problems	Serious behaviour problems at age 10 or below. These problems include persistent lying, cheating, theft, robbery, fire-setting, violence and bullying.
13	Lack of realistic, long-term goals	Lives day by day and lack plans, with little thought about the future. May set unrealistic goals with no plans on how to achieve these goals.
14	Impulsivity	Behaviour is generally impulsive, unpremeditated and lacking in reflection.
15	Irresponsibility	Fails to honour commitments to others and has little or no sense of duty or loyalty to family, friends, employers, society or causes. Behaviour may put others at risk of harm.
16	Failure to accept responsibility for own actions	Unwilling to accept responsibility for their own actions. May use excuses, blame others or deny their actions.
17	Unstable interpersonal relationships	Unstable, superficial and turbulent extra-familial relationships. Friendships may fail because of lack of interest, effort or commitment.
18	Serious criminal behaviour	Has engaged in serious criminal behaviour. This is based both on convictions and self-report.
19	Serious violations of conditional release	Includes escape and attempted escape from an institution and breach of parole. May engage in criminal activities while on conditional release.
20	Criminal versatility	Has engaged in many types of criminal behaviours (for example, drug, property, violent and sexual offences).

**Table 1.** List of the items contained within the Psychopathy Checklist – Youth Version (PCL-YV) (Forth *et al.*, 2003) with a brief description of the theme of each item.

These needs are sometimes divided into criminogenic and non-criminogenic. Criminogenic needs are factors directly related to criminal behaviour, such as antisocial attitudes. They are important to address in treatment because the evidence indicates that programmes which target criminogenic needs are more likely to be effective (McGuire & Priestly, 1995). Particular attention should be paid to the risk management plan, including the setting where any intervention will occur (community, custodial, secure, etc.). This includes the safety of any professionals, family members or other young people in contact with the young person. Identified risks should be appropriately communicated to other individuals/agencies so that decisions regarding management can be made by other affected parties. In some high-risk cases a Multiagency Public Protection Arrangement (MAPPA) meeting may be needed, serving as a forum for communication between involved agencies.

When interventions are being considered there is often a question of whether therapy should target problematic behaviours or underlying personality. Blackburn (2000) points out that, 'the targets of "offence focused" interventions are frequently cognitive, affective and behavioural dispositions which merge into, and are often indistinguishable from, the dysfunctional traits defining personality disorders'. Indeed, Douglas *et al.* (1999) propose that dynamic risk factors to be targeted in treatment include impulsivity antisocial attitudes and beliefs, anger and hostility and these factors are associated with psychopathic traits.

Treatment targets will obviously vary between individuals but might include coping with trauma symptoms (many of these young people have been emotionally, physically and/or sexually abused), developing pro-social problem solving strategies, substance misuse, and offence-focused intervention (insight into offending behaviour and relapse prevention). Some flexibility should be maintained and treatment targets and priorities may change as management progresses. Frequent feedback to the young person is also an important component,

regardless of the approach used. Other common targets for intervention include the reduction of impulsivity (for example, using cognitive strategies) and consequential thinking. Self-harming behaviours are often found in adolescent offenders with psychopathic traits, particularly when there is comorbidity with borderline personality disorder. Self-harm can often be conceptualised as a maladaptive coping strategy and becomes a treatment target in itself. It is then addressed by helping the individual to understand and evaluate self-harm and develop more functional problem solving strategies (Schmidt & Davidson, 2004).

Once targeted needs and proposed interventions have been identified, consideration needs to be given to the modality of treatment delivery. This is to ensure treatment providers take into account the patient's personality, functioning and treatment non-compliance (Serin, 1995). This is known in the 'what works' literature as the responsivity principle (McGuire & Priestly, 1995).

A good starting point for developing a suitable treatment programme for offenders with psychopathic traits is to ask offenders about that factors that will keep them engaged. Ryan *et al.* (2002) noted that at that time there was no reported consultation with service users about the development of services for people with dangerous and severe personality disorder. They reported that participants most valued caring, understanding and experience among staff. An ideal service was identified as one with small, domestic living units, and providing group and individual therapies.

