Personality disorders at the interface of psychiatry and the law: legal use and clinical classification

Sally C. Johnson, MD; Eric B. Elbogen, PhD

Personality disorders have a complex relationship with the law that in many ways reflects their complexity within the clinical and research communities. This paper addresses expert testimony about personality disorders, outlines how personality disorders are assessed in forensic cases, and describes how personality disorders are viewed in different legal contexts. Reasons are identified why personality disorders are not generally accepted as significant mental illness within the legal system, including high incidence of personality dysfunction in criminal populations, frequent comorbidity of personality disorders making it difficult to determine direct causation, and difficulty determining where on a continuum personality traits should be defined as illness (or not). In summary, the legal system, to a significant degree, mirrors the clinical conception of personality disorders as not severe mental diseases or defects, not likely to change, and most often, under volitional control.

© 2013, AICH *Dialogues Clin Neurosci.* 2013;15:203-211.

Introduction

The role of personality disorders within the legal arena has been of interest to clinicians since the early days of psychiatry when physicians were called to court in an effort to explain criminal behaviors.[1] Clinical and legal interest, as well as fascination of the general public about understanding why people are involved in crime and other behaviors that offend, astound, harm, or frighten, continues to the present day.[2-4] Though it is often thought that this understanding remains the province of forensically trained psychiatrists or psychologists applying specialized skills to evaluating individuals who have entered the criminal justice system or claim to have been civilly wronged, there is no specific prohibition against any clinician providing expertise within the legal system. Many do so regularly in the contexts of involuntary commitment or assessing competency to make treatment decisions, or are asked by attorneys or

Keywords: *personality disorder; forensic psychiatry; expert testimony; mental health law*

Author affiliations: Department of Psychiatry, Forensic Psychiatry Program and Clinic, University of North Carolina-Chapel Hill School of Medicine, Chapel Hill, North Carolina, USA (Sally C. Johnson, Eric B. Elbogen); Mid-Atlantic Mental Illness Research, Education, and Clinical Center (MIRECC), Durham VA Medical Center, Durham, North Carolina, USA (Eric B. Elbogen)

Address for correspondence: Sally C. Johnson, MD, University of North Carolina-Chapel Hill School of Medicine, Forensic Psychiatry Program and Clinic, Department of Psychiatry, CB #7167, Chapel Hill, NC 27599, USA
(e-mail: sally_c_johnson@med.unc.edu)

Copyright © 2013 AICH. All rights reserved

the courts to share their specific content-related expertise. It is very common for questions to arise in these settings as to what significance, if any, should be given to the presence of personality disorders.

Mental illnesses, including personality disorders, can potentially modify applications of the law in criminal and civil contexts. Classification and specific definitions of mental disorders can have a major impact on how and when they serve as modifiers.[5] The legal system's perception of mental illness is defined by society, and it is the application of that understanding to a specific person or fact pattern that defines the relationship between mental illness and the law. Clinicians entering the forensic arena, however, for the most part, do not immerse themselves in thinking about the current social definition or understanding of mental illness. Because of their training and experience, clinicians most often resort to explaining mental illness through the lens of the most widely accepted classification system, which for the last 40 years, at least in the United States, has been the latest version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM).*

To date, the *DSM*[6] has utilized a categorical approach to personality disorder diagnoses, in that an individual must meet specific criteria in order to be categorized as having a personality disorder. But the *DSM* has cautioned clinicians and researchers (its intended user audiences) that inclusion of diagnostic categories does not imply that they meet legal criteria for what constitutes mental disease, disorder, or disability: "The clinical and scientific considerations involved in categorization of these conditions as mental disorders may not be wholly relevant to legal judgments, for example, that take into account such issues as individual responsibility, disability determination, and competency." (p xxxvii) The *DSM* has also cautioned "nonclinical decision makers" that etiologic understanding is not necessary for inclusion (of diagnosis) and that presence of a diagnosis does not define degree of individual control over personal behavior. At the same time, however, the *DSM* suggests that appropriate usage can assist "decision makers in their determinations" by enhancing reliability, increasing understanding, managing speculation, and improving decision making about the past and future impact of mental dysfunction. (p xxxiii)

For some time now, there has been debate about whether personality disorders are better defined categorically or dimensionally.[7] A categorical approach does not consider *to what extent* every person possesses traits potentially consistent with a personality disorder. Earlier in the preparation of *DSM-5*[8] it appeared that one of the most significant changes on the horizon of evolving classification of mental illness would be a move to a dimensional rather than a categorical approach.[9-12] In regard to personality disorders, this would include increased focus on interpersonal impairment and personality traits.[13] It was argued that this move would be both clinically helpful and scientifically sound, but after significant discussion and debate in the literature extolling the merits of this change and the shortcomings of the existing categorical approach to defining personality disorders, the decision was made not to implement the proposed changes. Nonetheless, documentation of that debate and the literature recounting the rationale for change remain available to attorneys and courts, who could use it to challenge the science behind existing conceptualization of personality disorders in legal proceedings.[14]

