
7. PERSONALITY DISORDERS WITH SERIOUS IMPLICATIONS IN PRISONS

Are people who commit crimes different from those who do not? How are they deviant? What are the social and economic factors that influence these behaviours? Are the stressful situations they face very unlike what others face? These are the common questions which come up. Answers to these questions can be provided from various perspectives. A sociological perspective might look at factors like discrimination; role of media; illiteracy; law and order in the society etc., An economic perspective would focus more on aspects like poverty, scarcity of resources; rise in prices etc., A psychological perspective would be from internal factors such as personality, temperament, emotions, greed, jealousy and impulsivity of a person. While sociological and economic factors have been studied in depth, factors such as personality and temperament have not got much attention. This chapter looks at criminal and deviant behaviour as a product of dysfunctional personality and focuses more on problematic personality disorders in prisons and how they can be managed.

Personality

Everyone in this world has their distinctive personality that makes them unique. There are many definitions of personality. In simple words, personality consists of ingrained, pervasive, enduring and habitual ways of psychological functioning that characterise one's style. It is a tightly interrelated organisation of attitudes, perceptions, habits, emotions and behaviours that characterise a person's distinctive way of relating to others and to self (Millon T, 1981; Millon T, 1987). Each person has a unique personality moulded by his/her past experiences, attitude, culture, religion, lifestyle, mood, relationships, energy levels and hobbies. Normal personalities are productive at work, well-adjusted socially, cope well with stressful situations and operate well within the social and cultural norms. Similar to personality, 'temperament' does not have a consensual definition. A temperament refers to a distinctive profile of feelings and behaviours, rooted in biological systems and emotion is basic to temperament (Rothbart MK, 1989; Goldsmith HH et al., 1987). Personality is made up of a combination of distinguishing qualities and characteristics called traits. Traits refer to a distinctive set of attributes such as thinking, feeling, attitude and behaviour.

Personality Disorders

The combined and consistent patterns of emotion, thought and behaviour that make an individual unique comprise personality. However, when this pattern interferes and impairs the day to day functioning of the individual, it is referred to as “personality disorder” (Hales et al., 2008). In other words, they are patterns of inflexible and maladaptive personality traits and enduring behaviours that cause subjective distress, significant impairment in social or occupational functioning, or both (American Psychiatric Association, 2000). These patterns deviate markedly from the culturally expected and accepted range and are manifest in two or more of the following areas: cognition, affectivity, control over impulses and need for gratification, and ways of relating to others (American Psychiatric Association, 2000; Hales et al., 2008). The symptoms are pervasive and they are exhibited across a broad range of contexts and situations rather than in only one specific triggering situation or in response to a particular stimulus or person. Finally, the patterns must have been stably present and enduring, since adolescence or early adulthood (American Psychiatric Association, 2000).

According to the International Classification of Diseases -10 guidelines, “personality disorders are deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme of significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Such behaviour patterns tend to be stable and encompass multiple domains of behaviour and psychological functioning. They are frequently, but not always, associated with various degrees of subjective distress and problems in social functioning and performance (World Health Organization, 1992). People with personality disorders believe that the world should change to accommodate them and view their own features as being acceptable and not in need to change.

People with personality disorder constitute up to 10-15% of the general population (Torgersen et al., 2001; Reich et al., 1989). They are the frequent visitors to the emergency departments at hospitals , as a result of social crises, relationship breakup, violence, injuries, self-injurious behavior, suicide, over intake of drugs, impulsivity and sudden violent death (Warren et al., 2002; Verona et al., 2001; Watzke et al., 2006). They are also at a high risk of getting into conflict with the law because of self-injurious behavior, sexual offences, violence, substance use, murder and recidivism (Dunsieth et

al., 2004; Watzke et al., 2006; Black et al., 2007). As per the International Classification of Diseases, there are ten different types of personality disorders seen in the general population. However, there are many people with temperamental problems within the general population, which is also reflected in the prison population. In this chapter, we focus more on problematic personality disorders, which are commonly seen in prison population and are very difficult to manage.

