Blinders to Comprehensive Psychiatric Diagnosis

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Introduction

Accurate diagnosis is a critical component of treating patients with psychiatric disorders. Rendering an accurate diagnosis for patients suffering from mental illness and comorbid diagnoses is a complex and elegant process and there are many *blinders* to that accuracy: misinformation, biases, stereotypes, and lack of knowledge, that can get in the way. While mental health clinicians of all kinds in all clinical settings are challenged by blinders, we think the blinders to accurate diagnosis of patients in the penal system are more setting-specific and subtle than the blinders facing clinicians working in outpatient and inpatient mental health facilities. This chapter focuses on identifying the blinders and makes recommendations on how to effectively negotiate those blinders.

The system for treating mental illness in the United States is in flux if not broken (Jaffe 2017, Torrey 2010, Roth 2018). Throughout the twentieth century and now, patients with the most severe or complex psychiatric disorders have been increasingly left to their own devices. The result is that aberrant, disruptive behaviors, delusions, homelessness, confusion, suicidality, and often minor criminality due to lack of resources promote police officers unwillingly to be primary mental health workers, and the path to beginning treatment very often begins only by getting arrested. This leads to a need for psychiatric treatment in settings not intended or adequately staffed and equipped to provide such treatment.

Jails and prisons have thus become way stations for the most severely mentally ill patients in the United States, in addition to those with lesser, but treatment-needed degrees of psychiatric symptomatology. The percentage of patients suffering from severe mental illness (SMI), co-occurring psychiatric disorders, and disorders presenting with complex psychiatric-medical problems in the US penal

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system far exceeds those of both outpatient and inpatient treatment facilities (Al-Rousan, 2017, Torrey, E.F, Kennard, A.D., Eslinger, D., et al., 2010).

The United States has more prisons than colleges and universities with by far the largest percentage of its populace incarcerated compared to other nations in the world (Al-Rousan, 2017). Recidivism rates continue to float around 80% (Jaffe, 2017, 48–49, Torrey, 2010). Sentences are longer across all offenses in the United States compared to other countries (Jaffe, 2017). Nonviolent inmates are spending weeks, months, or even years in 23-hour isolation (Weir, 2012). Mentally ill inmates spend greater time in prison *for the same offence* compared to nonclinical inmates (Torrey, 2010).

The path proposed in this chapter begins with identifying and reducing blinders, engaging in the process of making accurate psychiatric diagnoses, and utilizing a system designed to see and treat patients comprehensively that is consistent with well-established, but rarely achieved, standards of care. Although treating patients with complex and comorbid psychiatric difficulties is challenging in any setting, the environment of jails and prisons and a multiplicity of intervening factors affecting treatment render an already difficult clinical task into a sometimes insurmountable one.

First, we explore the diagnostic process with special emphasis on methodology and terminology as a tool for detecting and removing the blinders for patients suffering with the most severe, compound, or complex clinical psychiatric disorders. Second, we discuss how the imperatives of the penal system as a unique social environment create and influence many of the attitudes and biases about mental disorders held by citizens, penal staff, penal administrators, mental health professionals, and inmates. Evaluation of behavior *in context* is crucial for accurate psychiatric diagnosis. Specifically, utilization of a social context viewpoint reveals how the penal environment creates imperatives (rules) that influence the behavior of inmates, guards, and staff further influencing environmental or systemic markers utilized for accurate diagnosis.

Overview of Prevalence of Mental Illness in Penal Systems

The American penal system is considered the de facto mental hospital in this country (Roth, 2018; Torrey, 2014; Leifman, 2014). The prevalence of all diagnosable mental disorders in our penal systems ranges variably from 40% to 70% or higher. Around 15% is the figure given for the seriously mentally ill (SMI) (Torrey, 2010). With such high mental disorder prevalence, compounded by frequently undiagnosed traumatic brain injury (TBI) or substance abuse, and the high prevalence of coexisting mental disorders, it is no wonder that the penal system is burdened.

Since the first edition of this work, researchers have added greater diversity concerning the prevalence and diversity of mental illness in inmates. It appears that there is a rich combination of psychiatric disorders in inmates worthy of note beyond the three SMI categories so frequently reported upon. Compared to community samples, a range of Axis I disorders (a Diagnostic and Statistical Manual of Mental Disorders, fourth Edition, Text Revision (DSM IV-TR) designation containing all mental illnesses, except personality disorders and the developmental disabilities that are on Axis II) occur 3 to 12 times more frequently. Such disorders as posttraumatic stress disorder (PTSD), attention deficit hyperactivity disorder (ADHD), panic disorder, obsessive-compulsive disorder, agoraphobia, generalized anxiety disorder, and substance use disorders are reported. We refer the reader to these commendable sources: (Urbaniok, 2007), Westmoreland, et al. (2010), Brown, et al. (2013), Fries, et al. (2013), Prins (2014), Wetterborg, et al. (2015), Al-Rousan, et al. (2017).

