The Roots of Our Dilemma: Clinical Problems in a Forensic Setting

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The Roots

- Review of the history of the treatment of the mentally ill
- Discussion of the origins of mentally aberrant behaviors
- Examination of our current treatment paradigm

Philippe Pinel
1745-1826

- Took the chains off the mentally ill.
- Saw mental illness as functional, rather than organic, and therefore subject to treatment.
- Popularized the notion of treating the mentally ill, humanely, and with the intention of helping them regain functionality.

Moral Insanity

- An archaic term meaning loss of control over one's behavior, usually in the affective sense, but also in the sexual realm.
- Used to be attributed to the influence of evil, i.e. "the devil" on the behavior of the so-called morally insane individual.
- Lost its value as a concept when our understanding of other precipitants deepened.

History of the State Hospitals

- descended from the old insane asylums
- formerly housed the chronically mentally ill for indefinite periods
- many emptied out in the 70's
- abuses occurred; ACLU involved

Reagan-era deinstitutionalization

- Many mentally ill people were simply released.
- The promised outpatient services never materialized.
- The vast increase in homelessness dates from that period.
- Criteria for admission to state hospitals changed.

Other Concurrent Influences

- The arrival of more and better pharmaceuticals
- The innovation of paying patients a disability check for a mental illness
- Ramping up the War on Drugs

Work has changed.

- Population being treated in state hospitals has changed. (How?)
- Pressures have increased to offer more treatment.
- Budgets continue to be tightened.
- Greater emphasis is being placed on the use of meds;
- Less emphasis is being placed on the use of psychotherapy.
- More reports are being generated. (Who reads these reports?)

Current state hospital population

- Traditionally, the state hospitals have been used for long term treatment and/or containment of the chronically mentally ill.
- Most patients are now coming to state hospitals from correctional facilities.
- Even though someone in that referring facility thought your new patient was sick enough to warrant a stay at the state hospital, the patient may not be as chronically ill as most patients formerly admitted to state hospitals.

Professional Responsibilities

- to the patient
- to your employer
- to the public
- to yourself

What reasons provoke a referral to the state hospital?

- Incompetent to stand trial
- Not guilty by reason of insanity
- Too sick or dangerous to be housed elsewhere

Legal Fictions

A person is either guilty, or not guilty.

A person is either sane, or insane.

A person who is "temporarily insane" can be "restored" to sanity.

A person is innocent until proven guilty.

Hospitalization now a desired commodity

- Patients may wish it who seek to avoid incarceration
- nothing like incarceration to provoke the insight necessary to actually seek healing
- families may seek it
- judges may seek it

Forensic populations: who is coming your way from jail, and why: remember: Jail is....

Not a treatment facility.

- In general, psychotherapy is not available.
- Inmates may not get the meds they want, or have gotten in the past.
- Therapeutic measures cannot always be done.

Go to Jail

- Go directly to jail
- Do not pass go
- Do not collect $200

What behaviors get you noticed in custody?

Abnormal behaviors (Problematic behaviors in custody)

- Disrobing
- Playing with urine and/or feces/becoming incontinent
- Drinking from toilet
- Refusing food/fluids
- Continuous yelling or other noisemaking
- Continuous crying/sobbing

- Masturbation (excessive and/or public)
- Self-injurious behavior
- Muttering
- Hallucinating
- Hostile and oppositional behavior
- Passive-aggressive behaviors, i.e. refusal to follow orders; refusal to speak, refusing meds for idiosyncratic reasons

Factors affecting behaviors in custody

- Age/maturity
- Other demographic variables: race, culture, gender, education, intellect
- Previous experience with incarceration
- Influence of substances
- Medical problems
- Other psychosocial stressors, including poverty, job/financial, personal, legal
- Mental Illness

What is psychosis?

- out of touch with reality/loss of reality testing
- presence of certain symptoms (hallucinations, delusions, thought disorder)
- behaving abnormally (see previous 2 slides)
- behaving unpredictably

Distinguishing between psychosis and other acute mental states

- acute anxiety
- intense anger/frustration
- grief and despair

Distinguishing between psychosis and other chronic abnormal mental states

- history of head trauma
- drug induced hallucinosis/paranoia
- other organic impairments

Reasons why people might be exhibiting abnormal behaviors

- chronic psychotic disorder (chronic schizophrenia, chronic delusional disorder, chronic paranoia)
- acute psychotic disorder
- acute intoxication
- delirium

Reasons why people might be exhibiting abnormal behaviors

- acute withdrawal delirium
- dementia
- history of a traumatic brain injury
- developmental disability
- other more acute insults to the brain

What's Missing?