Prison populations are known to house certain personality disorders

The common saying about prison is that it houses the ‘SAD, MAD and BAD’ of the society (Rotter et al., 2002). *Sad* indicates that at least 50-75% of the prison population suffer from depression, *Mad* depicts that at least 30-15% of them have mental illness and *Bad* suggests that 20-10% of them are psychopaths (Rotter et al., 2002). Persons suffering from personality disorders have their reasoning powers fully intact; hence none of the countries have granted insanity defence to those with personality disorders. However, they have been provided with an opportunity for treatment and rehabilitation.

Prevalence of personality disorders is high in prison population when compared to the general population (Brink, 2005; Andersen, 2004; Butler et al., 2006). In a systematic review of 62 surveys, it was reported that 65% of the men had personality disorders with 47% having anti-social personality disorder. 42% of the women had personality disorder and 21% had anti-social personality disorder (Fazel and Danesh, 2002). In another study, prevalence of alcohol and drug addiction was 90%, personality disorders were 80% and antisocial personality disorder was 60% (Langeveld and Melhus, 2004).

In a recent study, personality disorder was observed in 30% of the prison inmates. The distribution of personality disorders was as follows; 12% with Antisocial Disorder, 12% with Borderline Disorder, 3% with Paranoid Disorder, 2% with Narcissistic Disorder, and 2% and Schizoid disorder (Arroyo and Ortega, 2009). Presence of anti-social personality disorder is a high risk for developing mental illness (Andersen, 2004) and suicide (Verona et al., 2001). Studies have reported that 50% of the mentally ill patients also have personality disorder. Men had a higher prevalence of alcohol abuse and antisocial personality, while women more often showed depression, anxiety disorders and borderline personality disorders (Watzke et al., 2006).

Emotionally unstable personality disorder was present in 30% of the inmates. The percentage of women meeting criteria for borderline personality disorder was more than

twice that of men (Black et al., 2007). A more recent study reported that personality disorders, especially antisocial and unstable personality disorders are strongly related to the manifestation of violent acts (Fountoulakis et al., 2008). One of the possible reasons being that both disorders have a common base in impulsive personality traits, but the behavioural differences between them are shaped by gender (Paris, 1997). Prevalence of antisocial personality is more common in men and unstable personality is more common in women.

Anti-social personality disorder

Anti-social personality, usually comes to attention because of a gross disparity between the individual's behaviour and the prevailing social norms. Characteristics of Antisocial personality disorder are as follows:

Characteristics of Anti-Social Personality Disorder

- (a) Callous unconcern for the feelings of others;
- (b) Disregard for social norms, rules and obligations;
- (c) Gross and persistent attitude of irresponsibility;
- (d) Inability to maintain enduring relationships, though having no difficulty in establishing them;
- (e) Very low tolerance to frustration and a low threshold for discharge of aggression, including violence;
- (f) Inability to experience guilt or to profit from experience, particularly punishment;
- (g) Marked proneness to blame others, or to offer plausible rationalisations for the behaviour that has brought the patient into conflict with society.

Includes: amoral, dissocial, psychopathic, and sociopathic personality

Source: World Health Organization, 1992

Conduct disorder during childhood and adolescence, though not invariably present, may further support the diagnosis. An Iranian study reported that 23% of the prison population were 'psychopaths' (Assadi et al., 2006). Antisocial personality disorder is associated

with substance use, gambling, depression, self-injurious behavior, suicide and poor quality of life (Black et al., 2010).

Systematically conducted study from India reported that thirteen for every hundred prisoners could be diagnosed as having a conduct disorder in childhood and UTPs were significantly more likely to have received this diagnosis compared to CTPs. Nearly fifteen for every 100 UTPs received a diagnosis of antisocial personality disorder. This is 7-8 times more than the general population (Math et al 2011).

Antisocial personality disorder does not manifest out of the blue. It can be traced back to difficult behaviours in childhood and adolescence, in the form of externalising disorders (characterised by impulsivity, attentional deficits, negative and defiant attitudes to authority, conduct problems which include violation of social norms and an inability to learn from past experience). The disorder is attributed to a combination of genetic vulnerability, temperament, subtle brain dysfunction, learning difficulties and environmental adversity.