The personality disorders receive more mention in recent years, even though some earlier authors called attention to reasonably accurate reports of antisocial personality disorder (ASPD) (Fazel &

Danesh, 2002) and borderline personality disorder (BPD) (Trestman, 2000). The personality disorders are abnormalities in four areas: cognition, affectivity, interpersonal functioning, and/or impulse control (two or more are required to make a diagnosis). Such personality disorders as antisocial personality (Gunter, et al., 2008), borderline personality, narcissistic personality, and psychopathic personality disorder (not a Diagnostic and Statistical Manual of Mental Disorder (DSM) category) along with several other personality disorders are particularly relevant for this discussion (Blair, 2005, Faustino, 2017). These relatively stable, long-standing personality styles (usually present from adolescence or early adulthood) contribute to difficulty in complying with authority, living in a highly structured environment, and taking responsibility for behavior, just as do people suffering from many of the traditionally defined SMI disorders. The thinking that personality disorders are not treatable is false. There are useful psychotherapeutic and psychopharmacologic interventions for some of them. Trestman (2000) demonstrated that penal institutions have consistently had a high prevalence of personality disorders even prior to the modern era because criminal behavior is sometimes one of their manifestations. The belief that personality disorders are untreatable or too difficult to treat contributes, then and now, to their lack of formal assessment and identification and becomes a blinder to accurate, that is, complete, psychiatric diagnosis. We argue that psychiatric comorbidity considerations should include statements about personality disorders in a comprehensive psychiatric evaluation. That the autism spectrum disorders, fetal alcohol syndrome, mental retardation, and traumatic brain disorders are rarely mentioned is a significant omission given, when present, their occurrence can be another blinder to accurate diagnosis and therefore management.

Crocker et al. (2005), in a longitudinal analysis of ASPD, psychopathy, and violence in persons with comorbid severe mental disorders, found that the Self-Report Psychopathy Scale II "had limited associations with criminality and violence, whereas ASPD, having a thought disorder, negative affect, and earlier age at initial psychiatric hospitalization were predictive of aggressive behavior" for the 203 subjects over 3 years. This is further confirmation of the prevalence of comorbidity and speaks to a reversal of the concept that psychopathy alone is more predictive of aggressive violence; so too is environment.

But there is a caveat about behavior in the prison culture. Generally, the diagnosis of a personality disorder is made if behavior deviates significantly from the expectations of the individual's culture (American Psychiatric Association, 2013). The prison culture is not necessarily the person's culture, but, *when imprisoned, it is the cultural context.* Hence, violent behavior does not necessarily deviate from the person's culture "of the moment." It is arguable that violent behaviors would not be used toward diagnosis if the context were different. Likewise, the pattern must manifest in two of four areas: cognition, affectivity, interpersonal functioning, and/or impulse control. Situation-specific behaviors would have to be demonstrated in more than just one area. General Criteria B and C would require an *enduring pattern* of inflexible and pervasive behaviors across a "broad range" of personal and social situations. Finally, in order to make a diagnosis of a personality disorder (using the current criteria), General Criterion D states that the pattern is "stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood." If these general criteria are not met, and much of this would have to be demonstrated to have happened before imprisonment in many cases, behavioral changes unique to the prison setting would not count toward or support a diagnosis.

The untreated severely mentally ill are both more violent and more likely to be victims of violence than the general population. They are more likely to commit major and minor infractions of the law than the general population (Jaffe, 2017, pp. 134–136). We accept, as the obvious fact it is, that an increasing population of jail inmates and prisoners have impairing mental illness and psychiatric diagnoses are being missed.

Diagnostic Terminology and Methodology

The literature concerning the prevalence of mental illness in general, and in the penal system more specifically, is replete with the phrase *serious mental illness*. The term SMI refers to three categories of psychiatric diagnoses: the psychoses (including the schizophrenias, paranoia, and other psychoses), bipolar disorder (particularly with manic episodes), and major depressive disorder (Jaffe 2017, 65–76, Roth, 2018, 15–17). These are singled out because of the severity of their symptomatology and because they are considered the psychiatric diagnoses with the most support for being properly understood as disorders of brain function with high difficulty of treatment.

Institutions including the National Institute of Mental Health (NIMH), numerous state-funded agencies variably, and researchers add additional diagnoses such as posttraumatic stress disorder (PTSD), personality disorders, attention deficit hyperactivity disorders (ADHDs), anxiety disorders, and substance use disorders as SMI when reporting prevalence in penal institutions. Such conditions contribute to significant psychopathology, especially when co-occurring. Inclusion or exclusion of this additional class of psychiatric disorders to SMI is one of the reasons for a wide variability in the reported prevalence of mental illness in the penal system. Bronson and Berzofsky (2017) reported in the 2011–2012 National Inmate Survey (NIS-3) on data from over 600 jails, prisons, and special facilities with more than 100,000 inmate participants. They defined the catchphrase *serious psychological distress in the past 30 days* to denote the dividing line for threshold estimations. The report selected diagnoses including major depressive disorder, bipolar disorder, schizophrenia/other psychotic disorders, PTSD, anxiety disorders, and personality disorders. The disparities in prevalence estimates by other authors clearly derive from different methodologies and purposes in the various studies. This chapter uses the conventional phrase serious mental illness (SMI) to include the psychoses, bipolar disorder, and major depressive disorder and, where relevant, specifies other psychiatric diagnoses aside from those.

Since the advent of the "Decade of the Brain" in the 1990s, a significant segment of psychiatric research has focused on the fact that diagnostic conditions are disorders of the brain. Studies on inheritance, brain imaging, sociobiology, neurophysiology, and neurobiology seemed to support this contention, although no clear consensus exists (Camara & Binyet, 2017, Malla, et al., 2015, Bolton, 2013, Lieberman, 2015, 188–189). Marcella (2014) reports the heritability of ADHD, autism, schizophrenia, and bipolar disorder to be in the 75–80% range and Sullivan (2012) states that genetic factors account for 35–50% of the variability in major depression and alcohol addiction.

This evidence and more leads us to endorse the hypothesis that diagnosable psychiatric disorders are best understood as disorders of the brain and that presenting those conditions as such is an important adjustment in terminology that helps eradicate bias and stereotype. Patients suffering from these conditions are not "bad" but rather, "mad," to put it in memetic terms. That is, without intent, the brains of many inmates suffer from brain disorders and require treatment as patients in addition to punishment or rehabilitation as inmates.