Axis II Disorders

- Schizoid
- Schizotypal
- Paranoid
- Borderline
- Histrionic
- Narcissistic
- Sociopathic
- Obsessive-Compulsive
- Dependent
- Avoidant

Remember, these are the same patients who:

- are likely to abuse drugs and alcohol
- have lots of relationship difficulties
- have a history of trauma in early life

Emotionally Underdeveloped: Causes

- Maternal and perinatal harm
- Early childhood trauma
- Repeated trauma
- Lack of adequate parenting

"When, owing to internal demons arising from their own childhoods or to external stressors in their lives, parents are unable to regulate--that is, keep within a tolerable range--the emotional milieu of the infant, the child's brain has to adapt; by tuning out, by emotional shutting down, and by learning to find ways to self-soothe through rocking, thumb-sucking, eating, sleeping, or constantly looking to external sources of comfort. This is the ever-agitated, ever-yawning emptiness that lies at the heart of addiction."

Gabor Mate

Emotionally Underdeveloped: Features

- are emotionally overreactive
- have lots of issues with trust and boundaries
- regress under stress, i.e. are impaired in their ability to self-soothe
- resist attempts at external control

Is This an Illness?

- Adaptation to environmental forces
- Developmental error
- Learning disability

The "Medicalization" of Mental Illness

- Conflict between the psychodynamic and the so-called biological models.
- The emphasis on symptom clusters that drives diagnosis.
- The interlock between symptoms and pharmaceuticals.
- Addiction is also viewed as a disease.

Reductionism in our models

- excessive or unwanted emotion is pathology
- neurotransmitters, receptors and chemicals
- genes
- "chemical imbalances"

The Urge to Medicate

- Blind faith in the value of psychiatric drugs
- Ignoring, minimizing, and outright denial of the morbidities imposed by pharmacotherapy, especially chronic drug therapy, is the shadow side of our profession.
- Financial incentives

What We're Missing

- Psychodynamic implications of our paradigm of care
- Professional imperatives; how the "standard of care" drives our choices
- Substitution of "treatment" for healing

Potential Long Term Harms of Psychopharmacology

- Use of antidepressants and stimulants provokes bipolar symptoms.
- Use of mood stabilizers actually makes manic episodes more frequent and more severe.
- Use of antipsychotics provokes psychosis.
- Use of benzodiazepines provokes chronic (severe) anxiety, and many other neurological symptoms.
- Long term use of any type of psychotropic medication generally leads to polypharmacy, with all of the associated ills.

More Axis II patients in forensic settings

- Harsher arrest patterns
- Longer stays
- Fewer ISTs go to hospitals
- Some contrive to get arrested, and stay incarcerated, due to fewer other options

Conundrums in the Treatment of Borderline Personality

- Meds don't help very much.
- Individual psychotherapy is expensive, and fraught with peril for patient and therapist.
- Forensic settings tend to amplify pathology, rather than reduce it.

Qualifying for Care

- Are you disabled enough to require financial assistance?
- Do you have an Axis I diagnosis?
- Do you need meds in order to cope?

Making the Acute Chronic

- Six weeks of relief; six weeks of follow up
- Offering addictive drugs for chronic conditions: good or bad?
- Pharm industry's goal: Better tolerated.

Affective Disturbances

- Provoked by abandonment and disruption of relationships
- Narcissistic meltdown
- Borderline rage
- Exacerbated by substance use

Complaints that borderlines have about therapy

- It costs too much
- It's too hard to develop the necessary relationship (trust)
- It's unavailable when I really need it
- It takes too long to see benefits

How to make borderlines worse

- Co-depend any comorbid behaviors, such as substance abuse or eating disorders
- Set no limits (or few limits) on inappropriate behavior
- Reward inappropriate behavior
- Lower one's expectations
- Cast all misbehaviors in terms of "mental illness"

Psychosomatic Psychosis: Fanning the Flames

- role of volition, or choice
- role of dissociation
- set and setting
- transient vs. chronic

Why behave psychotically?

- in hopes of being sent to a hospital
- to avoid prison
- to get housing changed
- to get meds
- to be declared IST
- in response to boredom

People use what they have

- And can't use what they don't have.
- Axis II individuals will use regression, dissociation, acting out, aggression, i.e. whatever they have available.
- Many of them truly do not have the skills and coping mechanisms that healthier people take for granted.

Malingering

- Extremely common in jail population (Voices)
- A sociopathic behavior
- All psycopaths malinger, but not all who malinger are psychopathic.
- An Axis I Diagnosis is a goldmine

Diagnosis and Treatment

- Diagnosis should be as accurate as possible.
- Treatment should be effective.
- Potential for long term harm should be weighed against benefits of short term treatment.
- Treatment and healing are not the same thing.

Other Conundrums in Treatment*

- the IST who isn't motivated to recover
- not psychotic now, but wants an NGI
- patient is disabled, but not strictly psychiatric

Improper Diagnosis: Why is this a problem?

- Overdiagnosis of Axis I Disorders, such as schizophrenia, schizoaffective, and especially bipolar, leads to overaggressive and improper overmedication, sometimes lifelong, with all of the attendant problems that that implies.
- Underdiagnosis of Axis II individuals deprives our entire system of the data it needs to be responsive to real needs of the Axis II population, who are also mentally ill.

