Working with Mental Health and Criminogenic Factors in Justice-Involved Populations

Day One 12/9/21

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IN OUR GRIT, OUR GLORY

Last updated 12.8.21

1

Welcome

Thanks **to the State of Nebraska Department of Health and Human Services and the UNL Public Policy Center for this opportunity to spend time with you today.**

2

Disclaimer

All opinions stated are strictly those of the author and are not intended to represent the Nebraska Department of Health and Human Services, the Public Policy Center or the University of Nebraska.

I have no conflicts of interest to report.

3

Objectives:

1. Describe Mental Health and Criminal Justice approaches to working with consumers and how to integrate these approaches.
2. Identify DSM V Indicators of Personality Disorders, substance use disorders, and the roots of criminogenic behavior.
3. Describe common challenges to integrating mental health and criminal justice approaches for consumers with mental health diagnoses who are involved in the Criminal Justice system.

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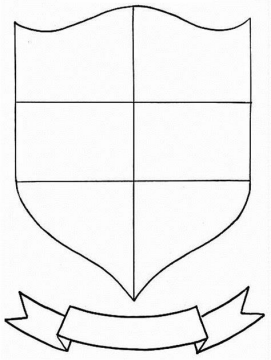

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Who is here today?

1) Mental Health Counselor
2) Social Worker
3) Psychologist
4) Substance Abuse
5) Administrative Staff
6) Parole/Probation Officer
7) Para-professional
8) Consumer
9) Other

6

Criminal Justice Definition

Laws, procedures, institutions, and policies at play before, during, and after the commission of a crime. As a modern concept, criminal justice expresses two central ideas. The first is that criminals and victims of crime have certain rights, while the second is that criminal conduct should be prosecuted and punished by the state following set laws.

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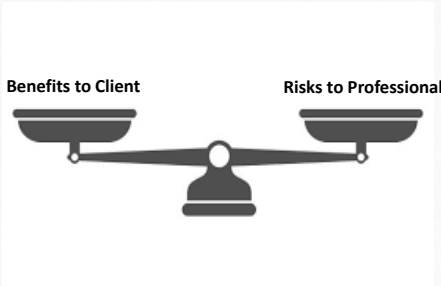
Defensive Practice



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How confident are you in your abilities?

- **Surveyed 129 mental health professionals o No participants rated their skills as below average o 75th percentile was modal rating o 25% rated their skills at the 90th percentile or above**
- **We likely tend to overestimate our skills and competencies, like everyone else**

(Walfish, et al., 2012)

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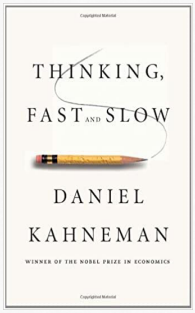
Taube



Two thinking systems:

1)For routine, quick decision-making

2)More critical/deliberate decision-making

The higher the risk, Taube recommends:

"*Festina Lente*"

(Make Haste Slowly)

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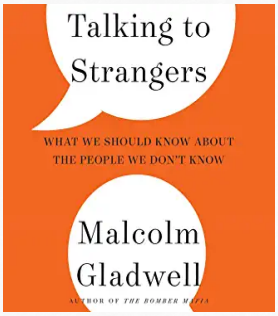


"We are quick to believe the things that we expect to see, so we ignore or discount the things we don't expect to see."

11

Criminal Justice

Nebraska Standardized Model for the Delivery of Substance Use Services

12

Risk-Need-Responsivity Principles

- Risk Principle

Match the level of service to the individual's risk to re-offend. There is growing support in the research for reserving treatment resources for higher risk offenders.

- Need Principle

Assess each person for known criminogenic needs and target treatment based on their most salient needs.

- Responsivity Principle

Maximize the potential success of rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, "secondary" needs, motivation, and strengths of the offender.

(Bonta & Andrews, 2003)

13

Citizens versus Criminals

Citizens

Follow the rules
have things worth protecting
invest in their future
believe in golden rule
have higher self-esteem
interest in other's welfare
respect authority
willing to struggle/defer gain
Value pro-social values

14

Citizens versus Criminals, continued

Criminals

Primarily self-interest
don't care about rules or authority
laugh at golden rule
don't feel they have a future
may not have much to protect
impatient for gain
sees themselves as living "outside the village"

15

Cutting off the top is not enough: Criminal Justice

Criminal lifestyle
Police record
Living outside of societal boundaries
Weapon and substance use

Thinking errors
Antisocial attitudes and values
Avoidance of responsibility/hard work
Sense of shame and embarrassment
Substance and/or MH problems

16

Notes: Criminal Justice

What's the quickest way to bring the change process to a halt?

Side with the client against the P.O. Don't report to the P.O. that your client has relapsed or is struggling with getting their medication or hanging around with negative peer influences.

