Personality Dynamics Behind Bars: Improving Mental Health Services in a Correctional Facility

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Abstract

Mental health services provided in correctional facilities require improvement (Fazel et al., 2016). One strategy for improving care in these facilities may be to give consideration to a patient's personality dynamics when planning interventions or interacting with the patient. Understanding a patient in the context of their personality dynamics can give members of a treatment team an increased ability to predict a patient's experience of, and response to, different interventions, situations, and stimuli. This brief report identifies three treatment issues relevant to correctional settings and then uses clinical material from three cases to illustrate how conceptualizing each patient's personality dynamics helped address these issues by facilitating more considerate and patient-centered interactions between staff and patient, assisting in the planning of behavioral interventions that are better suited for a patient's personality, and by guiding approaches to building rapport and encouraging a patient's engagement in their own treatment. These brief cases demonstrate the diverse utility of attending to each patient's personality dynamics in correctional settings.

Keywords: Personality; Forensic Psychology; Psychoanalytic Theory

Personality Dynamics Behind Bars: Improving Mental Health Services in a Correctional Facility

Prevalence rates of mental illness in correctional facilities are two to four times those of the general population in the United States (Prins & Draper, 2009). Mental health services provided in these facilities require improvement (Fazel et al., 2016); bearing in mind a patient's personality dynamics when planning interventions or interacting with the patient in a given context may be one strategy for improving care in correctional facilities. Contemporary psychodynamic understandings of personality are based on the premise that personality dynamics are organized around themes, with each theme reflecting core conflicts and patterns of preoccupation (see Lingardi & McWilliams, 2017). Conceptualizing an individual's personality allows for a greater ability to understand why the individual thinks, feels, and behaves the way they do, and psychodynamically-informed perspectives of personality consistently address situational variability, underlying processes, and the person's subjective experience of self, other people, and self-other interactions (Bornstein et al., 2018).

The nuanced understanding of a patient afforded by considering their personality dynamics can give members of a treatment team the increased ability to predict a patient's experience of, and response to, different situations and stimuli. For instance, this knowledge can inform decisions regarding how to interact with the patient in a manner that is most likely to produce a desired outcome (e.g., de-escalation). In the following, I acknowledge three treatment issues relevant to correctional settings and then illustrate how understanding the patient's personality dynamics helped address each issue and improved patient care.¹

¹ Case material has been deidentified and disguised in accordance with APA ethical standards to protect the identity of patients.

Interactions with Correctional Officers

Possibly with the exception of those in private practice who also handle their own scheduling, all treatment settings involve interactions between the patient and an individual with little – or no – mental health training. In correctional settings, those interacting the most with patients are also the individuals who often have the least amount of mental health training. Correctional Officers (COs) receive a minimal amount of mental health training, commonly dedicated to crisis intervention (Kois et al., 2019). COs are present in the institution 24-hours a day, seven days a week, during which they are regularly interacting with patients in various ways. Beyond transport and ensuring safety and rule adherence, COs engage with patients in meaningful conversation and recreation (e.g., card games, boardgames, etc.). Still, the quintessential role of the CO within the correctional facility is to ensure safety and compliance. This role can foster an othering mentality among both COs and patients, which can interfere with treatment, or worse, create dangerous situations for all those involved (see Peternelj-Taylor, 2004, for an exploration of othering in correctional environments and recommendations). COs are an ever-present element in each patient's environment and they *can* be a vital part of a patient's treatment – in my personal experience, many COs are very interested in learning how they can better help patients on their units.

The Case of Mr. Jones

Mr. Jones was a 50-year-old man admitted to a jail's psychiatric unit due to a history of bipolar disorder and recurring provocative behaviors that included cussing, flooding, and threatening/assaulting staff and peers; his behaviors required a use-of-force scenario his first day on the unit (and many thereafter). During his time on the unit, Mr. Jones participated in a social skills group and weekly individual behavioral therapy.

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Mr. Jones' personality structure was characterized by an omnipotent sense of self, one fearful of vulnerability due to expectations of manipulative others, and a consequential need to feel his impact upon others (i.e., I must assert my power over others before they can use me). These pathogenic beliefs were accompanied by an indifference toward others and deliberate, ego syntonic manipulations to satisfy his personal needs and striving for dominance. This psychopathic (antisocial) personality organization and Mr. Jones' proclivity for action over ideation regularly resulted in acting out behaviors (e.g., flooding his cell, banging, smearing feces, and other destructive behaviors he perceived to be exhibitions of his power to impact others) and a minimization – or complete disavowal – of personal responsibility. These behaviors were amplified in situations where Mr. Jones' omnipotence was threatened, such as when a CO attempted to appropriately validate the patient's agony over his mother's death. The patient's perception of affect's direct association with weakness would not allow him to acknowledge or reveal his emotional experiences. Rather, he would defend against affect and any ego dystonic experiences of shame, weakness, and vulnerability by engaging in actions that would reduce these unpleasant states of arousal, confirm his omnipotent control, and restore his self-esteem. In his exchange with the CO noted above, he stated "Fuck that and fuck you!" and then attempted to physically assault the CO.

