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The Role of Mental Health in Addressing Institutional Misconduct of Offenders with Personality Disorders

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Abstract: Personality disorders, particularly cluster B, pose significant challenges to the successful management of inmates in correctional institutions. Maladaptive personality traits coupled with negative prison environments tend to magnify the dysfunctional behavior of incarcerated individuals and increase the potential for institutional misconduct. The aims of this article is to address some of the barriers to the management of inmates with personality disorders and discuss possible solutions for mental health professionals and prison administrators alike.

Keywords: personality disorders, institutional misconduct, mental health, Cluster B, segregation

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Mental health staff in correctional institutions face a number of challenges related to the management of inmates with personality disorders. A handful of these inmates with cluster B and sometimes cluster A personality disorders, routinely engage in institutional misconduct, thereby exhausting the already scarce resources available to the inmate population. When custodial efforts fail to curtail rule-violating behaviors, administrators turn to mental health staff for solutions.

Among the numerous challenges faced by prison psychologists working with inmates is the lack of resources necessary to address rule-violating behaviors. For instance, when the behavior is fueled by a personality disorder (PD), there is a limited ability to rely on psychiatric interventions. Psychopharmaceuticals provide a faster response than traditional psychotherapy and are well-suited for the treatment of clinical symptoms such as depression, anxiety, and psychosis. Conversely, personality disorders are characterological deficits that cannot be managed with medication, but rather are treated with psychological interventions such as cognitive therapy (CT), schema-focused therapy (SFT) and cognitive-behavioral therapy (CBT). These therapies can be long-term and typically require well-trained mental health staff with time and resources (e.g. space that is private for confidentiality but safe

for the practitioner, appropriate for individual and group therapy, access to inmates in special housing units such as segregation, etc.) that correctional systems generally cannot provide.

Moreover, some inmates with co-occurring disorders experience clinical symptoms that can be treated with psychiatric medication, but their personality deficits may continue to sustain their disciplinary infractions. The latter are treatable with well-designed cognitive-behavioral interventions that are scarce in most correctional systems. Furthermore, both clinical and personality disorders are often compounded by a history of long-term illicit substance use, which further complicates the treatment of offenders. In-prison substance abuse treatment often remains only available to a small percentage of those who need it. For many offenders, clinical disorders may be treated during incarceration, while substance abuse treatment is unlikely. Even less likely is the chance that long-standing dysfunctional patterns of thinking and behaving are addressed therapeutically in the prison environment. When the primary mental health concern is personality, interventions are hard-to-find and isolation from the general population (segregation) often results when the maladaptive behavior leads to policy violations. Isolation increases the risk for suicide (Correia, 2000) and other self-harming behaviors such as self-mutilation, ingestion of foreign objects, and destruction of property. However, the typical response to institutional misconduct (isolation) tends to result in increased stress, tension, mental health symptoms and more misconduct (Medrano *et al.*, 2017).

In addition to the general lack of resources necessary to address co-morbid presentations, malingering for secondary gain, (e.g. changes in housing, drug-seeking, or to hasten medical attention) is common in correctional systems (McDermott *et al.*, 2013). Even assessments used for this purpose may not always detect offenders who have become proficient at feigning symptoms (McDermott & Sokolov, 2009). Additionally, risk assessment results, which may be based on inmate self-report, can be incompatible with the clinical judgment of mental health staff. Malingering leads to resource inefficiency and staff burnout.

Another challenge faced by mental health staff and prison administrators alike in managing this population involves the scarce availability of prison programs. Due to budget constraints, particularly in state corrections, there often are not enough programs to accommodate all prisoners. This results in lengthy program wait lists and individuals releasing from prison without benefiting from evidence-based programming.

When offenders are eligible to participate in programs, other institutional barriers lead to the removal of inmates from programs. These may include extended time in segregation, no upcoming release dates (e.g. inmates who are discharging first are typically given priority for programming), illiteracy, and refusal to participate due to distrust of prison staff. This latter characteristic may stem from childhood trauma, prison politics that dictate certain gangs or races are barred from participating in programming, negative prior experience with correctional staff, or having a paranoid or other dysfunctional personality trait. The aims of this article is to address some of the barriers to the management of personality disordered

inmates and discuss solutions that ameliorate the problem of institutional misconduct as it relates to personality disorders.