An example of the problem of language is in the term "treatment." Appraisals of the penal system are replete with criticism regarding treatment (e.g., Bowers et al., 2006; Carr, 2014; Gottfried & Christopher, 2017). SMI and complex/co-occurring diagnosis patients experience treatment through medication dispensation and monitoring but little to no psychotherapeutic treatment. Psychiatrists become restricted to 12–15 min sessions with patients and see inmates infrequently. In the penal system, treatment has been subsumed under control and submission, and we think this is predominantly because of the restraints, fiscal and bureaucratic, placed on service providers. Most importantly for our purposes is the fundamental proposition that treatment planning is dependent upon diagnosis, and satisfactory treatment is impossible without accurate diagnosis and other resources including the time needed to complete the diagnoses.

Psychiatric diagnoses constitute a description of our current level of understanding of mental illnesses and their effect on function, not a label of judgment. To view a patient in context is essential for accurate psychiatric diagnosis; more will be said of this later. For now, we resolve to be circumspect about language and understand that its use can itself become a blinder to effective treatment.

Martin et al. (2016) take up the problem of cognitive errors in diagnosis in a rare paper on this topic in the field. They estimate at least 10–15% of inmates may be misclassified on the single issue of presence or absence of a mental illness. They did not address errors in specific diagnostic categories. Citing from two papers in the general psychiatric literature (Croskerry, 2003, Crumlish and Kelly, 2009), they hypothesize psychoactive medications started on an inmate due to urgent need but with either a generic provisional diagnosis such as "psychosis" or an unclear psychopathology. This is the cognitive error of *commission bias. Diagnostic momentum* may account for the persistence of that diagnosis over time without further diagnostic assessment. Another psychiatrist may be unwilling to change a colleague's diagnosis and management due to *anchoring.* Or, if the medication is perceived as working, then *confirmation bias* may perpetuate the existing designation with no further information being collected. Most psychiatrists are familiar with any or all these errors. We think any of them may be playing a role for various reasons in penal psychiatry.

State of Psychiatric Treatment of the Mentally Ill

The mental health industry, along with psychiatry as a medical specialty, finds itself to be a relatively unique outlier from the rest of the specialties. It has no coherent understanding of the etiology and pathogenesis even for the most serious of the psychiatric disorders described in DSM-5 much less for the arguably subordinate yet disruptive or distressing disorders including personality disorders. Psychiatric diagnoses are empirical combinations of descriptive symptoms with often confusing overlap. Excesses, deficiencies, inconsistencies, and inappropriatenesses in observable behavior or patient self-perceptions have thus become the generic categories by which the various psychiatric diagnoses are distinguished. Only a few diagnoses have known biological markers and etiologies.

Psychiatric diagnoses are primarily useful in the selection of psychopharmacotherapy for selected symptoms or problems subsumed by that diagnosis. Inaccurate or insufficient identification of accurate psychiatric diagnoses has its greatest impact in this arena of appropriate psychopharmacologic intervention, often with more than one agent, especially when, as is quite common, there are coexisting psychiatric diagnoses.

Although not a psychiatric diagnosis, a condition of the brain called anosognosia should be in the lexicon of anyone doing or wanting to know about psychiatric treatment or even having oversight responsibilities for dealing with or managing people with the disorder such as jail or prison staff (Jaffe, 2017; Torrey, 2010). First described in traumatic brain injuries, strokes, and the dementias, anosognosia is a neuropsychiatric condition in which the afflicted person has impaired ability to be fully aware or conscious of their physical or mental incapacity. The frontal lobes of the brain are crucial for providing self-insight including the capacity to recognize any bodily or mental dysfunction. This "lack of insight" is increasingly recognized to be a feature of severe mental illness and is present in some 50% of people with schizophrenia and 40% of people with bipolar disorder; it is the most frequent reason for medication refusal and resistance to treatment of any kind. In this condition, brain scans demonstrate evidence of anatomical disruption of the brain. For the seriously mentally ill and other similar psychiatric conditions, a specific informed evaluation for this condition as part of a mental status evaluation should be performed at intervals over a patient's course of management and treatment. The blinder of ignorance about this condition may significantly affect how penal staff and health professionals engage with a person having anosognosia.

Comorbidity and the Differential Diagnosis

A full understanding of the presenting mental disorders in each patient is critical for creating an effective plan for intervention. An important step in disbursing the blinders present to mental health and medical care delivery in penal institutions is the process of conceptualizing a *differential diagnosis*: a listing of *any and all* diagnoses that might account for the presenting symptoms. This systematic diagnostic method entails identifying which of several diagnostic possibilities might be present when there are overlapping criteria. The absence of reliable biomarkers (objective measures) for most psychiatric diagnoses, having only empirical combinations of descriptive symptoms, predisposes clinicians to confusion in ways often more complex than diagnostic dilemmas in other specialties of medicine. Because the presence of more than one legitimate psychiatric diagnosis is the rule rather than the exception, the differential diagnosis in psychiatry becomes especially important.

An unknown but very high number of today's physicians were trained and essentially socialized with the clinical value of "the law of parsimony," namely, *don't render two diagnoses when one diagnosis adequately explains the symptom presentation.* While parsimony and economy are useful in academic writing, and where scientists are well advised to consistently seek it, we argue that strict adherence to that practice both creates and inserts blinders into the diagnostic process that may render understanding of a patient either incomplete, inaccurate, or both. Central to the understanding of psychiatric diagnosis and case conceptualization in any clinical situation is the necessity to determine comorbidity and the importance of environment (e.g., a system in which the patient lives and the rules that govern the system).