Attrill and Mann (2003) reported that imprisoned psychopathic offenders highlighted the following factors as motivating: status orientation (wanting to work with high status professionals); being given personal choice and feeling in control; the opportunity for game playing; the need for stimulation, having specialised treatment that meets their needs; and being future focused. In relation to regimes, this group of offenders report that they are motivated to engage if the regime has clear rules and the staff have chosen to work on the unit. They become dis-

interested in treatment if they feel bored and frustrated, if there is repetition, if treatment or treatment providers are associated with low status, if there is no choice, if there are no clear and transparent rationale for their engagement and if there is ambiguity in rules and consequences. This research helped to inform a motivational approach to working with psychopathic offenders. Similarly, Cooper and Hopper (2004) found that offenders are motivated to engage in treatment if it is personally meaningful, they receive honest feedback and staff are motivated to deliver the treatment. Of course, these findings relate to the adult population and do not tell us about the views of adolescents. The author has started to conduct such a study with adolescent offenders with prominent psychopathic traits in a secure setting.

#### *Pharmacological interventions*

Whilst no large scale scientific trials of medication specifically for use in young, offending populations with marked psychopathic traits have been published, such individuals are often considered for pharmacotherapy. Medication may be prescribed in an attempt to target a number of problems in this population. If mental illness is present alongside developing personality disturbance then the usual treatments are indicated (e.g. antipsychotic medication in early-onset schizophrenia).

In the past, virtually every class of psychotropic medication has been used in an attempt to reduce aggression, both in community and institutional settings. For a review of pharmacological strategies for reducing aggression in young people see Steiner *et al.* (2003). Early studies of mood-stabilisers, such as Lithium, in adult prison populations reported promising findings in relation to reducing institutional violence (Sheard *et al.*, 1976). No such trials in juvenile offender populations have been conducted, although the anti-convulsants/mood stabilisers, such as sodium valproate, may be still be prescribed to reduce disinhibition and aggression, particularly where organic problems exist (e.g. epilepsy, learning disability, head injury). In young people with conduct disorder

and ADHD (see earlier) stimulant medication (e.g. methyl-phenidate, the generic name for Ritalin) may be effective in reducing levels of aggression. However, this strategy is unlikely to be helpful where conduct disordered juveniles fail to meet the criteria for a coexisting hyperkinetic disorder such as ADHD (Connor *et al.*, 2000). There is some evidence to support the effectiveness of the antipsychotic drug risperidone in reducing the levels of aggressive behaviour, at least in the short term, in conduct disorder, whether accompanied or not by a diagnosis of ADHD (Findling *et al.*, 2000; Snyder *et al.*, 2002). However, at present larger scale trials of longer duration (i.e. exceeding 12 weeks) have yet to be published and the list of potentially serious side-effects with this medication is considerable. It is probable (though not proven) that youths with prominent psychopathic traits may respond less dramatically to such pharmacological strategies.

#### *Psychological treatment*

The difficulty treating adult psychopaths has been widely accepted among some researchers and clinicians for many years. Often they are seen as more suitable for environments where their behaviour can be monitored and controlled rather than addressed therapeutically (Skeem, Monahan & Mulvey, 2002).

Research to date appears to go some way to support this. It indicates that adolescent and adult offenders with psychopathic traits are less likely to attend and comply with treatment, more likely to engage in institutional misconduct during treatment, and perform poorly in treatment (Alterman, Rutherford, Cacciola, McKay & Boardman, 1998; Ogloff, Wong & Greenwood, 1990). Adult psychopaths have even shown an *increase* in recidivism following treatment (Rice, Harris & Cormier, 1992; Seto & Barbaree, 1999). The affective traits, for example, callousness and shallow affect, in particular are associated with recidivism in treated psychopaths (Hare *et al.*, 2000). Perhaps this is because the affective traits of psychopathy are less amenable to change than the behavioural traits.



Such findings have led some to conclude that conventional psychological treatments may not be suitable for this population (Rice *et al.*, 1992) and this led to the exclusion of adult psychopathic offenders from psychological treatments. This presents an interesting position given that psychopathic offenders present a high risk of criminal behaviour and harm to others, both inside and outside of institutions. With adolescents, however, there seems to be less therapeutic nihilism regarding the reduction of psychopathic traits and associated offending behaviour (Frick, 2002; Lynam, 2002). Forth *et al.* (2003) stipulate that the PCL-YV should not be used to exclude young people from treatment, as has happened with the PCL-R. They argue that a primary goal of identifying youth with psychopathic traits should be to target them for early intervention. In addition, more positive findings in relation to treating this group of offenders are emerging (see below).