Cluster A Personality Disorders

There are three cluster A personality disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). These include paranoid personality disorder (PPD), schizoid personality disorder, and schizotypal personality disorder. Of the three cluster A personality disorders, the one most often associated with instances of misconduct in correctional settings is the paranoid personality disorder (PPD). The other cluster A personality disorders, including schizoid and schizotypal personality disorders tend to have fewer instances of rule-violating behaviors. These PDs are characterized by attitudes of indifference. Generally, these individuals reflect an air of apathy and disinterest in other people and the world around them. In the case of schizotypal individuals, there is an added element of bizarre behavior or thinking which sets them apart from the individuals with schizoid personality disorder.

Interestingly, associations have been found between schizoid personality disorder and offenses involving kidnapping as well as schizotypal personality disorder and the crime of arson (Roberts & Coid, 2010). Nonetheless, whether the personality trait tends to manifest in an aloof individual or an aloof and bizarre presentation, neither of these two cluster A personality disorders tends to be overrepresented on lists of institutional rule-violating repeat offenders. Comparatively, of the three cluster A personalities, paranoid personality disordered individuals generally come to the attention of administrators to a greater extent than the other two due to their involvement in institutional rule infractions and admissions to the infirmary for suicide watch.

Paranoid Personality Disorder

Of the cluster A personality disorders, paranoid personality disorder (PPD) is often the most diagnosed disorder in segregated units. Inmates who are diagnosed with PPD tend to be mistrustful of staff and suspicious that they are being treated in negative ways that is inherently different from that of other inmates, and therefore unfair. Their perceived unjust persecution at the hands of prison staff leads to paranoia, animosity, acting out, propelling bodily fluids and other assaultive behaviors towards staff. This behavior only reinforces the desire of prison staff to retaliate against them.

Offenders with PPD tend to overreact to situations, and respond with misbehavior (e.g. breaking sprinkler heads in their cells, pulling out electrical wiring from outlets). Interestingly, paranoid traits are also present in individuals with antisocial personality features, where prevalence rates among incarcerated individuals are already significantly higher than in general population.

Researchers have also found links between PPD and violence, robbery, and blackmail (Roberts & Coid, 2010). If individuals with certain PDs have a proclivity toward certain behaviors, interventions may be designed to target both the mentality that facilitates the behavior and the resulting conduct itself.

Cluster B Personality Disorders

According to Kirkpatrick *et al.* (2010), the most predominant personality disorders diagnosed in prison are antisocial personality disorder (APD), borderline personality disorder (BPD), and paranoid personality disorder (PPD). PPD was discussed in the previous section as it is a cluster A disorder.

Antisocial Personality Disorder

Among incarcerated individuals, a large portion of violent offenders have been diagnosed with antisocial personality disorder (APD). These offenders often have long histories of arrests for violent offenses that began in adolescence (conduct disorder) and continue into adulthood. Individuals with APD continue their propensity for physical assault in incarcerated settings. According to Abbiati *et al.* (2019), there is three times more violence in prison than in the community and 1 out of 10 inmates are victims of violence during their incarceration.

Brazao *et al.* (2015) found that paranoia, anger, and shame are associated with APD. Working through those emotions with a well-trained therapist can help lower the intensity of them and provide the skills necessary for individuals to react differently. While offenders who have been diagnosed with APD should not be placed in therapeutic communities (TC) where they might learn to how to improve their ability to malinger, intensive schema or affective group therapy can teach them to challenge their own thinking and respond in more pro-social ways (Saradjian *et al.*, 2013).