17

Doing time versus doing treatment: Criminal Justice

Doing Time	Doing Treatment

18

Historical (past)	Clinical (present)	Risk management (future)
H1. Previous violence	C1. Lacks insight	R1. Plans lack feasibility
H2. Young age at first violent incident	C2. Negative attitudes	R2. Exposure to destabilisers
H3. Relationship instability	C3. Active symptoms of major mental illness	R3. Lack of personal support
H4. Employment problems	C4. Impulsivity	R4. Non-compliance with remediation attempts
H5. Substance use	C5. Unresponsive to treatment	R5. Stress
H6. Major mental illness		
H7. Psychopathy		
H8. Early maladjustment		
H9. Personality disorder		
H10. Prior supervision failure		

(Webster et. al., 2002)

19

HCR 20 Risk Assessment Scheme
Version 2

Webster, Douglas, Eaves & Hart (1997)

Thanks to Kevin Douglas, Ph.D. at douglask@sfu.ca

HCR20 Short.ppt

20

Chris Webster, Ph.D. U. British Columbia

21

What are the things that could make me come back to prison?

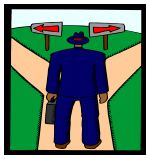
What makes people violent?

22

What keeps you free and safe?

What do you need to do, and ***not*** do, to keep from coming back to prison?

Would it help you to know what your ***risk factors*** are ?



23

The best results will come from you identifying your risks/targets, then working with a team to help you stay sober, stable and free…

24

Scoring the Risk Items

"2" = Yes, this item definitely applies to me or is a major problem in my life

"1" = Maybe, this item possibly applies to me or might apply to me

"0" = No, this item definitely does not apply to me – no problems here

25

Previous Violence (H1)

Do you have a history of fighting /using violence to get your way?

Did you grow up in a violent family/group of friends?

Have you been convicted of more than two Assault/violent MR's?

0 ---- 1 ---- 2
Not Me Maybe Me Definitely Me

26

Young Age at First Violent Incident (H2)

Were you under 12 years old when you first got into trouble for being violent?

Were you under 12 years old when you first hurt someone?

0 ---- 1 ---- 2
Not Me Maybe Me Definitely Me

27

Relationship Instability (H3)

Do you always seem to be in 'hot water' with other people?

Do people always 'misunderstand' your good intentions?

Do you feel that people just don't 'get you?'

Are most of your relationships short-term (less than 6 months)?

0 - - - - 1 - - - - 2
Not Me Maybe Me Definitely Me

28

Employment Problems (H4)

What's the shortest length of time you ever stayed at one job?

Have you ever quit a job without having another job lined up?

Have you ever held a job for at least 6 months?

0 - - - - 1 - - - - 2
Not Me Maybe Me Definitely Me

29

Substance Use Problems (H5)

Are you usually 'using' when you get locked up?

Do you have two or more DUI/DWI/MIP charges?

Have you tried to 'get clean and sober' before, but struggled or failed?

Does using make your mental illness worse?

0 - - - - 1 - - - - 2
Not Me Maybe Me Definitely Me

30

Major Mental Illness (H6)

Have you been diagnosed with a major mental illness (like Schizophrenia or Bipolar)?

Have you been hospitalized or placed on psychiatric meds? How about other members of your family?

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

31

Psychopathy (H7)

- Psychopaths are people who enjoy hurting, conning or 'getting over' on others
- Are you really good at lying to others?
- Don't you think you are smarter than everyone else?

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

32

Early Maladjustment (H8)

Were you kicked out of day care?

Were you in trouble with the principal more than 3 times in your elementary school?

Did your behavior bring stress to you and/or your family?

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

33

Personality Disorder (H9)

Have you been diagnosed with/told you have a personality disorder?

Do you tend to get into trouble with others over and over again?

Personality Disorders:
Paranoid, Schizoid, Schizotypal
Antisocial, Borderline, Histrionic, or Narcissistic
Avoidant, Dependent, Obsessive-Compulsive

34

Prior Supervision Failure (H10)

If you've got a chance on probation or parole, did you make it?

If the Judge gave you a break, did you take advantage of it?

0 ---- 1 ---- 2
Not Me — Maybe Me — Definitely Me

35

Lack of Insight (C1)

Do you understand yourself better than most people?

How well do you know your 'red flags'?

If you have a problem (like mental illness or addiction), do you know it and will you be willing to do something effective about your problems?

0 ---- 1 ---- 2
Not Me — Maybe Me — Definitely Me

36

Negative Attitude (C2)

Do you have a 'bad attitude' when others try to help you?

Do people think of you are stubborn or 'hard headed?'

Are you open to letting others give you feedback?

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

37

Active Symptoms of Major Mental Illness (C3)

If you have an illness, are you lots of symptoms right now?

If your mental health symptoms are active right now, are you willing to partner with us and take steps to manage them?

It's harder to make good decisions if your brain isn't working right

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

38

Impulsivity (C4)

Do you get into trouble because you "leap before you look?"

Have you ever made decisions that you later regret?

Are you sometimes your own worst enemy?

0 ---- 1 --- - 2
Not Me Maybe Me Definitely Me

39

Unresponsive to Treatment (C5)

Do you get sick & tired of the team telling you what to do?

Have you ever "dropped out" or been "kicked out" of treatment?

Do you resent having to take medications and follow the rules?

0 ---- 1 ---- 2
Not Me Maybe Me Definitely Me

40

Plans Lack Feasibility (R1)

How confident are you in your discharge plans?

Do your peers/team 'roll their eyes' when you talk about your plans?

Does your discharge plan make your social worker pull her hair out?

0 ---- 1 ---- 2
Not Me Maybe Me Definitely Me

41

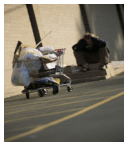
Exposure to Destabilizers (R2)

Do people tell you to change your playmates and playgrounds?

