Sticks and Stones

The Abuse of Psychiatric Diagnosis in Prisons

By Joel A. Dvoskin, Ph.D., A.B.P.P.

Diagnosis is supposed to give clinicians meaningful clues about what to expect and how to help people who are in various forms of distress. The purpose of diagnosis in medicine, psychology, and related disciplines is to more accurately predict the course of a condition and to foster activities which will assist the person in improving their condition and circumstances. Diagnosis, at its best, is a road map, showing the most efficient route, even shortcuts, to effective treatment and meaningful recovery. In order to fulfill this vital role, diagnoses must have accuracy, meaning, relevance to the person diagnosed and to the context in which the diagnosis takes place, and utility. That is, treatment should be more likely to work when a diagnosis is accurate than when it is not.

Simply put, not all mental health diagnoses foster treatment. In fact, there are some diagnoses that hurt people very much. All too often, the result of psychiatric diagnosis is to stigmatize certain people as dishonest, unlikeable, and, worst of all, hopeless. Nowhere are these iatrogenic (harm created by treatment) effects of diagnosis more pernicious than in the criminal justice system, and no diagnosis hurts more than that of a personality disorder.

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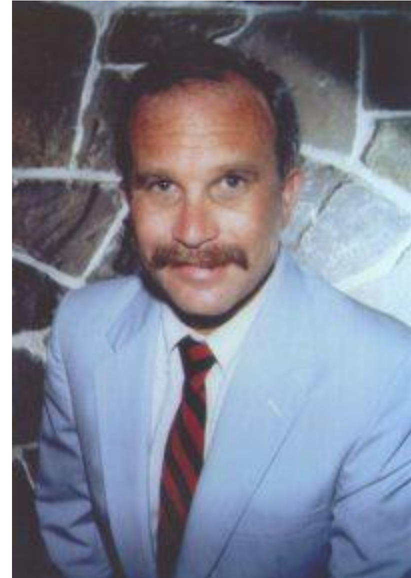
Axis II of the Diagnostic and Statistical Manual (DSM) includes personality disorders such as antisocial personality disorder and borderline personality disorder (BPD). Early in my career, I accepted uncritically the label of BPD as an explanation for a constellation of disruptive behaviors within the prison. There were many inmates of both genders who would seek and then reject intimacy and dependency, overreact to seemingly slight emotional cues, and not infrequently injure themselves. These people, I was told, engaged in these behaviors because they were "Borderlines." And we knew that they were "Borderlines" because they performed these behaviors. This tight little circle of logic had the added advantage of letting me, as a prison psychologist, completely off the hook when I failed to help them; because "Borderlines," I was told, were difficult or impossible to treat.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In jails and prisons, the attributions that derive from psychiatric and psychological diagnosis can have profound effects upon the lives of captives. Many decisions in correctional settings are made on the specific basis of the behavioral attributions that follow diagnosis. For example, experience and research show that segregation settings include an over-representation of inmates with mental illness, largely because their "bad behavior" has been deemed unreflective of mental disability; attributed instead to a vague disease of the spirit called "Axis II." "Axis II" is a horrible thing to be. Though DSM IV lists along Axis II a variety of personality disorders, people who are so described are treated as if their disruptive and self-destructive acts are simply evidence of *moral weakness, dishonor, and perhaps evil.*

For example, people diagnosed with BPD are often pejoratively called "manipulative." Manipulation, often, is listed on treatment plans as a problem or symptom, and patients are insulted and punished when their behavior is so described. Yet, no matter how often punished, how seldom rewarded, the behavior continues. With almost religious fervor, we clung to our ridiculous notion that ruining one's own life was somehow a scam; that *our* miserable, meager, and often mean-spirited attention was a sufficient reward to overwhelm the punitive and tortuous effects of these so-called manipulative behaviors. And why? Because if we were to attribute these behaviors to mental disability, then *we are the failures*. On the other hand, if we call it *free will*, the fault is theirs.

Why would psychiatry and psychology turn so viciously against a group of people they call mentally disordered? Apparently, the greatest sin a patient or client can commit is the sin of poor response to treatment. What is apparently so *wrong* about these unfortunate souls is that they have yet to demonstrate the ability to get better in response to our treatment. Thus, *they* don't make *us* feel very good. (You are forgiven if you find this observation ironic, perhaps under the misguided impression that it was supposed to be the other way around.) With a few notable exceptions, we have simply given up on helping people who desperately need us to do a better job of helping them.