Borderline Personality Disorder

The literature on institutional misconduct points to a number of factors that contribute to offender disciplinary problems in incarcerated settings. These include: younger male offenders with a history of prior violence, time spent in solitary confinement, those with longer criminal histories, those with longer sentences, and those who are single-celled (Medrano *et al.*, 2017; Bosma *et al.*, 2020). In addition to these demographic and institutional characteristics, inmates diagnosed with borderline personality disorder (BPD) tend to have more institutional infractions than the general population (Moore *et al.*, 2018). Due to the nature of BPD, namely a disruption in the ability to self-regulate affective responses, the resulting behavior is often manifested in self-injurious behaviors.

In addition to suicide attempts and suicidal gestures such as placing nooses made with bed sheets or clothing around their necks, offenders with BPD also engage in self-harm

(e.g. repeated ingestion of non-edible objects such as glass, razors, or concrete; inserting foreign objects under their skin or in their rectum; hitting their heads on walls; pulling out sutures and filling wounds with fecal matter). These behaviors, while extreme and disruptive to the daily operations of correctional facilities, serve a purpose for the individual (Navines *et al.*, 2013). That is, to relieve the pressure and frustration of their current mental state and obtain a response from staff. Gardner *et al.* (2016) describe the emotional disturbance in individuals with BPD as resulting from unfulfilled attachment needs, which has been prominent throughout their lives and continues into incarceration.

The importance of mental health staff providing therapeutic solutions to these disruptive behaviors and educating other staff and officers on BPD cannot be overstated. In doing so, the tendency to become frustrated with these offenders, to lash out at them, or to ignore them which only exacerbates the situation, can be minimized. With an understanding that segregating individuals with BPD does not curtail the tendency to violate rules, prison psychologists may focus on other interventions that are more appropriate for this population and more effective at changing the behaviors.

Interventions for Personality Disorders

Due to the inflexible and pervasive nature of personality disorders, treatment in community settings is often very challenging for mental health professionals. In prison environments, where resources are scarce and budgets are limited, the difficulty is compounded. The growing inmate population has not been matched by the number of staff in correctional facilities. Mental health departments are lacking the staff and resources to properly address the increasing number of inmates seeking psychological services. Due to the complexity of PDs and the variability in which they manifest in correctional settings, the resulting prisoner misconduct leads to long periods in segregated housing and isolated cells. Segregation, as noted earlier, only increases the behavior.

Dialectical Behavior Therapy (DBT)

Developed in the 1980's by Marsha Linehan from the University of Washington, Dialectical Behavior Therapy (DBT) is used to treat individuals with borderline personality disorder (BPD) and other PDs. DBT is considered to be one of the most effective treatments for severe personality disorders. DBT teaches acceptance skills through mindfulness and distress tolerance, as well as change skills in emotion regulation and interpersonal effectiveness (Linehan & Wilks, 2015).

The first of the four skills or DBT modules is the mindfulness skill. Mindfulness is considered a core skill and is incorporated in all four modules of the training. This core skill helps individuals focus on their current emotions in order to learn how to improve their reactions to them.

The distress tolerance skill, teaches individuals to increase their ability to tolerate frustration and stressful situations. Individuals with PDs often have low frustration tolerance and tend to overreact to situations. If these exaggerated responses are learned from experience, as seen in cognitive-behavioral approaches, then increasing one's frustration tolerance can also be learned by addressing dysfunctional beliefs and maladaptive cognitions (core schemas) (Saradjian *et al.*, 2013; Brazao *et al.*, 2015).

Emotion regulation is key to improving individuals' ability to relate better to the external world, to reduce unhealthy emotional reactions to others, and to increase their resilience to negative feelings. As affective dysregulation improves, so do the skills in selecting effective coping strategies.

The interpersonal effectiveness skill teaches individuals to better manage conflict with others and improve their ability to relate to and communicate with others. This change skill is crucial to changing how the individual responds and reacts to others in their daily lives. A common mistake made by individuals with PDs is to misinterpret the intentions of others and then react negatively towards them. Interpersonal effectiveness addresses these errors in judgment and improves the individual's reaction.

Research on DBT in correctional settings has yielded positive results for participating inmates. For instance, treatment has yielded reductions in both prison misconduct and self-harming behaviors (De Motte *et al.*, 2017; Nee & Farman, 2007). In addition to DBT, other prison programs can be beneficial to offenders with personality disorders.