Are you spending time with people/in places that are bad for you?

Are you working with people who are passionate about your sobriety, stability and freedom? If not, why not?

0 ---- 1 ---- 2
Not Me Maybe Me Definitely Me



42

Lack of Personal Support (R3)

We all need people on our 'team' to be successful:
Who's on your team who really cares about you?

Do you have people who will 'go to bat' for you?
If not, where can I find or develop these relationships?

0 ---- 1 ---- 2
Not Me — Maybe Me — Definitely Me

43

Noncompliance with Remediation Efforts (R4)

Will I work with the discharge plan my team has developed?

Am I planning to "ditch my plan" at the first opportunity?

0 ---- 1 ---- 2
Not Me — Maybe Me — Definitely Me

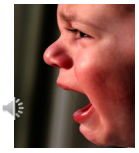
44

Stress (R5)

Do I have good skills at managing my stress level and staying sober?

Can I stay true to my goals 'when the going gets tough?'

0 ---- 1 ---- 2
Not Me — Maybe Me — Definitely Me



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Now that you know the *risk factors*,

- Take a few minutes and rate each of your risk factors – be honest with yourself
- When you're done, identify the two or three highest risk factors (greatest threats to your freedom – then make a plan to protect your future against each risk factor

46

Questions to consider:

"If I don't get honest about my problems and take action to solve them, who will?

"When I do decide to take care of my problems, how will things get better for me?"

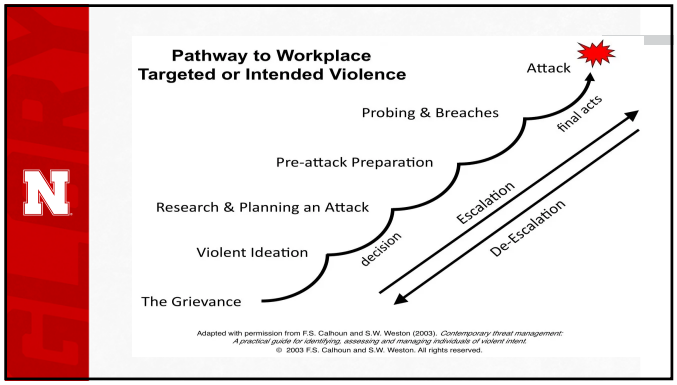
"What is it I want for my life? Can I get there if I don't take care of my risk factors?"

47

Risk versus Threat Assessment

Risk Assessment	Threat Assessment
Risk to general population	Risk to a specific target
Target can be anonymous	Target in generally known
Diffuse/impulsive motivation	Grievance-based

48



49

50

Integrating Mental Health and Criminal Justice Approaches

- Concurrent, not sequential treatment work best for co-occurring
- Weave mental health and criminality together at every stage
- Focus on interventions that hit both target areas (MH and CJ)
- Work with Stages of Change
- Use motivational interviewing (power of self-interest)
- Role model being a strong team member and expect in-kind
- Act as though the "People of Nebraska" are in the room with you

51

Possible areas of conflict for mental health and criminal justice

1) Attribution of intent
2) Lack of clarity about expectations
3) Forensic contract: we are here to serve the public

52

Psychopathy Check List – Revised

Hare Psychopthy Checklist-Revised (Hare, 2003)

Total Scores range from 0 – 40 (score 0,1,2)

Factor I: core features of psychopathy

Factor II: core features of antisocial personality disorder

(Hare, 2003; Meloy & Yakely, 2014)

53

Psychopathy Checklist

PCL-R Factors 1a and 1b correlate with narcissistic personality disorder and histrionic personality disorder. It is associated with extraversion and positive affect. Factor 1, the so-called core personality traits of psychopathy, may even be beneficial for the psychopath (in terms of nondeviant social functioning).

PCL-R Factor 2a and 2b strongly correlate to antisocial personality disorder and criminality and is associated with reactive anger, criminality, and impulsive violence. The target group for the PCL-R is convicted criminals.

54

Psychopathy Checklist

PCL-R Factor 1 (core traits of psychopathy) correlates with narcissistic personality disorder and histrionic personality disorder.

Glibness/superficial charm
Grandiose sense of self-worth
Pathological lying
Cunning/manipulative
Lack of remorse or guilt
Shallow affect
Callous/lack of empathy
Failure to accept responsibility for own actions

55

PCL-R Factor 2 strongly correlates with antisocial personality disorder and criminality and is associated with reactive anger, criminality, and impulsive violence.

Need for stimulation/proneness to boredom
Parasitic lifestyle
Poor behavioral control
Promiscuous sexual behavior
Lack of realistic long-term goals
Impulsivity
Irresponsibility
Juvenile delinquency
Early behavior problems
Revocation of conditional release

56

Historical Origins

History of Philosophy

History of Psychology

History of Assessment

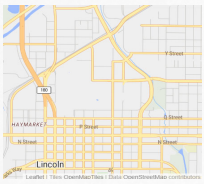
57

Personality Disorder: Waves of theorists

Magicians and Shamans
Ancient Greeks, Egyptians and Chinese
Faith-based healers (Christians and Muslims)
Early Anatomists (Galton et al)
Freud and Neo-Freudians (Jung and Kohut)
Behaviorists (Watson and Skinner)
Cognitive Behavior Therapists (Beck and Meichenbaum)
Interpersonal Theorists (Heppner and Benjamin)
Family Therapists (Haley and the Minuchin)
Group Therapists (Yalom and Kivlighan)
Abnormal Psychologists (Widiger and Trull)
Developmental Psychologists (Bowlby and Ainsworth)
Evolutionary Psychologists (Millon)
Trauma Theorists (Linehan and Bessel Van der Kolk)