Antisocial personality and psychopaths are almost the same in terms of callousness, breaking rules, irresponsible, low frustration tolerance, lack of remorse and inability to learn from past experience (Coid and Ullrich, 2010). However, there are researchers who argue that they differ in the severity of the antisocial behaviour. Psychopaths form the most severe form of antisocial personality. They are characterised by low anxiety, egocentricity, selfishness, violent behaviour, sexual aggression, promiscuousness, high pleasure seeking and lack of emotional regulation. They deceive, manipulate, smart and destroy the lives of others for their gratification. Persons suffering from antisocial personality disorders are very difficult to treat. Most of these individuals are referred for treatment by the judiciary. However treatment options in our prison systems are poor to nonexistent. Once they understand the prison system and mental health service, they manipulate the system using several techniques, include malingering. There are high chances that they will be placed in forensic mental hospitals rather than in prisons. Such facilities are non-existent in India. Till date no medicine or therapy has been found to be effective. Recidivism continues to be high in this population because of the key personality characteristic that they do not learn from past experiences.

Emotionally unstable personality disorders

This personality is more common among young women. People with this personality often have difficulty in forming and maintaining long lasting relationships and can be particularly vulnerable for impulsive and aggressive acts such as self-harm, suicide, wrist slashing and so forth. There is a marked tendency to act impulsively without consideration of the consequences, together with mood instability. The ability to plan ahead may be minimal. Outbursts of intense anger may often lead to violence or "behavioural explosions". Two variants of this personality disorder are specified, and both share this general theme of impulsiveness and lack of self-control.

Characteristics of Emotionally Unstable Personality Disorder

There are two variants of emotionally unstable personality.

Impulsive type characterised by:

- Impulsivity
- Emotional/mood instability
- Inability to plan ahead
- Outbursts of violence or threatening behaviour which are common particularly in response to criticism by others.

Borderline type characterised by:

- Often unclear or disturbed self-image, aims, and internal preferences
- Chronic feelings of emptiness.
- Series of suicidal threats or acts of self-harm
- Liability to become involved in intense and unstable relationships
- Repeated emotional crises and may be associated with excessive efforts to avoid abandonment

Source: World Health Organization, 1992

Clinical signs of the disorder include emotional dysregulation, impulsive aggression, repeated self-injury, and chronic suicidal tendencies, which make these patients frequent users of mental-health resources.

Management of personality disorders

The behaviour management plan presented here is a guideline to address the issues of personality problems in prisons. The population with personality disorder pose a big challenge to any correctional and mental health staff. They tend to take up a huge amount of time and resources. Working with offenders with personality disorders can be emotionally very draining and stressful. The reasoning power of those with personality disorder is well preserved; hence treating them against their will is not recommended. However, treatment for personality disorder against their will is advocated with the permission of the court, in certain conditions where the individual is dangerous to self and/or others. The best policy is to work in partnership with people with personality disorder and help them develop their autonomy and promote choice by ensuring they remain actively involved in finding solutions to their problems, including during crises and encouraging them to consider the different treatment options and life choices available to them, and the consequences of the choices they make (NICE, 2009).

Treatment for any comorbid disorders should happen regardless of whether the person is receiving treatment for personality disorder or not. For, example a prisoner with personality disorder using alcohol and cannabis on a daily basis needs to undergo de-addiction before the personality disorder is addressed. Developing a good patient and doctor relationship is a crucial part of the individual therapy. A recent literature review to know the effect of personality disorder on mental illness revealed that the presence of a personality disorder is a poor predictor for response to treatment of mental disorders (Bieling et al., 2007).

The prison behaviour management plan consists of six essential elements:

1. Assessing the risks and needs of each inmate at various points during his or her detention.
2. Assigning inmates to housing.
3. Meeting basic needs of the inmates.
4. Defining and conveying expectations for inmate behaviour.
5. Supervising inmates.
6. Keeping inmates occupied with productive activities

Source: Hutchinson et al., 2009

Implementing a prison behaviour management plan requires clear directives, in the form of written policies and procedures for each step of the plan. Availability of trained staff and supervising them to ensure that the plan is implemented according to the adapted policies and procedures is crucial. Systematic documentation and recordkeeping of all activities related to the prisoner's behaviour management plan is necessary (Hutchinson et al., 2009). Another essential area that is required to be addressed is needs of the staff to be trained in crisis management.

