Personality disorders in the courts:

Definitions, Treatment Possibilities, and Management

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Definitions

What is personality?

An enduring pattern of perceiving, relating to, and thinking about the environment and oneself that is consistent across most contexts.

What is a personality disorder?

An enduring pattern of perceiving, relating to, and thinking about the environment and oneself that is consistent across most contexts **and so maladaptive and inflexible that it causes significant distress and impairment in functioning**.

Prevalence

Personality disorders

In the general population[1]:	11%
In the clinical population[1]:	64%
In the justice-involved population[2]:	up to 47%

Borderline PD[3]

In the general population:	1 - 2%
In the justice-involved population:	35 - 57%

[1]Skodol, A. Overview of Personality Disorders. In: UpToDate, Stein, M (Ed), Wolters Kluwer. (Accessed on March 7, 2024.)
[2]Metzner J, Cohen F, Grossman L, *et al*: *Treatment in prison and jails, in Treatment of Offenders with Mental Disorders.* Edited by Wettstein RM. New York: Guilford Press, 1998, pp 211–64
[3]Chapman, A. L., & Ivanoff, A. (2018). Forensic issues in borderline personality disorder. In B. Stanley & A. S. New (Eds.), *Borderline personality disorder* (pp. 403–419). Oxford University Press.

How do PDs develop?

Early development – sense of self vs. others and the environment is developing

- A child must learn how to manage both positive and negative aspects of emotional states
- If the caregiver is inconsistent/unreliable, violent, or unavailable
  - Child comes to believe that people and the world are unreliable and dangerous
- How to cope with this dangerous reality
  - If good and bad can't be tolerated at once, splitting can occur
- **Emotional inflexibility starts as a way to protect oneself**

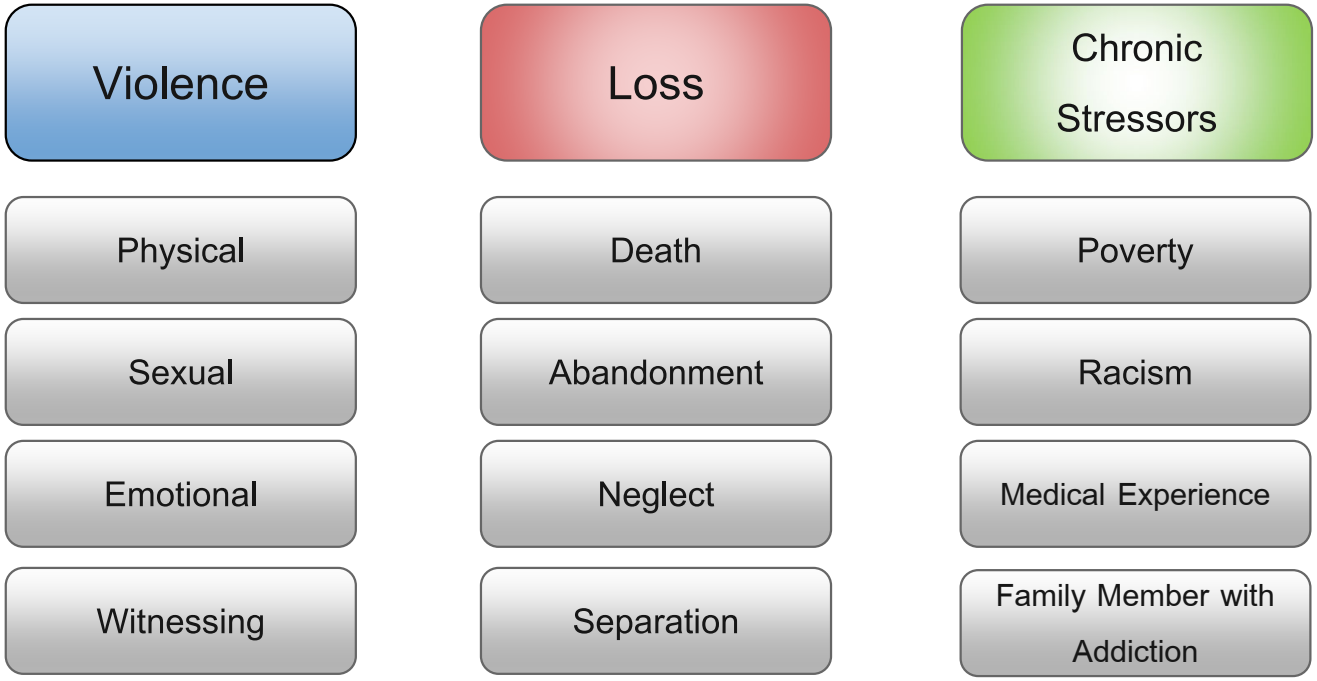
PDs and Early development

Trauma

- High rates of trauma among people with PDs
- Physical, sexual, emotional abuse, emotional neglect in developmental years
  - Leads to difficulty with sense of self and others
  - Challenges with behavioral control
- "Developmental antecedents of borderline personality disorder"[1]
  - sexual violence (65%)
  - physical violence (60%)
  - neglect (40%)
- **TRAUMA vs trauma**

[1]Helgeland M.I., Torgersen S. Developmental antecedents of borderline personality disorder. *Compr. Psychiatry.* 2004;45:138–147.

