Commentary: The Forensic Relevance of Personality Disorder

Stephen D. Hart, PhD

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In the last half of the 20th century, research and practice in forensic mental health were focused more on major mental illness than personality disorder. This is both ironic and frustrating. The irony lies in the fact that it was alienists working in forensic settings in the late 19th and early 20th centuries who provided the first clinical descriptions of what we now call personality disorder.[1] Mental institutions at the time housed patients suffering from "total insanity"—conditions associated with a general deterioration of mental functions. In forensic settings, however, patients had a variety of chronic but rather specific deficits in emotion or volition. This extension of the concept of mental disorder beyond the realm of total insanity greatly increased the scope and relevance of psychiatric evidence in forensic proceedings. In some respects, then, the relationship between personality disorder and forensic psychiatry is intimate—perhaps even symbiotic.

The frustration, in contrast, stems from the fact that personality disorder is so important in forensic decision-making, because of its prevalence and its prognostic relevance.[2,3] It appears that the lifetime prevalence of personality disorder in the United States is about 10 to 15 percent.[4] The rate for the form of personality disorder for which the best prevalence data are available—namely, antisocial personality disorder—may be as high as 3 to 5 percent.[5] Epidemiological data in forensic settings are scarce, but the lifetime prevalence rate may exceed 80 percent for any personality disorder[6] and 50 percent for antisocial personality disorder.[5] A reasonable conclusion is that prisons and jails in the United States have evolved into *de facto* psychiatric facilities that specialize in the institutional management of personality disorder—a purpose for which they were not designed and are not adequately resourced. With respect to prognosis, it is becoming clear that personality disorder may be associated with increased risk for criminal and violent behavior,[7,8] as well as with poor response to psychosocial rehabilitation and crime reduction programs.[9]

It was, therefore, with both interest and relief that I read the article by Warren *et al.*[10] in this issue of the Journal. I found the results very interesting and, perhaps more important, the article stimulated me as a reader to think more deeply about several important concerns. My comments will focus on three themes: challenges to research on the forensic relevance of personality disorder with respect to the epidemiology of personality disorder; the prognostic relevance of personality disorder; and gender differences.

The Epidemiology of Personality Disorder

Warren *et al.*[10] are to be congratulated for the methods they used to examine the prevalence of personality disorders. They took steps to maximize the participation rate and to use a two-stage sampling procedure that oversampled women with Cluster B personality disorders. Also, rather than relying on self-report questionnaires (which are of dubious validity in forensic settings, due to factors such as response distortion, literacy problems, and lack of insight), they used a standardized clinical interview, the SCID-II. This was no doubt a considerable burden in terms of training and administration time, but well worth the effort.

The consequence of the recruitment and sampling procedures is that we can be very confident that the findings based on this sample accurately reflect the larger institutional population, but for two reasons, I caution readers against overinterpreting the findings.

Dr. Hart is Professor of Psychology, Department of Psychology, Simon Fraser University, Burnaby, British Columbia, Canada. Address correspondence to: Stephen D. Hart, PhD, Department of Psychology, Simon Fraser University, 8888 University Drive, Burnaby, British Columbia V5A 1S6, Canada. E-mail: hart@sfu.ca

One is that the study reports raw or uncorrected prevalence rates, rather than weighted or corrected prevalence rates. Because women with Cluster B features were deliberately oversampled, the observed prevalence of Cluster B disorders probably overestimates their actual prevalence. Weighted prevalence can increase the complexity of data analysis and interpretation, but may yield findings that are more useful for the purposes of planning service delivery. Another reason is that the generalizability of findings beyond the home institution is unclear. Because the incarceration rate for female offenders is so low (at least, compared with that for male offenders), institutionalized women may differ substantially from noninstitutionalized women, and, similarly, women in one institution may differ substantially from those in another. It would be wrong to assume that the findings in this study are representative of, say, female probationers or female offenders in other facilities. The only way to settle this question is to conduct more epidemiological research.

