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DSPD or 'Don't Stigmatise People in Distress'

Invited commentary on … Challenges in the treatment of dangerous and severe personality disorder[†]

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Abstract Working with people who have criminal convictions for endangering others is certainly challenging. The place of psychiatric or psychological intervention is still uncertain but for some people, for example those who have a background of physical or sexual abuse, it seems reasonable to provide them with access to interventions that seem to benefit those who do not have such convictions. The dangerous and severe personality disorder (DSPD) system provides an environment to do this. However, if it is ever to be successful in enabling future safe community placements, it has to address issues of stigmatisation.

How has the term 'dangerous and severe personality disorder' (DSPD) ever found currency in scientific and political circles? Although it is necessary to use diagnostic terms to discriminate for the purposes of research, teaching, management and public protection, such a term, focusing as it does on dangerousness, seems designed to be stigmatising as well. No individual should be summarised by one such characteristic. This makes change less possible because of the associated invocation of society's stigmatising attitudes and automatic social exclusion.

Indeed 'personality disorder' in itself could and should be described as a term of abuse. It damns an individual's core being – their personality – as disordered, thus perpetuating and amplifying the abusive experiences that so many have experienced in childhood. Appleby, before taking his current position of influence, was co-author of an excellent, thought-provoking paper suggesting personality disorder to be a diagnosis used for those patients psychiatrist's dislike (Lewis & Appleby, 1988). To add the terms 'dangerous and severe' labels the individual inexorably for a lifetime of ostracism and denigration. As psychiatric diagnoses, DSPD and, broadly, personality disorder lack precision, validity and reliability (Laptook *et al*, 2006) although this is certainly not a unique position in current classification systems. As it becomes clearer that schizophrenia and depression can have features originating in childhood (Schiffman *et al*, 2004) and certainly can have enduring effects on relationships, the customary criteria for 'personality disorder' also differentiate less and less. The positive findings of follow-up studies of personality disorder suggest that this is not necessarily a life-long disorder (Zanarini *et al*, 2003), although some characteristics may persist in some people, again as with schizophrenia and depression.

The government does now seem to be restraining itself from using the term DSPD in its legislative forays, gradually retreating towards positions of consensus and common sense. But it continues to be used in the context of the treatment units established in its more 'gung-ho' days as described by Howells and colleagues (2007, this issue). We have argued that naming is very important in addressing stigma (Kingdon *et al*, 2007) in the context of schizophrenia and would argue similarly here. 'What's wrong with you?' cannot be adequately answered symptomatically with, for example, 'I experience paranoia' or 'I have a behaviour disorder' or even less 'I have an individualised formulation', however important that may be therapeutically. The group identified for intervention are those who have been convicted by the courts. Many have a combination of criminal

[†]See pp. 325–332, this issue.

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Box 1 Diagnostic criteria for complex PTSD

(a) Impairment of affect regulation, including impulse dyscontrol and self-destructive behaviour
(b) Altered states of consciousness, with amnesia and dissociative symptoms
(c) Alterations in self-perceptions, including intense feelings of guilt and shame
(d) Distorted relations to others, with isolation and distrust
(e) Somatisation
(f) Alterations in one's system of meanings

(Spitzer *et al*, 2006)

behaviour and features of post-traumatic stress disorder (PTSD) (Spitzer *et al*, 2006). They differ from people presenting with PTSD in some ways, generally because their traumatic experiences have been repeated – often because of accompanying parental neglect – and a more suitable descriptor for these individuals, as with many described as having personality disorder, might be either PTSD (repeated episodes), i.e. PTSD following repeated traumatic episodes, or what Spitzer *et al* (2006) call complex PTSD (Box 1).

Personality as manifested through temperament and character is an important consideration in any stress–vulnerability model of mental and behavioural conditions, probably as the major mediator of genetic effects, and different aspects of personality can present as strengths or weaknesses, depending on circumstances. 'Personality disorder' is therefore an anomalous, and for the most part unhelpful, term which has probably survived because of a reluctance to use a diagnosis of 'mental illness' in a group of people who until relatively recently did not seem to benefit from psychiatric interventions. However, this is also due to confusion about what a diagnosis of 'mental illness' may mean and the mixed messages given – if they are ill, shouldn't they be absolved of responsibility for their actions; if bad (or 'personality disordered') they should be fully responsible. The use of the broader and more neutral term 'mental condition' might reduce such confusion (Kingdon & Young, 2007). Management issues are not dependent on whether someone is 'ill' but whether they can benefit from interventions – as is the case in this instance with complex PTSD. It does not exclude behavioural intervention (e.g. custodial sentences) where protection of the public is warranted and individuals are given the opportunity to learn from the consequences of their actions.

Gender issues are relevant. Broadly speaking, following similar life experiences, men present with a combination of complex PTSD, criminal conviction and aggression equating to a diagnosis of antisocial personality disorder; women with borderline or emotionally unstable personality disorder. None of these terms is particularly accurate. People who attract these diagnoses, male or female, can be very sociable and charming individuals who unfortunately include in their repertoire of emotional coping skills activities that involve breaking the law or causing harm to themselves. And 'borderline' with what? There is certainly overlap with psychosis, merging into a 'traumatic psychosis' (Kingdon & Turkington, 2005) but on a continuum, not just sitting near some arbitrary border. Emotionally unstable likewise is a strange term for use in classification and sounds quite judgemental – labile maybe, especially when under stress, but unstable?

Integrate or separate?

The location in which treatment is offered is a very important issue for the individual. It also affects the hospital and prison staff who manage them and the patients who are managed with them. Vulnerability of people with other mental conditions, male and female, needs to be taken into account, as does the safety of staff. There is therefore a sound basis, as described by Howells *et al*, for using separate units for people with combined complex PTSD and criminality for managing risk and providing focused appropriate intervention. Locating these in both prisons and hospitals allows for more individualised treatment and can assist in balancing the therapeutic and risk issues.

The argument against separate units is that this involves discrimination against a group who are not therefore being treated with their peers. This can perpetuate the stigmatisation described above and deprive them of access to services available locally in their community. Balanced against this is that if they remained in standard prison facilities, treatment would be much more difficult and if they were transferred to hospital, risk to others would be more difficult to manage. However, the DSPD label will make it more difficult for this group to move on into local services when they are judged to be ready and this is a very important practical reason to change the terminology.

Distress deserves treatment

Treatment, as described by Howells *et al*, focuses primarily on reducing criminal behaviour. This is very understandable in view of the individual's offences, but work with individual distress and disability then seems secondary, unlike that

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increasingly being offered, albeit relatively recently, to this group's community counterparts. A case can be made that reducing unacceptable distress and disability should be the primary therapeutic focus, regardless of where an individual with mental health problems is situated (Kingdon *et al*, 2004). Discussing the offences and reducing reoffending will be a part of this broad holistic approach and the latter may – or may not – be a consequence of it. Developing empathy is an issue but can be easier if the often very sad past histories of individuals are understood. Management plans need to take full account of the evidence that the criminal behaviour is frequently deeply ingrained and although change can occur over time, repetition of such behaviour can be catastrophic. But, despite this, reduction in distress, overt and covert, is a perfectly reasonable focus whether or not it leads to a reduction in reoffending. The complex PTSD units and secure treatment units do seem to be offering this in high-security settings but they should be evaluated on treatment as well as offending outcomes.

Declaration of interest

None.

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