- Underdiagnosis of substance abuse leads to very skewed statistics on the role that substance abuse plays in criminal activity.
- Has very serious consequences for treatment implications.
- Distorts our collective understanding of why certain behaviors occur.
- Undermines our professional integrity.

Over-Diagnosis of Axis I Disorders

- Criteria are simpler and easier to remember
- Justifies the use of medication
- Justifies charging one's fees
- Patients like these diagnoses
- Legitimizes the patient's suffering

Under-Diagnosis of Axis II Disorders

- Said to be more difficult to diagnose
- Still stigmatizing
- Therapy is still treatment of choice
- Even therapy doesn't cure PDIs
- Governments and institutions don't want to pay for the treatment of PDIs

Systemic consequences of underdiagnosis of Axis II

- Since we're institutionally ignoring their existence as much as possible, the costs of taking care of them are "off-budget"
- Routinely excluding them from all drug testing (which we do, to the extent that that is possible) skews available data
- If we offer them only meds, then meds is what they'll get (remember, they're looking to upgrade)

- PDIs are very ambivalent about meds and are often looking to upgrade
- Axis II disorders do not respond as well to any kind of medication as do Axis I disorders
- PDIs are more likely to develop side effects and complications
- PDIs are more likely to sue
- The healthier the PDIs get, the fewer meds (and lower doses) they are likely to need

Crimes and Misdemeanors

- Confusing "won't cooperate" with "can't cooperate"
- Bribing the patient, i.e. using benzos or other sweetheart meds to gain cooperation
- Aiding and abetting PSAs
- Overmedicating/polypharmacy

Forces that Contribute to Misdiagnosis

- Insurance companies (and local, state and federal programs) will pay to treat Axis I Disorders, but not Axis II.
- Medications are intended to treat Axis I Disorders (but not Axis II).
- Standard of care increasingly implies medication.
- Lack of therapy (esp in custody)
- Changing parameters for diagnosis
- Expectations of the patient

Identifying the Axis II Individual: Clues

- Self-defeating behaviors, i.e. domestic violence
- Many are serious substance abusers who want, and expect, a substitute. For example, nonpsychotic people who insist they need an antipsychotic.
- Hx of Decompensation/Regression, esp. in custody
- Dynamics (attention-seeking behavior)
- Malingering

Why do so many patients complain of anxiety?

- Life itself is anxiety-producing these days
- Use of chemicals now almost universal in this population
- Most of these patients are anxious "from birth"
- Anxiety meds are more pleasurable drugs
- Anxiety meds treat boredom too
- Other self-soothing strategies unavailable

Substance Abuse and Dependence

- A huge factor in the management of chronic mental illness
- Vastly underdiagnosed in state-hospitalized patients
- Abuse of prescription drugs now a bigger problem that the abuse of illicit drugs
- Many psychiatric medicines are also abused

Psych meds with abuse potential

- Seroquel (and Zyprexa, to a lesser extent)
- Klonopin (and other benzos)
- Wellbutrin
- Adderall; other stimulants
- Sedating antidepressants (Elavil, Remeron, etc.)

Reasons to avoid Seroquel

- Abuse potential
- Expense (both early and late)
- Suicide
- Syndrome (wt gain, elevated cholesterol, diabetes)
- Other longterm consequences (insurance)

Treatment Considerations

- First things first: violence, suicide, assaultive behavior: Safety must come first
- After acute medical needs met, address:
- Addictions (and other self destructive behaviors)
- Desires and beliefs about medication in the context of addiction
- Discuss behavior in the context of choice

Treating the Axis II individual as inpatient

- Offer all of the above, and
- Broaden life choices
- Set goals for treatment, long term as well as short term
- Support efforts towards wellness & healing, including becoming medication-free

- Discuss the diagnoses and treatment plan with them.
- Choose meds judiciously
- Admit limitations and realities of hospital-provided treatment
- Hold a vision of hope
- Empathize with their suffering

Realities of the workplace

- pressures to shorten stays
- rising caseloads
- budget squeeze
- commercialization

Moral Insanity?

- We are back to incarcerating, punishing, and retraumatizing the mentally ill.
- Our paradigm of care is harmful to many, if not most, over the long term.
- We use addictive meds to treat chronic conditions, including addiction.

Cutting the costs

- fewer meds
- cheaper meds
- shorter periods of time on meds
- more judicious use of meds
- greater use of other modalities, i.e., therapies

"For in diseases of the mind, as well as in all other ailments, it is an art of no little importance to administer medicines properly; but, it is an art of much greater and more difficult acquisition to know when to suspend or altogether omit them."

Philippe Pinel

Future Portents

- Finding alternatives to hospitalization
- Reducing the use of meds in custody, especially expensive meds
- Aging population is more expensive to take care of
- Better systems integration
- Commercialization?

My Wish List

- Better care for all pregnant women, including access to abortion for those who are not ready to be mothers.
- An end to the War on Drugs.
- Better access to spiritual wisdom

The End