Variously, comorbidity can mean:

1. Mental disorders that occur related to organic, body disorders such as stroke and depression, hyperthyroidism and anxiety, or treatment of traumatic brain injury (TBI) and personality change. More, within these pairings, the necessity for additional rule-outs emerges.
2. Mental disorders that occur in the presence of substance use, abuse, and dependence that are also DSM-5-defined mental disorders.
3. Mental disorders co-occurring with each other exclusive of substance disorders.

These three types of comorbidities are significant in all patient populations across settings, including penal patients. Too often, the third type of comorbidity is little recognized even by psychiatrists and psychologists. A lack of adequate definition and exploration of comorbidity in the literature paired with antagonistic training models that socialize mental health professionals differently from one another creates a context where clinical thinking becomes artificially constrained to just a single working diagnosis when others are present. More commonly, and more realistically, when this blinder is removed what comes into view is a collection of analytically distinct problems that often have an interactive nature. To capture these is to possess all relevant data regarding psychiatric presentation and very often alters, to the benefit of refinement and accuracy in diagnosis, case conceptualization, differential diagnosis, and therefore treatment.

Whether in prison, in a psychiatric hospital, or in the community, the person with one or several mental disorders deserves the same form of assessment and treatment, ethically and legally. Errors in diagnosis are rarely discussed in penal mental illness research but could approximately be at least 10–15% (Martin, et al., 2016). We find that though widely used, the term "comprehensive" is often misunderstood and misapplied in clinical work across settings, and propose that the process of arriving at comprehensive psychiatric diagnoses would mean that *each and every diagnostic condition should be ruled in or ruled out* based on the current level of understanding and within a clear and

convincing degree of medical/psychiatric certainty. It should also stand as implicit to the process and as a fundamental component of standards of care that the differential diagnostic process and its results are *dynamic*, in that they can and should be refined and potentially altered as more data are acquired subsequent to the initial evaluation and over the course of treatment. It would be well to acknowledge that this idealistically conceived notion is rarely achieved, except perhaps in the few dedicated full psychiatric units functioning within penal institutions. The implication of this assumption is that psychiatric care in ordinary penal settings consistently lacks comprehensive information.

As more data come in with the passage of time for a given person, the probability of diagnostic change increases. This is a fundamental and underlying assumption of the DSM-5 itself and is a hallmark component of treatment in the clinical world. Yet, we undermine or forget this reality because of our blinders and "myside biases" (Mercier & Sperber, 2017, 218–221) which seek single cause correlation and cause-effect schemes. For example, most professionals know that where there is a history of recurrent major depressive disorder over time, there is the need to rule out bipolar disorder. Most realize that impulse control disorders are potential precursors to attention deficit hyperactivity disorder. And the seeds of personality disorders are often found by reviewing the history of previous psychiatric diagnoses. Without an accurate history about the patient, the blinders of ignorance of history and of single-factor diagnosis obscure from our vision psychiatric comorbidity as well as the development and expression of more serious psychiatric difficulty (e.g., many psychiatric conditions, untreated, get worse as we age). If we think of patients and problems as both static and single shot, the probability that we are missing very important details that inform case conceptualization and diagnosis increases significantly.

More, the history of a given individual is complex and multifaceted. The inmate is not, and therefore should not be, the only source of data on history. Previous treatment records, collateral data interviews, patient reporting, health and education records, previous incarceration data, previous psychological testing—all these data and more represent components of "the history." Moreover, this does not simply refer to a biopsychosocial review of systems. It also contains history of all the presenting problems, both at the current time and sequentially over past time. Any assessment that does not capture all this information is incomplete and the treatment has blinders.

Outpatient and inpatient psychiatric treatment settings contain a system-level exploration (about the social context and other people involved), regardless of the theoretical orientation of the clinician. Its dynamics are captured and explored throughout the assessment/evaluation and treatment process. Nowhere in the psychiatric world can we think of an environment where the rules of the system have a more significant influence on patients than in the jail and prison context. Therefore, a dispassionate awareness of the system in which the patient is functioning and experiencing impairment and the theoretical knowledge that this system contains formal (explicit) and informal (understood or inferred) rules are essential. Some of these are known to the individual and some are not and yet, nonetheless, influence an inmate's decision-making and behavior. What may appear to be antisocial behavior in civil society may be adaptive fitness coming from an inmate's "rational" assessment and conclusion about the behavioral necessities for survival in prison and not a long-standing personality disorder indicator. What appears to be anathema and disproportionate in terms of response to stimuli in the free societal environment may be *iron clad rule* and necessity in the prison system. This allows us as observers of the human condition to both see and measure how those rules influence behavior: both patterns of interaction and communication. And we need to accept what the rules of jails and prisons are. An important blinder to remove and resolve involves this definition of acceptance versus endorsement. That we accept violence as a necessary act in order for an inmate to prevent being perpetually victimized is not to endorse violence in jails and prisons.

Attitudinal Bias Concerning Interpretation of Behavior and Diagnosis

In Israel, Rubinstein (2006) studied right-wing authoritarianism in border police officers, career soldiers, airport security guards, and controls. In general, scores fell significantly from the border police officers to the soldiers to the guards (who had similar scores), to the controls. To the extent one can extrapolate from these subjects to the penal system, we predict that high authoritarianism would be the mode in that setting. This presents a further blinder to assimilating and utilizing knowledge about mental disorders.