Within the law, mental illness can be viewed as an excusing condition, a mitigating or aggravating condition, or simply an explanation. Its application is often not without social outcry and misunderstanding within the community, nor is it without inconsistencies and argument within the legal and mental health professions. Historically, its utility has been expanded or narrowed in response to social pressures, high-profile cases, or early acceptance of new clinical knowledge. Increased scientific understanding of mental illness has been heralded in the past as the key to understanding and even eliminating criminal behavior.[15] Despite previous disappointments in this area, more recent neuropsychiatric and genetic research is likely to again fuel the search for such a key.[16]

Not all mental illnesses, however, are viewed equally by the law. As would be expected in a system based on the core premises of competence, responsibility, and accountability, most interest and acceptance lies with those illnesses that more overtly diminish individual performance. Illnesses that are more defined by descriptions of excesses or extremes of behaviors typically seen on the continuum of normal experiences are of less interest in the law. Where, how, and why on the continuum behavior is defined as abnormal, and how much significance and personal responsibility we give for that abnormality, clinically and legally, has varied over time, but is crucially significant to understanding the role of personality disorders within the legal system.

Clinicians and the law have not routinely conceptualized personality disorders as major mental illnesses. The concept of "personality" being defined by a collection of traits is widely accepted within the lay and professional communities. The *DSM*[6] definition of personality traits (p 686) as "enduring patterns of perceiving, relating to and thinking about the environment and one's self that are exhibited in a wide range of social and personal contexts" itself offers little controversy. Clinically, however, it is only when personality traits are maladaptive, and cause significant functional impairment or subjective distress, that they are viewed as constituting personality "disorders," and make the transition into identified illness.[17] The debate about personality disorders within the law, at its core, revolves around this definition as an illness.

Major mental illness, severe mental illness, or severe and persistent mental illness, has most often been interpreted in previous *DSM* editions as including only previous Axis I diagnoses of psychotic disorders, affective disorders, and certain organically based conditions such as dementias. This occurred despite *DSM IV-TR*'s admonitions "The coding of Personality Disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for disorders coded on Axis I." (p 28).[6] The *DSM* indicated that the listing of Personality Disorders on a separate axis was designed to ensure "that consideration will be given to the possible presence of Personality Disorders … that might otherwise be overlooked." The abolishment of an axis system in *DSM-5* means that personality disorders will be included among listings of all other mental disorders.[8] This may result in more or less clinical attention to this category of illnesses, but may also promote more mainstream acceptance in the law.

The law defines the importance of mental illness and its role in the legal system through statutes and the development of precedence. Legislative change generally requires much debate and the development of precedence happens slowly, on a case-by-case basis, across multiple jurisdictions and through decisional appeals that work their way through the hierarchy of state and federal systems. The exception to this is the rare occasion when intense social pressure, usually in reaction to a major tragedy or incident, precipitates legislative action.

Personality disorders, the law, and expert testimony

Personality disorders have had a complex relationship with the law that in many ways mirrors their complexity within the clinical and research communities.

As noted, the legal system tends to borrow heavily from accepted classification systems of medical and mental disorders, and clinicians or forensic experts serve as the conduit to bring that understanding into the legal system. Information on mental disorders and their relationships to legal issues is introduced through use of expert witnesses, who if qualified under the Federal Rules of Evidence, Rule 702 as experts "by knowledge, skill, experience, training or education"[18] may testify in the form of an opinion or otherwise if:

a) The expert's scientific, technical, or specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue
b) The testimony is based on significant facts or data
c) The testimony is the product of reliable principles and methods and
d) The expert has reliably applied the principles and methods to the facts of the case.

The landmark Supreme Court case *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,[19] a product liability/malpractice case, established the judge as the gatekeeper to allow or exclude expert testimony. Subsequently in *Kumho Tire Co. v. Carmichael*,[20] the Court found that this function applied to all expert testimony. Daubert established a list of factors for courts to consider in determining the reliability of proposed expert testimony including: (i) is the proposed theory testable? (ii) has it been tested with valid, reliable procedures? (iii) has it has been subjected to peer review or been published; (iv) what is the error rate if known or available? (v) are standards or controls in existence? and (vi) is there general acceptance by the scientific community?[21] This is not an exclusive or exhaustive list, and there is no requirement that all factors be applicable in any particular case. Nonetheless, it is a guideline for experts seeking to testify about mental health issues.

Hearings on admissibility are often referred to as "Daubert Hearings." A judge is under no obligation to conduct a Daubert hearing in any particular case. Federal Rules of Evidence, Rule 703[22] also requires the court to determine if information forming the basis of the expert's opinion is of a type relied on by other experts in the field.