58

'The map is not the landscape"



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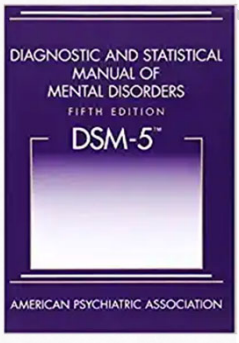

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61

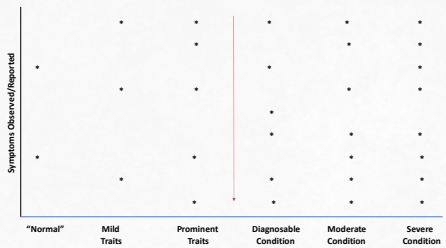
Categorical versus Dimensional

Categorical: qualitatively distinct clinical syndromes

Dimensional: maladaptive variants of personality traits that may blend/merge with one another

62

Continuum of symptoms



63

The most important questions? Assessment

Assessment and Diagnosis

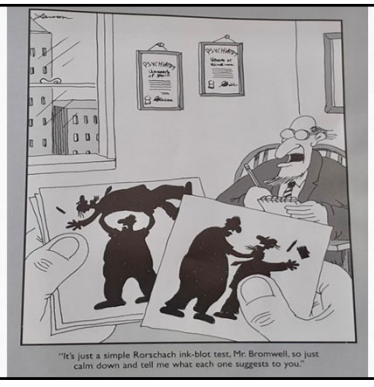
Mental Health providers have to have a question to answer in order to complete an evaluation of the consumer's strengths and needs

64

Commonly used assessment instruments: Personality Disorders

MMPI	Minnesota Multiphasic Personality Inventory (Hathaway)
MCMI	Millon Clinical Multiaxial Inventory, 4th Ed. (Millon)
NEO PI-R	Revised NEO Personality Inventory (Costa & McCrae)
SCID	Structured Clinical Interview for Diagnosis, 2nd Ed. (First)

65



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67

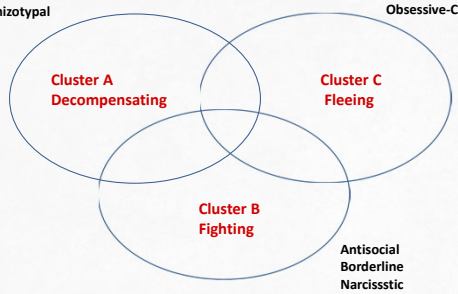
DSM V Personality Disorders

Cluster A	Paranoid Schizoid Schizotypal	"Odd or bizarre"
Cluster B	Antisocial Borderline Narcissistic Histrionic	"Problematic or troubling"
Cluster C	Avoidant Dependent Obsessive-Compulsive	"Anxious or fearful"

68

Paranoid
Schizoid
Schizotypal

Avoidant
Dependent
Obsessive-Compulsive



Antisocial
Borderline
Narcissstic
Histrionic

69

General Personality Disorder

A. An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. Manifested in two (or more) of the following areas:

1. Cognition (ways of perceiving/interpreting self, others & events)

2. Affectivity range, intensity, lability & appropriateness of emotion

3. Interpersonal functioning

4. Impulse control

70

General Personality Disorder, continued

B. The enduring pattern is **inflexible and pervasive** across a broad range of personal and social situations.

C. The enduring pattern leads to **clinically significant distress or impairment** in important areas of functioning.

D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E. The pattern is **not better explained as a manifestation of another mental disorder.**

F. The enduring pattern is **not attributable to the physiological effects of a substance or medical condition**

71

Possible Contributors: Personality Disorders

Biology

Family

Culture

Traumatic Exposure

Substance Use

72

General Model of Treatment for Personality Disorders

1) Establish working alliance/rapport
2) Educate consumer about disorder/their pattern and teach coping skills
3) Teach consumer to identify and block maladaptive patterns
4) Reinforce prosocial coping skills strengthen the will to give up the maladaptive pattern
5) Transfer supports to consumer/community

(Benjamin, 1996)

73

DSM V Personality Disorders

Cluster A	Paranoid Schizoid Schizotypal	"Odd or bizarre"
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Cluster C	Avoidant Dependent Obsessive-Compulsive	"Anxious or fearful"

74

DSM V Cluster "A" Personality Disorders

Paranoid

Schizoid

Schizotypal

"Odd or bizarre"

75

Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others such that their motives are interpreted as malevolent, as indicated by **four** (or more) of the following:

1. Suspects, without sufficient basis, that **others are exploiting, harming or deceiving him or her.**

2. Is preoccupied with unjustified **doubts about the loyalty or trustworthiness of friends** or associates**.**

3. Is reluctant to confide in others because of unwarranted fear that the information will be used against him or her**.**

76

Paranoid Personality Disorder, continued

4. Reads hidden demeaning or threatening meanings into benign remarks or events.

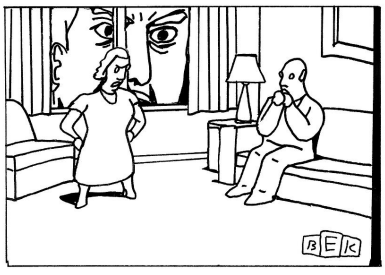
5. Persistently bears grudges (e.g., is unforgiving of insults, injuries or slights)**.**

6. Perceives attacks on his or her character or reputation that are not apparent to others; **quick to anger or counterattack.**

7. Has recurrent **suspicions regarding fidelity of spouse or sexual partner** (without justification).

(DSM V, 2013)

77



"I can't deal with your fear and paranoia."

