Behind Bars: Personality Disorders

Robert L. Trestman, PhD, MD

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A current national trend finds more individuals with severe and persistent mental illness revolving through our jails and collecting in our prisons.[1] Beyond those with the more readily acknowledged and diagnosed mental illnesses such as schizophrenia and bipolar disorder, and the highly prevalent and treatable depression and anxiety disorders, there are a host of other mental disorders that we are beginning to grapple with in the correctional environment.

It is a matter of record that there are many problematic individuals throughout all correctional systems who typically present with disturbed behavior that parallels the interpersonal dysfunction they demonstrated in the community. As more resources for the treatment of the mentally ill become available to those in the corrections environment, more of these troubled and troubling individuals are being clinically assessed. They are often found to meet criteria for one or more personality disorders.[2–4]

Historically, discussion about personality-disordered individuals in the corrections environment has focused on antisocial personality disorder and, more recently, on borderline personality disorder (BPD).[5,6] In fact, a range and spectrum of other personality disorders also occur within the system.[2–4]

I would like to describe the ways in which these disorders may present in the correctional environment and the potential opportunities that exist for effective treatment. The motivations for treatment in this context are more complex, and potentially more compelling, than usual. In addition to the basic tenet of reduced suffering on the part of the defined patient, there are the interwoven issues of public health and public safety. Given that in many situations, appropriate intervention may improve interpersonal functioning and reduce aggression, the boundaries between the historic forensic dichotomy of "mad or bad" arguably become more tenuous.[7]

Personality Disorders in Correctional Settings

An individual with paranoid or schizotypal personality disorder typically comes to the attention of clinicians in the correctional environment because of a referral from the correctional staff. An inmate receives multiple disciplinary recommendations (or "tickets") because of infractions stemming from a tendency to interpret all situations in paranoid fashion. All too often, this leads to an inappropriate need to respond to perceived aggression or affront with aggression. A paranoid interpretation of the environment, coupled with social and interpersonal deficits and other perceptual distortions, make it difficult to appropriately interpret the social cues that custody officers and other inmates provide.

Histrionic personality disorder, arguably more common in women than men even in the correctional environment, becomes problematic from a management perspective due to the persisting need for attention. An overblown or dramatic presentation of ambiguous complaints and the frequent need for staff interaction strains the limited time that is available for attention from correctional and medical staff. In a related fashion, those with dependent personality disorder in a correctional environment may find that they can manage the anxiety of incarcera-

Dr. Trestman is Associate Professor and Vice Chairman for Clinical Affairs, Department of Psychiatry/University of Connecticut Neuropsychiatric Institute, University of Connecticut Health Center. Address correspondence to: Dr. Robert L. Trestman, Vice Chairman for Clinical Affairs, Department of Psychiatry/UCNPI UCHC, 263 Farmington Ave., Farmington CT 06030-1410.

tion by high medical and mental health service utilization. This in turn leads to a devaluing of the underlying concerns, as well as to exposing these individuals to unneeded, and potentially harmful, invasive medical tests, medications, and procedures.

Inmates with narcissistic personality disorder, characterized by self-aggrandizing behavior, will frequently create situations for themselves that exacerbate ongoing difficulties. This is commonly played out in such a way as to antagonize inmates and guards and to cause extreme difficulty for many of these individuals in the highly structured correctional environment.

Antisocial personality disorder is endemic to correctional settings. Individuals who meet this diagnosis have difficulty cooperating with authorities, living in a structured fashion, and assuming responsibility for their behaviors. They are commonly seen as manipulative and impulsively aggressive. BPD is the diagnosis that is characteristic of many of the most troubling and difficult individuals found in correctional settings. Prevalence rates of BPD in prison studies have been estimated at 12 percent of male prisoners[8] and 28 percent of female prisoners.[3] Individuals with BPD, by definition, have severe impairment of interpersonal skills. They are impulsive and emotionally labile. They may be self-mutilatory, aggressive toward others, and may frequently attempt, and ultimately commit suicide. These individuals also are seen as manipulative and commonly provoke staff responses such as irritation, frustration, and anger. However frustrating these individuals may be, it appears to be clear that they are disturbed, literally out-of-control, and that the risk of self-harm is very high.

Comorbidity Issues

Major DSM Axis I Syndromes

As a further complication, many, if not most, of those with personality disorders also have diagnosable Axis I disorders such as mood disorders, traumatic stress disorders, anxiety disorders, and psychotic disorders.[1] While there are unresolved arguments about the primacy of diagnoses, it does appear that there is a substantial population of inmates with, for example, combined post-traumatic stress disorder and BPD who would substantially benefit from aggressive treatment. This will require substantial intervention: these are the inmates for whom simple evaluations and straightforward interventions are usually inadequate. Furthermore, the functioning of the correctional environment would almost certainly be expected to improve as a consequence of such interventions.

Substance Abuse

In parallel with other major Axis I syndromes, substance abuse and dependence are very common comorbidities among those with personality disorders. There is also evidence that members of this population are more likely to fail substance abuse treatment programs than those without personality disorders.[9, 10] There almost certainly exists a synergy between the two sets of disorders, as well. Substance abuse typically disinhibits impulsivity, worsens affective lability, and intensifies paranoia/perceptual distortion.