In a simplistic world where choosing between dichotomies (and indeed manufacturing false dichotomies of either/or propositions instead of both/and propositions) is the path of least resistance, the only two choices are to view deviant behavior as either bad or mad in its origins (American Psychiatric Association, 2013). In the penal system, only those with flagrant psychosis are considered mad. The rest are labeled as bad. They are deemed to cheat, manipulate, malinger, or be factitious. And none of this is to say that does not happen and should not be considered. Such conclusions should not be simply automatic bias-based inferences but get virtually the same weighing of the evidence as is given to psychiatric diagnoses After all, factitious disorder is a psychiatric diagnosis and malingering is an important distinction needing determination if it is present. Malingering-feigning symptoms, a DSM-5 V-Code meaning it is a condition worthy of consideration, can be assessed with several structured assessments. McDermott and Sokolo (2009) reported in the Sacramento (CA) County Jail that the Structured Interview of Reported Symptoms (SIRS) is used when malingering is suspected. Sixty-six percent of those tested met inclusion criteria. A diagnosis of ASPD did not make malingering more likely. So, suspected malingering, similar to the psychiatric diagnoses we discuss, is amenable to potential formal identification.

Miresco and Kirmayer (2006) studied 127 psychiatrists and psychologists in a department of psychiatry concerning the presence of mind-body dualism (meaning the mind is distinct from the brain) in their view about patients. They found that if a problem (or set of symptoms) was deemed to originate "psychologically," the patient was viewed as more blameworthy for the symptoms, and if a neurobiological cause was posited, the patient was considered less responsible and blameworthy. If academic psychiatrists and psychologists still retain this atavistic dualism, which is rife in the general population, we can only expect that insiders (staff of penal institutions) would reveal a more malignant version concerning the prisoners for whom they have responsibility. And yet, few are more well acquainted with the private, nonpublished rules of their system than they. A cohort of prisons have embraced comprehensive treatment acknowledging the reality of co-occurrence and comorbidity, and some few have developed specialized psychiatric treatment approaches. Outstanding examples of this include the program at the Central New York Psychiatric Center (Smith & Sawyer, 2002). Peters, LeVasseur, and Chandler (2004) reported 20 co-occurring disorder treatment programs in 13 state penal systems.

Regardless, addressing knowledge deficits is not enough. Exposure to new information or conceptualizations must occur in the presence of accepting attitudes and open minds ready to use that information. The example of clinical professionals who "don't believe" ADHD is a *real* disorder (and more than one of us have dealt with psychiatrists and other physicians who take this view) is perhaps one of the most egregious examples of how attitudes affect the incorporation and use of information. Holding that people who commit criminal acts are simply immoral or evil by choice is a much more pervasive and destructive belief that often precludes any attempt to understand the underlying disorders of brain function that could be treated. Another example that forecloses on full treatment is thinking that if a person has schizophrenia, then they cannot also have obsessive-compulsive disorder or generalized anxiety disorder. While economy and parsimony are important elements of scientific inquiry writ large, being sufficiently satisfied with categorical data matching only one diagnosis and listing that as both *primary* and *only* may be incomplete, and ultimately, inefficient because diagnoses

inform treatment planning. If we cannot account for all that is operating in the diagnostic milieu, we could not conceivably construct a treatment approach that is either efficacious or efficient.

Blinder Prescription One: A Systems Perspective

Systems matter. Every system, be it a family system or a large social system like a corporation or bureaucratic agency, contains rules and those rules influence patterns of interaction and communication for all members. The rules of systems, the manner in which people interpret and apply those rules, and the effect that the application of rules has on system occupants are of considerable importance in understanding, describing, explaining, and attempting to predict behavior. Lacking knowledge of the system for a particular inmate is as much a problem as lacking knowledge of a patient's medical or educational history when it comes to rendering accurate diagnoses. Attitudinal bias about what a prison is and does, be it normative or practical, obscures rather than illuminates the full clinical picture.

Attitudinal bias lures observers into immediate intuitive inferences that behavior is bad in any inmate because that inmate is a "criminal" or "convict." While all inmates are properly understood as convicts simply on the basis that they have been convicted of or plead guilty to a crime and therefore received conviction, thinking of inmates as criminals or cons only is to enforce an artificial, one-dimensional view of a person that is completely inconsistent with reality. Patients are more than their depression. Inmates are more than their crimes. Intelligent observation of inmates reveals that behaviors are often influenced in significant ways by the rules of the system. Whereas blinders lead one observer to find pure pathology in a behavior, the other observer who has removed the blinder observes adaptive fitness designed for survival. Newly incarcerated inmates quickly learn the rules of their system and find them to be qualitatively different from the rules of civil society. To not account for the effect of this rule change on inmate behavior is to commit significant negligence when assessing inmate-patients.

System rules are a critical domain of the psychosocial review of systems. Whether they *ought* to exist is irrelevant for clinicians. *That* they exist is the salient feature. Blinders prevent clinical and security staff from properly interpreting observable behavior and quickly making intuitive inferences using historical schemes that classify behavior as bad or evil. Awareness and knowledge of rules help sharpen those initial intuitive inferences with reason, and through that process one finds that the fist-fight that emerges in the dining hall because one inmate stepped on another inmate's shoes is a result of rule following and not necessarily antisocial personality disorder. Should an inmate choose to remain ignorant of the rules of the new system in which they find themselves, they very often are choosing to be a victim in a system that rewards defiance and defense and severely punishes timidity and compromise.

Long before our current knowledge of neurobiology, Grant and Saslow (1971) proffered a set of principles for psychiatric treatment in an inpatient university-based psychiatric unit. This set of principles became the guidelines for staff "attitude and approach" to patients. In a sense, it was a blinder removal project and the deliberate construction of a conceptual lens through which to look to understand patients, behavior, and environment.