The approach to working with Mr. Jones, as is the case when working with most individuals possessing a psychopathic personality structure, can be counterintuitive. However, a strong case conceptualization based on the patient's personality dynamics allowed staff to counsel COs on their interactions with Mr. Jones to the benefit of the patient, staff, and the entire unit. Specifically, COs were taught – without violating HIPAA laws or regulations – that individuals similar to the patient will often "raise the stakes" when they feel challenged, that his response is

not inherently a personal attack, and some, as was the case for Mr. Jones, will escalate to a point of physical aggression. Rather, the validation of the patient's autonomy while emphasizing the possible realistic outcomes of his behavior without judgment would likely be more productive (e.g., "I'm telling you now to stop flooding your cell" versus "You know it's a violation to flood your cell; it's your choice whether you flood your cell or not, but [this is what will happen if you choose to flood your cell]"). Additionally, the (many) well-meaning COs offering empathy over the patient's loss were encouraged to "pull-back" and, instead, comment on how they would feel, without judgment of Mr. Jones' presentation (e.g., "People feel all kinds of ways when someone dies. I don't think there's a right way to feel but I remember feeling numb when my father died"). Within a month, Mr. Jones' interactions with the COs improved and the frequency of his more serious violations reduced partially as a result of these suggestions based on his personality dynamics.

Limited Resources

Mental health resources can be stretched incredibly thin at many correctional facilities and the overuse of limited resources by one patient can result in a lack of resources for another. Behavioral interventions, secondary to psychopharmacology, are often the first tool deployed to address behaviors that put disproportionate strain on a facility's limited resources (e.g., behaviors that require one-on-one observation, medical and security codes, restraints, etc.). Behavioral interventions can be particularly effective when their planning takes the patient's personality dynamics into consideration.

The Case of Mr. Rogers

Mr. Rogers was a 25-year-old man referred for a psychological assessment due to difficulties adjusting to incarceration and a lack of improvement seen while housed on a lower level of care

unit. He demonstrated very poor coping abilities, some interpersonal problems, and various deviant behaviors (e.g., frequent violence, pseudo seizures, disrupting a group session by stripping-down naked, which resulted in him being escorted back to his unit). On the surface, the patient's behavior would not strike most mental health professionals as a manifestation of a dependent personality. Yet, as portrayed below, Mr. Rogers was characterologically dependent.

Dependent individuals, such as Mr. Rogers, possess a helpless self-concept fostered by a perception of the self as powerless and ineffective, with a certainty that they need the care and protection of others who are viewed as comparatively powerful (Bornstein, 1993). As was the case for Mr. Rogers, some individuals will resent having these needs and may go to great lengths to mask their dependency while still satisfying their dependent needs² (e.g., using violence, which is seemingly an antithesis of dependency, to be placed on lockdown – confined to his cell – and assigned a one-to-one observation). This is perhaps extraordinarily so in correctional settings where being seen as weak or dependent might result in victimization. Understandable given his sense of self, Mr. Rogers possessed a persistent motivation to obtain and maintain nurturing, supportive relationships with prospective caregivers. His dependent strivings encouraged passive and active behavioral patterns (i.e., relationship-facilitating strategies meant to develop and strengthen his association with others) while simultaneously stimulating the emotional preoccupations that heightened his helpless self-concept (e.g., anxiety in the absence of relationships, fear of abandonment, fear of negative evaluation, performance anxiety).

Observing Mr. Rogers over the course of his psychological assessment revealed his dependent personality and clarified the link between his deviant behaviors and dependent

² Although not clearly portrayed by this patient, the interested reader is encouraged to refer to Bornstein (1993) and others to learn more about the counterdependent version of dependency, which includes the use of denial and reaction formation to mask dependent strivings.

strivings. A psychodynamically-informed conceptualization of the patient's personality dynamics, which easily accounted for the behaviors other models of dependency have difficulty explaining (e.g., violence and aggression), informed the development of a patient-centered behavioral intervention plan. For instance, the behavioral plan for Mr. Rogers included activities aimed at promoting self-confidence and autonomy (e.g., he was given a job on the unit in which he could take pride), as well as specific strategies for staff to address his agitation (e.g., communicating a given relationship was safe, such as validating that he was not in trouble and that staff were not mad at him). The behavioral intervention plan for the patient dramatically helped him avoid rule violations and, ultimately, reduced the frequency of which he was placed on lockdown. As such, more staff and other resources were freed-up for other patients and Mr. Rogers' behavioral change improved the atmosphere of the unit.