The existence and importance of an adversary system of justice was not precluded in *Daubert*[19]: "Vigorous cross-examination, presentation of contrary evidence, and careful instruction on the burden of proof are the traditional and appropriate means of attacking shaky but admissible evidence."(p 595) It is, however, ultimately the judge who determines whether or not an individual may serve as an expert for the court.

In the area of personality disorders, this begs the questions of what is the current state of assessment for personality disorders and what is the general acceptance of the use of personality assessment within the legal arena. Furthermore, the issues of whether assessment and acceptance should differ in criminal and civil situations remain pertinent.

Measurement of personality for the courts

The identification and labeling of personality disorders is highly dependent on use and analysis of psychological testing. The presence of personality disorder(s) is actually frequently suggested by the absence of clear evidence of another major psychiatric diagnosis. Use of the Minnesota Multiphasic Personality Inventory (MMPI) and the Personality Assessment Inventory (PAI) are quite common in the forensic evaluation process,[23,24] and, while they describe some psychopathology particularly related to antisocial and borderline personality traits, they are not primarily intended to assess for the presence of a personality disorder diagnoses in general.

Instead, there are a number of psychological measures and structured tools specifically developed for measuring personality disorders. The most widely used is the Millon Clinical Multiaxial Inventory (MCMI), which measures *DSM-IV* personality disorders in adults.[25] The MCMI was originally standardized on psychiatric inpatient and outpatient mental health settings. Although the MCMI was not at first intended for use in the general population, over the years, there has been empirical support for using the MCMI in nonclinical populations, including incarcerated samples. The MCMI requires at least an 8th-grade reading level and is composed of 175 true-false questions, taking approximately 30 minutes to complete. These responses load onto 14 Personality Disorder Scales, 10 Clinical Syndrome Scales, 5 Correction Scales, and 2 Random Response Indicators.

McCann and Dyer advocate the use of the MCMI to address a broad spectrum of forensic issues, including in civil (eg, child custody, personal injury, fitness for duty) and criminal (eg, sex offenders, competency to stand trial, criminal responsibility) cases.[25] The current version, MCMI-III, is one of the commonly used psychological tests in forensic evaluations.[23] However, it has been debated whether the MCMI *should* be used by courts. Rogers, Salekin, and Sewell argue that the MCMI does not meet Daubert criteria for admissibility; specifically, although they found evidence of construct validity for a few MCMI personality disorders, they also determined that most Axis II disorders lacked sufficient construct validity.[26,27] Others have argued that the MCMI does meet Daubert criteria given that it is based on peer-reviewed research including papers publishing error rates, is widely used, and is based on theory that can be empirically testable and verifiable.[23]

In the wake of this controversy, some research has sought to compare the MCMI with other methods for assessing personality disorder in a forensic context. In one study, multiple measures of personality disorder were administered to 156 mentally disordered offenders.[28] These measures included the International Personality Disorder Examination, Personality Diagnostic Questionnaire, and the MCMI. The study found that regardless of measure, convergence was good for some personality disorders (eg, avoidant, schizoid, and antisocial) and poor for others (eg, histrionic, narcissistic, and obsessive-compulsive). Some disorders were not even distinguishable from one another (eg, avoidant, schizoid, and schizotypal) across measurement techniques. The concept that interviews are superior to questionnaires was not supported by the data in this study. Indeed, the self-report MCMI demonstrated proportionately more "true" variance than other measures of personality disorders. As such, the authors conclude that the MCMI is at least as good as, and in many cases better psychometrically at measuring personality disorders than other assessment approaches.

Despite criticism of the MCMI, one advantage of the tool compared with virtually all other methods of assessing personality disorders is the inclusion of malingering and deception scales, especially relevant in forensic contexts. Since the MCMI relies on self-report, some offenders may be motivated to deny or exaggerate problems in order to achieve some secondary gain such as reduced criminal sentence.

There are several scales on the MCMI that are used to detect if such exaggeration is occurring. First, the Validity

Index (VI) measures endorsement of items of an improbable nature that should invalidate the test for interpretive purposes; for example, this index detects patients who answer questions randomly, who have reading disorders, or who are disoriented or confused. Second, the Disclosure Scale (X) assesses how much information the patient is revealing when responding; scores either too low or too high also invalidate MCMI profile results. Third, the Desirability Scale (Y) and the Debasement Scale (Z) assess "faking good" and "faking bad" respectively. Unlike the Validity Index and Scale X, scores on the Scale Y and Scale Z do not invalidate the test but rather are used to adjust specific scales that are particularly skewed if a patient is faking good or bad. Reviews of these malingering scales in forensic contexts indicates that while beneficial for ascertaining the validity of testing, validity scales of the MCMI remain the least researched and least validated of MCMI scales and hence could be subject to extensive cross-examination.[29]

Another widely used instrument related to, but not directly measuring, personality disorders is the Hare Psychopathy Checklist-Revised (PCL-R). The PCL-R is used extensively in the forensic context, mainly in the area of risk prediction.[30,31] Specifically, the PCL-R is a measure of psychopathic personality, which shares many attributes with Antisocial Personality Disorders (ASPD). Identification of an elevated score on the PCL-R (>30) indicating the presence of psychopathy may contribute to a diagnosis of ASPD, although the criteria for ASPD do not equate to presence of psychopathy. Within the legal arena, in many ways the difference carries little practical significance: both psychopathy and diagnosis of ASPD carry negative connotations. The usual assumption is that individuals with these problems are "more bad than mad."