The first principle still stands as relevant in understanding and dealing with human behavior in general and symptomatic behavior in particular. It is also consistent with modern neuropsychiatric understanding of underlying brain mechanisms and dysfunctions. The principle, which has been carried forward in both academic medicine and in outpatient clinical treatment as well as the training and supervision we all provide for psychiatric and psychological professionals, is this: *All people are doing the best they can at all times at their current level of understanding.* This means that in any set-

ting with its myriad influences at a given moment in time, a person will use the state of their brain at the time, strongly and jointly influenced by genetic heritage, previous learning, the instant emotional state, and environmental situation (including ingested psychoactive substances) to react more deterministically than volitionally with a given behavior. Whether that behavior is moral or immoral, symptomatic or not, it is the result of a final common pathway for dealing with the situation at the moment. Such a dispassionate understanding in staff maximizes the possibility to understand and accept the person and their behavior most fully and how to deal best with it.

To hold this principle foremost runs diametrically opposed to the mad versus bad or "behavioral" versus "organic" dichotomies. This *attitude and approach* principle requires learning and practice. It deals less with motives and more with acceptance and understanding in order to deal most humanely with repetitive behavioral excesses, deficiencies, inconsistencies, and inappropriatenesses that either make a person or those around the person miserable. The bias of the "people are doing the best they can at all times at their current level of understanding" principle runs counterintuitively for most people but is consistent with our modern understanding of brain function. Lest we not be misunderstood, a psychopathic serial murderer should be held responsible and sentenced appropriately to protect the public, but that murderer's brain could not do better at that time in that context and with that understanding than to demonstrate that awful behavior.

In a study of United Kingdom prison officers working with dangerous and severe personality disorders, Bowers et al. (2006) assessed staff attitudes toward personality disorders using the Attitude to Personality Disorder Questionnaire (APDQ). Over the 16 months of the study, those staff with a more positive attitude toward personality disorder had improved general health and job performance, less burnout, and a more favorable impression of managers. This supports the contention that positive attitudes toward any category of inmates, though highly variable prior to intervention, can be managed utilizing our "people are doing the best they can at all times" principle as a crucial first step in removing blinders to efficacious treatment and management of disordered inmate-patients. Toxic staff and clinician attitudes, and the judgment that "not all people are doing the best they can at all times (and I personally can tell the difference)," render a skewed, biased, incomplete, and often inaccurate diagnostic picture and therefore a flawed treatment approach to say nothing of the day-to-day interactions with inmates and the extent to which interventions can be deployed in robust ways.

To that, we believe that even guards can be important contributors of observational data as well as stakeholders negatively affected by blinders. We applaud those penal systems incorporating specialized training, education about mental illness, and sensitivity training for jail and prison guards (Walsh & Freshwater, 2009; Galanek, 2015; Parker, 2015). These various programs usefully add a component that includes the *attitude and approach* principle, although not explicitly stated.

The stigma of mental illness at times acts as a brake on the willingness of inmates to seek help with medical or psychiatric disorders just as much as it clouds the judgment of clinicians that what is in front of them is truly a patient suffering from the unintended consequences of behavioral excesses, deficiencies, inconsistencies, and inappropriatenesses. Howerton et al. (2007) indicate that *distrust* constitutes a major barrier to healthcare seeking in inmates during and after incarceration. They think that a positive precedent could be set by prison healthcare providers to "help de-stigmatize mental illness." Yet, the attitudes, biases, and the philosophy now rife in penal institutions play a major role in the current configuration of psychiatric care which discourages inmates from seeking it in prisons, and, indeed, afterward. The conservative approach with high authoritarianism is a blinder for perceiving the need for and implementation of a modern approach to psychiatric services in jails and prisons.

Blinder Prescription Two: The Problem-Oriented Medical Record

We recommend implementation and utilization of the Problem-Oriented System (also referred to in the literature as the Problem-Oriented Medical Record or POMR) first established by Laurence L. Weed (e.g., Weed, 1968), and modified by Grant for psychosocial therapies (Grant, 1979). POMR is the shorthand name for a system of recordkeeping that we find also to be a valuable tool that assists clinicians in the differential diagnostic process and in case conceptualization. In brief, the POMR has these four categories of patient data: an initial assessment, termed "minimum (predefined) database," a problem list, a problem-oriented treatment plan, and problem-oriented progress notes. Though a full accounting of this approach is beyond the scope of this chapter, we draw special attention to one particular component of POMR as something to be implemented immediately: the problem list.

Constructed from the beginning of a clinical interaction with a patient, the problem list is dynamic. It represents a snapshot of all identified problems in a patient's history as well as a current presentation of problems. It is listed and described in predominately nondiagnostic nomenclature and at the clinician's current level of understanding. Because items on the list can be added, refined, redefined, or resolved at any given time by any trained observer or member of a treatment team, the dynamic nature of the problem list grows and changes with the patient. The list also allows for a notation when data is missing or incomplete from the assessment process. With supervised clinical training, the problem list ideally may be viewed, updated, and altered by all staff members in a penal system ranging from primary psychiatrist to third shift prison guard, thereby creating an even more comprehensive description of the experiences and functional impairments of inmates and providing even more clarity in the diagnostic picture, the differential diagnostic process, and the formulation of treatment plans.

Conclusions

With rare exceptions, most prisoners, including those currently incarcerated in supermax facilities, will at some point be released. When inmates with serious mental illness are punished for their symptoms instead of effectively treated, recidivism rates remain high or potentially increase. For some, incarceration in perpetuity is a reality, and even for these prisoners, psychiatric treatment is both necessary and useful in a world where inmates have constitutional and moral rights to health care and where prison staff and fellow inmates have a right to safety and environmental protection. Inmates who in some way change or benefit from treatment will leave these facilities and attempt to reenter civil society. Quality mental health care while incarcerated is essential in reducing recidivism and protecting both the patient and the public. That we are in a position where prisons are our primary inpatient psychiatric units is a far more compelling, realistic, and urgent problem than debating whether prisons should be in this position. The least we can do is get the diagnoses right so that treatment while incarcerated and continuity of care once released can be useful and effective.