Implications for Treatment

Behavioral Management

While incarceration is a form of behavioral management, it is not designed to effectively moderate the troubling behavior of those with severe personality disorders. Individually designed treatment plans that operationally define the behaviors that are to be minimized and others that are to be rewarded and strengthened are indicated.

Psychotherapy

Symptom-targeted psychotherapy technologies are now evolving and are being tested in a range of settings. Some of these cognitive-behavioral approaches with a significant psychoeducational component may be well-suited to a correctional setting.[11–13] One such approach, dialectical behavior therapy,[12] was originally developed to provide skills training and directed therapy for women who were suicidal. It was rapidly adapted to self-mutilatory, impulsive, affectively unstable individuals with BPD. This approach is now seeing widespread application and testing, including in forensic settings. While data are not yet available, such approaches offer significant potential benefit and are deserving of rigorous testing in correctional settings.

Psychopharmacology

There are also other opportunities for the treatment of incarcerated individuals with severe personality disorders. Over the past decade, a literature has

developed that has begun to define personality disorder syndromes and symptoms that are targetable with medications.[14–16] This development derives both from empirical experience and from research suggesting an underlying pathophysiology.[17–19] Of relevance to correctional settings are virtually all of these targeted areas: impulsivity/impulsive aggression; affective lability; perceptual distortion; and anxious dependence.

The psychopharmacology of impulsivity and impulsive aggression has developed substantially in recent years[14, 15] and is of obvious potential benefit in the correctional environment. While relatively few well-controlled studies have been conducted, the growing data suggest that many individuals with impulsive aggression may respond to appropriate treatment. Such individuals usually meet the diagnostic criteria for narcissistic, antisocial, and/or BPDs. Selective serotonergic reuptake inhibitors,[20] beta blockers,[21] antipsychotic agents,[22] and several anticonvulsant agents[23, 24] each have demonstrated some efficacy in this population.[21, 25]

Affective lability or emotional instability may underlie the unstable interpersonal relationships that are characteristic of BPD. As with the cyclic mood disorders (e.g., bipolar disorder), treatment with lithium or anticonvulsant agents may have therapeutic benefit in the treatment of affective lability.[14, 26]

Perceptual distortion appears to best describe the extreme suspiciousness and paranoia of many individuals with schizotypal, paranoid, or BPDs. These distortions may contribute significantly to the aggressive stance taken by many such individuals that is exacerbated by what may be a paranoia-inducing correctional environment. Several studies now support the use of low-dose atypical antipsychotic medications in this population to reduce perceptual distortion,[15, 27, 28] which may in turn reduce inappropriate, and sometimes aggressive, behavior.

Anxious dependence, separate from an anxiety disorder *per se*, may contribute to the demanding, clinging nature of those with dependent disorder, histrionic disorder, or BPD. These behaviors contribute to an unnecessary or excessive use of medical services and may place an unrealistic burden on custody staff. While benzodiazepines may be problematic to use on a routine basis in the correctional setting, agents such as buspirone, selective serotonergic reuptake inhibitors, or beta blockers may be of help in the treatment of these disturbances.[14, 15, 20]

Implications for Custody Collaboration

Many people within mental health, general medical services, and custody staffs think that personality disorders are not amenable to treatment. Indeed, the difficulty can be a very entrenched expectation that people who are not overtly psychotic are not mentally ill and should be in control of, and responsible for, their actions. While that is largely accurate, psychiatrists are now potentially able to diagnose and effectively treat some of the more difficult inmates that correctional officers (COs) are responsible for managing. A critical component is the liaison and educational relationship needed between custody officers and mental health staff. Mental health staff are not present as ubiquitously as are the COs. If the COs were trained and attuned to recognize and refer personality-disordered individuals into treatment, all stakeholders (the inmate, the COs, and, upon release from custody, the community at large) stand to benefit.

Implications for Discharge Planning

Severe personality disorder is a chronic illness, responding best to consistency and continuity of care. Historically, however, when an individual was discharged from the corrections environment into the community, few if any linkages existed to assure care continuity. This is gradually improving in many jurisdictions, to the benefit of the individual and the community. Follow-up care in terms of medication management, psychotherapy, and case management all are critical for many of these individuals to reduce the risk of clinical deterioration and to minimize the behaviors that may lead to reoffense and reincarceration.

Summary

Individuals with severe, function-impairing personality disorders comprise a large proportion of the difficult-to-manage inmates. Personality disorders are reliably diagnosable using standardized criteria (DSM-IV),[29] and treatment options are now available. Through careful assessment, differential diagnosis, and differential therapeutic selection, clinicians have the opportunity to help these individuals gain more control over unstable affect, impulsive/irritable aggression, and paranoid perceptual distortions. Appropriate intervention holds the possibility, if not the promise, of reduced morbidity and recidi-

vism, and may reasonably contribute to the public safety mission of corrections and to the primary mission of clinicians, which is improved health.

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