Prison Programming

There are a number of prison programs that are designed to help offenders address their skill deficits and reduce recidivism rates. These programs range in topics from teaching inmates how to manage their anger, improve their parenting skills, increase their ability to be empathic, and reduce their criminal thinking. Availability and access to these evidence-based programs can be a barrier for offenders when correctional administrators fall short of obtaining proper funding or staff retention to facilitate these classes.

Correctional administrators often struggle with placement decisions of offenders with long sentences who are not eligible for programs (inmates with life sentences cannot participate in many reentry programs), with high attrition rates from programming due to inmates transferring out of housing units or to other prisons, and rule-violating behaviors that cause offenders to be removed from programs and placed in segregated housing. Offender housing and program assignments that take into consideration the dispositions of inmates with PDs, are an important part of effectively managing the population. Mental health departments should play a role in facilitating these decisions.

Appropriate placement of inmates in psychoeducational classes can help maximize the efficiency of these programs; an essential resource for departments with small budgets. The Risk, Need, Responsivity model (RNR) points to only moderate and high risk offenders

participating in programming. That is due to findings that low-risk offenders are less likely to recidivate (Andrews & Bonta, 2010). Compliance with the RNR principle requires a system in place to assess each inmate's recidivism risk, such as the Ohio Risk Assessment System (ORAS) that can be utilized to categorize moderate and high-risk offenders for programs.

If, as suggested by researchers, prison program participation correlates negatively with institutional misconduct (Courtney, 2019; Joseph & Benefield, 2010), the goal would be to maintain a high level of programming on each yard that complies with the RNR principle. This would provide inmates with access to various programs that address the risk factors contributing to their institutional misconduct and high recidivism rates. As such, evidence-based programs can provide a safer environment for both inmates and staff.

Individual and Group Counseling

Individual and group counseling in correctional settings provide a means for offenders to address their mental and behavioral health problems prior to release. As safety concerns take priority over confidentiality in correctional settings, inmates are made aware of the limits of confidentiality that include the ones seen in community mental health (e.g. mandatory reporting laws and Tarasoff notifications) as well as anything related to prison security (e.g. weapons, prison-made alcohol, illicit drugs, and escape plans). Even with the limited confidentiality, inmates continue to benefit from both individual and group therapy.

Inmates experience numerous benefits from participating in group therapy while incarcerated. Yalom (1995) points to the importance of group cohesion in maximizing learning and therapeutic benefit. When prison therapists build trust and respect with group participants, the group process allows offenders to gain new skills, to learn appropriate ways of challenging other group members' misconceptions as well as their own, to relate and learn from the experience of other group members, and to practice interpersonal skills.

While the group format is more cost-effective than individual therapy (Brazao *et al.*, 2015) simply due to the ability to provide the same service to several offenders at once, one-on-one counseling is also a valuable tool in combating maladaptive behavioral patterns. Individual therapy, particularly after trust and rapport have been established, provides an important resource for reality-testing of the individual's belief system; one in which the trusted therapist challenges the cognitive distortions and maladaptive schemas embedded in the PD. When carefully implemented, CBT-based interventions can ameliorate offenders' negative behaviors by helping them to overcome their own destructive thought patterns.

Conclusions

Managing hard-to-treat inmates in penal institutions requires an interdisciplinary approach that takes custodial safety concerns into account along with mental health considerations.

According to the Importation Model, the way in which prisoners adjust to the prison environment is based on their own characteristics or personality traits. Offenders import their personality traits into the prison environment (Bosma *et al.*, 2020; Mertens & Vander Laenen, 2020).

Conversely, the Deprivation Model posits that inmates' behavior is based on the conditions in which they are subjected to during incarceration. Thus, because they are deprived of everyday comforts that are enjoyed by free society, they react to the conditions of the prison. While it is likely that both models hold some truth, the Importation Model is more effective at explaining why a small number of inmates create most of the problems in correctional institutions (Bosma *et al.*, 2020; Mertens & Vander Laenen, 2020).