Non-Compliance with Forensic Assessment

A patient's level of compliance in forensic assessment, or any psychological assessment for that matter, can vary. However, assessment is often a medical necessity, as it is regularly needed to diagnose or treat a patient (U.S. Centers for Medicare & Medicaid Services, n.d.). Good rapport and clear explanations of the assessment's purpose and procedure can facilitate a patient's willingness to engage in the assessment process. Personality pathology can sometimes interfere with rapport building and the therapeutic alliance (Benjamin & Karpiak, 2001), thus a clear understanding of a patient's personality dynamics can help build these connections that benefit the process of assessment.

The Case of Ms. Kris

Ms. Kris was a 30-year-old woman referred to a jail's psychiatric unit for psychological assessment due to diagnostic uncertainty. The patient was initially uninterested in psychological

assessment. I explained the purpose of assessment as I did to each patient showing hesitance – I clarified that my goal was to figure out what was actually occurring, that I was interested in their experience and the truth. Perhaps by sheer luck, my mentioning of “the truth” caught the patient’s attention and she agreed to speak with me. As we spoke, I found myself feeling disinterested and to be putting little energy into encouraging her participation. My countertransference seemingly communicated my lack of a personal motive; my relatively cold presentation could irritate other patients but soothed Ms. Kris. Although this countertransference helped establish a rapport during our first encounter, she still withheld permission to obtain and review her hospital records, stating that the records were “useless” because “they are comprised of lies.”

Ms. Kris met diagnostic criteria for schizophrenia, but her personality was unmistakably organized around a paranoid personality structure. At the core of the paranoid personality organization is an attempt to control intolerable affects, thoughts, beliefs, and impulses through projection and subsequent disavowal. These negative qualities are then experienced as external threats. That is, internal threats and suffering are experienced as being outside the self and, thus, avoidable if one is able to thwart the harmful agendas of the outside world. For Ms. Kris, self-hatred and an underlying sense of badness were disavowed and projected onto others. Psychiatric institutions and treatment staff were the common recipients, resulting in the patient’s overwhelming fear that these others use their positions of power to deceitfully label her psychotic. It was her conviction that this unfitting label branded her as evil to the world, permitting institutions to keep her separated from others and abuse her for her badness. Ms. Kris’ response to these malevolent efforts, comprehensibly, was a grandiose presentation joined with hostility and aggression toward those she believed were bent on harming her. Paradoxically, the

negative pieces that Ms. Kris evacuated from her own consciousness were subsequently experienced by her treatment staff, facilitating the disgust, hatred, and punishment she feared and was defending against. Understanding the patient's paranoid personality dynamics was paramount to increasing the therapeutic alliance and being granted permission to request her records.

My validation of Ms. Kris' experiences, which for all intents and purposes were true in her reality and evoked in others through projective identification, and an invitation to help me figure out "the truth" ushered in her interest to participate more fully in the assessment. Noticing this, I utilized a technique from therapeutic assessment, a well-established, evidenced-based assessment model (Finn, 2007), to invite Ms. Kris to be a partner in my investigation. Understanding her chronic paranoid ideations centering on others maliciously falsifying information, I suggested we review her hospital records collaboratively; she literally jumped at the opportunity to point out "the lies" and gave consent to obtain her records. As I promised, Ms. Kris and I reviewed her hospital records and I made note of her commentary, which ultimately allowed me to document her projected self-hatred and underlying sense of badness in a manner that would not have been possible should I have discounted her personality dynamics or left her needs unaddressed.

Conclusion

Given the current state of affairs in the field of clinical psychology, it is imperative to continue recognizing the clinical utility of thoroughly understanding patients' personality dynamics and the assorted advantages such knowledge affords service providers for improving clinical care. In correctional settings, a basic knowledge of personality dynamics is worthwhile. Moreover, applying one's knowledge of personality dynamics in other situations, such as when

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providing services to other nontraditional and/or underserved populations, may prove to be a valuable endeavor as well.

As illustrated by the cases above, understanding patients with consideration paid to their personality dynamics can facilitate more considerate and patient-centered interactions between staff and patient, assist in the planning of behavioral interventions that are better suited for the individual patient, and guide approaches to building rapport and encouraging the patient's engagement in their own treatment. Yet, there are several ethical considerations when using one's understanding of an individual's personality dynamics in effort to facilitate behavior change (e.g., when encouraging a patient's participation in assessment). First and foremost, one should be knowledgeable of, and compliant with, legal and regulatory requirements at the federal, state, and local levels. It is also invaluable to recognize the actual or perceived power or undue influence one has over a patient, and one's understanding of a patient's personality dynamics should not be used for exploitation or adverse manipulation. Nevertheless, when used ethically, consideration for a patient's personality dynamics can have diverse utility. Remaining mindful of this will be important as the fields of psychology and mental health continue to evolve; the continued discussion and demonstration of the broad applicability of conceptualizing patients' personality dynamics is necessary.

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