Trauma is More Than Violence



SAMHSA

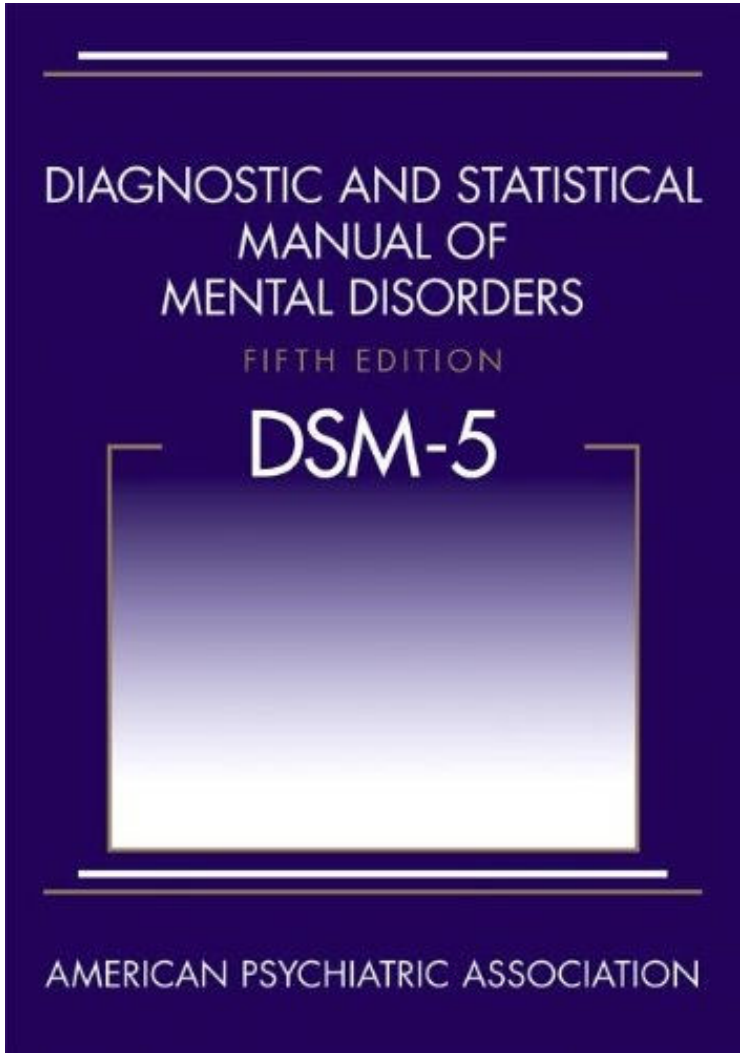
A note about personality disorders

This is not a choice

- People do not choose to behave in these ways
- Feeling overwhelmed by things which feel out of one's control
- Distressing/frightening to experience these feelings and behaviors
- "Just don't do it" does not work

Categories of PDs

- Borderline (volatile, impulsive)
- Antisocial (rule-breaking, aggressive)



No absolutes

- It is a fallacy that a PD is either present or not present
- Personality features occur on a spectrum
  - No clear demarcation between “normal” or “abnormal”

Borderline PD

Borderline PD

DSM-5 diagnostic criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, of self-image, and affects as well as marked impulsivity beginning by early adulthood and present in a variety of contexts as indicated by five or more of the following:

1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.
3. Identity disturbance: Markedly and persistently unstable self-image or sense of self.
4. Impulsivity in at least two areas that are potentially self-damaging, for example, spending, substance abuse, reckless driving, sex, binge eating, etc. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
5. Recurrent suicidal behavior, gestures or threats, or self-mutilating behavior.
6. Affective instability is caused by a marked reactivity of mood, for example, intense episodic dysphoria, anxiety, or irritability, usually lasting a few hours and rarely more than a few days.
7. Chronic feelings of emptiness.
8. Inappropriate, intense anger, or difficulty controlling anger, for example, frequent displays of temper, constant anger, recurrent physical fights.
9. Transient paranoid ideation or severe dissociative symptoms

Prevalence of indicators of BPD

1. Affective instability (95%)
2. Inappropriate anger (87%)
3. Impulsivity (81%)
4. Unstable relationships (79%)
5. Feelings of emptiness (71%)
6. Paranoia or dissociation (68%)
7. Identity disturbance (61%)
8. Abandonment fears (60%)
9. Suicidality or self-injury (60%)

Unstable emotions

Explosive angry outbursts

Losing touch with reality

Unstable identity

What does BPD look like on the ground?