The consequence of using the SCID-II is that personality disorder is diagnosed according to DSM-IV[11] criteria. The advantages of using the DSM-IV, such as ease of communication and comparability with other research, are readily apparent, but it is important to recognize that there is considerable dissatisfaction with the categorical model of personality disorder reflected in the DSM-IV. Critics have suggested that the use of a dimensional model would afford a better means of capturing the nature and severity of personality disorder symptomatology,[9,12] thus avoiding the problem of excessively high rates of comorbidity among categorical diagnoses, as was the case in the study by Warren *et al.*[10] It is important in subsequent epidemiological research to determine whether different conclusions regarding prevalence (or prognosis) are reached using different methods and models for assessing personality disorder.

The Prognostic Relevance of Personality Disorder

Warren *et al.*[10] conducted analyses to examine the association between personality disorder and history of criminal and violent behavior. These analyses have implications for the delivery of clinical services and also for the development of theories regarding the etiology of crime and violence. There is, however, a circularity in these analyses: criminal and violent behavior may form (in part) the basis for diagnoses of personality disorder that, in turn, are used to explain the occurrence of criminal and violent behavior. This tautology is, in some respects, unavoidable. The concept of personality disorder, like the concept of climate, is both descriptive and implicitly predictive. In future research, however, it is important to minimize criterion contamination as much as possible to determine the extent to which various symptoms of personality disorder have incremental predictive validity vis-à-vis other established risk factors for crime and violence. This can be done in several ways. First, it is possible to diagnose personality disorder without considering information related to crime and violence. Here, the researcher attempts to "de-bias" clinical data by excluding those portions of case files or interviews that focus on criminal history—a procedure that Cornell and colleagues[13] have used in previous research. Second, it is possible to analyze the association between personality disorder and antisocial behavior after excluding symptoms that directly or indirectly reflect crime and violence. Third, it is possible to use hierarchical analyses in which the variance in crime or violence attributable to personality disorder is estimated only after removing variance accounted for by other risk factors, such as age, prior criminality, and substance use. Finally, it is possible to examine the association between specific symptoms of personality disorder and antisocial behavior. If the association is significant, even with symptoms that are not diagnosed on the basis of crime and violence, then it is more plausible to conclude that personality disorder plays some independent causal role. (I noted with considerable interest that Warren *et al.*[10] observed that several forms of violence were associated with Cluster A personality disorders, the diagnostic criteria of which are not directly related to antisocial behavior.) The research strategies described in this article would be made easier by the use of methods for assessing personality disorder that provide detailed symptom-level information, as well as by the use of large samples.

Gender Differences

By studying female offenders, Warren *et al.*[10] remind us that the study of gender differences is critical in forensic mental health. One of the few and most important established "facts" in criminology is the disproportionate involvement of men in crime, especially violent crime.[14] The sources of this gender difference have been a focus of considerable research

and theory. Almost certainly, they include some combination of biological factors (e.g., sex differences with respect to hormones), psychological factors (e.g., gender identity), and sociocultural factors (e.g., gender roles). The practice of forensic mental health—both assessment and treatment—should be informed by research on gender differences.

An unfortunate obstacle to further research on gender differences, following on Warren *et al.*,[10] is that current diagnostic criteria for personality disorder may be gender biased. This bias could take the form of structural bias or metric bias. Structural bias refers to the situation in which the syndromal structure of personality disorder differs across gender. In contrast, metric bias refers to the situation in which the diagnostic relevance (e.g., sensitivity or specificity) of a particular symptom differs across gender. Evaluation of structural and metric bias requires symptom-level assessments, large samples, and complex statistical analyses. Only after structural and metric bias have been eliminated is it possible to examine gender differences in the prevalence and prognostic validity of personality disorder.

Conclusion

The concept of personality disorder is important in forensic mental health. If the recent proliferation of sex offender commitment laws—which permit indefinite detention of people at risk for sexual violence due to mental abnormality, including personality disorder[15]—is any sign, this situation is not likely to change in the near future. I hope the article by Warren *et al.*[10] signals that forensic psychiatry, armed with new intellectual tools, is turning its sights once again to this perplexing problem.

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