We need to think of inmate-patients completing sentences in the same way as patients are discharged from high-level facilities of psychiatric care. This means that while in the care of the prison system, an ideally blinder-free environment where accurate psychiatric diagnosis occurs and evidence-based treatment is provided, most patients can begin the process of healing and being less disordered in their thinking and behavior. Equipped with the gift of accurate diagnosis and a robust record of history and treatment, once discharged, these patients, bringing their POMR and treatment

history with them in any interoperable form, can then enter the next level of care and continue working through their Problem List until, eventually and theoretically, their psychiatric symptoms are reduced enough to allow greater functioning and perhaps a fuller integration into society. If the inmate has not received full and comprehensive treatment while incarcerated, the only seamless transition that may occur will be the one that happens on the bus that brings the inmate back into the prison.

Blinders in terminology, knowledge, attitudes, and perception are the most formidable barriers to diagnosis. Those blinders negatively affect treatment, growth, development, and improvement. We need a new *zeitgeist.* Today's prisoner will be tomorrow's co-worker or neighbor. The long-term interest of civil society is to invest in creating higher probability for successful emergence of released inmates and to provide ethical and clinically appropriate treatment behind and outside bars.

References

Al-Rousan, T., Rubenstein, L., Sieleni, B., et al. (2017). Inside the nation's largest mental health institution: A prevalence study in a state prison system. *BMC Public Health, 17*, 342. https://doi.org/10.1186/s12889-017-4257-0

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596.

Blair, J. (2005). *The psychopath: Emotion and the brain*. Blackwell.

Bolton, D. (2013). Should mental disorders be regarded as brain disorders? 21st century mental health sciences and implications for research and training. *World Psychiatry, 12*(1), 24–25. https://doi.org/10.1002/wps.20004

Bowers, L., Carr-Walker, P., Allan, T., et al. (2006). Attitude to personality disorder among prison officers working in a dangerous and severe personality disorder unit. *International Journal of Law and Psychiatry., 29*, 333–342.

Bronson, J., Berzofsky, M. (2017). *Indications of mental health problems reported by prisoners and jail inmates,2011–2012.* Bureau of Justice Statistics. http://www.bjs.gov/index.cfm?ty=pbdetail&iid=5946.

Brown, G. P., Hirdes, J. P., & Fries, B. E. (2013). Measuring the prevalence of currently severe symptoms of mental health problems in a canadian Canadian correctional population: Implications for the delivery of mental health services for inmates. *International Journal of Offender Therapy and Comparative Criminology, 59*(1), 27–50. https://doi.org/10.1177/0306624X13507040

Camara, N., & Binyet, E. (2017). Are mental disorders brain diseases and what does this mean? Brain. *Disorders and Therapy., 6*(3), 239–243. https://doi.org/10.4172/2168-975X.1000239

Carr, A. (2014). The impact of personality disorders on legally supervised community treatment: A systematic literature review. *Community Mental Health Journal, 50*, 664–672. https://doi.org/10.1007/s10597-013-9649-8

Crocker, A. G., Mueser, K. T., Drake, R. E., Clark, R. E., McHugo, G. J., Ackelman, T. H., et al. (2005). Antisocial personality, psychopathy, and violence in persons with dual disorders. *Criminal Justice and Behavior, 32*, 452–476.

Croskerry, P. (2003). The importance of cognitive errors in diagnosis and strategies to minimize them. *Academic Medicine, 78*(8), 775–780. https://doi.org/10.1097/00001888-200308000-00003

Crumlish, N. & Kelly, B. D. (2009). How psychiatrists think. *Advances in Psychiatric Treatment*,*15*(1), 72–79. https://doi.org/10.1192/apt.bp.107.005298.

Faustino, J. (2017). *Antisocial, borderline, narcissist and histrionic: Effective treatment for cluster b personality disorders*. Professional Education Systems Institute Inc. Seminar, March 2917.

Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 articles. *The Lancet, 359*, 545–550. https://doi.org/10.1016/S0140-6736(02)07740-1

Fries, B. E., Schmorrow, A., Land, S. W., et al. (2013). Symptoms and treatment of mental illness among prisoners: A study of Michigan state prisons. *International Journal of Law and Psychiatry, 36*(3–4), 316–325. https://doi.org/10.1016/j.ijlp.2013.04.008

Galenek, J. D. (2015). Correctional officers and the incarcerated mentally ill: Responses to psychiatric illness in prisons. *Medical Anthropological Quarterly., 29*(1), 116–136. https://doi.org/10.1111/maq.12137

Gottfried, E. D., & Christopher, S. C. (2017). Mental disorders among criminal offenders: A review of the literature. *Journal of Correctional Health Care, 12*(3), 336–346. https://doi.org/10.1177/1078345817716180

Grant, R., & Saslow, G. (1971). In G. M. Abroms & N. S. Greenfield (Eds.), *Maximizing responsible decision-making; or how do we get out of here?* (pp. 27–55). Academic Press Proceedings: The New Hospital Psychiatry.

Grant, R. L. (1979). The problem-oriented system and record-keeping in the behavioral therapies. *Journal of Community Psychology, 7*(1), 53–59.

Gunter, T. D., Arndt, S., Wenman, G., et al. (2008). Frequency of mental and addictive disorder among 320 men and women entering the Iowa prison system: Use of the MINI-plus. *Journal of the American Academy of Psychiatry and the Law., 36*, 27–34.