People with personality disorders are at high risk for pressing panic buttons for crisis management. Each staff in prison needs to be trained to face the challenges of crisis management. Following are the broader aspects to be considered during a crisis situation.

Skills required in crisis management

- ✓ Ensure your safety first, before you intervene
- ✓ Quick response is the key
- ✓ Maintain a calm, relaxed and concerned look
- ✓ Use of non-threatening attitude and posture
- ✓ Investigate the reason for crisis quickly
- ✓ Try to understand the crisis from the prisoner's point of view (empathy)
- ✓ Use open ended questions during the interview
- ✓ Use counselling skills to calm the patient down
- ✓ Avoid blaming or scolding
- ✓ Avoid instigating them
- ✓ Refrain from offering solutions before receiving full clarification of the problems and know your limitation and explain them
- ✓ Provide support and short-term help until medical team/ appropriate crisis team is available
- ✓ Documentation of the incident and action taken is also essential for legal purpose

Source: Modified and adapted from Chandrashekar et al., 2007

Management of antisocial personality disorder

Individuals with antisocial personality disorder rarely seek psychiatric help for the disorder. These individuals who seek care do so for other problems such as injuries,

sexually transmitted diseases, demanding sleeping medicines, alcohol or drug abuse, and suicidal thoughts. Usually, the court or the prison staff refers them to a mental health counsellor for evaluation. They lack insight into their problems. They also reject the diagnosis and help offered. Often they use these opportunities to complain against the medical officers for wrong diagnosis or else manipulate transfers to better inpatient medical facilities. Hence, antisocial personalities who seek help (or are referred) can be offered evaluation and treatment as outpatients. Inpatient care needs to be evaluated and considered if there are suicidal ideas/attempts. In fact, people with antisocial personality can be disruptive in inpatient units, whenever their demands are not met. These personalities go to any extent to manipulate the environment including deliberate self-harm (wrist cutting). There are incidents when antisocial prisoners have lost their life by suicide.

To date, there is no treatment available. The failure to cure or even treat such individuals has divided the medical and legal communities, as well as society in general. They are known to manipulate the situations, be litigious and bear grudges. They are well known to split the staff by complaining to one staff against the other. Generally, complaints received by these individuals against the staff are of malicious intent. Hence, such complaints need to be thoroughly verified and investigated before proceeding against the staff.

Though there is no cure for this disorder, it is crucial to identify and manage these individuals inside the prison to ensure that they do not create trouble for others in the prison. A large part of the problems inside the prison are attributable to this group. Staff should learn to handle these prisoners. These prisoners do well in structured and high-security prisons. However, psychotropic medicines are found to be very useful in emergency and certain inevitable situations such as violence, aggression, suicide, deliberate self-harm, demanding behaviours and illicit drug intoxication related abnormal behaviour. The medicines are also useful to decrease their aggression in the long run.

Treatment for any comorbid disorders should be given regardless of whether the person is receiving treatment for antisocial personality disorder or not, because such people are often excluded from routine care (Black et al., 2010). Suicidal threats and deliberate self-harm are very common in this population. The tendency to rationalise irresponsible acts, minimise the consequences of these acts, violence and manipulative behaviour, needs to be confronted on a daily and immediate basis. Close supervision with structured activity have been recommended. The most effective treatment may at times be simply to

consider high-security prisons. Many antisocial behaviours do tend to dissipate (or burnout) with time (Kay J and Tasman A, 2006; Frosch, 1983). There are studies done in the community which reported that cognitive behaviour therapy for violent men with antisocial personality disorder in the community did not show any improvement (Davidson et al., 2009).

Various countries have adopted different policies to manage prisoners with antisocial personality disorder. Majority of these policies are an immediate aftermath of certain incidents. In 1998, England was shocked by the apparently motiveless murders of a mother and two of her children by a person with personality disorder. He was convicted of their murders. Later, the government was determined to prevent this type of offence from recurring. Hence, in 1999 the UK government introduced a new concept called dangerous and severe personality disorder (DSPD). DSPD is a highly contentious concept and is not a medical diagnosis; it refers to the perceived levels of dangerousness of the individual to the society or to others. DSPD unit has subsequently become a treatment and assessment programme for individuals who satisfy three requirements: (1) have a severe disorder of personality, (2) present a significant risk of causing serious physical or psychological harm from which the victim would find it difficult or impossible to recover, and (3) the risk of offending should be functionally linked to the personality disorder (Maden and Tyrer, 2003). Later, the UK government proposed a preventive detention programme to those with dangerous and severe personality disorder (Kendell, 2002).