78

CBT Targets: Paranoid Personality Disorder

"The world is out to get me"

"I'm the only one in the world I can trust"

"I'm going to screw with you before you can mess with me"

"Trusting others is for suckers – I've trusted others and been hurt"

"I can't stand the thought of others talking trash about me."

"The world is very dangerous and I have to constantly be on guard."

"I know they said 'this,' but they really meant 'that'"

79

Transference/Counter-Transference: Paranoid Personality Disorder

Attempt to control treatment

Hypersensitive to therapist's criticism

Slow to trust, critical of therapist

Tendency to withdraw

Provider must be sensitive to impact

(Benjamin 1966)

80

Paranoid Personality Disorder, Continued

Core feature: over-interpreting hostile intent from neutral stimuli

Walter Menninger: "If you are not a little paranoid, then you're not paying attention"

Paranoid ideation is circular and very difficult to disprove

Differential Diagnosis: substance abuse, cultural factors, etc.

Hypothesized to come from genetics or disconfirming family?

(Fox, 2014; Simmons, 2009)

81

Paranoid Personality Disorder

Prevalence:
2 to 4%
associated with relatives with Schizophrenia/delusional disorder

Differential:
PPD & Schizotypal are paranoid, but SzPD have magical thinking
Schizoid PD usually are aloof but not paranoid
Avoidant PD don't share due to fear of embarrassment

82

Cluster "A:" Schizoid Personality Disorder

A. A pervasive pattern of **detachment from social relationships** and a **restricted range of expression of emotions** in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by **four** (or more) of the following:

1. Neither desires nor enjoys **close relationships,** including being part of a family.
2. Almost always chooses **solitary activities.**
3. Little, if any, interest in **sexual experiences** with another person.

(DSM V, 2014; Fox, 2014)

83

Schizoid Personality Disorder, Continued

4. Takes **pleasure** in few, if any, activities.
5. **Lacks close friends or confidants** other than first-degree relatives.
6. Appears **indifferent to the praise or criticism** of others.
7. Shows **emotional coldness, detachment or flattened activity.**

84

CBT Targets: Schizoid Personality Disorder

"I just want to be left alone"

"I don't need anything from anybody"

"This counselor keeps trying to compliment me –
they can go to hell!"

"I know that I'm supposed to care about all this legal stuff,
but I really couldn't care less."

85

Transference/countertransference: Schizoid Personality Disorder

Transference/countertransference
- Attempts to avoid engagement
- Difficult to 'find the handle' that allows you to connect with client

Clinical/case management challenge
- Provider should lower expectations
- Provider should not be put off by lack of expressed emotion and amotivation

86

Schizoid Personality Disorder

Prevalence: estimated at 3-5%

Differential:
Autism has earlier onset, social and non-verbal difficulties, focus on routine and greater emotionality
SPD negative symptoms without positive cognitive/mood symptoms
SPD doesn't have persistent psychotic symptoms like Schizophrenia
SPD doesn't have the paranoid of PPD

87

Cluster A: Schizotypal Personality Disorder

A. A pervasive pattern of **social and interpersonal deficits** marked by acute discomfort with, and **reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior**, beginning by early adulthood and present in a variety of contexts, as indicated by **five** (or more) of the following:

1. Ideas of **reference** (excluding delusions of reference).

2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., superstitiousness, belief in clairvoyance, telepathy or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).

88

3. Unusual perceptual experiences, including bodily illusions

4. Odd thinking/speech (e.g., vague, circumstantial, metaphorical, overelaborate or stereotyped).

5. Suspiciousness or paranoid ideation.

6. Inappropriate or **constricted affect.**

7. Behavior or appearance that is **odd, eccentric or peculiar.**

8. Lack of close friends or confidants except first-degree relatives.

9. Excessive social anxiety that persists and is more about paranoid than poor self-esteem.

89

CBT Targets: Schizotypal Personality Disorder

"I'm not telling this guy about the bugs in my head – no way!"

"I'm not sure how to where I 'fit in' in the world"

"I'm afraid to share my thoughts 'cause others already think I'm weird"

"I don't trust this probation officer – they are probably trying to get me to talk just to get me in trouble with the judge."