- Sudden changes in mood
- **Black and white thinking**
- All good or all bad
- Sense of self depends on the situation – always changing
- Appearance or comportment may change frequently
- May dip into and out of paranoia or confusing/erroneous perceptions of reality
- **Bipolar disorder diagnosis that does not respond to medication**

Chapman J, Jamil RT, Fleisher C. Borderline Personality Disorder. [Updated 2023 Jun 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK430883/

Co-occurring mental illness is common

- Mood disorders - 80% to 96%
- Anxiety disorders - 88%
- Substance abuse disorders - 64%
- Eating disorders - 53%
- ADHD - 10% to 30%
- Bipolar disorder - 15%
- Somatoform disorders - 10%

Skodol AS. Borderline Personality Disorder: treatment overview. In: UpToDate, Stein, MB (Ed), Wolters Kluwer. (Accessed on March 10, 2024.)

Complications of BPD

- Engaging in risky behavior (e.g., rash driving, risky sex)
- Drug abuse
- Not completing education
- Job loss
- Getting in trouble with the law
- Problems with relationships
- Suicide attempts

Chapman J, Jamil RT, Fleisher C. Borderline Personality Disorder. [Updated 2023 Jun 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK430883/

Issues for teams: Risks

- Imminent risk of high lethality behaviors including self-harm due to overt suicidal ideation or impulsivity
- Rapid decompensation of comorbid psychiatric diagnoses or severe substance abuse
- Severe social stressors causing intense negative thoughts or transient psychosis

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Issues for teams: Splitting

- When the patient cannot form a realistic view of another person
- Others seen as totally good or totally bad
- Leads to impairments in interpersonal relationships
- ***Also destructive for treatment teams

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Treatment options

Borderline PD – treatment options

Psychotherapy	Medications	Psychosocial Interventions
• Dialectical behavior therapy (DBT) • Mentalizing-based therapy (MBT) • Transference-focused psychotherapy (TFP)	• No medications are FDA-approved for the treatment of borderline PD • BUT medications can help with symptoms	• Supportive social interventions • Stabilizing basic and other needs • Building community • Psychoeducation

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Borderline PD – psychotherapies

- Dialectical behavior therapy (DBT)
  - Mindfulness
  - Started as an intervention for patients with suicidality
- Mentalizing-based therapy (MBT)
  - Skills for understanding the thoughts, feelings, and needs of others
- Transference-focused psychotherapy (TFP)
  - Utilizes the patient-therapist relationship as model for difficult interpersonal dynamics

Chapman J, Jamil RT, Fleisher C. Borderline Personality Disorder. [Updated 2023 Jun 2]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK430883/

Borderline PD – treatment caveats

- Long process - courts are time-limited
- Catch-22:

the features of BPD associated with less treatment efficacy

=

the same traits that result in people ending up in jail/treatment courts

  - Aggression
  - Impulsivity
  - Substance use

Antisocial PD

Antisocial PD – DSM 5

- A pervasive pattern of disregard for and violation of the rights of others, since age 15 years, as indicated by three (or more) of the following:
  - Failure to conform to social norms concerning lawful behaviors, such as performing acts that are grounds for arrest.
  - Deceitfulness, repeated lying, use of aliases, or conning others for pleasure or personal profit.
  - Impulsivity or failure to plan.
  - Irritability and aggressiveness, often with physical fights or assaults.
  - Reckless disregard for the safety of self or others.
  - Consistent irresponsibility, failure to sustain consistent work behavior, or honor monetary obligations.
  - Lack of remorse, being indifferent to or rationalizing having hurt, mistreated, or stolen from another person.
- The individual is at least age 18 years.
- Evidence of conduct disorder typically with onset before age 15 years.
- The occurrence of antisocial behavior is not exclusively during schizophrenia or bipolar disorder.

Slide credit: Bipin Subedi, MD

Antisocial PD

- a pattern of socially irresponsible, exploitative, and guiltless behavior with reckless disregard for the safety and well-being of others
- begins in childhood or early adolescence
- fully manifest by the late 20s or early 30s.
- usually lifelong and causes disturbance in functioning (eg, family relations, school, and work)

Black D. Antisocial Personality Disorder: Epidemiology, clinical manifestations, course, and diagnosis. In: UpToDate, Friedman,M (Ed), Wolters Kluwer. (Accessed on March 11, 2024.)