Clinical experience suggests that highly psychopathic young people can be difficult to focus, overbearing and controlling in treatment. In order to meet the responsivity needs of psychopaths, Hemphill and Hart (2002) suggest several strategies, including formally assessing motivation to participate in treatment, highlighting criminal lifestyle as low status, helping psychopathic offenders understand the rationale behind psychological interventions, and exploring the offender's personal contributions to problems. In addition, because psychopathic offenders strive towards control and dominance, therapists should be honest, upfront and spend time getting to know the offender.

#### *Behaviour management*

Behaviour management programmes can be useful in shaping young people's behaviour when they first arrive in an institution. These involve reward systems, whereby the young person can earn points which are exchanged for agreed privileges. It is recognised that these are extrinsic motivators and as a result the positive behaviour tends to be short lived; usually once the extrinsic motivator is gone, so is the change. It is useful if motivational interviewing techniques are also

adopted by staff to help enhance intrinsic motivation to change using both a therapeutic style and adopting specific strategies such as evaluating reasons for and against behaviour change (Prochaska & DiClemente, 1982). More general strategies for managing aggressive behaviour in adolescents are outlined in dosReis, Barnett, Love, Pharm & Riddle (2003), and include creating a non-aggressive milieu and a sense of choice and personal control for patients.

#### *Cognitive-behavioural treatments*

Cognitive-behavioural treatments are designed to address and change thoughts, feelings and behaviours. There have been reports of success using this approach with psychopathic adult offenders (Hughes *et al.*, 1997; McMurrin *et al.*, 2001) with some suggestion of better outcomes with longer, more intensive courses of treatment (Lösel, 1988). The authors are not aware of similar work with adolescent offenders with psychopathic traits.

Schema-focused cognitive therapy aims to modify and weaken maladaptive schema (enduring and relatively inflexible attitudes and beliefs) and construct ones that are more adaptive (Young, 1990; Young, Klosko & Weishaar, 2003). This is achieved by reviewing evidence in support of the schemas, critically examining the supporting evidence, reviewing evidence contradicting the schema, developing flashcards that contradict the schema, and challenging the schema whenever activated outside the session (Young, Wattenmaker & Wattenmaker, 1995). Common maladaptive schemas in young people with psychopathic traits commonly relate to themes of entitlement (believing they can take what they want, regardless of others) and mistrust.

Adolescents may also lack self-reflection skills and externalise their difficulties by acting out or abusing substances (Eliahy, 1992), can be suspicious and distrustful of those in authority and therefore resist the help of other, particularly when treatment is mandatory (Farabee *et al.*, 1993). As a result of the characteristics they may require more additional pre-motivational work prior to treatment than adults.

### *Family work*

It may be useful to include family work in the treatment of these young people, particularly if offending, personality difficulties or motivation to change are related to family dynamics. For example, families of sex offenders often support offenders in their denial in order to protect them from confrontation and conflict (Sebfarbi, 1990; Stevenson, Castillo & Sefarbi, 1989). Family work to undermine denial can be extremely valuable; when the family are more willing to accept the young person's behaviour, they are more likely to encourage honesty and treatment compliance in the adolescent.

### *Therapy outcomes*

Skeem *et al.* (2002) point out that in some of the published studies into treatment, psychopaths were treated for substantially shorter periods than non-psychopaths and these possibly insufficient treatment dosages may partly explain their poor performance in treatment (Alterman *et al.*, 1998; Seto & Barbaree, 1999). Some of the evidence suggests longer term treatment may be more effective in psychopaths. For example, Gretton *et al.* (2000) followed up a sample of adolescent sex offenders for 10 years. Of those rated high on the PCL-YV, they found only 30 per cent who completed the treatment programme re-offended violently, compared to 80 per cent who did not complete the programme. It seems that as treatment duration increases, so does treatment effect. Reich and Vasile, however, consider that there is not yet enough evidence that psychopaths are noncompliant (Reich & Vasile, 1993).

