National Offender Management Service

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Co-morbidity of Personality Disorder, Psychopathy and Clinical Disorders

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Putting the talk into context

Study 1: Co-morbidity between Clinical Disorders and Psychopathy with High-Risk Personality Disordered prisoners.

Study 2: Co-morbidity between Personality Disorder and Clinical Syndrome in High-Risk incarcerated offenders.

Study 3: Co-morbidity between Personality Disorder and Psychopathy is currently being conducted.

Our understanding so far…

Co-morbidity between Axis I and Axis II has previously been examined;

- High secure hospitals (Coid, 2003; Blackburn et al., 2003)
- Inpatient samples (Oldham et al., 1995)
- Prison samples (Coid et al., 2009)
- Community Samples (Links & Eynan, 2013)

- **Prevalent findings from these studies;**
  - Depression is significantly (and positively) associated with Borderline PD; 35% general prison population (Coid et al , 2009) and as high as 61% in high secure hospital (Coid, 2003).
  - Cluster A and Schizophrenia co-exist to a significant level (Coid, 2003; Coid et al., 2009).
  - Substance Misuse most prevalent Axis I and highest co-morbidity with PD; Antisocial (Coid et al, 2009) and Borderline (Blackburn et al., 2003).

Our understanding so far…

Research into Axis I and Psychopathy is scant;

- High prevalence of clinical disorder within forensic psychopathic samples (Blackburn et al., 2003; Bennet and Johnson, in press).

- In terms of co-occurrence;
  - Psychopathy being positively correlated with substance misuse disorder and negatively associated with schizophrenic and other psychotic disorder, major depressive disorder and anxiety disorders (Hemphill and Hart, 2002)
  - No significant difference in co-morbidity when comparing prisoners with a PCL-R of 25 + with -25 (Coid and Ulrich, 2010)
  - Psychopathy “relatively independent” of major mental disorders with only substance abuse being significantly associated (Pham and Saloppe, 2010; Hildebran and de Ruiter, 2004).

Rationale

- Restrictions on the generalisability of previous findings.
- To date there is no study that has exclusively explored prevalence of co-morbid diagnoses within high-risk incarcerated offenders diagnosed with personality disorders.
- Clinical utility for practitioners to understand co-morbidity within offenders.
- The discernible presence of clinical disorders, PD and psychopathy can impact severely on treatment engagement. These manifest in the form of treatment interfering behaviours which impact and impede on engagement and ultimately treatment efficacy.
- The two studies (and the third) were explorative in nature with the overarching aim to examine co-morbidity within a sample of adult male offenders who have met criteria for a high-risk, high need, personality disorder treatment service.

Method

Sample:

- 115 Personality Disordered Offenders who had met criteria (high risk, complex PD and functional link with offending) for the specialist treatment service between 2004 to 2015.

Retrospective study:

- Participants had been assessed by MDT of qualified professionals upon admission with a standarised assessment procedure:
  - Axis I – Structured Clinical Interview DSM-IV (SCID-I; First et al (1997)
  - Axis II – International Personality Disorder Examination (IPDE; Loranger, 1999)
  - Psychopathy – Psychopathy Checklist-Revised (PCL-R; Hare, 2003)

Axis I and Axis II disorder

Axis I Disorder Category	N (%)
Mood	30 (26.09)
Schizophrenia and other Psychotic	15 (13.04)
Substance use	92 (80.00)
Anxiety	54 (46.96)
Somatoform	4 (3.48)
Adjustment	2 (1.74)

- 87% had at least one Axis I diagnosis
- 93% had at least one Axis II diagnosis (94% receiving multiple diagnoses).

Axis II	N (%)
Cluster A	47 (40.87)
Cluster B	108 (93.91)
Cluster C	27 (23.48)
Axis II Disorder	
Paranoid	38 (33.04)
Schizoid	17 (14.78)
Schizotypal	7 (6.09)
Antisocial	104 (90.43)
Borderline	70 (60.87)
Histrionic	12 (10.43)
Narcissistic	32 (27.83
Avoidant	23 (20.00)
Dependent	4 (3.48)
Obsessive-compulsive	3 (2.61)

Psychopathy (PCL-R)

PCL-R	Mean score
Total PCL-R	**29.76**
Factor 1	11.19
Factor 2	14.37
Facet 1	4.38
Facet 2	6.79
Facet 3	7.51
Facet 4	7.99

- Mean PCL-R score of 29.76 – not surprising given the criteria for PD treatment service.

Study 1: Clinical Disorder and PD

PD Diagnoses	Co-morbid Clinical Disorder	χ2 value	p
Paranoid	Major depressive disorder	3.83	.049*
	Specific phobia	4.184	.041*
	Hallucinogen abuse	10.062	.002**
Schizoid	Alcohol abuse	3.914	.048*
Borderline	Major depressive disorder	5.598	.018*
	Dysthymic disorder	4.842	.028*
Narcissistic	Alcohol abuse	3.977	.046*
Avoidant	Major depressive disorder	4.398	.036*

Individual PD and clinical disorders;

- 81% had diagnoses within both Axis I and Axis II disorders.
- Paranoid PD and MDD has previously been found in prison samples (Coid et al., 2009) but not in high-security hospital samples (Coid, 2003).
- Avoidant PD and MDD has been found in a hospital sample (Coid, 2003) but not general prison population.
- Borderline and depression has been found in general forensic and high secure samples.
- Anxiety disorder was not considered to hold comorbidity with any PD. Literature base makes this another surprising result.
- No trend with substance use. Surprising result?

Study 2: Clinical Disorder and Psychopathy

1. Pearson correlations were used to explore relationships between levels of psychopathy and presence/absence of diagnoses within clinical disorder categories;
   - Significant, negative correlations between a diagnosis of schizophrenia/other psychotic disorder and Factor 1 ($p = .010$) and Facet 1 ($p = .011$).
2. Logistic regression tested the two factors and four facets of PCL-R to evaluate the contribution to clinical disorder diagnoses;

   Factor 1 (affective and interpersonal) was significantly associated (negatively) to schizophrenia/other psychotic disorders.

   

   Facet 1 (interpersonal) were associated with schizophrenia/other psychotic disorders.

   

   Therefore absence of traits (glibness/superficial charm, grandiose sense of self worth, pathological lying and conning/manipulative) are associated with schizophrenia or other psychotic disorder.

   

   Overall Psychopathy was not predicative of any clinical disorder diagnoses.

What does this mean in terms of practice?

- High level of variation in results, with previous literature emphasising the clinical importance of PD services being guided by research exploring their own specific population.

- High prevalence of clinical disorders, PD diagnoses and Psychopathy accentuates both the levels and complexity of treatment need within this population.
  - Accurate assessment is needed to reduce the risk of misdiagnoses.
  - Clinicians should assess and treat disorders as distinct disorders.
  - The importance of PD services providing treatment to address clinical disorder symptoms.

- Further research is needed to increase our understanding on whether;
  - Are findings are consistent across risk level? This is imperative given the introduction of services across the Offender Personality Disorder Pathway and it's continuing development across settings and security levels.
  - Female offender populations.

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