Forensic contexts involving assessment of personality disorders

In general, the law, a system that must be applicable across diverse situations and populations, takes a fairly parsimonious approach to the credence it gives to mental impairments and their potential impact within the legal system. It is not surprising that the law tries to titrate the use of mental illness and the potential impact of these illnesses. The system is based on the premises that most people are competent and responsible for their behavior. The significance of personality disorders in the legal system remains highly dependent on how personality disorders are viewed within the mental health community. To the extent personality disorders fall short of being defined as severe and independent disorders clinically, they will have less significance in the law. If the law has to decide to draw a line somewhere, why not look to clinicians and see what illnesses they view as most important and where they focus most of their clinical and research attention? Perceptions (eg, if personality disorders are not defined as "major" or "severe" mental illnesses, then they must be "minor" or "mild" problems) may carry more weight in the courtroom than clinically intended.

There are primarily two personality disorders of interest in forensics: ASPD and Borderline Personality Disorder (BPD). ASPD is of primary focus within the criminal forensic realm, whereas BPD is of considerable interest in the civil arena. ASPD tends to be excluded as a pertinent mental illness that qualifies as decreasing responsibility because it is a disorder that is in general defined by "bad" or socially less tolerated or accepted behavior.[30,32] BPD retains criminal legal interest when it crosses into symptoms of psychosis and it is often identified as underlying, previously existing psychopathology in civil litigation. The combination of ASPD/BPD has been found to represent a criminogenic blend of traits that is overrepresented in high-secure forensic samples.[33]

Both psychiatry and the law define behavior as either within or outside of the norm, and define behavior as acceptable or not. The law defines certain behaviors as crimes and certain actions as torts. Psychiatry defines certain behaviors and symptoms as abnormal or pathological, changeable or fixed, and treatable or not treatable. Both the law's definition of mental illness and psychiatric definitions are often responsive to social pressures. Legal definitions of mental disorders are often quite vague across statutes and can at times be inconsistent with the psychiatric definitions.[34]

Usefulness in law does not necessarily mirror clinical conceptualizations or definitions.[35] Statutory inclusion or exclusion of certain disorders can occur. The law has clarified (or claimed) its right to establish its own definitions of mental illness and by extension its own utility of the concept of personality disorder, as evidenced in the US Supreme Court decision for *Kansas v. Hendricks*[36] and *Kansas v. Crane*.[37] In contrast to expressed clinical opinion, but in response to considerable social pressure, the court held sexually violent offense behaviors as integrally related to personality dysfunction defined as mental ill-

ness. This has then been bridged to a system of potentially indefinite detention, justified primarily on the police powers of the state but not exclusive of at least an implied rehabilitative intent.

The legal definition of personality disorder as applied to sexual offenders is distinct from how personality disorders have more recently been viewed in the civil commitment process. Some states have excluded personality disorders (Arizona) or specifically ASPD (Florida), from their definition of mental illness for the purposes of civil commitment.[38] Limited available mental health resources have been focused on acute intervention and treatment of psychoses, major affective disorders, and dementias. Personality-disordered individuals are often excluded from treatment programs and settings. This in turn contrasts with the acceptance of personality disorders as a listed impairment to warrant disability status under Social Security Disability.[39] The Americans with Disabilities Act[40] also extends to any mental disorder, but specifically excludes personality traits that fall short of a formal diagnosis.[38]

Although there is some argument to the contrary,[41] within the criminal justice system, there has been a strong push to exclude personality disorders, specifically ASPD, from the types of mental illnesses potentially significant enough to warrant exculpation of fault or consideration of decreased criminal responsibility. The American Law Institute Model Penal Code,[42] which has been adopted in a number of jurisdictions, proposed the exclusion of ASPD by defining mental disease or defect to not include "an abnormality manifested only by repeated criminal or otherwise antisocial conduct." The federal standard for insanity requires the presence of "a severe mental disease or defect" which is most often interpreted to not include personality disorders as the sole diagnoses of concern.[43] Some state statutes (ie, California and Oregon) go as far as excluding all personality disorders with respect to the insanity defense.[44]

The Supreme Court in *Foucha v. Louisiana*[45] accepted expert testimony that ASPD was not a mental illness for the purpose of detention of individuals after being found not guilty by reason of insanity. Identification of ASPD generally does not support leniency or treatment recommendations at the time of sentencing, and in capital sentencing proceedings is often presented as an aggravating factor.