Skeem *et al.* (2002) propose that psychopaths may be more prone to premature self- or staff-induced termination of treatment because of poor motivation. Hemphill and Hart have gone further and explained how psychopathic characteristics are inconsistent with the characteristics considered necessary for engagement with, and motivation for change in treatment programmes (Hemphill & Hart, 2002). For example, affective deficits may make it difficult for psychopaths to explore themselves or their

behaviour emotionally, psychopaths may not be interested in changing exciting behaviours, and psychopathic offenders frequently find little wrong with themselves or their behaviours and often have ulterior motives for engaging in treatment, such as parole.

Rather than suggest these deficits are insurmountable, these authors suggest that psychopaths have motivational strengths that can be used to engage them in treatment, such as appealing to their status orientation (a need to feel superior to others), tolerance of novelty and desire to be in control.

This literature has implications for the way in which we work with adult and adolescent offenders with psychopathic traits. It suggests we should emphasise providing longer-term, structured treatment and make every effort to ensure the offender completes the prescribed treatment. Staff working with adolescents will also need to relate to this group and have an understanding of the process of adolescence.

### *The impact on professionals*

An important aspect of overall management of psychopathic individuals is supporting the professionals who are working with such clients. There has been some research into the impact of working with offenders with psychopathic and other personality disorder traits. The general consensus appears to be that this can provoke a range of reactions in staff, some positive but many negative. Bowers reports that being manipulated arouses strong negative emotions towards the manipulator and can affect the ability to care for and treat for that person (Bowers, 2003). This population have other characteristics that can be difficult to cope with including self-harm, violence, complaints, childhood sexual abuse, and a lack of remorse for actions.

Staff respond to these difficulties, at both a cognitive and emotional level. Jones outlined potential responses to working with personality disordered patients, namely anger, involving discharge from treatment, seclusion and restraint and therapeutic nihilism, and submission, involving emotional withdrawal, denying dangerousness

and calling in sick (Jones, 1997). Freeman and Jackson (1998) suggested there are core staff skills required for working with personality disordered patients; staff must be able to gain a working alliance, set and agree realistic goals, and avoid collusion with patients' distortions (such as the pointlessness of therapy and victim stance). Professionals should have a problem-solving coping strategy and the ability to detach from emotional consequences of work, using strategies such as humour (Roger, Jarvis & Najaran, 1993). For these reasons, staff should be carefully selected, trained and supervised (Lösel, 1988). The present (first) author has compiled a training package for institutional staff working with this population. This comprises: identifying and dealing with the difficulties presented by this client group, formulation, and recognising stress. Regular supervision is particularly important in ensuring staff interact in a productive and therapeutic way.

There is an ever-present risk of conflict and 'splits' within professional systems working with young people with prominent psychopathic traits due to the intense feelings that such individuals can generate in others, in addition to the proneness to manipulation they exhibit. Splits also occur as some members of the team view the adolescent as victim and in need of rescuing whilst others view him/her as a perpetrator and treat him/her with control and hostility. Regular, clear and direct communication between team members and other professionals should minimise these risks, in addition to the measures outlined above.

## **Conclusions**

It is important that professionals identify and target adolescent offenders with psychopathic personality traits for treatment when they are young as this is when they are likely to be most receptive to treatment, when traits and behaviours may be more malleable and when attempts to contain risk are most likely to be successful (Vincent *et al.*, 2003).

The nature of their personality traits may make them difficult to engage in psychological treatment, so this should be addressed. Special issues with this client group also need to be considered, including impulsivity, aggression and the tendency to manipulate their social environment. Whilst there is some limited evidence for the effectiveness of some treatment approaches in reducing aggression and offending behaviours in this group it is highly likely that effect-sizes are less than those that would be observed in non-psychopathic offenders. Overall management should focus on the monitoring and communication of risk and addressing coexisting difficulties. In addition, staff should be carefully selected, trained and supported in order to work effectively with this particularly challenging group of young people.

There is an important role for teachers and educators in working with this group. In completing assessment, school records are imperative in assessing personality as they provide information about peer relations and emotional functioning. Teachers can also provide important information to Multi-Agency Public Protection Meetings, where risk management plans are put into place. Teachers working in secure settings can also work as part of a multi-disciplinary team to help this group overcome difficulties and live a pro-social life. Every attempt should be made to keep this group in education, particularly because of the link between poor schooling and future offending (e.g. Borum *et al.*, 2003), but at the same time there is a need to protect teachers and other pupils.

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