90

Notes: Schizotypal Personality Disorder

Transference/countertransference
- May see therapist as attacking/humiliating
- May keep their distance to maintain safety
- May be susceptible to negative peer influence

Clinical/case management challenge
- Provider goal is to increase social supports/team contact

91

Schizotypal Personality Disorder

Prevalence:
1 to 4.6%; slightly more common in men than in women
more likely to have relative with schizophrenia

Differential:
SPD don't need relationships, SzPD and PPD both do but are scared
BPD may also experience psychotic symptoms, but stress-related

92

Case Vignette: Cluster "A" Personality Disorders

Truth be told, Will, now 21 and on probation for trespassing at a church, had always been remembered as being a little odd or strange. He was quiet and introverted, slow to warm to others (if at all) and had odd thoughts that he shared out loud. He told the same story to his counselor and P.O., "I just wanted to get out of the cold," but he was only three blocks from his apartment when he broke into the church. He was bright enough, but just didn't seem to care what anyone else thought and would get mad if he thought anyone was talking about him. Will was difficult to engage, as he would often stare off into space and either ignore the provider or softly whisper things under his breath.

93

Survey Question: Cluster "A" Personality Disorder Case Vignette

What is Will's most likely diagnosis?

a) Antisocial Personality Disorder

b) Paranoid Personality Disorder

c) Schizoid Personality Disorder

d) Schizotypal Personal disorder

e) B, C, and D

94

DSM V Cluster "B" Personality Disorders

Antisocial

Borderline

Histrionic

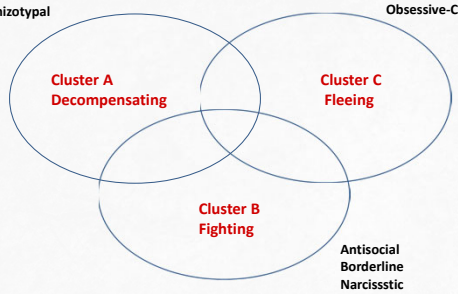
Narcissistic

"Problematic or troubling"

95

Paranoid
Schizoid
Schizotypal

Avoidant
Dependent
Obsessive-Compulsive



Antisocial
Borderline
Narcissstic
Histrionic

96

Cluster B: Antisocial Personality Disorder

A. A pervasive pattern of disregard for and violating the rights of others, occurring since age 15 years), as indicated by three (or more) of the following:

1. Failure to conform to social norms with respect to lawful behaviors, as indicated by repeatedly performing acts that are grounds for arrest.
2. Deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure.
3. Impulsivity or failure to plan ahead.

(DSM, 2014; Fox, 2014)

97

Antisocial Personality Disorder, Continued

4. Irritability and aggressiveness, as indicated by repeated physical fights or assaults.
5. Reckless disregard for safety or self or others.
6. Consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations.
7. Lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated or stolen from another.

98

CBT Targets: Antisocial Personality Disorder

"I should be able to do whatever I want, whenever I want"

"The MAN is always trying to mess with me and get in my way."

"The world is not fair, so I have to cheat to get what I want"

"I've been hurt, so it's cool that I get to hurt others, right?"

"Lying is not big deal – grow up, it's just a part of the game"

"Anyone who wants to help is out to screw me – I'll show them"

99

100

Clinical/case management challenge: Antisocial Personality Disorder

Not always reliable partners in the public safety endeavor

Sometimes the best part of the day is making you look like a monkey

Experts at finding loopholes in our bullet-proof policies & procedures

Counter-transference can be problematic (love 'em or hate 'em)

Triangulation is the rule

(DSM, 2013; Fox, 2014; Meloy & Yakely, 2014)

101

Antisocial Personality Disorder

Prevalence:
2%-5 among males, 1-2% among females
in prisons estimates are in the 50 to 80% range; can "age out" into 40's
MZ twins were 55% concordant for criminal behaviors, DZ twins 13%
risk for ASPD is higher if you have a first-degree relative with disorder

co-occurs with anxiety 68%, suicidality 76% substance use disorders78%

Differential:
ASPD exploit others for money/power, SzPD for revenge/payback
ASPD exploit for money/power, BPD for need to control/self-regulate

102

Cluster B: Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and 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. (x suicidal or self-mutilating behavior covered in Criterion 5).
2. A pattern of unstable/intense interpersonal relationships characterized by alternating between idealization devaluation.
3. Identity disturbance: markedly and persistently unstable self-image or sense of self

103

Borderline Personality Disorder, continued

4. Impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating).
5. Recurrent suicidal behavior, gestures or threats, or self-mutilating behaviors (parasuicidality).
6. Affective instability due to a market reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days).

104

Borderline Personality Disorder, continued

7. Chronic feelings of emptiness.
8. Inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights).
9. Transient, stress-related paranoid ideation or severe dissociative symptoms.

105

CBT Targets: Borderline Personality Disorder

"I'll never be safe in this world – no who really knows me will ever love me"

"Even if I find someone who loves me, they are bound to leave me"

"I can't stand feeling this exposed and lonely in the world"

"I hate people who betray me – and everyone betrays me"

106

Borderline Personality Disorder

Prevalence:
1.6 to 5.9%; 3 females for every male
Relatives of those with BPD are 5X likely to have BPD Dx; childhood abuse/parental neglect/family dysfunction contributory

Often co-morbid with depressive and bipolar disorders as well as anxiety, PTSD and eating disorders (women)

Neuroimaging studies suggest hippocampus (learning and memory) and amygdala (emotion) involvement; persons with BPD tend to over-respond to emotional stimuli