In contrast, in a New Jersey Supreme Court case, *State v. Galloway*, the Court held that a defendant's BPD was capable of impacting cognitive functioning such that the elements of the mental state required for the crime of murder could not be met (eg, purposeful action).[46] Similarly, in New York, a defense of extreme emotional disturbance requires courts view circumstances from the defendant's perspective by specifically taking in to account "underlying personality disorders."[47]

The US Army has a history of allowing discharge of soldiers who demonstrate symptoms of personality disorders that existed prior to their recruitment.[48] This has raised significant controversy when soldiers suffering from other psychiatric or physical combat related conditions (eg, post-traumatic stress disorder) and personality disorder are discharged without health related benefits. Recent amendments have limited this action to the first 24 months of service and require more detailed diagnostic confirmation for combat-exposed soldiers.[49]

Perhaps because of their relatively high prevalence within the criminal justice system, personality disorders have to some degree lost their identity as mental illnesses, and instead are often seen as common population characteristics.[50] The diagnoses of Antisocial Personality Disorder, other Cluster B Personality Disorders, and Personality Disorder Not Otherwise Specified are among the most frequently made diagnoses within offender and prison populations.[51] Their expression no longer falls outside of the norms when the offender population is considered the population of concern; thus, they lose their usefulness as differentiating factors within at least part of the legal system.[50]

An area where personality disorders have garnered increased attention in the law is in the area of risk assessment and prediction.[52] In general, personality disorder pathology, especially defined as psychopathy, is seen as a predictor of violence risk and risk for recidivism.[31,53] In England, significant controversy has arisen around the Dangerous Severe Personality Disorder program designed to manage individuals with personality disorders who are thought to be at risk of violence, primarily because personality disorders remain difficult, if not impossible, to treat in many cases.[54]

Conclusion

Whether categorically or dimensionally defined, personality disorders in the law remain at their core socially defined concepts. Consistent with the lay perspective, the most important qualifiers for the law may be severity of

symptom presentation, followed closely by duration of symptoms. Since social deviance and minor symptoms are viewed as existing along the continuum of normal behavior, they rarely suffice to differentiate an individual from the larger group of defendants or litigants. In fact, identification of personality disorder in a criminal defendant or civil plaintiff or an individual applying for a position of disability most often casts suspicion on that individual. As noted, the presence of a diagnosis of personality disorder is not always used consistently in the law. This inconsistency in the use of defined illness is unique to this subcategory of mental illness.

Further, identification of personality disorders can serve to exclude mental illness from consideration on a specific legal question or even exclude an individual from being eligible for services. The presence of a personality disorder, as a comorbid condition, can overshadow or call into question the validity of other psychopathology.[49] This can then diminish the importance of other major mental illness in the eyes of the law.

From a practical perspective there are a number of reasons that personality disorders are not well accepted as significant mental illness within the legal system. These include, but are not limited to:

1. The incidence of personality dysfunction is quite high in populations of concern.[55-57]
2. Personality dysfunction is often a comorbid condition, making it difficult to determine direct causation.[17,58] Although comorbidity as a clinical concept can increase understanding, in the legal arena it can lead to confusion by making apportionment of responsibility or fault more difficult.
3. The diagnostic subcategories are not clearly or exclusively defined.[59]
4. There is significant overlap with what law individuals would perceive as accepted variation on normal functioning (most individuals have experienced to some degree many of the symptom criteria identified).[60]
5. It is hard to determine where on a continuum personality traits should be defined as illness.[61]
6. The characteristic dysfunction of personality disorders often appears to be under volitional control.
7. Individuals suffering from personality dysfunction often do not self-define their symptoms and behaviors as illness.
8. There is no quick or obviously effective treatment interventions that are likely to result in change, with some personality disorders (ASPD) often viewed as untreatable.[62,63]
9. The most widely understood personality disorder (ASPD) within the legal system too closely mirrors our general concept of criminality. This negative connotation colors the way all personality dysfunction is viewed within the legal system.
10. Personality disorders are rarely viewed as removing an individual's capacity to make a choice.

In summary, the legal system, to a significant degree, mirrors the clinical conception of personality disorders as:

a. Not severe mental diseases or defects
b. Not likely to change
c. Not in need of special consideration within the medical/psychiatric community as far as resource allocation goes
d. Not preferred patients in either inpatient or outpatient settings
e. Not a primary national research focus.