Features of ASPD

- Behaviors:
  - criminality and failure to conform to the law
  - failure to sustain consistent employment
  - manipulation of others for personal gain
  - failure to develop stable interpersonal relationships
  - Lying, exploiting others, stealing
  - Impulsivity and violence
- Qualities:
  - Lack of empathy for others
  - rarely experiencing remorse/guilt
  - Not learning from the negative consequences of one's experiences

Black D. Antisocial Personality Disorder: Epidemiology, clinical manifestations, course, and diagnosis. In: UpToDate, Friedman,M (Ed), Wolters Kluwer. (Accessed on March 11, 2024.)

Comorbidities are common

- substance misuse
- mood and anxiety disorders
- attention deficit hyperactivity disorder (ADHD)
- specific learning disorders
- gambling disorder
- other personality disorders

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Treatment options

Antisocial PD – treatment options

1. Treat any comorbid diagnosis first
    - ADHD, mood issues
    - Substance use disorders
2. Treat aggression with **medication**
    - Antipsychotics
    - SSRIs
    - For those with organic illness only - trazodone, buspirone, propranolol

Black D. Antisocial Personality Disorder: Treatment overview. In: UpToDate, Friedman,M (Ed), Wolters Kluwer. (Accessed on March 12, 2024.)

Antisocial PD – treatment options - therapy

Depends on severity

- For mild-moderate ASPD
  - Psychotherapy is possible - **Cognitive-behavioral Therapy (CBT) for ASPD**
  - Psychosocial interventions can work
    - Psychoeducation
    - Family/marital therapy
  - Works better for people with comorbid disorders and those with family/interpersonal difficulties
- For severe ASPD (psychopathy), psychotherapy is **not** recommended
  - Instead, monitor clinically

***Efficacy…?

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Personality disorder vs. traits

Important to distinguish

- Disorder:
  - Seen as fixed and unchangeable
- Traits:
  - Something everyone has
  - Can be changed
  - Not a characterological flaw but a feature that can change and grow

Black D. Antisocial Personality Disorder: Treatment overview. In: UpToDate, Friedman,M (Ed), Wolters Kluwer. (Accessed on March 12, 2024.)

Antisocial PD vs. Antisocial traits

- Risk-Needs-Responsivity (RNR) treatments
  - For antisocial cognitions - **Thinking for Change (T4C)**[1]
  - For antisocial personality - **Forensic DBT**
- Seeing antisocial traits as survival skills
  - **Address underlying trauma**
  - **SPECTRM**[2]

Inmate Code *Adaptations dictated by inmate code and environmental factors*	**Behaviors in a Therapeutic Setting** *The same behaviors are interpreted by staff as resistance in the therapeutic setting*
Do your own time	Lack of treatment involvement
Don't be a snitch/rat	Don't talk to staff
Don't trust anyone	Don't engage with staff or other patients
Respect	Violent or threatening behaviors
Strength and Weakness	Medication refusal, Violent or threatening behaviors
Fear and Vigilance	Medication refusal, Violence as a response to threat
Freedom Limited	I did my time, Hospital or Prison
Extortion, Gambling, Drug Trafficking and Use	Treating the hospital or residence program as an extension of prison; e.g., trading cigarettes and commissary
Transiency	Lack of treatment involvement; does not engage with staff or other clients
Lack of Privacy	No eye contact; strict demands regarding personal space

(Rotter, Larkin, Schare, Massaro, & Steinbacher, 1998).

Slide attribution: Merrill Rotter, MD

[1] *Thinking for a Change 4.0.* (n.d.). Home | Thinking for a Change 4.0. https://inf

[2] Rotter, M., McQuistion, H. L., Broner, N., & Steinbacher, M. (2005). Best practices: The impact of the "incarceration culture" on reentry for adults with mental illness: A training and group treatment model. *Psychiatric Services, 56*(3), 265–267. https://doi.org/10.1176/appi.ps.56.3.265

Risks of diagnoses: BPD and ASPD

- Promotes negative bias
  - Diagnosis may influence future treatment providers, courts
- Missed opportunity to treat a potentially reversible condition
- Influence on legal case
- Places blame on individuals rather than the system
  - Labels the patient is “untreatable”
  - Discourages curiosity about causes of behavior

Slide attribution: Bipin Subedi, MD

"An abnormal reaction to an abnormal situation is normal behavior."