To manage these individuals, various countries have adopted closed monitoring systems such as 'supermax prisons' or 'special housing units' (Pizarro and Narag 2008, Mears 2008). Supermax prisons are those with high level of security with electronically operated doors, surveillance cameras, and no windows. Visitors are also not allowed inside (Mears and Castro 2006). A special housing unit is a solitary confinement of the prisoners in a closed room without windows and they are generally allowed out of their cells for only one hour a day. These are managed by using proper protocol and for limited periods only (Mears 2008). However, these kinds of settings are often misused by the prison authorities and also very costly to maintain such prisons (Pizarro and Narag 2008, Mears 2008). Certain individuals with antisocial personality disorder with severe violence and aggressive tendency need isolation. But the need for continuing to keep them in such settings needs to be assessed periodically by risk assessment and the decision needs to be taken by a group of professionals such as representative of a judiciary, prison administration, medical staff, and social worker so that human rights violations are

monitored closely. This needs to be documented. Finally, management of prisoners with antisocial personality should be focused on providing symptomatic relief and clear guidelines about expected behavior from them in prison. However, there is an urgent need to do research to answer, whether supermax prisons are warranted, effective, or efficient in Indian settings.

Management of emotionally unstable (Borderline) personality disorder

Borderline personality disorder is characterised by a pervasive pattern of instability in affect regulation, impulse control, interpersonal relationships, and self-image. Mood disorders, substance-related disorders, eating disorders (usually Bulimia), posttraumatic stress disorder, attention-deficit/hyperactivity disorder, suicide, deliberate self-harm and other personality disorders frequently co-occur with this disorder (Lieb et al., 2004; Zanarini et al., 1998; Gunderson and Ridolfi, 2001; Paris, 2005; NICE, 2009). On comparing individuals with antisocial personality disorders with those with emotionally unstable personality disorder, it has been found that in case of the latter, patients improve with time. There is an evidence base for treatment using both psychotherapy and psychopharmacology in emotionally unstable personalities (Paris, 2005; NICE, 2009).

Dialectical behaviour therapy, cognitive behaviour therapy, interpersonal therapy, systems training for emotional predictability and problem solving (STEPPS) programmes are effective treatments. Psychotropic medications are effective in treating emotional, impulsive, mood swings and depressive symptoms that frequently are associated with borderline disorder. Medicines can reduce depression, anxiety, and impulsive aggression but need to be used judiciously used and supervised. (Lieb et al., 2004; Paris 2005; American Psychiatric Association, 2001).

Suicidal threats and deliberate self harm are very common in prisoners with emotionally unstable personality (Gunderson and Ridolfi, 2001). There is a need to sensitise staff about the suicide threats. There are incidents when prison staff has challenged the prisoner's suicidal ideas or threats by saying 'your suicidal threats are just an act'. This has lead to actual suicidal attempt by the prisoners. There is an urgent need to implement suicide prevention strategies inside the prison. Staff needs to be trained in handling these prisoners.

Personality disorders are a common form of mental health problems seen in prisons. Managing antisocial personality disorder and emotionally unstable personality in prison

is a challenge to any staff and mental health team. The prison administration should be aware of the symptoms of these personality disorders. Antisocial personality disorders do well in a highly secured and structured environment. The borderline personality disorder needs therapy. Co-morbid conditions need to be treated irrespective of the treatment status of the personality disorder. Prison staff plays a crucial role in preventing suicide. They need to be trained in managing suicide and deliberate self-harm inside the prison.

In conclusion, there are indeed certain groups of people who by virtue of their dysfunctional personality are more prone to crimes. There are those who may have committed crimes as a way of coping with stressful situations or have made an error in judgement by taking law into their hands. While in case of the former, bringing about a change in the personality while in prison might be a herculean task, in case of the latter, appropriate counselling and behavioural interventions can help by preventing the dysfunctional behaviours and thought process leading to the crime from becoming ingrained as part of the personality.

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