107

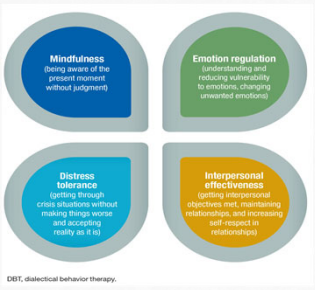
Borderline Personality Disorder

Differential Diagnosis

HPD have emotional volatility without self-destructiveness/self-hatred
PPD and NPD have more stable self image
ASPD's manipulate for profit/power, BPD's to earn caretaker concern
BPD's react to abandonment with rage, but DPD seek appeasement
BPD's hallmark is intense and unstable relationships

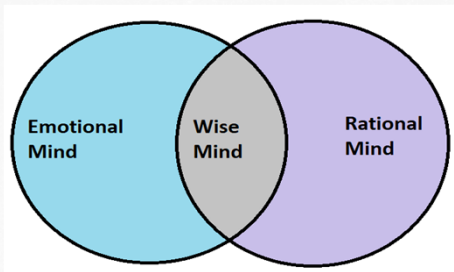
108

Marsha Linehan - Dialectical Behavior Therapy for BPD



(Linehan, 2014)

109



Thesis Synthesis Antithesis

110

Cluster B: Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following;

1. **Is uncomfortable in situations in which he or she is not the center of attention.**
2. **Interaction with others in often characterized by inappropriate sexually seductive or provocative behavior.**
3. **Displays rapidly shifting and shallow expression of emotion.**

111

Histrionic Personality Disorder, continued

4. Consistently used physical appearance to draw attention to self.
5. Has a style of speech that is excessively impressionistic and lacking in detail.
6. Shows self-dramatization, theatricality, and exaggerated expression of emotion.
7. Is suggestible (i.e., easily influenced by others or circumstances).
8. Considers relationships to be more intimate than they actually are.

112

CBT Targets: Histrionic Personality Disorder

"No one understands how much my needs and how painful my life is"

"All is fair in love and war – I will use all resources at my disposal"

"I paint with a broad brush; don't hold me responsible for the details of my life"

"You are either with me or you are my sworn enemy"

113

Histrionic Personality Disorder

Prevalence:
around 1.8%, mostly females (70%)
females may be over-diagnosed due to gender/social bias

co-morbid with somatic/conversion disorders, BPD and Depression

Differential:
manipulates to gain attention/nurturance v ASPD for profit/power
demand attention while HPD may be more passive/"one down"
More stable sense of self than BPD

114

Notes: Histrionic Personality Disorder

Engages in emotional/dramatic behavior to be center of attention

Live in a high-drama world where boredom can be the enemy

May demand approval through being overly provocative/seductive

Siding with them is the only metric

They live their life making mountains out of mole hills

May demand dramatic response (or else) they feel rejected

(DSM, 2014; Fox, 2014)

115

Cluster B: Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning in early and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate accomplishments).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty or ideal love.

116

117

Narcissistic Personality Disorder, continued

3. Believes that he or she is "special" and unique and can only be understand by, or should associate with, other special or high-status people/institutions.

4. Requires excessive admiration.

5. Has a sense of entitlement (i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations).

6. Is interpersonally exploitive (i.e., takes advantage of others to achieve his or her own needs).

118

Narcissistic Personality Disorder, continued

7. Lacks empathy: is unwilling to recognize and identify with the feelings and needs of others.

8. Is often envious of others or believes that others are envious of him or her.

9. Shows arrogant, haughty behaviors or attitudes.

119

CBT Targets: Narcissistic Personality Disorder

"I'm the only one that's important in the world; you're only players on my stage"

"You can't possibly begin to understand what I'm feeling"

"I deserve the best of everything or I simply can't stand it (and you'll pay)"

"What so wrong with stepping on others if I have to meet my needs?"

"I can't stand it when anyone else gets attention/praise, I hate them!"

120

Management: Narcissistic Personality Disorder

Constant demands for support, admiration and fealty

May get furious if provider can't/won't meet consumer's wants and needs

At high risk to withdraw/sabotage progress when the going gets tough

There may not be any oxygen left in the room for anyone else

121

Narcissistic Personality Disorder

Prevalence: varies, up to just over 6% of community samples, almost 2:1 males (caveat about gender socialization)

Differential:
Compared to other Cluster "B" PD's, the key is grandiosity
BPD have unstable self-image and self-destruction
HPD don't show exaggerated pride, disregard for others
SzPD and PPD also fear exposure but may seem odd
NPD v ASPD: no history of conduct disorder as teenage, drive for admiration/envy v profit/power

122

Case Vignette: Cluster "B" Personality Disorders

Marcus is a 24 year-old inmate with NDCS; he is serving 2-4 years for assaulting his neighbor and jams next month. He has a long history of school fights, being fired from jobs and an impressive rap sheet for such a young man. He glares at his P.O. when they meet for pre-release planning, dismissing offers of help, saying, "I'll be all right." While in prison, Marcus got in trouble for "running store," CTG activity, fighting and 'talking trash' to staff, especially female staff. He is clearly bright and loves to "stir the pot." Marcus dreamed of being a chef when he was younger, but dropped out of high school and now seems to be on track for "having several more numbers in him."