- Dr. Victor Frankl

Slide credit: Bipin Subedi, MD

Thank you

Implementing Dialectical Behavior Therapy (DBT) in a Treatment Court Setting:

Five Felony Treatment Courts in Queens

- Queens Treatment Court (QTC)
  - Opened May 1998 to serve individuals with first time felony drug driven offenses
- Queens Mental Health Court (QMHC)
  - Opened in 2005 to serve felony offenders with mental health or co-occurring disorders
- Queens DWI Court (QDWI)
  - Opened in 2006 to serves individuals with first time felony DWI offenses
- Queens Judicial Diversion Court (QDDC)
  - Opened in 2009 as a result of NYS legislation allowing Judges to sentence some felony offenders with substance abuse problems to treatment programs instead of incarceration without the consent of the District Attorney.
- Queens Veterans Treatment Courts (QVTC)
  - Opened in 2010 to serve Veterans with felony level offenses

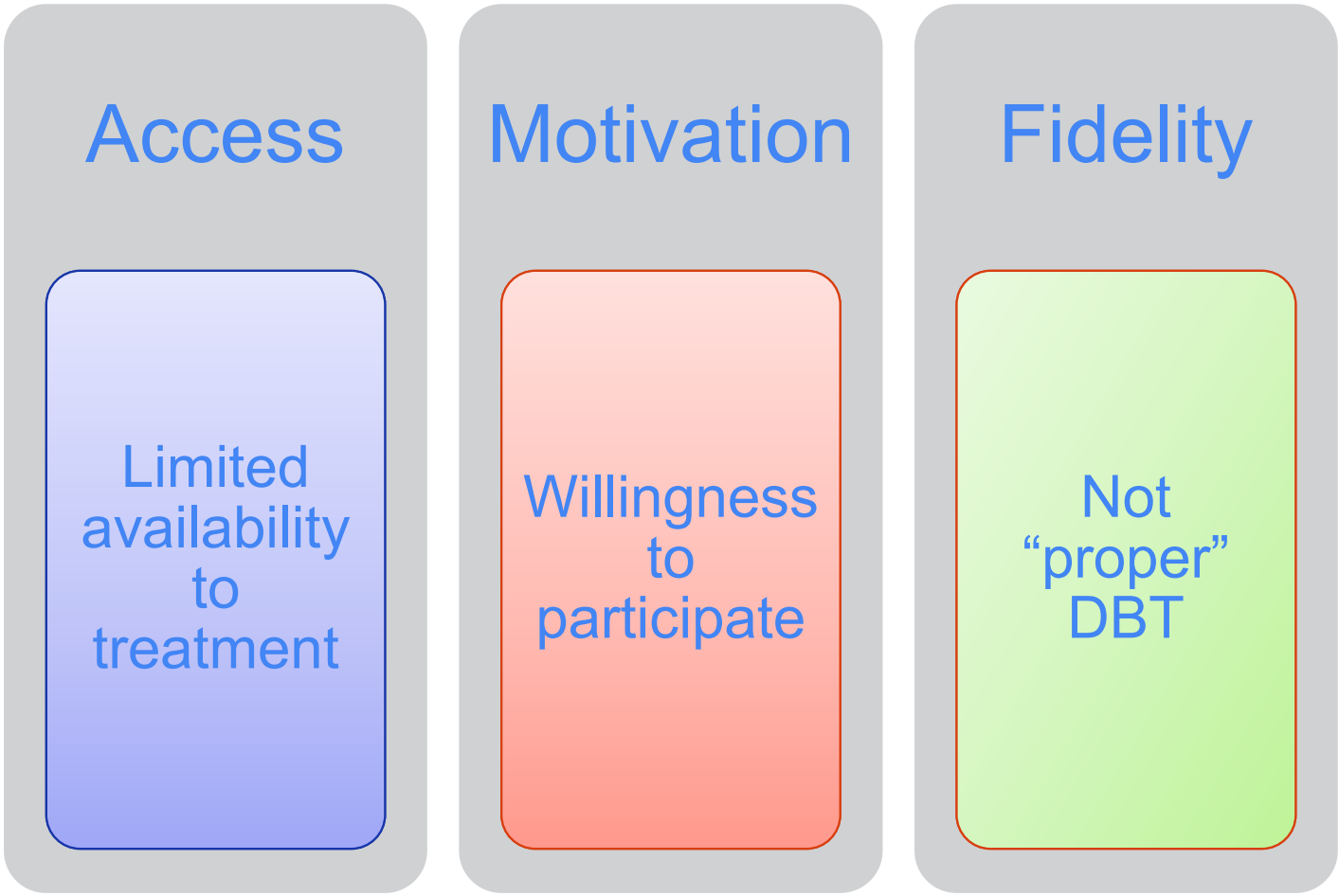
DBT is the Gold Standard!

- This highly researched intervention has shown great promise in working with uniquely challenging populations.
- As previously discussed, having a client come through the justice process and enter a DBT treatment would be ideal.
- DBT also addresses many of the risk factors associated with recidivism, which makes it even more enticing to apply with the population that is justice involved.