When people cut themselves, we dismiss this behavior as manipulation. We dismiss their despair and say that they did it for our attention. Of course, what *they* say is quite different: "It is the only way I can feel calm." Our dichotomous scientific minds lead us to see things as either willful or the result of disability. I suspect a middle ground, where people with precious few alternatives for feeling better choose one that we find offensive. Like all of us, they learn to cope the best they can. It may be that cutting is the best treatment for anxiety they have come up with. Of course, before we criticize their treatment of choice for anxiety, it is worth considering what alternatives are typically offered in prison. The free world treatments of

choice, modern medications such as SSRI's or cognitive-behavioral treatments for anxiety, are seldom offered in prison. Perhaps if such treatments were the result of a diagnosis of BPD, I might not mind it so much.

How does a person come to acquire such a curious and apparently self-defeating constellation of coping behaviors? For years I have wondered why so many people diagnosed along Axis II, especially in prison, seemed to tell credible, often corroborated and documented, stories of sexual and physical abuse or neglect as (often very young) children. It has become almost trite to assume that "borderlines" and "psychopaths" have been abused, but how exactly did abuse cause people to behave in ways that were so obviously *not* self-serving? Finally, Dr. Bruce Perry, a Psychiatrist at the ChildTrauma Academy at the Baylor College of Medicine, seems to be able to demonstrate exactly what has gone wrong. Studying very young victims of severe abuse and neglect, Dr. Perry has demonstrated that kids protect themselves in two common ways; *and that these strategies permanently change the way their brains process certain kinds of information*. One way, often used by boys, is to become chronically hyperaroused, perhaps in an effort to drown out their pain by overwhelming it with other stimuli. The second way, more often used by girls, is to shut down their systems of stimulus input, trying to endure until the threat finally goes away.

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When I first read and heard of Dr. Perry's work, I was stunned by the simplicity of what my clients had been trying to tell me all those years: Why some men would require constant thrill-seeking in order to feel alive, and why some women would "space out," "dissociate," or even come to believe that they were someone else in the face of reminders of intimate threats.

Please do not assume that I am blaming parents for the criminal behavior of their children. Certainly, kids from the same family grow in very different directions. But remember, parents are not the only people who hurt kids. And some trauma, such as accidental injury, illness, or the death of a parent, are undoubtedly the result of simple bad luck. Nor do I wish to excuse criminal behavior because some of the children who have been traumatized grow up to take their pain out on others. Remember, most do not. Rather, the importance of Bruce Perry's work for clinicians in the criminal justice system is far more simple and profound. Now that we know what went wrong, perhaps we can again begin to hope. And hoping, we will no longer have to despise these people with whom we have failed so miserably.

Working with adults, Dr. Marsha Linehan teaches that the problem shared by nearly all people diagnosed with BPD is their pervasive difficulty in regulating their affect (i.e. expressed emotion). And being a reasonable and logical person, she set about teaching them to do just

that. And her therapy has helped. Outcome data for Linehan's "Dialectical Behavioral Therapy" for BPD is solidly positive. While this brief description does no justice to Professor Linehan's excellent work, it does demonstrate the inaccuracy of our clinical pessimism regarding BPD.

Once the mental health professions get over our counter-transferential need to insult, dismiss, and condemn people with personality disorders, we will perhaps begin to look at what Drs. Perry, Linehan and precious few others are trying to teach us. People whose lives are filled with counter-productivity, torment, and despair can use all the help we can give them. They need our effort, our hope, and our willingness to keep failing until we figure out how to help them. If regulating affect is a problem, we can teach them to do it better. If anxiety disrupts their every day, David Barlow has already taught us how to teach people to feel less anxious. And if they don't have the tools to legally satisfy their material desires (and we shouldn't call theirs greed unless we are prepared to call our own by the same ugly name) Frank Porporino and his colleagues have shown that *life skills training* indeed lowers criminal recidivism.

The power to name things is not to be taken lightly. People, it seems, live up (or down) to our expressed expectations. Diagnosis, calling them names, *can* hurt people very much. Axis II diagnoses, when misused, can cost them voice, history, competence and hope:

- Voice - we don't listen to or believe them, which makes them less honest.
- History - we see their problems as current moral weakness, not the scabs of old wounds; so instead of healing, they do wrong.
- Competence - we label their coping behaviors as weak instead of resourceful, and they quit trying.
- Hope - we truly don't believe they can heal, and they get worse.

I suppose that sooner or later I will have to accept some sort of label for the people I have tried to describe. Certainly, there are striking similarities that warrant generalization. But I suspect I will feel better about such generalizations when they seem to help; to lead those labeled to a safer and more hopeful life.

This article originally appeared in Vol. 8 No. 1 of *The Journal of the California Alliance for the Mentally Ill*. The entire issue is available for $10.00 by sending a check to:
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