As clinicians, we can rarely say that in personality disorders the individual has lost the ability to not break the law or to make a reasoned choice.[64]

The law is less interested in the understanding of behavior than in determining cause and effect or specific competences at specific points in time. The law at most wants to use mental illness as a way to define or explain behavior. It is behaviors, not symptoms, which define personality disorders. These are core behaviors, not symptom-influenced behaviors. When the legally suspect behavior is also a defining behavior for the diagnosis, not much additional useful insight can be offered to the system.

For the most part, the law has accepted the validity of past conceptualization of personality disorders. The "new" science backing a push for change in classification of personality disorders could cast a negative light on the credibility of current understanding of personality disorder diagnosis in the courtroom. During any period of clinical reaccommodation and acceptance of any classification changes, it will also be hard to define general acceptance within the scientific/professional community. There is always a lag time for research to catch up with classification changes and the applicability of previous research to the validity of a new system is often difficult to figure out.

As the science of personality disorders continues to evolve, it may be useful to consider more closely whether, and how, a move to a dimensional rather than categorical approach to diagnosis would influence the

importance of personality disorders within the law. If personality disorders are relegated to "second-class" status/interest within the legal system, would a dimensional approach to classification change this? Or because a dimensional approach highlights the continuum of personality disordered behaviors with normal functioning, would it diminish the importance of personality disorders even further and counterbalance any possible impact of increased understanding of the neurochemical/genetic aspects of personality disordered behavior?[65,66] Though these questions are unlikely to be answered in the near future, the debate about what importance should be given to personality disorders within the legal system is likely to continue. This subject, which was so integral to the origins of psychiatry at the turn of the last century, continues to pique the interest of both mental health professionals and the community. ❑