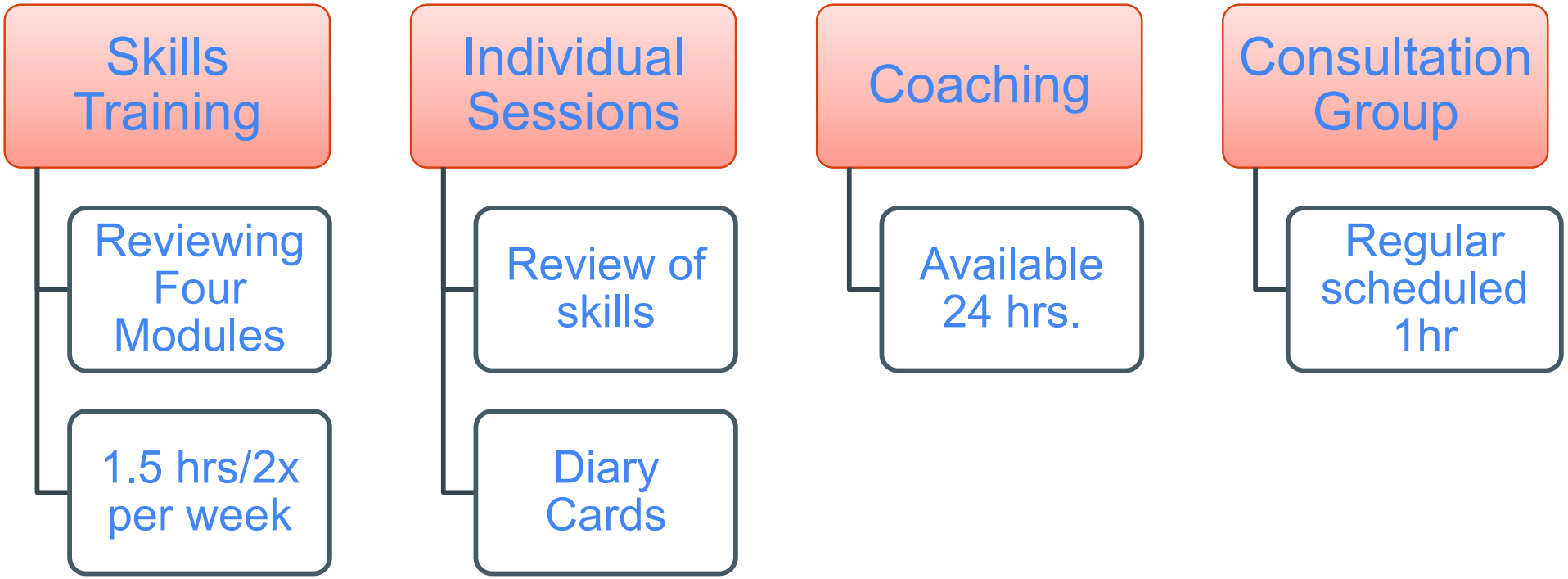
Incorporating DBT Into Court Mandate

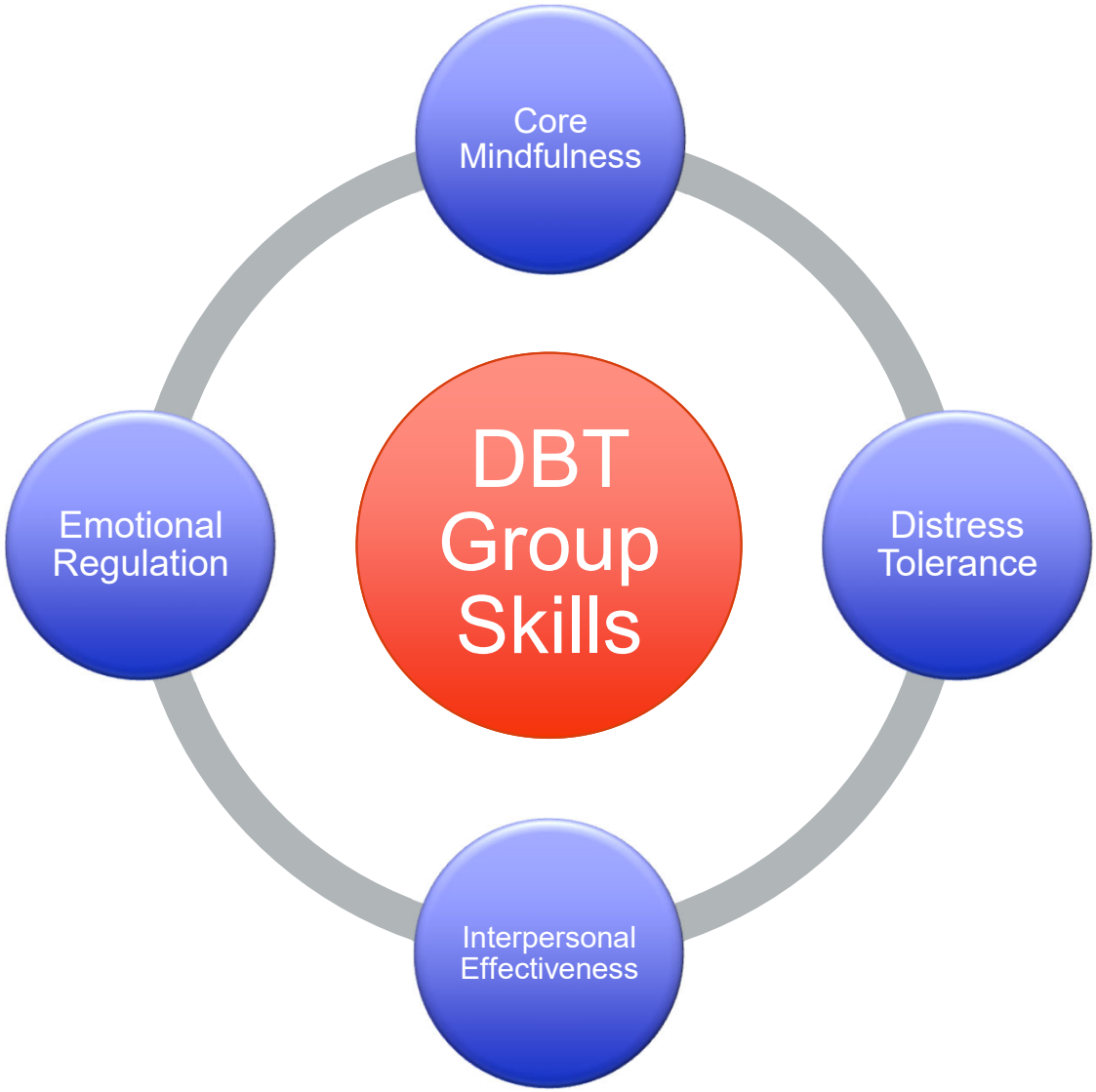
- Within a treatment court, there are referrals that are "sick but not that sick."
  - While they may benefit from a therapeutic intervention, their history and presentation indicate more of a repetitive pattern of behavior associated with personality characteristics.
  - Bipolar, Schizophrenia, MDD, etc., there are psychiatric medication interventions that assist
  - What about those that do not benefit as much from that intervention?