As discussed above, offenders with maladaptive characterological traits or PDs misjudge the intentions of others around them and react in maladaptive ways that create problems for themselves as they make their way through their environments, in correctional institutions and in free society. These individuals tend to misinterpret the motives of others as malevolent and react defensively. Furthermore, individuals with PDs tend to have poor coping skills and reduced ability to adjust to new settings. Psychological interventions play an important role in addressing these deficits.

By definition, PDs are rigid and inflexible which leads to overreactions and rule infractions. If the disciplinary process is perceived to be unjust or unfair, an overreaction typical of an offender with a PD is to act-out even further and transgress while in segregated housing. For this reason, it is crucial that the system of disciplining offenders be perceived as reasonably fair by the inmate population (Butler & Maruna, 2016) and that overall the relationship between staff and inmates be a positive one (Bosma *et al.*, 2020).

As noted earlier, institutional misconduct also has implications for recidivism. In-prison rule-breaking is associated with post-release continued criminality in the community (Bosma et al, 2020; Cochran et al, 2014; Trulson et al, 2011). Therefore, it stands to reason that if rule-violating behavior is curtailed in correctional institutions, the same may occur on the outside. Key to changing dysfunctional behaviors is, as discussed earlier, high-intensity targeted interventions such as DBT, SFT, and CT, in both group and individual modalities.

Because the response to PDs is most effective when it is interdisciplinary, involving both custody and mental health departments, training for both disciplines is vital. A portion of most departmental budgets is set aside for training. It is recommended that training for both disciplines have a focus on managing offenders with PDs. There are a number of cognitive-behavioral approaches to treating PDs that are taught in trainings similar to DBT but are not as lengthy or costly. Because prison staff are impacted negatively by inmates with PD (Cooke *et al.*, 2017), and this results in apathy, burnout, and high turnover (Smith *et al.*, 2019), it is worthwhile for staff who work with PDs to be offered training in this area.

Additionally, training for officers is available through the National Alliance of Mental Illness (NAMI) and programs such as Crisis Intervention Training (CIT) as well as Critical

Incident Stress Management (CISM) help to improve custody's response to offenders with mental illness (Gangemi, 2019). As a result, the inmates are less reactive to officers and easier to manage.

Prison psychologists should focus on programs that improve offenders' coping responses to reduce aggression (Dunne *et al.*, 2018) and utilize interventions that target PDs. While the research on associations between education and institutional misconduct is mixed (Courtney, 2019; Clark & Rydberg, 2016), improving offenders' overall mental health can reduce aggression and improve the safety of correctional institutions (Joseph & Benefield, 2010).

Effectively managing offenders with PDs is crucial to the safety of prison environments. An inmate who was questioned about his unprovoked attempt to stab an officer with a pencil explained his behavior by declaring, "I felt pokey." An area of interest for future research may be to focus on possible associations between poor impulse control, language deficits, and violent behavior. Also, future research might examine the link between Social Information Processing Theory, in other words how the individual processes information (e.g. blames others, feels persecuted, etc.) and aggression (Brazao *et al.*, 2015).

The role of mental health in addressing PDs in correctional settings is to recommend the types of programs (evidence-based, DBT, and other cognitive-behavioral interventions) that have been proven effective in reducing aggression and incidents of institutional misconduct. Prison psychologists may also help design and implement these programs and recommend appropriate staff for the delivery of services in these treatment units.

In addition to well-designed interventions for PDs, prison psychologists may also assist the administrators in recommending alternative sanctions to locking inmates up in segregated housing. This may include loss of privileges within treatment programs, loss of phone or tier time. Recognizing the importance of finding new solutions to the problem of institutional misconduct with offenders with PDs is crucial to changing the behavior. In order to reduce extended isolation for offenders with PD and focus on skills training such as impulse-control and anger management, as well as increasing educational opportunities such as vocational and literacy skills, requires a coordinated approach to treatment between administrators, custody, mental health, and inmates alike.

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