REFERENCES

1. Berrios GE. *The History of Mental Symptoms: Descriptive Psychopathology since the 19th Century*. Cambridge, UK: Cambridge University Press; 1996.
2. Vaughn MG, Howard MO, DeLisi M. Psychopathic personality traits and delinquent careers: an empirical examination. *Int J Law Psychiatry*. 2008;31:407-416.
3. Caspi V, Moffett T, Silva, PA, Stouthamer-Loeber M, Krueger RF, Schmutte PS. Are some people crime prone? Replications of the personality crime relationship across countries, genders, races, and methods. *Criminology*. 1994;32:163-195.
4. Miller JD, Lynam D. Structural models of personality and their relationship to anti-social behavior. *Criminology*. 2001:39:75-192.
5. Mellsop GW, Fraser D, Tapsell R, Menkes DB. Courts' misplaced confidence in psychiatric diagnoses. *Int J Law Psychiatry*. 2011;34:331-335.
6. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 4th ed, Text Revision. Washington, DC: American Psychiatric Association; 2000.
7. Blackburn R, Logan C, Renwick SJD, Donnelly JP. Higher-order dimensions of personality disorder: hierarchical structure and relationships with the five-factor model, the interpersonal circle, and psychopathy. *J Pers Disord*. 2005;19:597-623.
8. DSM-5: The Future of Psychiatric Diagnosis. 2013. Available at: http://www.dsm5.org/Pages/Default.aspx. Accessed March 2013.
9. Hopwood CJ, Thomas KM, Markon KE, Wright AGC, Krueger RF. DSM-5 personality traits and DSM–IV personality disorders. *J Abn Psychol*. 2012;121:424-432.
10. Skodol AE, Clark LA, Bender DS, et al. Proposed changes in personality and personality disorder assessment and diagnosis for DSM-5 Part I: description and rationale. *Personal Disord*. 2011;2:4-22.
11. Miller JD, Levy KN. Personality and personality disorders in the DSM-5: introduction to the special issue. *Personal Disord*. 2011;2:1-3.
12. Skodol AE. Personality disorders in DSM-5. *Ann Rev Clin Psychol*. 2012;8:317-344.
13. Wright AGC, Pincus AL, Hopwood CJ, Thomas KM, Markon KE, Krueger RF. An interpersonal analysis of pathological personality traits in DSM-5. *Assessment*. 2012;19:263-275.
14. Livesley J. Tradition versus empiricism in the current DSM-5 proposal for revising the classification of personality disorders. *Crim Behav Ment Health*. 2012;22:81-90.
15. Sapolsky RM. The frontal cortex and the criminal justice system. In: Zeki S, Goodenough O, eds. *Law and the Brain*. New York, NY: Oxford University Press; 2004:227-243.
16. Dressing H, Sartorius A, Meyer-Lindenberg A. Implications of fMRI and genetics for the law and the routine practice of forensic psychiatry. *Neurocase*. 2008;14:7-14.
17. Decuyper M, De Fruyt F, Buschman J. A five-factor model perspective on psychopathy and comorbid Axis-II disorders in a forensic-psychiatric sample. *Int J Law Psychiatry*. 2008;31:394-406.
18. *Fed. R. Evid*. 702.
19. *Daubert v. Merrell Dow Pharmaceuticals Inc*., 61 U.S.L.W. 4805, 113 S.Ct. 2786 (1993).
20. *Kumho Tire Co., Ltd. v. Carmichael*, 119 S.Ct. 1167 (1999).
21. Grove WM, Barden RC. Protecting the integrity of the legal system: The admissibility of testimony from mental health experts under Daubert/Kumho analyses. *Psychol Public Policy Law*. 1999;5:224-242.
22. *Fed. R. Evid*. 703.
23. Bow JN, Flens JR, Gould JW. MMPI-2 and MCMI-III in forensic evaluations: a survey of psychologists. *J Forensic Psychol Pract*. 2010;10:37–52.
24. Borum R, Grisso T. Psychological test use in criminal forensic evaluations. *Prof Psychol*. 1995;26:465-473.
25. McCann JT, Dyer FJ. *Forensic Assessment with the Millon Inventories*. New York, NY: The Guilford Press; 1996.
26. Rogers R, Salekin RT, Sewell KW. Validation of the Millon Clinical Multiaxial Inventory for Axis II disorders: does it meet the Daubert standard? *Law Hum Behav*. 1999;23:425-443.
27. Rogers R, Salekin RT, Sewell KW. The MCMI-III and the Daubert standard: Separating rhetoric from reality. *Law Hum Behav*. 2000;24:501-506.
28. Blackburn R, Donnelly JP, Logan C, Renwick SJD. Convergent and discriminative validity of interview and questionnaire measures of personality disorder in mentally disordered offenders: a multitrait-multimethod analysis using confirmatory factor analysis. *J Pers Disord*. 2004;18:129-150.
29. Craig RJ. Testimony based on the Millon Clinical Multiaxial Inventory: review, commentary, and guidelines. *J Pers Assess*. 1999;73:290-304.
30. DeMatteo D, Edens JF. The role and relevance of the Psychopathy Checklist-Revised in court: aA case law survey of U.S. courts (1991-2004). *Psychol Public Policy Law*. 2006;12:214-241.
31. Hare RD, Neumann CS. Psychopathy: assessment and forensic implications. *Canadian Psychiatr Assoc J*. 2009;54:791-802.
32. Edens JF, Colwell LH, Desforges DM, Fernandez K. The impact of mental health evidence on support for capital punishment: are defendants labeled psychopathic considered more deserving of death? *Behav Sci Law*. 2005;23:603-625.
33. Howard RC, Huband N, Duggan C, Mannion A. Exploring the link between personality disorders and criminality in a community sample. *J Pers Disord*. 2008;22:589-603.
34. Winick BJ. Ambiguities in the legal meaning and significance of mental illness. *Psychol Public Policy Law*. 1995;1:534-611.
35. Frances A, Sreenivasan S, Weinberger LE. Defining mental disorder when it really counts: DSM-IV-TR and SVP/SDP statutes. *J Am Acad Psychiatry Law*. 2008;36:375-384.
36. *Kansas v. Hendricks*, 521 U.S. 346 (1997).
37. *Kansas v. Crane*, 534 U.S. 407 (2002).
38. Melton GB, Petrila J, Poythress NG, Slobogin C, Lyons PM Jr, Otto RK. *Psychological Evaluations for the Courts: a Handbook for Mental Health Professionals and Lawyers*. 3rd ed. New York, NY: Guilford Press; 2007.
39. 20 CFR section 404, subpart P appendix 1 chapter 12:00 and 12:08, 2007.
40. *The American with Disabilities Act*. 42 U.S.C. Section 12101 et. seq.
41. Kinscherff R. Proposition: a personality disorder may nullify responsibility for a criminal act. *J Law Med Ethics*. 2010;38:745-759.
42. American Law Institute, *Model Penal Code*, Section 4.01 (2)
43. 18 U.S.C. Section 17.
44. Bonnie RJ. Should a personality disorder qualify as a mental disease in insanity adjudication? *J Law Med Ethics*. 2010;38:760-763.

Trastornos de personalidad en la interfaz de la psiquiatría y la ley: uso forense y clasificación clínica

Los trastornos de personalidad tienen una complicada relación con la ley, lo que por diversos aspectos refleja su complejidad dentro de los grupos de clínicos y de investigadores. Este artículo aborda el testimonio de expertos acerca de los trastornos de personalidad, destaca cómo se evalúan estos trastornos en casos forenses y describe cómo son considerados los trastornos de personalidad en diferentes contextos legales. Se identificaron razones del porqué los trastornos de personalidad generalmente no son aceptados como enfermedades mentales importantes dentro del sistema legal, a pesar de la alta incidencia de disfunciones de personalidad en poblaciones criminales, la frecuente comorbilidad de trastornos de personalidad que dificulta precisar una causalidad directa y lo difícil que es determinar dónde deben definirse en un continuo los rasgos de personalidad como enfermedad (o no). Se puede resumir que, de manera importante, el sistema legal refleja la concepción clínica de que los trastornos de personalidad no son enfermedades o defectos mentales graves, que probablemente no van a cambiar y que la mayoría de las veces están bajo control voluntario.