Summary of Barriers



Components of Dialectical Behavioral Therapy




Core Mindfulness
Distress Tolerance
Interpersonal Effectiveness
Emotional Regulation
DBT Group Skills

Fidelity

Treatment Fidelity: This places competence in applying a testable model that adheres to a manual. This ensures that it can be easily replicated and is key to lending itself to research.

- Going back to the access, we don't have it!

Evidence-Based Practice: Competence and a manualized approach that is based on expertise and client needs. This lends itself more to real world situations and what occurs in the laboratory cannot always be duplicated in real life

Practice Based Evidence: Whichever of these models is used collecting data on the practice level and adjusting to client needs is necessary.

Research Supports Contextual Model

- High adherence is not necessary, but coherence is important[1]
- Real world client, and in our case, forensic clients in a mandated program, can differ from those selected to be in a research program.
- Adapting treatment models is mainstream practice and an evidenced based approach[2].
  - Supported by APA since 2006
    - Research
    - Clinical expertise
    - Client culture/characteristics/preferences
    - Ongoing monitoring and adjustment of therapy based on data

[1] Webb, C.A., DeRubeis, R.J., & Barber, J.P., (2010). Therapist adherence/competence and treatment outcome: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78(2)*, 200-211.
[2] Pederson, L. (2020). Telehealth and DBT: Best practices, essential skills, and ensuring safety.

Adaptation of DBT

“There is no a priori reason why one skills training program cannot be substituted for another…In a sense, what I am recommending is that if you do not use the DBT skills training manual as is, you consider writing one of your own or modifying the manual to suit your own purposes.” Linehan, p. 155

Linehan, M.M. (1993). Skills training manual for treating borderline personality disorder. New York, NY: Guilford Pres

Implementation

Ideal

- Group Skills In Person
- Individual DBT Case Management
- Consultation Group
- Participants

Practice

- Where?
- Timing
- Facilitators?
- Staff and Training

Is this real "DBT"?

- This model for this population does not exist
  - Our goal was not to implement DBT as applied to other groups but to adapt the model to work for our population.
  - Recognizing limitations and adapting, all in the context of COVID-19
- Mandated clients pose a unique challenge
  - They are not willing per se, but we are meeting them where they are. Offering an opportunity to engage in a treatment.
  - Practice based evidence from clients, the feedback has been that it creates opportunity for access where they otherwise may not have the opportunity
- Remaining true to the underlying purpose of the model while also remaining effective to the population we serve has driven our decision making process
  - Research has supported DBT/other therapeutic interventions and through virtual platform
    - Emphasis on group and application of skills