Howerton, A., Byng, R., Campbell, J., Hess, D., Owens, C., & Aitken, P. (2007). Understanding help seeking behaviour among male offenders: Qualitative interview study. *British Medical Journal, 334*, 303–306. https://doi.org/10.1136/bmj.39059.594444.AE

Jaffe, D. J. (2017). *Insane consequences*. Prometheus Books.

Leifman, S. (2014). *People with mental illnesses involved in the criminal justice system.* Mental Health Policy.org. Testimony to the Subcommittee on Oversight and Investigations of the Energy and Commerce Committee of the United States House of Representatives. https://mentalillnesspolicy.org/wp-content/uploads/judgeleifmanpsychhospitaltestimony-pdf.

Lieberman, J. A. (2015). *Shrinks: The untold story of psychiatry*. Little, Brown & Company.

Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other illness": A critical examination of the statement and its impact on patient care and society. *Journal of Psychiatry and Neuroscience., 40*(3), 147–150. https://doi.org/10.1503/jpn.150099.

Marcella, R. (2014). Mental disorders are somatic disorders: A comment on *M. Stier* and *T. Schramme*. *Frontiers in Psychology.* https://doi.org/10.3389/fpsyg.2014.00053

Martin, M. S., Hynes, K., Hatcher, S., & Colman, I. (2016). Diagnostic error in correctional mental health: Prevalence, causes, and consequences. *Journal of Correctional Health, 22*(2), 109–117. https://doi.org/10.1177/1078345816634327

McDermott, B. E., & Sokolov, G. (2009). Malingering in a correctional setting: The use of the structured interview of reported symptoms in a jail sample. *Behavioral Sciences & the Law, 27*(5), 753–765. https://doi.org/10.1002/bsl.892

Mercier, H., & Sperber, H. (2017). *The enigma of reason*. Harvard University Press.

Miresco, M. J., & Kirmayer, L. J. (2006). The persistence of mind-brain dualism in psychiatric reasoning about clinical scenarios. *American Journal of Psychiatry, 163*(5), 913–918. https://doi.org/10.1176/ajp.2006.163.5.913

Parker, G.F. (2015). Impact of a mental health training course for correctional officers on a special housing unit. *Psychiatric Services*, *60*(5), 640–645. https://doi.org/10.1176/ps.2009.60.5.640

Peters, R. H., LeVasseur, M. E., & Chandler, R. K. (2004). Correctional treatment for co-occurring disorders: Results of a national survey. *Behavioral Sciences & the Law, 22*, 563–584. https://doi.org/10.1002/bsl.607

Prins, S. J. (2014). Prevalence of mental illnesses in U.S. state prisons: A systematic review. *Psychiatric Services, 65*(7), 862–872. https://doi.org/10.1176/appi.ps.201300166

Roth, A. (2018). *Insane: America's criminal treatment of mental illness*. Basic Books.

Rubinstein, G. (2006). Authoritarianism among border police officers, career soldiers, and airport security guards at the Israeli border. *Journal of Social Psychology., 146*(6), 751–761. https://doi.org/10.3200/SOCP.146.6.751-761

Smith, H., Sawyer, D. A., & Way, B. B. (2002). Central New York psychiatric center: An approach to the treatment of co-occurring disorders in the new your state correction mental health system. *Behavioral Sciences & the Law, 20*(5), 5223–5524. https://doi.org/10.1002/bsl.488

Sullivan, P. F., Daly, M. J., & O'Donovan, M. (2012). Genetic architecture of psychiatric disorders: The emerging picture and its implications. *Nature Review Genetics., 13*, 537–551. https://www.nature.com/articles/nrg3240

Torrey, E. F. (2010). *American psychosis: How the government destroyed the mental health treatment system*. Oxford University Press.

Torrey, E. F., Kennard, A. D., Eslinger, D., et al. (2010). *More mentally ill persons are in jails and prisons that hospitals: A survey of the states.* Treatment Advocacy Center. http://www.ncjrs.gov/App/publications/abstract.aspx?ID=252565.

Trestman, R. L. (2000). Behind bars: Personality disorders. *Journal of the American Academy of Psychiatry and the Law., 28*(2), 232–235.

Urbaniok, F., Endrass, J., Noll, T., et al. (2007). Posttraumatic stress disorder in a Swiss offender population. *Swiss Medical Weekly, 137*(9–10), 151–156. http://nbn-resolving.de/urn:nbn:de:bsz:352-0-384244

Walsh, E., & Freshwater, D. (2009). Developing the mental health awareness of prison staff in England and Wales. *Journal of Correctional Health, 15*(4), 302–309. https://doi.org/10.1177/1078345809341532

Weed, L. L. (1968). Medical records that guide and teach. *New England Journal of Medicine., 278*(11), 593–600. https://doi.org/10.1056/NEJM196803142781105

Weir, K. (2012). Alone in "the hole:" psychologists probe the mental health effect of solitary confinement. *Monitor on psychology., 43*(5), 54. http://www.apa.org/monitor/2012/05/solitary

Westmoreland, P., Gunter, T., Loveless, P., et al. (2010). Attention deficit hyperactivity disorder in men and women newly committed to prison. *International Journal of Offender Therapy and Comparative Criminology, 54*(3), 361–377.

Wetterborg, D., Langstrom, N., Andersson, G., & Enebrink, L. (2015). Borderline personality disorder: Prevalence and psychiatric comorbidity among male offenders on probation on Sweden. *Journal of Comprehensive Psychiatry., 61*, 62–70. https://doi.org/10.1016/j.comppsych.2015.06.014