Troubles de la personnalité à l'interface de la psychiatrie et de la loi : utilisation légale et classification clinique

Les troubles de la personnalité ont une relation complexe avec la loi, ce qui traduit à bien des égards leur propre complexité aux niveaux clinique et fondamental. Cet article présente le témoignage d'experts concernant les troubles de la personnalité, expose la façon dont ces troubles sont évalués dans les cas médicolégaux et décrit comment ils sont envisagés dans différents contextes légaux. Les raisons pour lesquelles ces troubles ne sont généralement pas acceptés comme une pathologie mentale avérée dans le système légal sont identifiées, y compris la haute incidence de dérèglement de la personnalité dans les populations criminelles. La comorbidité fréquente des troubles de la personnalité rend difficile la détermination de la cause directe et sur quel point du continuum les traits de personnalité doivent être définis comme pathologiques (ou non). Pour résumer, le système légal, de façon significative, reflète le concept clinique des troubles de la personnalité comme des troubles ou des maladies mentales non sévères, non susceptibles de changer et le plus souvent susceptibles d'être contrôlés par la volonté .

45. *Foucha v. Louisiana*, 504 US 71 (1990).
46. *State v. Gallaway*, 133 N.J. 631, 628A.2d 735 1993.
47. Dyer FJ, McCann JT. The Millon clinical inventories, research critical of their forensic application, and Daubert criteria. *Law Hum Behav*. 2000;24:487-497.
48. Army Regulation 635-200: Active Duty Enlisted Administrative Separations. 2005. Available at: http://www.apd.army.mil/jw2/xmldemo/r635_200/head.asp. Accessed March 2013.
49. Weiser C. Guaranteeing health benefits for America's wounded soldier: closing the pre-existing personality disorder loophole. *Fed Circuit Bar J*. 2010;20:101.
50. Fabian JM. Death penalty mitigation and the role of the forensic psychologist. *Law Psychol Rev*. 2003;27:73-120.
51. Keulen-de-Vos M, Bernstein DP, Clark LA, Arntz A, Lucker TPC, de Spa E. Patient versus informant reports of personality disorders in forensic patients. *J Forensic Psychiatry Psychol*. 2011;22:52-71.
52. Monahan J, Steadman HJ. *Violence and Mental Disorder: Developments in Risk Assessment*. Chicago, IL: University of Chicago Press; 1994.
53. Cooke DJ. Personality disorder and violence: Understand violence risk: an introduction to the special section personality disorder and violence. *J Pers Disord*. 2010;24:539-550.
54. Beck JC. Dangerous severe personality disorder: the controversy continues. *Behav Sci Law*. 2010;28:277-288.
55. Hart SD. Commentary: The forensic relevance of personality disorder. *J Am Acad Psychiatry Law*. 2002;30:510-512.
56. Robins LN, Tipp J, Przybeck T. Antisocial personality. In: Robins NL, Reiger D, eds. *Psychatric Disorders in America: The Epidemiologic Catchment Area Study*. New York, NY: Free Press; 1991:258-290.
57. Neighbors HW, Williams DH, Gunnings TS, et al. *The Prevalence of Mental Disorder in Michigan Prisons*. Final report for Michigan Department of Corrections; 1987.
58. Widiger TA. Integrating normal and abnormal personality structure: a proposal for DSM-V. *J Pers Disord*. 2011;25:338-363.
59. Widiger TA, Trull TJ. Plate tectonics in the classification of personality disorder: shifting to a dimensional model. *Am Psychologist*. 2007;62:71-83.
60. Kendell RE. The distinction between personality disorder and mental illness. *Br J Psychiatry*. 2002;180:110-115.
61. Hall DL, Miraglia RP, Lee LW. The increasingly blurred line between 'mad' and 'bad' treating personality disorders in the prison setting. *Albany Law Rev*. 2011;74:1277-1300.
62. Bailey J, MacCulloch M. Patterns of reconviction in patients discharged directly to community from a special hospital: implications for after care. *J Forens Psychiatry*. 1992;3:445-461.
63. Dolan B, Coid J. *Psychopathic and Antisocial Personality Disorders: Treatment and Research Issues*. London, UK: Gaskell/Royal College of Psychiatrists; 1993.
64. Peay J. Personality disorder and the law: Some awkward questions. *Philos Psychiatr Psychol*. 2011;18:231-244.
65. Keihl KA. A cognitive neuroscience perspective on psychopathy: evidence for paralimbic system dysfunction. *Psychiatry Res*. 2006;142:107-128.
66. Jang KL. Classification and diagnosis. In: *The Behavioral Genetics of Psychopathology*. Mahwah, NJ: Lawrence Erlbaum Associates; 2005:47.