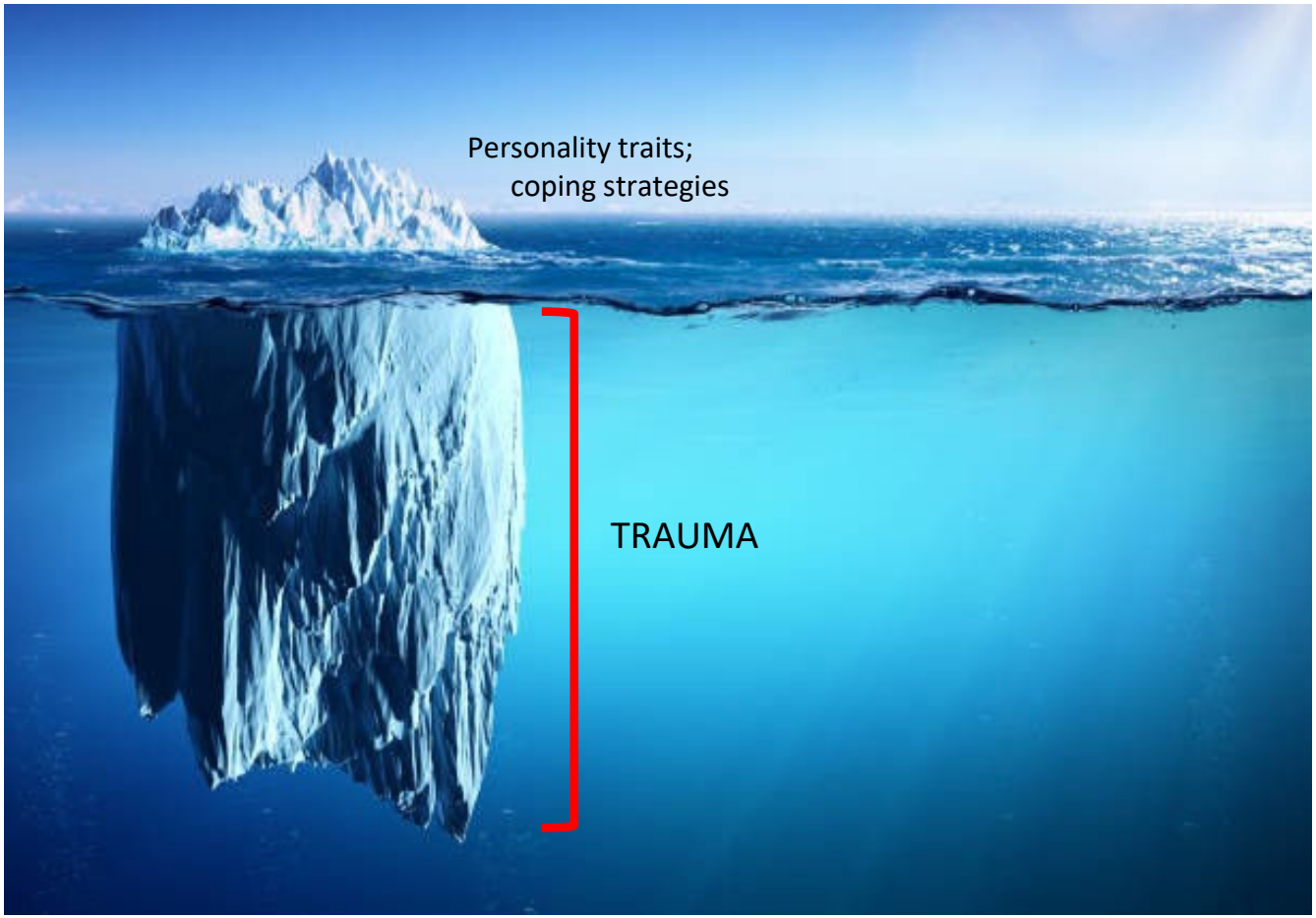
Thank you

Perspectives from community psychiatry

- Disorder vs. Trait
  - Providing an everyday environment that is a place of safety
- Managing our reactions
  - Being aware of the feelings these clients are triggering in us
  - Understanding that this is part of the disorder
- Intentions
  - Unconditional positive regard
  - Growth process
- Setting reasonable expectations
  - Building trust
  - Understanding that change is a slow process

Trauma: the behavior is the tip of the iceberg

- Trauma informed practices
  - Giving clear, transparent explanations about things before they happen (anticipatory guidance)
  - Giving choices
  - Preserving autonomy to the extent possible
  - Consistency is key



How to manage 'splitting'

- Pay attention to how the team is functioning
  - Polarization may be a sign that the team has fallen victim to splitting

- Preserve team integrity
  - Recognize splitting
  - Discuss what is happening explicitly within the team
  - Formulate a plan for all team members to follow
    - Boundaries
    - Limits
    - Requirements
  - There will be turbulence along the way – expect this
  - Give each other unconditional positive regard

Thank you