123

Survey Question: Cluster "B" Personality Disorder Case Vignette

What is Marcus's most likely diagnosis?

a) Antisocial Personality Disorder

b) Borderline Personality Disorder

c) Histrionic Personality Disorder

d) Narcissistic Personality Disorder

e) All of the above

124

Case Vignette 2: Cluster "B" Personality Disorders

Paula is a 27 year-old woman who has just been paroled from the NDCS Correctional Center for Women in York (again) and is back in jail for violating release conditions – as her parole officer, you've heard that she can be "a handful". Paula enters the interview room complaining loudly about how no one understands her and that the "system is trying to screw me over again." She is overtly flirtatious with the escort officer. You heard that she filed several complaints against her last parole officer. She likes abusing pills, but the substance abuse counselor has already given her a glowing review; you get an uneasy feeling as she makes herself at home in the chair just across from your desk and glares at you. She has bright red scratches visible on both wrists.

125

Survey Question 2: Cluster "B" Personality Disorder Case Vignette

What is Paula's most likely diagnosis?

a) Antisocial Personality Disorder

b) Borderline Personality Disorder

c) Histrionic Personality Disorder

d) Narcissistic Personality Disorder

e) All of the above

126

Why are Personality Disorders so hard on MH/CJ Providers?

1) They are enduring over time
2) They are very resistant to change
3) They can be resistant to logic
4) They can be resistant to consequences
5) They can be higher functioning than other clients
6) They can be skilled at "managing" providers
7) They can challenge provider self-efficacy
8) They can contribute to provider burn-out

127

Survey Question: Provider Self-Care

How many days a working month (out of 20 days) do you experience significant levels of frustration or burnout?

1) 0 - 2
2) 3 - 5
3) 6 - 9
4) 10 or more

128

WORLD HEALTH ORGANIZATION, continued.

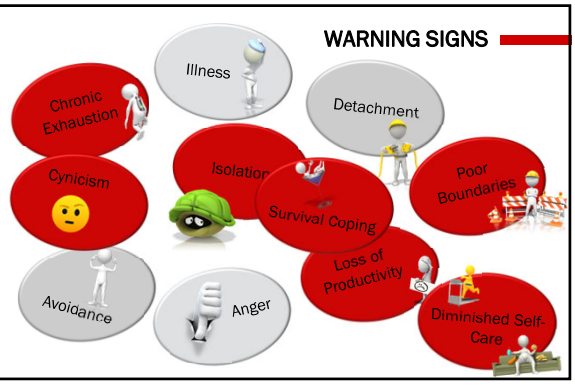
"Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions:

- feelings of energy depletion or exhaustion
- increased mental distance from one's job, or feelings of negativism or cynicism related to one's job
- reduced professional efficacy.

Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life."

129

WARNING SIGNS



130

Top 10 signs you're stressed

You're so tired you now answer the phone, "Hello, this is Hell."

Starbucks is listed as your emergency contact.

You wake up to discover your bed is on fire, but go back to sleep because you just don't care.

You have so much on your mind, you forget to go to the bathroom unless it's on your schedule.

You need a vacation so badly, you've contemplated plotting your own kidnapping.

You consider Red Bull part of a balanced diet.

Your muscles are so tense, you're convinced you were the Tin Man in a previous life.

Your partner throws your iPhone out the window after you answer a work call or email for the tenth time during your date.

Your best friends think you have moved away because they have not heard from you in so long.

You fall asleep during trips to the dentist's office because it's the only time you put your feet up.

131

Steps to Stress Reduction: Address Workplace Concerns

Evaluate your options.

Seek support.

Try to find some value in your work.

Make friends at work.

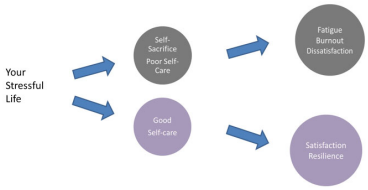
Take time off.

Set boundaries.

Take a daily break from technology.

132

The importance of self-care



133

This is not self-care

134

135

Basic Human needs:

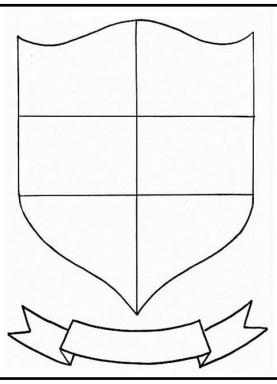
- We want the world to make sense
- We want to feel that life is fair
- We want to feel that others understand and support us
- We want don't want to feel alone or left out
- We all need reassurance

136

If COVID takes, then you…

When Covid takes:	*you can…*
• Seeing your family	set up a zoom meal
• Sense of connection	build new relations
• Your sense of safety	build in security
• Your belief in good	dig a new foundation

137

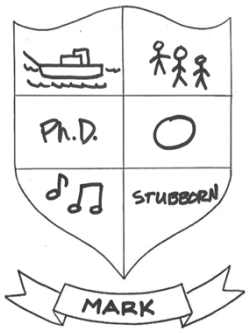


138

Your shield of self…

1. Someone from your family that you love and admire. Living or dead.
2. Your BFF. Real or imaginary. Who would really have your back?
3. Your hopes. Who or what will you become in your dreams?
4. Your faith. What beliefs sustain you and give you hope?
5. Your jam. It may be your pet, your favorite lyric, whatever amps you.
6. Your strength. What's your gift? Are you passionate, stubborn, kind?

139



140

Working with Mental Health and Criminogenic Factors in Justice-Involved Populations

Thanks for coming today!

See you at 8:00 a.m. 12/16/21

Saved 12/28/21 5:45 p.m.

IN OUR GRIT, OUR GLORY.

141